**THE NOTTINGHAM INQUIRY**

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**FIRST WITNESS STATEMENT OF**

**DR MICHAEL SKELTON**

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I, Dr Michael Skelton, BM, BS, MRCPsych, MSc, will say as follows: -

1. I have been a consultant psychiatrist at Nottinghamshire Healthcare NHS Foundation Trust (the Trust) since March 2019.
2. This witness statement is made to assist the Nottingham Inquiry (the Inquiry) with the matters set out in the Rule 9 request dated 10 September 2025 (the Request). I have received drafting support from the external solicitors acting for the Trust in respect of the Inquiry, following discussions in writing by email and by video conference. I also sought advice from my Medical Protection Society (MPS).

## Career and role

3. My qualifications are as follows:

- Section 12(2)/Approved Clinician status. Next renewal due 12 August 2026.
- MSc in Mental Health Research Studies, University of Nottingham, 2015; Distinction. Dissertation title: Can classical ERP biomarkers aid in diagnosing schizophrenia?
- Membership of the Royal College of Psychiatrists (MRCPsych), February 2012.
- Certificate of Completion of Training (CCT), 31 July 2015. On the Specialist Register of the General Medical Council (GMC), with speciality in General Psychiatry and sub-specialty in Rehabilitation Psychiatry. GMC Registration no. 6162524.
- BM BS. University of Nottingham Medical School (Graduate Entry) 2003-2007.

4. My professional memberships are as follows:

   - Member, Royal College of Psychiatrists (RCPsych). Member no. 850284. CCT achieved 31 July 2015.
   - I am on the Specialist Register of the General Medical Council (GMC), with speciality in General Psychiatry and sub-specialty in Rehabilitation Psychiatry. GMC Registration no. 6162524.

5. I completed my foundation years one and two at the Royal Derby Hospital and the Queen's Medical Centre (QMC) in Nottingham between 2007-2008, as an academic Foundation Trainee. I completed my Core training in Psychiatry via the East Midlands Deanery between August 2009 and July 2012, followed by

my higher training academic clinical posts in psychiatry between August 2012 to July 2015, undertaking the role of Clinical Assistant Professor and Honorary Specialist Registrar in General Adult psychiatry (the role was divided between the NHS and the University of Nottingham). My academic role focussed on schizophrenia and psychosis, under Professor Peter Liddle. My training roles were in a variety of posts in either Derbyshire Healthcare NHS Foundation Trust, or the Trust. I received an endorsement in Rehabilitation Psychiatry following training as a higher trainee (ST6) in the Trust's psychosis community teams and open rehabilitation unit.

6. I worked as a consultant psychiatrist for Derbyshire Healthcare NHS Foundation Trust between December 2015 to March 2019 in an inpatient ward and then in a community team from August 2017, providing care with the community team for approximately 400 people with a range of psychiatric disorders. During that time, I was a responsible clinician for patients under the Mental Health Act 1983 (MHA) both as inpatients and in the community.
7. I started working for the Trust in March 2019. I was a consultant psychiatrist in the Crisis and Home Resolution Treatment team (CRHT) from March 2019 to December 2024. Since September 2025, I have been the clinical director for the Trust's Mental Health Community Care unit. I am also the chair of the Mental Health Senior Medical Staff Committee and am a Mental Health Mission (MHM) Clinical Trials Investigator in Mood Disorders for the Trust.
8. I have had extensive MHA assessment experience in a variety of settings and with a wide range of mental disorders over approximately 13 years. I am approved under the MHA with section 12(2)/Approved Clinician status.

9. Outside of my NHS work, I also have a private psychiatry practice based in Derby, with a clinic one day a week.

## PART A

10. In this section of my statement, I cover general points about mental health assessment, care and treatment. This is to provide background and context to the second part of my statement (Part B), which deals with Valdo Calocane's (VC's) assessment and treatment. It is relevant to my statement and therefore the evidence that I can assist the Inquiry with, that I have not worked as a substantive inpatient consultant since 2017, which was for a different NHS trust (Derbyshire), and that my substantive role in the Trust since 2019 was as a consultant Psychiatrist in the Nottingham CRHT. I am therefore only able to set out my understanding of that context in so far as it related to my practice as a CRHT Consultant Psychiatrist. Questions around practices and procedures in inpatient care are best addressed by my colleagues working in those settings.

### Inpatient Mental Health Services

11. There are several elements of guidance which assist with the broad clinical aims of providing treatment to inpatients detained under the MHA. These include: NHS England (NHSE) 2023 Guidance 'Acute Inpatient Mental Health Care for Adults and Older Adults' [NHSE0000042] and the Royal College of Psychiatrists 'Standards for Inpatient Mental Health Services 2019' [WITN0207003].
12. The NHSE guidance states that admissions should be purposeful, and that people should only be admitted to inpatient care when they require

assessments, interventions or treatment that can only be provided in hospital. If admitted it should be to the most suitable available bed for the patient's need, and there should be a clearly stated purpose for the admission [NHSE0000042, p.13]. It gives guidance on therapeutic inpatient care, stating that 'care is planned and regularly reviewed with the patient and their chosen carer/s so that they receive the therapeutic activities, interventions and treatments they need each day to support their recovery and meet their purpose of admission' [NHSE0000042, p.13]. I discuss discharge planning and follow up in the relevant section below (paragraphs 47 - 71). These principles apply to all people regardless of whether they are voluntary patients or detained under the MHA. There may be several differences between patients detained under the MHA and voluntary patients. Typically, a patient who has been detained under the MHA would lack capacity to consent to assessment or treatment in hospital, and the nature of the risks that the mental disorder presents would typically be of a higher magnitude than for a voluntary patient, although this would not always be the case. The broad clinical aim of admission for both groups would be to assess the underlying mental disorder/s and to treat accordingly, using a biopsychosocial approach, such as psychiatric nursing and medical care and assessment; the use of a range of treatments such as medications (common medications might include benzodiazepines, antidepressants or antipsychotics, depending on need). Some people may require other treatments, for example, electroconvulsive therapy (ECT), whilst others may need physical care as appropriate in a psychiatric setting, such as to manage issues such as self-neglect. The overall aim of treatment would be to restore the patient to their usual health, in so far as is possible and to assess whether

the their care could be safely managed in the community afterwards, bearing in mind that many psychiatric disorders are long term in nature, and require longer term treatment. For most patients this longer-term treatment would be in the community (such as via a community health team or their GP), whereas others might need long term hospital care in other psychiatric settings, such as rehabilitation hospitals or forensic hospitals.

**Section 2 and section 3, Mental Health Act 1983**

12. I have been asked by the Inquiry to outline my understanding of the general procedure and scope of inpatient services provided by the Trust to individuals experiencing an acute mental crisis and address the treatment, care, and management of individuals detained under section 2 and section 3 of the MHA.
13. With respect to the specific application of the Mental Health Act 1983: Code of Practice, 2015 (MHA Code of Practice) [DHSC0000007] to the general procedure and scope of inpatient services provided by the Trust to individuals experiencing a mental health crisis, this would be best addressed by an inpatient consultant psychiatry colleague.
14. With respect to guidelines set out by the MHA Code of Practice, the following is relevant.
    14.1. Paragraph 14.4 of the MHA Code of Practice states that section 2 applies if the patient is suffering from a mental disorder of a nature or degree which warrants their detention in hospital for assessment (or for assessment followed by treatment), for at least a limited period and that they should be detained in the interest of their own health or safety, or with a view to the protection of others.

14.2. Paragraph 14.5 of the MHA Code of Practice states that section 3 allows detention only if all of the following criteria apply: the patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive mental treatment in hospital, and it is necessary for the health or safety of the patient, or for the protection of other patients, 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.

15. For practical purposes, both sections allow inpatient treatment to take place, and some form of assessment will be necessary in both cases to guide that treatment. The main difference regarding this aspect, would be that section 2 is of duration up to 28 days, whereas a section 3 is up to a duration of 6 months. The MHA Code of Practice defines medical treatment for mental disorder in paragraph 23.2, and states 'medical treatment includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care.' Habilitation means equipping someone with skills that they have never had, whereas rehabilitation means helping them recover skills and abilities they have lost. It defines medical treatment for mental disorder in paragraph 23.3, as meaning medical treatment which is for the purpose of alleviating or preventing a worsening of a mental disorder, or one or more of its symptoms or manifestations. The MHA Code of Practice defines a framework for assessment and treatment of people detained.

15. I have been asked by the Inquiry about the relationship between the service provided by inpatient teams at Highbury Hospital and other agencies which carry out care planning and treatment in this area. Furthermore, I've been

asked to explain the difference between the treatment, care and management provided by inpatient mental health services, CRHT and additional treatment teams such as CMHTs (CMHTs), and to explain what role I consider inpatient services to have in the context of the 'Care Programme Approach' (CPA).

16. NHSE's guidance on "Acute Inpatient Mental Health Care For Adults And Older Adults" (2023) [NHSE0000042] identifies key services for effective key partnership working in inpatient mental health care. This includes a wide range of potential partners including CRHTs, CMHTs, A&E, psychiatric liaison and diversion services, primary care, housing services, local authorities (in particular Approved Mental Health Professionals (AMHPs), rehabilitation services, financial and employment support services, as well as a wide variety of other potential services (p12). I would state that details of the relationship between services such as those and inpatient teams at Highbury Hospital are best explained by an inpatient consultant psychiatrist colleague.

17. There are several similarities as well as differences between the treatment, care, and management provided by inpatient mental health teams, CRHTs, and CMHTs. Regarding similarities, both teams will typically have access to a similar range of skilled staff within a multi-disciplinary team (MDT), such as a consultant psychiatrist, psychiatric nurses, clinical psychology (where available), as well as similar types of treatment, such as medication, psychological treatments, as well as appropriate medical and nursing assessment and treatment, and support for a variety of issues including financial support and housing. Differences can be considered in terms of aspects of care and treatment that tend to be unique to each area. Inpatient care typically allows the highest level of ongoing monitoring and assessment of

an individual, such as multiple times daily, and with the ability to restrict the individual's freedom of movement, if needed, such as to a ward area or if severely agitated to a seclusion area. A patient can be monitored if needed by several nurses, in very close proximity to the patient. Where patients are detained under the MHA, the higher levels of staffing, as well as the legal framework of the MHA, enables patients to be treated against their will, where appropriate, such as in the form of oral medication or by an intramuscular injection of an antipsychotic medication such as haloperidol or a quick acting benzodiazepine, such as lorazepam. The higher staffing and resources can then be deployed to the safe monitoring of the patient following such medication. Legal protections under the MHA are in place for patients detained on the MHA, such as the right to tribunals, the use of second opinion appointed doctors (SOADs) for when a detained patient either refuses treatment, or is unable to consent (see the MHA Code of Practice). There are some treatments that could be delivered either in hospital or the community but are typically delivered in hospital when the patient is acutely ill, such as Electroconvulsive Therapy (ECT).

18. Detailed information on CRHTs can be found in the RCPsych "Practice Guidelines for Crisis line response and Crisis Resolution and Home Treatment teams" (2022) [NHNB0003187]. This notes that CRHTs came into existence from 2000 onwards, and that there are several models of care [p.6]. It identifies that the main purpose is to provide intensive support at home for people experiencing an acute mental health crisis, as an alternative to hospital admission. It states that CRHTs gatekeep all requests for acute inpatient beds and serve to facilitate good functioning for inpatient units by facilitating early

discharge and to reduce the length of hospital admissions. Regarding home treatment, it considers it an appropriate alternative to hospital admission for working age older adults with severe mental illness (e.g. schizophrenia and severe depressive disorders), with an acute psychiatric crisis of such severity, that without the involvement of the CRHT, hospitalisation would be needed. It notes that such a patient should be willing to receive home treatment, which should be able to be safely provided in the home environment [p.16]. The guideline provides detailed information regarding CRHTs [pp.17-43], including purpose, access, referral modes, assessment, home treatment, RAG ratings (Red, Amber, Green ratings), care planning, risk assessment and management and other issues. It has sections on joint working with CMHTs (p33), and on facilitating early discharge from hospital (in reach) [pp 33-37].

19. Whilst CRHTs are unable to monitor patients as intensely, nor restrict their movements, in comparison with inpatient services, CRHTs can nevertheless provide multiple home visits when needed. The range of treatments offered can be similar, and because the patient remains within the community, it can be easier to maintain ongoing links with other agencies, such as CMHTs, families, and friends. The range of medication treatment is on the whole similar except that CRHTs are not able to give any medication against a patient's will, if they refuse. Some treatments that would otherwise have to be initiated in hospital, such as clozapine (which initially requires frequent monitoring) can often be given by a CRHT with the patient's consent. Because the patient is in the community, there are additional risks compared to when the patient is in a contained environment on a ward. CRHT treatment therefore needs to be prompt and effective.

20. Detailed information regarding CMHTs can be found in the NHS England document 'The Community Mental Health Framework for Adults and Older Adults' [NHNB0004953]. It describes that CMHTs were established for adults 30 years ago [p.2] and sets out a framework to apply to people, irrespective of their diagnosis, which includes 'co-existing frailty, co-existing neurodevelopmental conditions, eating disorders, common mental health problems such as anxiety or depression, complex mental health difficulties associated with a diagnosis of "personality disorder", co-occurring drug or alcohol use disorders etc. and severe mental illnesses such as psychosis or bipolar disorder' [p.5]. It describes a wide range of potential interventions, including: assessment, advice, and consultation for mental health problems, advocacy services, co-ordination and delivery of care, support for co-occurring drug and alcohol use disorders, employment, education, volunteering and training services, psychological and pharmacological treatment, help and advice around finances [p.10].

21. CMHTs have much in common with inpatient mental health services and CRHTs with respect to treatment, in that it is delivered by a MDT service. As it occurs in the community, there is often a greater opportunity to involve family and carers, and establish a better understanding of the individual's health before the illness arose (premorbid function). An important strength of a CMHT is its ability to monitor a patient on a longer timeframe than inpatient or crisis services and build longer term therapeutic relationships. Its monitoring and treatment cannot be as intense as either an inpatient or CRHT might be. During treatments there is an opportunity for longer term relationship building and psychoeducation as well as longer term psychological treatments. Regarding

medication treatment, dose escalation and type of treatment is more cautious than inpatient or CRHT services, due to a reduced ability to monitor the medication and different risk/benefit ratio.

22. I have been asked by the Inquiry to explain the role that I consider inpatient providers have in the context of the CPA. This question would be best answered by an inpatient consultant colleague. I would comment that the CPA was proposed to be replaced by the "Community Mental Health Framework for Adults and Older Adults" (NHS England, NHS Improvement and National Collaborating Centre for Mental Health, 2019) [NHNB0004953] (p7], which is discussed in detail in [NHSE0000252, (pp1-11], emphasising the need to transition from CPA to the new framework (p.9-10]. I discuss care planning below (paragraph 38).

**MHA Assessment**

23. In considering what factors and indicators are relevant when undertaking a MHA assessment, the MHA Code of Practice sets out relevant criteria when considering whether or not a patient should be detained under the MHA, for admission to hospital under section 2 and 3 of the MHA.

    23.1. Paragraph 14.4 states that a patient can be detained for assessment under section 2 only if both the following criteria apply: "The patient is suffering from a mental disorder of a nature or degree which warrants a detention within hospital for assessment (or for assessment followed by treatment for at least a limited period); and the patient ought to be so detained in the interest of their own health or safety or with a view to the protection of others".

23.2. For section 3 it states that a patient can be detained for treatment under section 3 only if all the following criteria apply: "the patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment in hospital and it is necessary for the health or safety of the patient or the protection of other patients 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" (paragraph 14.5).

24. With respect to these criteria, the MHA Code of Practice defines nature as referring 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" (paragraph 14.6). It states that degree refers to "the current manifestation of the patient's disorder" (paragraph 14.6). The MHA Code of Practice also states a variety of other considerations to take into account, including whether there are any alternative means of providing the care and treatment which the patient requires, as well as consideration of a variety of other factors, such as the patient's wishes and views, or other needs (paragraph 14.7 – 14.8). With respect to risk, the MHA Code of Practice considers that risks of suicide, self-harm, and self-neglect should be considered, as well as the risk of further deterioration in mental health, and factors such as the patient's capacity to consent to or refuse admission or treatment, and whether they are objecting to treatment for the mental disorder, or are likely to (paragraph 14.9). Paragraph 14.10 of the MHA Code of Practice also states that other factors to consider are for the protection of others. Other factors the MHA Code of Practice sets out are that it is necessary to consider

alternatives to detention under the MHA (paragraph 14.11) such as informal admission to hospital, or community treatment, such as by a CRHT, and consider issues with respect to capacity to give or to refuse consent to admission or treatment (paragraph 14.12).

25. The MHA Code of Practice also gives guidance on deciding whether to use section 2 or section 3 of the Act, in paragraphs 14.26 - 14.29. It states that a section 2 should only be used if the full extent of the nature and degree of the patient's condition is unclear, that there is a need to carry out an initial inpatient assessment in order to formulate a treatment plan, or to reach a judgement about whether the patient will accept treatment on a voluntary basis following admission, or that there is a need to carry a new inpatient assessment in order to reformulate a new treatment plan, or to reach a judgment about whether the patient will accept treatment on a voluntary basis.

26. The MHA Code of Practice states that section 3 should be used if: the patient is already detained on section 2 (detention under section 2 cannot be renewed by a new section 2 application), or the nature and current degree of the patient's mental disorder, the essential elements of the treatment plan to be followed and the likelihood of the patient accepting treatment as an informal patient are already established, which makes it unnecessary to undertake a new assessment under section 2. The MHA Code of Practice states that in any event, that the rationale for decisions to use section 2 or section 3 should be clearly recorded.

27. When I conduct a medical examination as part of a MHA assessment, I follow guidance set out in the MHA Code of Practice such as paragraph 14.71, that a direct patient examination of the patient and their mental state should take place

(the only exception to this was for a short time during the COVID-19 lockdown when a small number of MHA assessments that I took part in were done at least partly online, but this was not the case with my MHA assessment of VC which was face to face), and there be consideration of all available relevant clinical information, including that in the possession of others, professional or non-professional. For practical purposes, in the pre-assessment planning phase I would do my best to have read relevant medical records, such as the Trust's electronic patient records (Rio) if the patient was known to the Trust, and this would include relevant sections from the progress notes as well as a review of stored documents such as previous letters or relevant discharge summaries. A review of the psychiatric notes would also be of assistance in determining whether the nature of the patient's mental disorder and the elements of the treatment plan to be followed, were already sufficiently established, such that it would be likely that a section 3 would be more appropriate than a section 2. This phase would also include discussion with colleagues regarding relevant other information, such as the basis for calling the MHA assessment, a review of any other documents such as information from the police, which would be typically available if the patient had been detained under section 136 of the MHA. Other information would include a verbal handover from nursing or medical professionals as well as any information that has already been obtained from the patient's family.

28. I have been asked by the Inquiry to address what factors, indicators, and presentations distinguish a patient admitted for treatment from a patient admitted for assessment. I would point out that patients admitted for assessment under a section 2 of the MHA can also be treated following an

assessment. It is also the case that for patients admitted for treatment under section 3 of the MHA, there is typically some assessment required before recommencing treatment. Therefore, the differences for practical purposes are not as significant as might appear, apart from that patients under section 2 can only be detained for up to 28 days, whereas a patient detained on a section 3 can be detained for up to 6 months. The other significant difference is that patients detained under section 2 are able to apply to a MHA tribunal much earlier than patients on section 3 (if on a section 2, a patient can have a tribunal as early as 10 days from the point of admission, whereas for a patient on section 3, the earliest hearing would be 2 months). Patients who are detained under section 3 of the MHA are required to meet the requirements of the MHA Code of Practice as discussed above at paragraph 26. This typically means that the patient would have a well-established diagnosis and the nature of their mental health disorder be well understood, as well as that there be an appropriate treatment plan for them. For a patient admitted for assessment (section 2) the assessment would be needed because the underlying nature of the patient's mental disorder may not be sufficiently understood, nor the treatment plan clearly established, and would therefore require an assessment. With respect to presentations, for a section 3, one would expect that the current presentation is part of an understood mental disorder such that it is in part a repeating pattern of past behaviour and symptoms, unlike a patient requiring assessment under section 2, where there is insufficient past evidence of the presentation. For both section 2 and section 3 to be utilised, it is also necessary that the patient be detained in the interest of their own health or safety or with a view to the

protection of others, as well as in the case of section 3, that appropriate medical treatment is available.

29. I have been asked by the Inquiry to describe the criteria that I follow in determining whether I have enough evidence to form a view that an individual is acutely unwell. I will assume that the question is intended to mean this in the context of whether the patient was acutely unwell and required detention under the MHA. As discussed above, I would follow the relevant criteria from the MHA Code, such as section 14.4 and 14.5 (paragraphs 14 and 23). Typical evidence would include that there is a marked change in that patient's behaviour, with accompanying symptoms to suggest that this is a mental disorder as well as relevant other information (e.g. collateral history from family). Acute changes in a patient's mental state might include a marked deviation from their usual baseline if known, in terms of mood, appearance, behaviour towards others, anxiety symptoms, energy levels, change in sleep, and other symptoms such as whether the patient might be hearing voices or having beliefs that are out of keeping from their usual beliefs and those commonly held from others. I would consider to what extent the degree of these changes required rapid treatment in hospital for their protection or for the protection of others. For those patients that I might assess as being acutely unwell but not immediately requiring a hospital admission, I would assess whether or not there was a reasonable and safe prospect of alternative forms of treatment, such as community treatment such as the CRHT being effective, and whether the patient was likely to comply with such a treatment plan and whether that would have a reasonable prospect of success.

**Psychosis**

30. "Psychosis" is not a diagnosis per se in the most common psychiatric classification system used in the UK and mandated standard in the NHS (The ICD-10 Classification of Mental and Behavioural Disorders. World Health Organisation (WHO)) [WITN0207005]. ICD-11 will eventually replace this in the next 5 years according to [WITN0207015 – NHS England Terminology and Classifications]. ICD-10 describes a variety of mental disorders of which psychosis is a key characteristic [WITN0207005, pp 22-40], and these range from organic mental disorders, such as dementia (diagnostic codes F00 – F09), to mental and behavioural disorders due to psychoactive substance abuse (diagnostic codes F10 – F19) e.g. of cocaine, amphetamines, to 'schizophrenia, schizotypal and delusional disorders' (diagnostic codes F20 – F29), as well as other non-organic psychotic disorders e.g. mania with psychotic symptoms (diagnostic code F30.2) or severe depressive episode with psychotic symptoms (diagnostic codes F32.3).
31. The specific type of psychosis may initially be unclear and require a period of assessment, e.g. testing for substance misuse, eliciting symptoms and obtaining a collateral history, as there are common differences in the nature of the above disorders in both course and type of symptoms: e.g. in an organic psychosis it is more common to see visual hallucinations than in other types of psychosis. A hallucination is a perceptual experience for the individual that they would not normally have and that others present would not be experiencing. Hallucinations can be experienced in a variety of senses, such as auditory (hearing voices that others cannot hear) as well as visual hallucinations or occasionally tactile hallucinations, such as a sense that something is crawling

under the patient's skin such as a parasite. Where mood disorders such as bipolar disorder cause psychosis, the type of psychosis is typically mood congruent (in keeping with the patient's mood) e.g. in mania with psychotic symptoms, the patient may have grandiose delusions or hallucinations or extreme motor activity and excitement to such extent that they become incomprehensible to others. A patient with a severe depressive episode with psychotic symptoms may have hallucinations, delusions of guilt, psychomotor retardation or stupor, as well as suicidal thoughts. For all types of psychosis, the patient will have a fundamental belief in the abnormal thoughts or perceptions as being reality and will typically be acting upon it. If the level of belief is of a milder intensity but still abnormal this may be described as an overvalued idea. In psychosis, there are typically marked changes in the patient's behaviours including sleep, interactions with others, ability to concentrate, mood (irrespective of whether there is an underlying mood disorder such as bipolar disorder or severe depression), anxiety, and relationships with family, friends and work colleagues.

**Paranoid Schizophrenia**

32. ICD-10 describes paranoid schizophrenia as one of 8 sub-types of schizophrenia [WITN0207005, pp 84, 86-95]. It describes paranoid schizophrenia as being dominated by relatively stable and often paranoid delusions, usually accompanied by hallucinations, particularly of the auditory variety and perceptual disturbances. It states that disturbances of affect, volition, speech, and catatonic symptoms, are either absent or inconspicuous. It describes all schizophrenic disorders as being characterised generally by

fundamental characteristic distortions of thinking and perception and affects that are inappropriate or blunted. Clear consciousness and intellectual capacity are usually maintained, although certain cognitive deficits may evolve over the course of time. The most important psycho-pathological phenomena include thought echo, thought insertion or withdrawal, thought broadcasting, delusional perception, delusions of control or influence or passivity, hallucinatory voices commenting or discussing the patient in the third patient, thought disorders and negative symptoms. It describes that the course of schizophrenic disorders can be either continuous, episodic or that there can be one or more episodes with complete or incomplete remission. It states that the diagnosis should not be made where there are extensive depressive or manic symptoms unless it is clear that the schizophrenic symptoms pre-date that. It also states that schizophrenia should not be diagnosed where there is overt brain disease or during states of drug intoxication or withdrawal. The duration of symptoms for a diagnosis of schizophrenia should be greater than one month, according to ICD-10 [WITN0207005, p 88].

**Treatment, care, and management of patients experiencing psychosis**

33. In determining whether a patient who is detained under section 2 or Section 3 of the MHA should be held in seclusion, detailed guidance on seclusion is contained in the MHA Code of Practice in chapter 26. This defines seclusion as 'the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the containment of severe behaviour or disturbance which is likely to cause harm to others.' (26.103) The types of risks

could include agitated behaviour to others, such as assault and a variety of types of violence.

34. It is standard practice to seek detailed information from the police when a patient has been assessed for admission as a result of an arrest or in connection with alleged criminal behaviour. The MHA Code of Practice sets out detailed guidance regarding the police and the MHA, including chapter 16 (Police powers and places of safety), and in chapter 14, paragraphs 14.47-14.48, discusses that commissioners, local authorities, providers and the police should have locally agreed arrangements on the involvement of the police.

35. In considering what behavioural changes I would rely upon to determine when and whether seclusion should be terminated, the MHA Code of Practice, paragraph 26.111, notes that it can be difficult to judge when the need for seclusion has ended. It notes that, subject to suitable risk assessments, it can be possible to evaluate a patient's mood and degree of agitation under a lesser degree of restriction, without terminating the seclusion episode, by flexible use of allowing patients to receive visitors, facilitating brief periods of access to secure outside areas or allowing meals to be taken in general areas of the ward, subject to suitable risk assessments. The MHA Code of Practice, paragraphs 26.144 – 26.146, gives guidance on ending seclusion. My practice is to take a holistic view of the patient, in determining when seclusion should be terminated. This would typically include a multidisciplinary discussion with the nursing team, and review of nursing observations and mental state, as well as considering the reasons for the seclusion being required in the first place. I would also conduct a medical seclusion review with the patient, and assess whether their behaviour had consistently calmed sufficiently for them to be taken out of seclusion, as

well as assess whether there was change in the underlying mental disorder which had contributed to the agitation in the first place. This would include a review of their mood, sleep and appetite, psychotic symptoms if appropriate, their interactions with the nursing team and medical colleagues, as well as with their immediate environment, such as their bed area and ability to self-care. I would also assess their insight into the underlying mental disorder, and their capacity to make decisions regarding assessment and treatment in hospital. Where I suspected that the behaviour was heavily contributed to by substances such as excessive alcohol or drugs, I would take into account the initial suspected dose and time elapsed since ingestion. The patient rapport with me and the nursing team would be very important, as I would need to feel assured that other patients and staff would be safe once the patient's seclusion was terminated, as well as the patient.

36. I have been asked to address what factors to take into account when determining inpatient observations for patients detained under the MHA, and particularly regarding the initial period of observation. These matters relate to inpatient care and are therefore best commented upon by one of my inpatient consultant psychiatry colleagues.

**Mental State Examination**

37. A mental state examination (MSE) is an objective assessment of a patient's mental function at a specific moment in time, and it forms part of the information used to form a working diagnosis for the patient, along with other information that is gathered in a psychiatric history assessment. A useful guide to this can be found in 'How to approach the mental state' examination' (British Medical

Journal (BMJ 2017; 357: j1821) [WITN0207007]. When I am assessing a patient's mental state, this begins from when I meet the patient, although it is typically formally recorded towards the end of the psychiatric history. The common structure of an MSE is as follows: appearance and behaviour, speech, mood and affect, thought content and process, perception, cognition, insight. A risk assessment typically then follows (I comment on this later below, in paragraphs 41-46).

37.1. Factors to consider regarding appearance and behaviour include the patient's age, sex, body mass index, ethnicity, how the patient is dressed, and their personal hygiene. Behaviour would be considered in several ways e.g.: their behaviour towards me, for example whether they were friendly or aggressive or shy or fearful, whether they were talkative or mute. I would note their facial expression and body language, such as folded arms or downward gaze or whether they were able to maintain appropriate good eye contact, as well as any body movement such as tics or whether they began responding to stimuli that I couldn't see or hear, such as looking around or muttering to themselves.

37.2. Regarding speech I would consider the rate of speech, such as were they speaking very fast, its volume (such as whether it was loud, normal or quiet), its tone (such as whether they were happy, sarcastic or just monotonous), as well as its flow.

37.3. Regarding mood and affect, mood refers to the patient's subjective perception of how they feel, and affect refers to my objective assessment of their mood.

37.3.1. When assessing mood, I would ask them about how they were feeling (such as whether happy or sad), as well as biological symptoms such as sleep or appetite.

37.3.2. Regarding affect, I would note whether the patient appeared elated or low or irritable or anxious and whether they had a steady or unstable emotional state.

37.4. Regarding thought content, I would explore their beliefs and ideas, to ascertain what they were thinking about. In the case of potential delusions, I would explore carefully whether there were underlying beliefs such as whether they believed they were being spied upon or persecuted (delusions of persecution), or had delusions of reference such as believing that ordinary objects or events had a special significance for them. I would also explore whether they had delusions of control, if relevant, such as a belief that they were being controlled by an external force, either in terms of bodily function or thoughts. These are just some examples of delusions, and I would explore other types of delusions if I considered them relevant.

37.5. Regarding other thought processes, I would explore whether there were obsessions, compulsions or overvalued ideas. I would also comment on the patient's thought processes such as whether it appeared to be a normal pattern or if there were abnormalities such as loosening of associations, circumstantial thoughts, tangential thoughts, or thought interference (such as losing their train of thought, having thoughts that they believed were not their own or believing other people could hear their thoughts (thought broadcast).

37.6. Perception refers to how the patient perceives the world through their senses. Regarding hallucinations I would explore whether these appeared to be visual, auditory, tactile or other. Regarding auditory hallucinations, I would assess whether the patient was hearing multiple voices, whether the voices were speaking to each other and whether they were speaking to the patient, and the content of this, including whether they were instructing the patient to do things (command hallucinations).

37.7. Cognition would include an assessment of the patient's alertness, orientation, attention, concentration and memory. This would include an assessment of whether the patient was orientated in time, place, and person. If there were concerns, there are more detailed examination questions that I could use, such as to assess registration and recall of information and working memory.

37.8. Insight is typically on a spectrum and it is important to note where on that spectrum the current level of insight is. A common step-wise way to address this with a patient would be to ask:

37.8.1. whether they believed they were unwell currently,

37.8.2. whether they believed they had a mental health problem,

37.8.3. whether they believed that their current signs, symptoms and behaviours were being caused by that disorder,

37.8.4. whether they believed that they needed treatment, and then

37.8.5. whether they agreed the necessary treatment was what would reasonably be expected for the circumstances, including if appropriate, hospital admission.

**Summary and Care Plan**

38. I have been asked by the Inquiry to provide information regarding the aim and purpose of a 'Summary and Care Plan'. Care plans have been used for many years as part of the Care Programme Approach (CPA) [WITN0207004], alongside other elements including providing a care co-ordinator. The NHS approach to mental health care planning has shifted away from CPA, as set out in the Community Mental Health Framework for Adults and Older Adults in the NHS (NHS England, NHS Improvement and National Collaborating Centre for Mental Health, 2019) [NHNB0004953]. Both types of care planning are discussed in detail in [NHSE0000252, [pp 1-11]]. This states that the aim of the Community Framework is "to enable services to shift away from an inequitable, rigid and arbitrary CPA classification and bring up the standard of care towards a minimum universal standard of high-quality care for everyone in need of community mental healthcare." (p3). That document sets out five broad principles for care planning: "a shift from generic care co-ordination to meaningful intervention-based care; a named key worker for all service users with a clearer multidisciplinary team (MDT) approach; high-quality co-produced, holistic, personalised care and support planning for people with severe mental health problems living in the community; better support for and involvement of carers; a much more accessible, responsive and flexible system." (pp3-4). Whilst this is to replace CPA, I understand that CPA is still in use for some patients, and that there is a process of transition. Information regarding CPA care planning can be found in the NICE guidelines, 2011 "Service user experience in Adult Mental Health: Improving Experience and Care for people using adult NHS mental health services" [NHSE0002386, pp1-33]. This sets out

details, including that the care plan should be jointly developed with the patient, and include activities which promote social inclusion and provide support to help the patient realise the plan, and that they have an up-to-date written copy of it. Risk management strategies as well as a crisis plan should be jointly developed with the care coordinator to include: possible early warning signs of a crisis; support available to help prevent hospitalisation; where the patient would like to be admitted in the event of hospitalisation; details of an advance statement of advanced decisions; and the extent to which they would like family or carers involved. There should also be a section where the patient can document their views and preferences, and any differences of opinion with health and social care professionals. [pages 17 – 18]. The care plan should also support effective collaboration with social care and other care providers during any transitions, including details of how to access services in times of crisis [pages 23 – 24]. The Trust recorded CPA care planning on a "Summary and Care Plan" form on Rio, which would be typically completed by a patient's care co-ordinator to address these points as part of this framework, or if the patient were in hospital, by an inpatient nurse. Detailed further information regarding this would be best addressed by nursing colleagues who complete these forms. How risk assessments are used in the formulation and development of an inpatient care plan, would best answered by an inpatient colleague. The new Trust care plan forms to meet the NHS Community Framework guidelines are called "AMH Community Care Plan" and "AMH Inpatient Care Plan" on Rio.

**Insight & Masking**

39. The definition of "insight" applies to patients whether they are detained under the MHA or are not. It is a broad concept with varying degrees; typically this includes several aspects: does the person have an awareness they are not well in some way, to then appreciating they have a mental disorder which is affecting them, to then understanding they have a specific mental disorder and the nature of that disorder (i.e. that whilst they might be currently well, that the disorder can recur, and that when it recurs, that there are usually typical signs and symptoms that they might or might not notice, but that others might notice); that they appreciate the varying degrees of risk types that can occur. It also includes treatment: do they understand and believe that various types of treatment can help and can vary, depending on the way the disorder manifests itself; and are they willing to take this treatment and do they understand the benefits and risks associated with the treatment. Even if they do accept the treatment, the concept includes whether this is a capacitous decision or is made due to other factors e.g. a patient taking it to avoid negative consequences at the time (e.g. if an inpatient, fearful they would not be discharged, or accepting treatment reluctantly in the community, due to pressure from their family). Some people may consistently take medication but not fully have capacity around that e.g. some patients may trust family member's advice that they need it, but not fully understand or believe that they do.

40. Masking, in respect of patients who are experiencing psychosis, refers to any attempt by the patient to conceal or minimise their symptoms. This might take the form of the patient making a conscious decision to not visibly respond to auditory hallucinations when in the presence of others, but rather to do this

when they were alone and not observed. It would also include if the patient were to deny their symptoms, despite those symptoms being present, or seeking to hide their distress regarding the symptoms in the presence of others. It could also broadly refer to the patient withdrawing from others, as part of an attempt to hide symptoms.

**Risk Assessment**

41. I have been asked by the Inquiry to identify what information from a patient's history is relevant to identifying the types of risks they might pose to themselves and/or others, in the event that they were to deteriorate and experience a psychotic crisis, or if they were to become acutely unwell. Guidance on risk assessment is available from the Royal College of Psychiatrists' Good Practice Guide 2016: 'Assessing and Managing Risk of Patients Causing Harm' [NHFT0015099, pp1-14].
42. Of particular importance, is to understand the patient's previous risk history as well as current identifiable risks, as patterns of behaviour commonly recur. Regarding risks to others, this would include knowledge of any previous violence, (whether this was investigated or not, and whether convicted or not, and the context of that to the patient's mental state at the time), knowledge of who that violence was directed to (particularly family or carers), if there was any history of domestic violence, and knowledge of any previous use of weapons, and whether there was ongoing access to those.
43. Regarding risks to themselves, this would include knowledge of any prior suicide attempts, and the specific means used, as well as their planning and particular intent at those times, and consideration of the dangerousness of the

method. It would include past self-harm, such as cutting, burning, or ligature, and the frequency of that and its current nature. It would also include risks to self, such as self-neglect including malnutrition.

44. Risk assessment would include considering the degree to which risks might manifest if they were to experience a psychotic crisis or become acutely unwell. Relevant factors would include whether the patient had supportive relationships such as family and friends who had a good understanding of the illness and could detect early warning signs and seek help, particularly if the patient would not become aware of those warning signs. It would be important to know about the patient's relapse signs and the time available from the point that relapse begins until the point that risks significantly emerge, as well as the time until insight decreases to such an extent that they would no longer agree to any treatment, and that the MHA might need to be considered for inpatient admission. It would also include knowledge of the patient's personality, especially traits such as impulsivity, or a history of antisocial behaviour, or personality traits such as psychopathy (a lack of remorse towards hurting others).

45. Assessment would also take into consideration other factors which could destabilise a patient, such as significant alcohol or substance misuse or unstable relationships. The history would also include consideration of the patient's mental state, to ascertain whether they had relapsed and were, for example, now experiencing a psychosis, and whether symptoms were present such as delusions that the patient was being persecuted by others, or that their mind or body was being controlled by external forces. These could be signs that the patient might seek to take action to harm others. It would also include

an assessment of their emotional response in relation to potential hallucinations or delusions, such as anger.

46. It would also be important to obtain as much collateral history as possible from other sources, as if the patient was relapsing or was now having a psychosis, the patient might either minimise symptoms or not be aware of the full extent of those.

**Discharge planning and follow-up**

47. I understand that the Trust's 'Service Guide for Adult Mental Health Inpatient Wards' outlines that it is the responsibility of 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]. It expands on this in paragraph 6.2 Admission Process, paragraph 7.0 Care & Treatment, paragraph 8.0 Board Review, Ward MDT Meeting and Ward Review, 9.0 Leave, Transfer and Discharge. These contain detailed guidance, such as that a registered mental health nurse (RMN) work with a member of the medical team to "clerk in" patients, commence the assessment process, and liaise with community teams as appropriate. A pre-prepared template set of forms is available. Care planning is to be commenced and all patients are to be involved in their care planning and subsequent reviews with their named nurse. The document states that assessment and formulation of needs (including risk) is ongoing, that risk assessments should be completed on admission and dynamically following this, to ensure they demonstrate current risks. Community teams should attend each ward round where possible. A ward review should be held at least weekly,

and there is extensive guidance on involvement of families. Guidance on discharge planning states that attention will be given to the home and community situation [p22] and that patients should be given advice to prevent readmission/relapse. Further questions regarding this would be best addressed by an inpatient consultant psychiatrist colleague.

**Community Treatment Orders**

48. I have been asked by the Inquiry to describe the circumstances in which I would consider that a patient experiencing psychosis and/or diagnosed with paranoid schizophrenia could not be discharged from inpatient treatment, without a Community Treatment Order (CTO) in place. Whilst this question would be best answered by an inpatient consultant psychiatry colleague, I hope the following information is of assistance to the Inquiry. The MHA Code of Practice sets out detailed information regarding CTOs in chapters 31 and 32. It describes that where an unrestricted patient (i.e. under Section 3, but without other restrictions available under the MHA) may need to be subject to the powers of the MHA whilst living in the community, that there are three options: guardianship (this is social care led and is primarily focussed on patients with welfare needs), leave of absence (section 17), or a CTO. Section 17 leave of absence is primarily intended to allow patients detained under the MHA to be temporarily absent from hospital, where further inpatient treatment as a detained patient is still thought to be necessary. A CTO should not be used for those patients who require further treatment under the MHA in hospital.
49. A CTO (section 17A of the MHA) is a framework for the management of patient care in the community and gives the responsible clinician the power to recall

the patient to hospital for treatment if necessary (MHA Code of Practice, para 29.6). It can only be considered for patients detained in hospital under section 3. The criteria to be met are that: the patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment; it is necessary for their health or safety or for the protection of others that they should receive such treatment, subject to them being liable to be recalled; that such treatment can be provided without them continuing to be detained in a hospital; it is necessary that the responsible clinician should be able to exercise the power under section 17E (1) of the Act to recall them to hospital, and appropriate medical treatment is available to them. CTOs aim to prevent a "revolving door" of readmissions and harms from relapse.

50. The MHA Code of Practice gives guidance on when a CTO is appropriate, rather than longer-term leave: there should be confidence that the patient is ready for discharge from the hospital on an indefinite basis; there should be good reasons to expect that the patient will not need to be detained for the treatment they need to be given; the patient appears prepared to consent and comply with the treatment they need, but risks mean that recall may be necessary; the risk of arrangements in the community breaking down or of the patient needing to be recalled to hospital for the treatment, is sufficiently serious to justify a CTO but not to the extent that it is very likely to happen. The main focus is on ensuring that the patient continues to receive necessary medical treatment for their mental disorder without having to be detained again and that compulsory recall to hospital for treatment might well be necessary, and a speedy recall would be likely to be important.

51. I have been asked whether there are specific CTO criteria for patients with any of the following factors: a history of aggression in the community and/or inpatient settings, at risk of becoming violent in the absence of treatment, with a history of violence, with a history of non-concordance with medication, with a history of social isolation, with a history of disengagement of treatment, and with a history of masking psychotic symptoms. The criteria for responsible clinicians when completing form CTO 1 MHA (Section 17: a community treatment order) are as discussed above (paragraphs 48-50). With relevance to these factors, the MHA Code of Practice (paragraph 29.9) requires that: "it is necessary for the patient's health or safety of for the protection of others that the patient should receive such treatment." The MHA Code of Practice gives further guidance in paragraphs 29.12-29.16 regarding risks:

51.1. Paragraph 29.12: "In making a decision to place the patient on a CTO, the responsible clinician must assess what risk there would be of the patient's condition deteriorating after discharge, e.g. as a result of refusing or neglecting to receive treatment.

51.2. Paragraph 29.13: In assessing that risk, the responsible clinician should take into consideration the patient's history of mental disorder, previous experience of contact with services and engagement with treatment. A tendency to fail to follow a treatment plan or to discontinue medication in the community and then relapsing may suggest a risk justifying use of a CTO rather than discharge into community care.

51.3. Paragraph 29.14: Other relevant factors will vary, but are likely to include the patient's current mental state, the patient's capacity to make decisions about their care and treatment and attitude to treatment and risk of relapse,

the circumstances into which the patient would be discharged, and the willingness and ability of family and/or carers to provide support (especially where aspects of the care plan depend on them).

51.4. Paragraph 29.15: Taken together, all these factors should help the responsible clinician to assess the risk of the patient's condition deteriorating significantly after discharge, and inform the decision as to whether continued detention, a CTO or discharge would be the right option for the patient at that particular time. The responsible clinician should consider the likelihood that a CTO will benefit the patient and take account the patient's views about the use of a CTO.

51.5. Paragraph 29.16: 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 discharged. The responsible clinician must be satisfied that the risk of harm arising from the patient's disorder is sufficiently serious to justify having the power to recall the patient to hospital for treatment. CTOs should only be used when there is reasonable evidence to suggest that there will be benefits to the individual. Such evidence may include:

51.5.1. a clear link between non-concordance with medication and relapse sufficient to have a significant impact on wellbeing requiring treatment in hospital;

51.5.2. clear evidence that there is a positive response to medication without an undue burden of side effects;

51.5.3. evidence that the CTO will promote recovery, and evidence that recall may be necessary (rather than informal admission or reassessment under the Act)."

52. It would be usual to then specify the specific details for that in the narrative of the CTO. In my opinion, this would commonly apply to people who have a history of multiple admissions and subsequent relapses, with a history of medicine non-concordance, as well as to people who had some significant risks to either self (e.g. suicide, self-neglect ) or others (e.g. violence) and particularly where the time from stopping medication to onset of severe symptoms was so brief that enforcement of medication via a CTO would be necessary.

53. It is important to say that a CTO has wider powers than just regarding medication compliance; it can also require that a patient reside in a particular place, and this might need to be used for a patient where they needed appropriate care in a community setting and that without the CTO they would not reside there. If a patient was thought to be unlikely to sufficiently regain insight, such that it would become highly likely that they would stop taking medication and there were significant risks, a CTO would be needed.

**Non-concordance and depot medication**

54. The types of behaviours and/or observations that would lead me to conclude that a patient poses a risk of non-concordance with medication, and the circumstances in which I would consider that a patient cannot be discharged from inpatient treatment, unless they agreed to accept their medication through depot, would be best addressed by an inpatient colleague. However, I make some observations below in paragraphs 55-60.

55. When considering issues of non-concordance, I would first consider what the patient's insight is regarding their mental disorder, and would take a stepwise approach to this: i.e. whether they believed that they have an underlying mental disorder, whether their view of it was similar to mine, whether they believed the current symptoms were attributed to that, and whether they specifically believed the treatment that I was offering was broadly appropriate. I would consider their understanding of the risks that could be present, or might emerge as part of their mental disorder. I would consider not only their own comments and whether I thought they were reliable, but other evidence e.g. from family/friends, their community team and care-co-ordinator, including their engagement with those sources of support. I would also consider their risk history and whether there was a pattern in the past of the patient not taking their medication. I would also need to ensure that the prior treatment had been sufficiently effective, as it can be the case that where this is insufficient to prevent further episodes, it can appear erroneously that non-concordance is the cause, whereas it may be a very late signal that symptoms were relapsing, even whilst the patient was taking the medication. This would be important to establish, as re-starting the prior medication type and dose could give false confidence and be insufficient. I would also consider the type of mental disorder, as there are certain disorders where non-concordance is more likely. Schizophrenia is one of those disorders e.g. 74% of 1493 patients with schizophrenia stopped taking their antipsychotic medication within 18 months, in a very large landmark US study (Effectiveness of anti-psychotic drugs in patients with chronic schizophrenia; New England Journal of Medicine 2005; 353:1209-1223 [WITN0207008]).

56. Other specific behaviours and observations regarding risks of non-concordance include: patients not collecting their medication in the community; concerns from family members (e.g. if they are assisting with administrating medication at home); or if in an observed setting such as inpatient or CRHT settings, if the patient was seen to spit medication out or throw it away or not present themselves for observed medication monitoring. If the patient was challenged with these concerns and did not take the concerns seriously or address them, this would be a significant concern.

57. An anti-psychotic depot is antipsychotic medication which has been formulated into a longer-acting liquid and is injected into a patient's muscle intramuscularly (IM), typically into the largest muscle (the gluteus), but some can be used in other muscles such as the deltoid. The medication is stored in the muscle (hence the word depot, meaning, store) and is slowly released over a period of time, which can vary from one week to four weeks commonly, although there are some preparations now which are available for multiple months. It is important, if possible, to trial the oral antipsychotic version first for a few weeks to assess if it is effective, and that there are no undue side-effects, before gradually changing this to a depot (which also requires a short assessment to ensure the patient is not allergic to the liquid, which is uncommon in my experience). Unfortunately, not all oral anti-psychotic medications are available as depot medications, notably some important antipsychotic medications such as clozapine and amisulpride. This is a particular problem in schizophrenia, where amisulpride, has been shown to have higher effectiveness than most conventional antipsychotics [WITN0207016, p4]. Furthermore, there is no depot preparation of clozapine, which is the treatment of choice for patients with

treatment resistant schizophrenia (estimated at 28% of all schizophrenia patients). Furthermore, clozapine may only be effective for approximately 40% of people with treatment resistant schizophrenia. These factors need to be considered regarding whether a patient could be discharged from inpatient care to receive their medication through a depot.

58. Broadly speaking, having considered the circumstances for which a depot would be needed, it would be for patients who would be highly likely to stop taking their oral medication, which would lead to significant risks to self, others, and property, and lead to such a deterioration that acute treatment would then need to be reinstated. Using a depot ensures that if the patient misses a dose, this can be detected and quickly escalated, whereas this would not be the case for oral medication. It is important to say that a depot on its own would be insufficient for the patient not wishing to take treatment, and a CTO would be required to enforce it.

59. Not all depot medication needs to be given against the patient's wishes and some patients recognise the obvious benefits for depot, such as that they are not required to take a tablet every day. This can be particularly helpful when people are prone to forget their medication, and so therefore a CTO is not always required for an individual who is taking a depot medication, whether on discharge from hospital or if a depot is to be started in the community. There are other potential benefits e.g. patients on depots tend to have more support from their community teams.

60. For the patient who may not be able to benefit from a depot, such as in treatment resistant schizophrenia, where they need oral clozapine, a care plan can include some enhanced monitoring (including blood tests which can

indicate if they are medication concordant or not), and where needed, a CTO can be used to enforce treatment in a particular setting e.g. a care home or open rehabilitation hospital .

**Crisis Resolution and Home Treatment Teams**

61. CRHTs provide intensive support at home for individuals experiencing an acute mental health crisis, as an alternative to hospital admission. NHS England ("Crisis and acute mental health services") set targets that by 2021 every area in England would have a 24/7 mental health crisis service which would be open access (people could self-refer including those not already known to services) and that there would be investment in 24/7 intensive homecare treatment by 2021 [NHSE0002718, p1)]. Detailed information regarding the purpose, general principles, access and availability, modes of referral, assessment, treatment, RAG ratings, care planning, interventions, physical health review, involvement of family and carers, risk assessment and other issues are discussed in detail in the RCPsych "Practice Guidelines for Crisis Line Response and Crisis Resolution and Home Treatment Teams" (October 2022) [NHNB0003187]. Nationally, there are various models. Following an assessment by a CRHT, potential next options would include home treatment, admission to a mental health inpatient unit, no further secondary care follow up and therefore referred back to the GP with a plan for further management, or referred and accepted by another mental health service. Treatments available could include potentially: subsequent medical and nursing reviews, practical support, structured medication including medication monitoring and concordance via home visits, anxiety management, carers assessment, and relapse management.

62. I have been asked by the Inquiry to outline my understanding of the general procedure and scope of CRHT services provided by the Trust to individuals experiencing severe mental health distress or an acute crisis [NHFT0000981, p.2; NHFT0006966 at p.2]. As I was a consultant psychiatrist in the Nottingham City and Nottingham County CRHTs, I will restrict my experience to that only and not include the Mid-Notts. or Bassetlaw teams. Detailed Trust specific information is available in the following documents: "The service specification for CRHT for the period 1 April 2019 – 31 March 2020" [WITN0207009] and "Crisis Resolution and Home treatment (CRHT) Teams: Standard Operating Procedure (AMH Greater Notts, Mid-Notts & Bassetlaw. December 2021) [NHFT0006966].

63. With reference to these documents, regarding the general procedure and scope of the CRHT, my understanding is that the CRHT offered an intensive assessment and home treatment service for patients who were potentially severely mentally ill. Where possible, the CRHT would treat patients in the community as an alternative to admission to hospital (given the substantial advantages that there are to that), whilst also making judgements about when home treatment was no longer possible and that admission was required. It therefore had a gatekeeping function: to make decisions regarding when patients should be directly admitted to hospital, as well as a role in liaising with AMHPs, and where possible, conducting CRHT initial assessments as well as requesting and coordinating MHA assessments and attending those if able. Standards included: "Mental Health Crisis Care Concordat" (HMRC, 2014) [WITN0207010] and Core Crisis Resolution Team Fidelity Scale, version 2 (Camden and Islington NHS FT, UCL) [CQCM0016063]. The Nottingham

CRHT operated as a 24/7 service. The MDT structure included a dedicated crisis consultant psychiatrist, a variety of other doctors including resident doctors (foundation, GP (VTS), core or higher trainees), as well as an experienced GP, team leaders who typically had a nursing or social care background, and a band 7 clinical lead who were more senior experienced community psychiatric nurses (CPNs) and CPNs of a variety of grades, support workers, a clinical psychologist (for part of the time I was there) and CRHT service managers, as well as on occasion social workers. The individual staffing levels would vary, from time to time, based on recruitment and vacancies. With respect to these roles, the role of the consultant psychiatrist was to provide leadership and expertise into the team, reviewing patients on the team caseload (either face to face assessments or a review of medical information in their notes and discussion with the team), doing MDT reviews with the team, liaising with colleagues and referrers, and MHA assessments. Structures in place included a RAG system, which I discuss below at paragraph 68, as well as MDT meetings, and the teams also had regular meetings. The CRHT had two teams, Nottingham City in one room and adjacent to that, Nottinghamshire County South.

64. When I was in post, there were three CRHT consultant psychiatrists (me, Dr Ben Di Mambro and Dr Ben Lomas). We had a rota to enable us to cover longer hours (Monday-Friday 9am-8pm), with one consultant designated to be the duty consultant each of those days, to support both teams. There was also a rota for one of us to do more planned work, twice a week, such as a clinic or planned home visits, called the non-duty rota. There was also a Band 7 nurse on duty each day, covering both teams. Each of the teams otherwise mainly had their

own staff, but would help each other out as needed where possible, if there were staffing shortages. Some types of staff that might also be shared included the clinical psychologist, if in post.

65. When the CRHT would receive a referral from an inpatient setting, the CRHT would have a verbal handover from the referrer as well as any documentation sent and the referral information would be recorded. Where the patient was already known within the Trust, the CRHT member would have access to the same recorded medical information as the referrer and would discuss those issues with the referrer regarding risk as appropriate. This would be more challenging when receiving external referrals from private hospitals, as they would not be on the same shared Patient Management System (PMS). On some occasions, their discharge summaries were not provided to CRHT before CRHT had taken over care, which represented a potential risk from lack of information until that was provided; typically, when I detected this, I would request the team to liaise with the private hospital. As the process of reception of referrals was done by the CRHT nursing team, more detailed information could be provided by a CRHT nursing colleague.

66. If a patient was referred to crisis but refused to engage, the team would assess whether to follow a set of approaches based upon the available clinical information. This would include knowledge of past and current risks, as well as detailed information in the referral regarding the patient's potential mental disorder, and a review of what was known about whether the disengagement was being driven potentially by a lack of mental capacity and worsening mental illness. Where there were concerns by CRHT staff, this would be typically escalated to more senior nursing colleagues as well as to the duty consultant,

as needed. This might then require the team take approaches such as visiting the patient unexpectedly (a cold call) or requesting a MHA Assessment where needed.

67. As discussed above, the CPA has been in the process of being phased out for most patients by NHS England and replaced by the Community Mental Health Framework (paragraphs 22-38). The CRHT has a vital potential role for all patients whether using CPA or the newer framework, to offer urgent and timely assessment and treatment for patients who are potentially seriously mentally ill, to help safely restore them to health as quickly and as safely as possible and co-ordinate this with the appropriate mental health teams in the community and/or inpatient teams. Within the CRHT's operating structure, the team would liaise with inpatient services, such as to facilitate appropriate early discharge where possible via In-Reach crisis nurses or to communicate effectively with CMHTs including joint visits (JVs or J/Vs) so that there would be joint agreed plans for patients.

**Care planning and discharge under CRHT**

68. The consultant would work closely with senior CRHT nurses (at least one Band 7 nurse would be on a rota daily to provide senior nursing leadership to the team). A RAG system was used, with patients on a Red "RAG rating" being those who needed daily or alternate day visits due to the severity of their mental disorder and/or risk. Amber RAG patients were those for whom there were clear plans, with less acute need for daily monitoring, and would typically have 2 to 3 visits a week. Green RAG patients were those close to discharge or transfer of care to the Trust's Local Mental Health Teams (LMHTs). The term LMHT is

synonymous with CMHT in the Trust. Green RAG patients would have a visit once a week. Most patients had home/community visits overall, but some would be seen at Highbury Hospital. The daily Red RAG MDT meeting was done by the duty consultant psychiatrist and the duty Band 7 CPN. Red RAG reviews would vary in length from patient to patient. They could be long and in-depth, such as if we needed to reassess a patient's plan, due to illness severity, risk e.g. by a detailed notes review of treatment effectiveness, or consider whether to request a MHA assessment or if we need to construct a formulation if it was unclear, and this might include asking individual CRHT nurses their views if they were directly involved with the patient's care. Alternatively, they might be relatively brief, if the plan was being followed successfully and there were no issues. Often, the Band 7 nurse attending the MDT would prepare in advance, including by talking with the Band 6 nurses.

69. The daily Red RAG review included patients who were being seen daily, and also those being seen on alternate days. The review would either create a new plan (if the patient was new), or monitor the existing plan, and consider if it needed adjusting in response to changes in the patient's mental health and/or risks. For Amber patients, each patient would have a review once a week with the wider CRHT MDT in their respective team of City or County.

70. Regarding transition of patients between the RAG types, nurses could independently increase a patient's RAG rating i.e. from Green to Amber to Red, or Green to Red, but could only downgrade from Amber to Green; Red patients required the Red RAG MDT of consultant/senior nurse to allow this to be reviewed. Observations regarding step down of patients from RAG levels would include noted improvements in patient's mental state, behaviour, insight,

risk reduction, reduction in family concerns, as well as views from community mental health colleagues at joint visits and the patient's ability to continue treatment safely

71. I have been asked by the Inquiry to address what role the CRHT MDT has in respect of care planning and discharge and follow-up with patients who are discharged to the care of LMHT and/or any other service. CRHT nurses would complete a care plan with the patient and liaise with other services as appropriate: e.g. if a LMHT was providing longer term care, CRHT nurses would arrange a joint visit, or telephone handover. Once a patient was discharged from the CRHT and the discharge process had been completed, including a care plan, then the CRHT would end its input at that point, until it received a new referral/re-referral. Further information on care planning and discharge could be obtained from a CRHT nursing colleague.

## PART B

72. In this section of my statement, I cover aspects of VC's treatment. I wish to set out at this stage that it is over five years since my first involvement with VC and given the passage of time, it is very difficult to say with certainty what documents I reviewed at the time. Since the events of June 2023, I have reviewed documents relating to VC's care for internal Trust reviews into the matter, and therefore I am conscious of the effects of confounding which happens with hindsight and from reviewing documents in the last two years.

## I. VC's Second Period under Community Care – Stonebridge Centre, NHFT (31 July 2020 – 3 September 2021)

### VC's discharge to CRHT

73. VC was discharged from his second admission of inpatient care at Highbury Hospital on 31 July 2020, to the care of the CRHT. CRHT nurse Mrs Merima Jordan had an in-reach role to liaise with the ward where VC was being cared for. She attended a ward round on 28 July 2020, while VC was an inpatient, to formulate a care / treatment plan with VC's inpatient consultant, Dr Seedat, prior to discharge from the inpatient ward. The medical record from this ward round [NHFT0000168 p105 – 108] states that Merima explained that the "*CRHT will see [VC] on Saturday and continue to provide close daily follow up for at least a week*". She also explained that the "*CRHT provide out of hours support for [VC] in addition to his LMHT*". VC's responsible clinician then explained to VC that he was being referred to CRHT because VC needs "*more support when he is discharged,*" and acknowledged that while VC has "*done some work on insight, concordance and it seems as though [VC] is saying the right things […] CRHT follow-up [is] to ensure this is the case*". This is a common reason why CRHT would be engaged: to be a stepping stone between inpatient and local mental health team care. Sometimes CRHT are engaged if there are delays with LMHT being able to follow up. As this decision was made by the inpatient team, it is best addressed by them. I believe that I would have seen these documents at the time. Typically, when a patient is new to me, I will filter Rio by "medical entries" and read as many as possible / scan the prior medical entries, often paying most attention to the most recent document and the first document, as well as scanning the other recent notes

for a recent chronology, to understand essential aspects such as diagnosis, treatment and past treatment response, risks and overall care plan. This was my usual practice, particularly for a new patient to CRHT that needed my input, as VC was.

74. The records of the ward review of 28th July 2020 show that Merima introduced herself to VC and "*explained that [the] CRHT are available to support Valdo in the community…and* are available at all times for [VC] if he needs support." "Merima explained that Crisis want to work to ensure that [VC] continues to take his medication." [NHFT0000168 at p.106]

75. CRHT nurse Merima Jordan entered the following plan onto the records on 28 July 2020 [NHFT0000168 at p.109]:

> "*Aim to discharge from hospital on Friday, 31 /8*[1]
>
> *CRHT to do 3 day follow up on Saturday 1/8 -time to be arranged*
>
> *CRHT to offer (initially) daily contact (monitor medication concordance/mental health)*
>
> *CRHT to liaise with CCO [care co-ordinator] on Monday 3/8 to arrange J/V*
>
> *Ward to refer to CRHT at point of discharge*".

76. A standard that "all people discharged from ICB-commissioned inpatient mental health services should be followed up within 72 hours", has been included in the NHS Standard Contract since 1 April 2020, therefore the requirement is for follow up within 3 days, and may be the day after discharge.

[1] Believed to be an error on the original document: should read 31/7

77. The information in paragraph 75 was also recorded in the CRHT internal referral form [NHFT0000030] on 28 July 2020.

78. The discharge summary of 31 July 2020 for this admission appears to have been prepared by Dr Hakan Ibrahim, Foundation Year 1 doctor, on behalf of VC's inpatient team. It notes that VC was admitted under section 3 of the MHA, due to "*increased risk to self and/ or others*" [NHFT0000222]. It further notes that VC's primary diagnosis was "*Paranoid Schizophrenia*". Page 2 provides a "Summary of Admission & Treatment" which highlights VC's issues with posing risks to others, non-concordance, and insight. I cannot now be sure whether I reviewed this document in 2020, but I would expect that key information (and more detail) would be contained in the ward reviews and other notes which are more readily available to view on Rio, in the running Progress Notes (and can be filtered by professional type), than in the separate discharge template which should be a summary of the above, and is also less easily accessible. My habitual practice was to review prior medical entries, filtering in Rio as well as often more recent multiprofessional entries, when trying to get a sense of a person, their diagnosis, treatment plan and risks.

79. I have been asked to comment on whether I sought information from the police in respect of the incidents of aggression that were noted in VC's discharge summary, or from staff who saw him through the Liaison and Diversion services. It is relevant to state that there was no handover from the inpatient ward that there was a need for CRHT to liaise with the police or Liaison and Diversion services, nor was this mentioned at the discharge planning ward review on 28 July 2020. I can see that there is a note by Dr Seedat at that meeting to VC's mother, stating he had enquired with the police "*who had told him that 80-90%*

*of the incidents wo not go on his record*" [NHFT0000168 at p 106). I would not normally seek information from the police in relation to a CRHT patient in circumstances where they had just been an inpatient following interaction with police, as inpatient colleagues would have had any contact with the police that they considered necessary. I felt that I had the information that I needed in the medical records.

80. VC's MHA assessment of 25 May 2020 would have been available on Rio; however, regarding the 14 July 2020 MHA assessment, only the AMHP report would have been available as the section 3 medical papers were not uploaded to Rio until 15 December 2020, which would have been an error. I cannot recall if I reviewed these in July / August 2020 but I would comment that those are the sort of documents that are more relevant when acting as an inpatient consultant, which I have done in the past, as they contain first hand impressions of a patient and the risks that justify detention under the MHA at initial contact and prior to admission. However, in order to fulfil a very different role, as a CRHT consultant to lead our team to fulfil the task that had been asked of it following an inpatient discharge, with no acute clinical issues arising to cause me to need to question the plan, I do not feel that it would have been necessary to review those MHA documents. Information about VC's presentation while detained, was contained in the Rio records. The focus for the CRHT, as required in our role, was on immediate clinical problems for the patient.

81. Regarding what I would have ascertained from my review of the note regarding diagnosis and risks, I made the following entry in the notes on 3 August 2020 at the Red RAG review: "*CRHT MDT MS AE* [myself and Mr Andy Esson, CRHT Band 7 CPN, the lead nurse for that day]: *Continue plan in place.*

*CRHT joint visit with LMHT to discuss how best to support Valdo with his consent; has recently been discharged from hospital and capacity to consent must be presumed; if Valdo is unhappy with CRHT concordance, it is best for a joint discussion with him and LMHT around recent relapses/potential for lack of insight/risks etc and achieve some agreement"* [NHFT0000168 p122]. This would have been our joint plan following discussion, a review of the notes, and any verbal handover we would have received e.g. it was common for the lead nurse to be informed by their colleagues of any concerns etc. The "*plan in place"* would be a reference to the current understood plan, which we would review to consider if still appropriate or needed amending. In this case, earlier that day, there was an up-to-date summary of that by Mrs Merima Jordan, CRHT CPN, summarising that VC had two recent admissions under MHA, posing an increasing risk to self and others and that he had stopped his medication. She extended the original plan from the discharge ward round of 28 July 2020: ("*CRHT will see [VC] on Saturday and continue to provide close daily follow up for at least a week*") to: "*In the light of the above, I would recommend for CRHT to stay involved for the next 2- 3 weeks at least and then review as Valdo is working towards his exams and pressure could be overwhelming and affect his mental health. PLAN: CRHT visit arranged for Monday 3/8 at 10:00 am, Arrange J/V with CCO, Continue red RAG until J/V with CCO, Will require crisis plan*." [NHFT0000168 p121].

82. To elucidate my thinking on 3 August 2020, it would have been that it was appropriate to continue CRHT community monitoring; I also noted that we needed to engage VC with his Early Intervention in Psychosis (EIP) community team as soon as possible; this is standard practice to bridge the gap between

inpatient care, assist the patient with someone they know over the longer-term (a CCO) and gain input to CRHT from the EIP team. I particularly raised issues about how to support VC with his consent, and this would almost certainly be in reference to potential issues of medication concordance and insight. I stated "*if [VC] is unhappy with CRHT concordance, it is best for a joint discussion with him and LMHT around recent relapses/potential for lack of insight/risks etc*" [NHFT0000168 p122], indicating I was aware of those relapses, risks etc. One step to try and improve this medication concordance was to see whether involving his own EIP team could help (as CRHT staff would be relative strangers and EIP would have a longer relationship). This would have been a common scenario for the CRHT to manage. It would be common for me, regarding medication compliance concerns, to monitor the severity of the patient's disorder and potential risks. If medication compliance remained a significant concern for any patient, despite CRHT doing its best, such as by least restrictive approaches, I would then consider whether there was sufficient evidence to request an MHA assessment. Ensuring that we had safely tried the least restrictive approaches was not only good practice, but also ensured that any requests for MHA assessments that we made to the AMHP team were dealt with as soon as possible, as our opinion and understanding of what treatment options were practical and safe in the community was highly valued.

83. The records show that VC was discussed daily at Red RAG MDT between 3 – 6 August 2020, before his RAG was reviewed as requested by our MDT of 6 August 2020 [NHFT0000168 p124], in anticipation of a joint visit that day between CRHT and EIP. The joint visit had the aim of a shared review of VC's mental health and risks and to consider what ongoing monitoring was required

between the teams. A plan was formed for three further CRHT visits, before a transfer of care back to EIP, approximately one week later, with a contingency to reassess that, if his mental health declined. The RAG was reduced to Green, signalling an impending transfer of care from CRHT to LMHT. There would not therefore have been a subsequent MDT review, unless the team were to have become concerned and increased his RAG rating again, which did not occur.

84. During the process of compiling this statement, I have had sight of a "Risk and Safety Assessment" [NHFT0000195] and a "Mental Health Clustering Tool" [NHFT0000181] prepared by VC's inpatient team in July 2020. As before, it is difficult after five years to be certain what documents were reviewed by me and when, but I would say that it would be my common practice to review Risk and Safety Assessments when needed, but also to review the Risks as documented in the Progress Notes and form a view of the change in presentation and risk over the period of detention. I discuss above, at paragraph 81-82, my reference to "recent relapses/potential for lack of insight/risks etc" at the MDT of 3 August 2020, but with the passage of time, I cannot be clear on which documents were reviewed.

85. It is unlikely that I would have reviewed the cluster tool, as it is not my typical practice because I consider that it serves little clinical purpose for acute CRHT needs and it would be unlikely to yield any additional information that was not already in the progress notes. Furthermore, as a system, clustering appears to me reductive, compared to a common international system such as ICD 10 (World Health Organisation) [WITN0207005, pp. 22-43]. The clustering document cited states cluster 11: ongoing recurrent psychosis (low

symptoms), whereas the diagnosis of "likely paranoid schizophrenia" in the progress notes of 28 July ward review, along with the clinical information including narrative on risk, would be much more useful for the purpose of understanding CRHT needs. Clustering was developed in 2012/13 as a method of currency, to potentially allocate payment per patient. The Royal College of Psychiatrists in 2014 issued a paper where it did not support the model, stating clinical validity had not been proven, that its members lacked confidence in it as a basis for payment and pricing and that it must include diagnosis and a wider range of complexity. Its use is therefore not clinical, but possibly administrative. My normal practice for new patients would be to read the relevant recent notes for all professionals and apply a filter on Rio to show the medical entries to get a longer term psychiatric view. I discuss in paragraphs 81-82 above, my review of a plan to address VC's needs at the time and risks.

**Overview of contact and assessment of VC under CRHT**

86. On the day following discharge from inpatient care, CRHT assessed VC's mental state on 1 August 2020. Nottingham City CRHT CPN Clive Chimbi and a county CRHT CPN visited him at home. Their assessment stated that "*from our assessment we found him to be pleasant and polite, he was free of agitation and irritability. He engaged well and it was easy to build a rapport with him. He did not appear disturbed by external stimuli. There was no evidence of paranoia or delusional ideas. He showed some insight into his mental health agreeing that he had been unwell at the time of admission. He feels he has improved a lot since then*" [NHFT0000168 p119]. VC agreed to take his medication in front of the CPNs and went to fetch them, then returned after

several minutes stating he had misplaced them. CRHT reinforced the need for him to take medications, which he said he was happy to take and agreed to have daily medication concordance. CRHT stated they would order some for the next day, if he could not find them; however, he later contacted CRHT to say that he now had them.

87. It is worth commenting that I would not expect to see any changes in presentation, if VC had missed only one day of medication. For most medications, one would see clearer signs if approximately five days were missed, although this depends on the medication and the disorder and individual. VC's presentation on day one post-discharge would not have been taken as evidence that he was taking his medication.

88. An assessment of a patient's mental health takes place on every direct contact with a patient, even if not formally labelled as MSE, as staff would be looking for indications of a patient's behaviour, mood and presentation. VC's mental state was therefore commented upon in varying levels of depth by CRHT nurses on several visits: Philip Lavelle on 2 August 2020 [NHFT0000168 p120], Clive Chimbi on 3 August 2020 [NHFT0000168 p122], Brandi Walters on 4 August 2020 [NHFT0000168 p123], Kelly Barber on 5 August 2020 [NHFT0000168 p124], Clive Chimbi on 6 August 2020 [NHFT0000168 p125), and Patrick Crolla on 8 August 2020 [NHFT0000168 p127] (there was no visit on 7 August, as VC was moved to Green RAG rating on 6 August, see below at paragraph 89). Of note, at Patrick Crolla's visit on 8 August 2020, it is recorded that VC accepted that he had been previously experiencing auditory hallucinations in the form of a running commentary, but was no longer. No external signs of psychosis were noted, although Patrick Crolla did comment that his responses were very slightly delayed.

89. At the MDT on 6 August 2020 by myself and Mrs Merima Jordan, CRHT band 7 CPN, we noted that there would be a joint visit that day with VC's CCO [from EIP] [NHFT0000168 p124]. We requested that the RAG rating be reviewed: it is common to review RAG following additional support being provided by LMHT teams and for LMHT teams to consider when/if they can manage a patient without CRHT, and this was in keeping with the plan of 3 August for Red RAG to continue until the joint visit with VC's CCO. On 6 August 2020 there were no acute concerns regarding VC's mental state; I had earlier on 3 August 2020 noted the need to involve LMHT given potential problems with VC's medication concordance, and there was some hope from the visit on 5 August 2020, when he was observed to take his medication with water, by Ms Kelly Barber, nursing student [NHFT0000168 p124]. The above joint visit with LMHT was held on 6 August, by Mr Clive Chimbi, CRHT CPN and and no concerns were noted. The RAG was reduced from Red to Green rating (indicating VC was almost ready for transfer from CRHT to LMHT) [NHFT0000168 p125].

90. VC was reviewed by Patrick Crolla, CRHT CPN on 8 August 2020 and there were no significant concerns about his mental state [NHFT0000168 p127]. VC was discharged from CRHT on 15 August 2020 by CRHT CPN Clive Chimbi [NHFT0000168 p130], after VC was seen by his EIP CCO, Claudia Birtles, on the prior day [NHFT0000168 p129].

**Monitoring of Medication Concordance**

91. Whilst there were no acute concerns about VC's mental state in this short period, there were concerns about medication non-concordance. As mentioned above at paragraph 86, on 1 August 2020 (one day after VC was discharged from the inpatient ward), CRHT Nurse Clive Chimbi attended VC's home address as part

of his discharge plan. Mr Chimbi's notes from this visit state that when he arrived to meet VC in the evening, VC stated that he could not find his medication, so the team made a plan to order them if he could not find them. They discussed the importance of medication, which VC accepted. The record states [NHFT0000168 p119]:

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

*Risk*

*Deterioration in mental state of non-compliant [sic] with medications*."

92. It is then recorded that VC called the CRHT later to confirm that he had found his medication.

93. I consider this to be an instance of CRHT not being able to physically see the patient take a medicine and of the team being aware of possible non-concordance. They were therefore taking steps to ensure that at the next visit there would be medicine available, so there would be no excuse for non-concordance.

94. It is recorded that on 2 August 2020, CRHT nurse Philip Lavelle met with VC. His notes [NHFT0000168 at p.120] record that VC has a history of issues with non-concordance. The record states that "*VC currently remains compliant*." However, clear evidence of compliance would have been to state that VC was seen to take the medicine with water and swallow it. It is therefore not clear if that was the case or if store was put on VC's word, or that VC might have shown empty parts of a tablet strip. It also would not be accurate to say VC "remained compliant", as he had not been observed to take medicine the prior day. When communication issues like this arose, when possible and needed, I would commonly ask colleagues directly what they meant or ask the lead nurse colleague with me at the MDT to speak with the team about it, particularly if we were acutely concerned about a patient. Whilst I cannot recall, I suspect I may not have done this at the time, as nurse Lavelle may not have been on shift at our MDT on 3 August 2020 and there was not an acute concern at that point.

95. On 3 August 2020 CRHT nurse Clive Chimbi undertook another visit to VC at 11:49 [NHFT0000168 at p.121-122]. VC told Mr. Chimbi that he had already taken his morning medication: *"He* [VC] *showed me the meds with evidence of tablets having been dispensed*." Mr. Chimbi informed VC that the CRHT team "*need to do medication concordance with him*," VC responded that this was "*a bit excessive of staff to come in and watch him take meds…. [he said that he] prefers to take his meds between 8 and 9. He said he did not want to take it any later. He would not give a valid explanation why*." The note records that the plan was still that CRHT would visit him again the next day to monitor medication compliance and to explain to him that if he refused, that there was a risk of relapse and possible admission. Mr. Chimbi also recorded that there should be a discussion during the

CRHT MDT, as to what should be done if VC continued to refuse medication concordance monitoring. VC was seen the next day, on 4 August 2020, by CRHT CPN Miss Brandi Walters at 09:55. He stated again that he had already taken his medication at 8am, but said he would wait for CRHT staff to arrive the next day before taking his medication [[NHFT0000168 p123]. This did happen the next day on 5 August 2020, when nurse student Miss Kelly Barber witnessed him taking his medication at 10:10 am [NHFT0000168 p124].

96. It would be my habit to review CRHT entries from the team to formulate an understanding and plan accordingly. With the passage of five years, I cannot be certain regarding which entries I might have reviewed; however, as I refer to issues around medication concordance in my MDT note of 3 August 2020 [**NHFT0000168** p122], I consider it to be very likely that I was aware of the episode on 1 August 2020, when VC said he did not have his medication at home. When medicine concordance is a key part of a person's CRHT plan, I would review recent entries to assess if that was being done, or if we needed to change the plan.

97. At the CRHT MDT on 3 August 2020 [NHFT0000168 at p.122] I made a note of the care plan as follows:

> "*Continue plan in place. CRHT joint visit with LMHT to discuss how best to support Valdo with his consent; has recently been discharged from hospital and capacity to consent must be presumed; if Valdo is unhappy with CRHT concordance, it is best for a joint discussion with him and LMHT around recent relapses/potential for lack of insight/risks etc and achieve some agreement*."

98. A core principle of the Mental Capacity Act 2005 is that "A person must be assumed to have capacity unless it is established that he lacks capacity." It would not be unusual for us to manage patients who lacked capacity to consent to

treatment, but who were willing to accept treatment. In my entry of 3 August 2020 at MDT, I stated "*has recently been discharged from hospital and capacity to consent must be presume*" [NHFT0000168 p122], and I would have been referring to his capacity to consent to treatment for his mental disorder, specifically for his psychosis, with treatment consisting of oral antipsychotic medication, monitored by CRHT on daily home visits. There are two relevant pieces of legislation; the Mental Capacity Act 2005 and the Mental Health Act. The MHA would be the appropriate legislation to consider using if VC were to refuse treatment; furthermore, the refusal would also imply he lacked capacity to consent to treatment. As VC had recently been treated under section 3 of the MHA and then discharged, it would be unusual to expect to see a rapid loss of capacity to consent to treatment, as the timeframe since discharge would be too short for his antipsychotic medication (aripiprazole) to leave his system, particularly as aripiprazole is long acting. As the purpose of the recent hospital admission was to treat VC due to medication non-concordance, it was reasonable to infer that the inpatient team were reasonably assured that he had regained capacity to consent to treat at the point of discharge. Capacity to consent to treatment does not require a perfect understanding of the disorder and treatment, but a sufficient one; at the discharge ward round on 28 July 2020 Dr Ibrahim wrote *"he agrees that there are difficulties with his mental health and acknowledges the importance of taking his medication when he is discharged*" [NHFT0000168 p80]. I discussed above, in paragraph 82, the relevance of CRHT taking steps to enhance his capacity, such as involving EIP, before considering further options, such as potentially another MHA with a view to a readmission. At that time, VC was not under the MHA and therefore we did not have any powers of compulsion. It also meant that we needed

to be alert to any changes in VC's mental state and behaviour which could signal him beginning to potentially lack capacity to consent to treatment. Examples could include if he were to make comments that he did not need medication (such as that he did not believe he had schizophrenia which required treatment), or were to show a pattern of evading CRHT contact for the purposes of medicine non-concordance, as this would be a marker of wider worsening of psychosis. During this episode, I did not assess VC in person. I would though, have reviewed the team's notes to monitor for signs of non-compliance and potential loss of capacity to consent to treatment. When on duty, I would expect staff to consult with me if they had significant concerns about a patient's capacity. I also considered it important for staff to be aware in general when they might be caring for someone who had lost capacity to consent to treatment, but who might not be objecting to treatment, as this was a sign that there could be other risks.

99. Where I stated on 3 August 2020 [NHFT0000168 at p.122] "*if Valdo is unhappy with CRHT concordance, it is best for a joint discussion with him and LMHT around recent relapses/potential for lack of insight/risks etc and achieve some agreement*", my recollection is that we were reaching an impasse and that involving his EIP team might help defuse this a bit, on the proviso that they knew him longer and had a better relationship, in order to get agreement to take the medicine. This is because during the visit on 3 August 2020, CRHT CPN Clive Chimbi saw VC appear pleasant and polite, but not engage with the medicine concordance plan (he showed Clive a pack of tablets with evidence of some being dispersed) and furthermore state in effect that he did not want staff to want to watch him take medicine. It would be usual practice (and was part of this plan) for CRHT to work actively with the LMHT, particularly the EIP CCOs, as they have

greater resources to input their time than non-EIP CCOs. It is also possible (although this might be hindsight) that I may have been thinking that if this least restrictive option was exhausted, we would have grounds, if needed, to trigger another MHA assessment, as VC would need to be readmitted to hospital if he was to be given medication without his consent or agreement. This is something we commonly did as a team with such patients, and we later did in relation to VC in 2022, after he failed to comply with a plan of daily medication concordance that was set out for him at a MHA assessment when I was one of the assessors. If needed, we should have been able to make a decision with his EIP team about whether to call a fresh MHA assessment, although in the event, this was not needed.

100. At the MDT review on Monday 3 August 2020, there was no clear evidence of the CRHT seeing VC taking his medication over the weekend, following his discharge from the ward on Friday. This was clear from Mr Chimbi's note of the 1 August 2020, although uncertain from Mr Lavelle's note of the 2 August 2020, who believed VC had been compliant. This led me to advocating to involve EIP to see if this would help as a first step to improve compliance. My assessment was that this was appropriate as there were no acute concerns about his mental state, as by implication I would have needed to consider use of the MHA to enforce non-compliance. CRHT CPN Katie Haines records on 3 August 2020 [NHFT0000168 at p123] that a joint visit with his EIP CCO, Miss Claudia Birtles, CPN, had been arranged for the next day. Miss Birtles telephoned VC later that day to confirm the JV with CRHT the next day.

101. CRHT nurse Brandi Walters recorded an entry on Rio at 12:00 on 4 August 2020, after visiting VC, and reported that "*he had already taken his medication*". She

recorded that after she had explained to VC that CRHT's role was monitoring medication concordance, VC said that "*he will wait for CRHT staff to arrive before taking medication as of tomorrow*" and that "*he will be a lot happier when the crisis team stop coming*." [NHFT0000168 at p.123]. I had already undertaken the MDT review and recorded it at 10:50 and therefore would not have seen nurse Walter's entry as part of the morning MDT review. I suspect I was not aware of it later in the day, as it does not appear from the note that nurse Walters was unduly concerned and so would likely not have raised this with me. I would note however, that one purpose of our daily morning MDT reviews for people on a Red RAG rating, was to review entries that arose after the prior day's MDT or after the prior Friday's MDT, if the MDT was on a following Monday. The above entry from nurse Walters would have been available to see for my consultant colleague, Dr Ben Lomas who led the MDT the following day, and who made a comment "[VC] *has stopped medication, though seemingly appears symptom free from last visit*" [NHFT0000168 p124].

102. Accordingly, on 5 August 2020 at that CRHT MDT led by Dr. Ben Lomas, he noted that although VC "*appeared symptom free*" on the previous day's visit (i.e. by nurse Walters), he should remain on "*red RAG for concordance, further assessment*" [NHFT0000168 at p.124]. Later that morning, when CRHT student nurse Kelly Barber visited VC, she recorded that VC took his medication in front of her [NHFT00000168 at p.124] and she commented on his mental state as follows:

> "[*VC] denied experiencing any visual or auditory hallucinations and could not recall the last time he had experienced this. No signs of responding to any*

*unseen/unheard stimuli during today's visit (although as previously noted, responses to questions were very slightly delayed*)."

103. I would have reviewed VC's case on 6 August 2020 with CRHT CPN Merima Jordan before we agreed the plan. Due to the passage of time, I cannot be certain if I personally reviewed the entries of Dr Lomas' MDT and student nurse Kelly Barber's entry of 5th August 2020, as well as discussed them, or only discussed them with Merima, as the MDT note was written by Merima, who had done the original in-reach visit at discharge on 28 July 2020 and who knew the case well. It was habitual for myself, Dr Lomas, and Dr Di Mambro to discuss patients when needed and we had a good working relationship; however I do not recall any discussion between us on this, although Dr Lomas and I did discuss his case at a later point, in 2022, prior to the MHA assessment that I participated in.

104. At the MDT of 6 August 2020, between me and Merima Jordan, it is recorded that there was to be a joint visit between CRHT and VC's CCO from LMHT, and to "*Review RAG*" [NHFT00000168 at p.124]. It was customary for RAG ratings to be reviewed at joint visits. Later that day, the joint visit took place and CRHT nurse Clive Chimbi entered the details into the records. This recorded that VC stated that he was happy to continue taking his medication. The following observation in respect of VC's presentation was made:

"*Since discharge Valdo has engaged with the crisis team. he has presented as free of psychotic symptoms and no negative effect on his mood and affect. he has denied paranoid and delusional ideation. there has been no evidence to dispute this. if there are any symptoms, they are probably well managed and not causing any distress. On the grounds of mental state and risk, Valdo does*

*not meet the CRHT admission criteria. he is not presenting as admission vulnerable. Risk is low in all areas and does not warrant crisis input.*

*it is worth noting that Valdo in the recent past has deteriorated rapidly after discharge. The original plan agreed with crisis at point of discharge was to offer support to avoid another rapid deterioration. in line with this handover to LMHT will be stretched out for another week. at the end of which if all remains stable CRHT can disengage*." [NHFT00000168 at p.125].

105. The RAG rating was changed from Red to Green in this entry on the records.

106. It is not possible for me to know after five years whether I discussed the home visit with nurse Chimbi at the time. Although I would frequently discuss patients with the team or any queries they had; looking at Clive's note, and the fact that he had no concerns, means that I suspect that Clive did not raise anything with me. It was within standard CRHT protocol [NHFT0006966, p10] for an experienced band 6 nurse to reduce a Red RAG (whether to Amber or Green) once the MDT had requested it be reviewed, once they had assessed that as appropriate. I therefore suspect that Clive and I did not discuss the home visit or the change in RAG rating.

107. In relation to the change of RAG rating from Red to Green, on 6 August 2020, we had done an MDT on 6 August recommending that following the visit that day with his CCO, that the RAG be reviewed. This was based on our observations to date including that he had been witnessed to take medication the day before, that there were no acute concerns about his mental state, and that the purpose of the joint visit was to get agreement from the CCO on a shared view of the RAG and trajectory towards transfer. There would have been a choice to reduce the RAG rating to Amber (which would lead to visits three times a week), instead of Green (which would lead to visits once a week), but it is difficult now to speculate on the

decision at that time, which I suspect was informed by VC presenting well on 6 August 2020 and being observed to take medication on 5 August 2020. There was still a recognition that if his mental state were to deteriorate, then the plan would be reviewed alongside the LMHT; it was not uncommon for patients to have RAG rating decisions changed, as prediction of behaviour associated with mental disorders can be very difficult. It is also the case that the frequency of visits in Mr Chimbi's plan was actually in keeping with an Amber RAG frequency which is two to three visits a week: *"Plan: CRHT to visit on the 8th to assess mental state. This should be followed by another two visits and patient can be discharged back to LMHT on the last visit late next week"* [NHFT0000168 p125]. In the event, there were 3 visits over 9 days, including discharge on the 15th, which approximates to Amber. I am not sure why Mr Chimbi did write Green RAG; I could speculate that it was as a sign to the LMHT to get ready to prepare for transfer of care, but I could not be certain. The one practical consequence it would have had was that there would not have been a MDT review in those 9 days, before the transfer of care to LMHT.

108. I did not review VC in person when he was under CRHT during this period. Consultant review in-person would not normally be required for medication concordance following a recent inpatient admission, unless we or the team had sufficient concerns that we needed to intervene e.g. to assess and consider if the MHA needed to be used, or consider if a planned review by the LMHT consultant was needed. My involvement in monitoring the agreed plan would have been until the 6 August 2020, when at the morning review with my Band 7 colleague, Mrs Merima Jordon, CPN, we noted that there was to be a joint visit with VC's EIP CCO that day and that the RAG should be reviewed, which meant that if

appropriate, it could be reduced. From that period onwards, once the RAG was reduced to Green, there would not be a direct consultant review of the case, but if the nursing team had any concerns, they could discuss that with the duty consultant psychiatrist for that day. It is relevant that contingencies were built into the plan of 6th August by Mr Clive Chimbi "*If mental state is poor, review the plan and involve LMHT in any further planning*" [NHFT0000168 p125] and given that the ultimate aim was to transfer care back to the LMHT, not an absolute discharge from services, this would not therefore have been seen as a risky thing to do.

109. Within the CRHT team, one of the three consultants would be the designated day duty consultant from a rota and be responsible for the daily management of the patients on the team's caseload. I therefore monitored VC's plan during my days on shift, with my colleague Dr Lomas doing this on the other days in this episode. In relation to "discharge planning" from CRHT, I would consider it to be more of a transfer of care from one team to another, i.e. from CRHT to LMHT (as opposed to the discharge of a patient to a GP, with no expected psychiatric follow-up). With regard to deciding whether or not VC's care should be transferred to LMHT or how long his care should be under CRHT, this was based upon a judgement on his overall mental health and care needs, and which team could meet those best. This is a nuanced judgement and hence our involvement with his EIP team via his joint visit. There were no concerns expressed by the CRHT CPNs or LMHT CCO in this respect (usually if a disagreement arose between the teams, this would be resolved by the nurses or escalated to us, and we would adapt the plan as needed). The issue of medicine non-concordance was likely reduced in concern, due to no acute changes in mental state or concerns otherwise noted, as well as that VC was seen to take his medicine in person on 5 August 2020, the day before

CRHT nurse Merima Jordan and I advised the RAG be reviewed on 6 August 2020 at the point of a joint visit with his CCO.

110. The risk for anyone who has a psychosis who states they are taking medication, but are not, is of the psychosis returning or worsening. The risks that would result from that are particular to that person, but as I have discussed above, can broadly be categorised into risks to self, others and property (e.g. paragraphs 17,45,51-52). Medication non-concordance may not only be due to a lack of willingness; some patients can become confused/chaotic due to their illness as it worsens and need assistance to prevent that worsening.

111. It is important to consider the context of the situation at that time regarding VC. Although there was evidence of non-concordance with medication, we would have needed evidence of an acute deterioration in VC's mental health in order to have been able to justify a MHA assessment, as hospital readmission under the MHA would have been needed to be able to enforce medication. At that time, this would not have been proportionate. Whilst VC's mental health presentation was stable, it was not unreasonable to believe that he was taking his medication, even if not witnessed. CRHT were therefore monitoring not only for medication concordance, but for signs of mental state deterioration, which would be a proxy marker of medication non-concordance. In the first instance, we did this via seeking additional support for VC via his EIP team. It would have been a common clinical situation in general for us to request a MHA assessment where appropriate, and this is something we later did in the case of VC on 27th January 2022, following a discussion between Miss Jo Baker, CRHT CPN and me, after concerns about not only non-concordance, but associated signs of mental deterioration.

112. I think that I would have been alive to the possibility that VC could be just "saying the right things" to CRHT, given that there were problems with medication concordance which I noted, and I attempted to address this risk by involving his LMHT EIP, as this could either aid our relationship with VC, and/or help further in assessing his mental state. We would also have taken into account that as there were no acute concerns about VC's mental state, we would have been unlikely to be able to obtain legal grounds, via the MHA, to readmit him to hospital. As VC was stating he was taking his medication and appeared reasonably well, suggesting he was taking medication, it would have been disproportionate to detain him then, particularly as neither CRHT nor his EIP CCO had significant overt concerns. His treatment of aripiprazole 10mg (from 14th July 2020) might take longer to take effect than other antipsychotic medication, and could be increased if needed. As CRHT is a short-term team, with EIP the longer-term team, this ongoing monitoring would have been considered best done by EIP, with CRHT having fulfilled the short-term remit of monitoring for any acute relapse. Transfer of care to EIP did not infer that CRHT necessarily felt VC's mental state and care was optimised but rather needed longer term management. At the final review of 15 August 2020, by Mr Clive Chimbi, CRHT CPN, whilst he noted that current risks appeared low, he recorded "*while at the present time he expresses that he is happy to continue with medications there is a possibility that he could become non compliant. This will possibly leads [sic] to another relapse*" [NHFT0000168 p130].

113. I have been asked by the Inquiry to consider the Royal College of Psychiatrists' "Good Practice Guide: Assessment and Management of risks to others" [NHFT0015099]. I do not believe that I have previously read that specific

document, but I have had other training and read literature on assessment and management of risk, as it is an essential part of psychiatric training and experience. Furthermore, I was the lead author on a Cochrane review into treatments for delusional disorders, a type of chronic psychosis, one of whose subtypes (delusional jealousy/Othello syndrome) is a high risk for murder of the delusional person's partner. Having read the Royal College document, the information within it would be overall familiar to me, though it seems to be more targeted at forensic psychiatrists.

114. Regard whether VC's risks were adequately addressed and planned for, in the short-term and long-term when VC was discharged from the care of the CRHT team, I would first of all note that CRHT is by its nature a short term team, similar to a daily A&E team. CRHT is the link between inpatient teams and community teams, although there are times that patients are on the CRHT caseload for longer periods, having a variety of home treatment interventions. Regarding long term risks, this is more complex as it depends upon a definition of the time frame and prediction of potential future events, which is difficult at best for any human behaviour, but much more so in the early course of any serious mental illness and VC's case is now strongly influenced by hindsight. This was a very early point in our understanding of his psychotic disorder. There was a gap of over 12 months to the next MHA assessment of VC, suggesting there was relative stability and that acute risks were accounted for then. Following CRHT transferring VC's care to EIP, EIP were able to build a therapeutic relationship with him. This was notably via his CCO, Claudia Birtles, CPN and Dr Billal Burri, psychiatrist, higher trainee. During that time, VC opened up about his symptoms in the early part of that 12 month period (10 November 2020) [NHFT0000168 p137-138], and aripiprazole

was gradually increased to 20mg daily by 1 February 2021. There appears to have been some response, but it was insufficient, as noted on 13 May 2021 by VC to his CCO [NHFT0000168 p152]. It may be reasonable to assume VC was taking his medication at that point, based on his openness about symptoms, and that fits with concerns raised by his mother, 16 days later that he had told his brother he had stopped his medication 2-3 weeks earlier, but it is not certain. EIP monitoring continued, and 3 months later his CCO on 31 August 2021 noted frank symptoms of psychosis, and this led to an MHA assessment and detention under section 2 on 3 September 2021. My summary view is that based on the information available, that the transfer of care plan from CRHT did account for acute risks and reasonably foreseeable longer-term risks, in the need for longer term care by EIP for longer term assessment of VC and to build long term rapport (which there evidently was with his CCO). There was some evidence for the effectiveness of this, as following EIP monitoring and later concerns, this led to VC's detention under the MHA on 3 September 2021.

115. Unfortunately, in the UK, there were additional unforeseen effects of the COVID-19 lockdown. This took a high toll on our patients (with social isolation considerably worsening mental health symptoms overall), and increased pressure significantly on most acute teams: inpatient and CRHT, which had to maintain ongoing face to face contact. There were 3 lockdowns in England in the period from 23 March 2020 to 8 March 2021, with most restrictions lifted during mid-2021. VC's care in this period therefore does need to be put in this context also. It would be difficult to estimate this impact, but it can only have adversely affected VC's care.

## ll. VC's third admission (under s.135 and then s.2 and s.3 of MHA 1983) in seclusion at Highbury Hospital, NHFT

Relevant dates at Highbury Hospital: 3 September 2021 – 11 September 2021 (8 days)

Relevant dates at Cygnet Victoria: 11 September 2021 – 1 October 2021 (20 days)

Relevant dates at Priory Arnold: 1 October 2021 – 24 October 2021 (23 days)

**Period in seclusion at Highbury Hospital**

116. On 3 September 2021, VC was detained under section 2 of the MHA. In summary, I understand that the context of this detention was that VC's CCO Miss Claudia Birtles, CPN, observed that VC had stopped taking his medication and was relapsing. An AMHP made an application for a section 135 warrant, which was granted and subsequently executed, by police officers and two independent medical practitioners: Dr Ben Lomas, my CRHT consultant colleague, and Dr Omar Manzar who attended VC's home address. On this occasion, VC resisted detention. Dr Lomas has recorded in the notes the following observations within his MHA assessment:

> "[*VC] repeatedly assaulted the male police officer particularly. He punched and headbutted him several times, and was able to wrestle the handcuffs off a female officer to use as a weapon. He was eventually subdued after police used CS gas and a tazer (2 or 3 discharges were required*)" [NHFT0000168 at p.167].

117. VC was then admitted to the Cassidy Suite at Highbury Hospital and nursed on seclusion [NHFT0000168 at p.165]. A PICU referral was made by Dr Lomas, which records his view that VC should be referred to a PICU bed due to the *"risk of serious physical assault to healthcare staff"* [CYGN0000085].

118. Three days later, on 6 September 2021 at 18:10, I undertook a medical seclusion review which included an assessment of VC's mental state.

119. Detailed guidance on seclusion, including nursing reviews, medical reviews, MDT reviews and independent reviews, is contained in the MHA Code of Practice in chapter 26. This defines seclusion (chapter 26.103) as "the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others." The Code gives guidance on a series of review processes to be instigated when a patient is secluded: multidisciplinary (MDT), nursing, medical and independent MDT reviews, including frequency, to be incorporated into a provider's policy on seclusion. It defines medical reviews (chapter 26.133) as an "*opportunity to evaluate and amend seclusion care plans, as appropriate. They should be carried out in person and should include, where appropriate: a review of the patient's physical and psychiatric health, an assessment of adverse effects of medication, a review of the observations required, a reassessment of medication prescribed, an assessment of the risk posed by the patient to others, an assessment of any risk to the patient from deliberate or accidental self-harm and an assessment of the need for continuing seclusion, and whether it is possible for seclusion measures to be applied more flexibly or in a less restrictive manner.*" The MHA Code of Practice recommends the medical review process to be as follows (chapter 26.112): an initial medical review within 1 hour of seclusion or without delay if the person is not known or there is a significant change from their usual presentation (unless seclusion is

authorised by a psychiatrist); medical reviews every 4 hours until the first [internal] MDT, then continuing medical reviews at least twice daily (one by the responsible clinician). The Trust accordingly had its own provider policy on seclusion in place at that time: "Trustwide Seclusion and Long-Term Segregation Procedure (Policy 04.04)" [WITN0207002], which it states is to comply with paragraphs 26.103-26.172 of the Code of Practice, MHA 1983. Further details can be found in this document; the policy considered all medical doctors, irrespective of grade or level of registration, to be competent to undertake medical reviews, on condition that they had read the procedure, always had access to senior medical (consultant) advice and always had access to senior nursing advice. The policy included details on which type of doctor should do medical reviews: e.g. four hourly reviews could be done by a duty doctor or more senior doctor, but at least one medical review in every 24-hour period should be carried out by the responsible clinician.

120. My usual practice when conducting responsible clinician seclusion reviews would be to review the relevant medical and nursing records, discuss with the nursing staff and if present the junior medical doctor, their views. With the passage of just over four years since I conducted this review, it would be hard for me to be precise about exactly which documents I would have reviewed at the time. Having said that, as my seclusion review took place on a Monday and VC was secluded on the Friday, I am reasonably sure that I would have reviewed my CRHT consultant colleagues' entry (Dr Ben Lomas) of 3 September 2021, as it would be particularly my practice to do that. His entry summarised the MHA assessment, presentation and risks very well, including the assaults on police officers, and in my note of 6 September 2021, I

reference "*significant risks including assault on police*" [NHFT0000168 at p.179]. I would also have reviewed VC's progress in seclusion per the plan that Dr Lomas set out on 3 September 2021, in particular, VC's response to the antipsychotic medication haloperidol. I commented, in my note of 6 September 2021, that there was ongoing psychosis, lack of insight, significant recent risks and that haloperidol should be continued once a day as injection of 10mg if he refused oral medication. My comment on haloperidol dosing was likely because 10mg of IM (intramuscular) haloperidol is large (5mg is standard IM) and to guide the nurses to have confidence to administer it, as I would have considered that the trade-off between risks/benefits was reasonable.

121. From my review of the Rio Notes, I do not see any entries from the nursing team regarding the police and so I doubt that I would have had access to any information from the police, but I note that Dr Lomas did comment on 3 September 2021 that "*There may be charges that result at a later date*" [NHFT0000168 p167].

122. From reading my notes, my assessment of 6 September 2021 was that VC lacked capacity to consent to treatment or admission. In my notes of this assessment, I recorded that VC had: "*Ongoing psychosis, lacks insight; significant recent risks including assault on police*" [NHFT0000168 p179]. This meant that his ongoing psychosis was of such a degree that he was not aware of its impact on him (lacks insight). Insight occurs on a spectrum from none (lacks insight) to partial degrees and full insight and I would typically comment on those degrees. As I recorded that he lacked insight, this would have meant that there was not at that time any partial degree of insight. The recent risks, including assault on police would have been markers of a complete change in

his behaviour due to the psychosis. My review also noted that he would not sit on his bed, which in the context of a seclusion review is a concerning sign of potential risk, as it would have made it easier for him to assault anyone who entered the room. It also indicated that he would not comply with a request from someone in a position of authority, as I was in that context, and this would have been due to the effect of the psychosis and lack of insight. Due to these factors, I interviewed him from the door, for the safety of all concerned, and furthermore, I noted that I wished not to provoke him, and so did not ask direct questions around his psychopathology (which would have been my normal practice). He also rejected physical health monitoring, which would have indicated likely paranoia towards the staff. My plan for ongoing seclusion, a relatively high dose of IM haloperidol (10mg) if he refused orals, reflected the effect of his psychosis on him, rendering him lacking capacity to consent to treatment or admission, with attendant risks.

123. Under the heading titled "*Imp*" [Impression], I note that "*Nurses report there may be a degree of reduction in agitation with haloperidol. Given he's only had 2 doses of IM haloperidol 10mg and the recent assault, he will need to stay in seclusion for now. A useful marker of improvement will be to note when he allows orals*" [NHFT0000168 p179]. Here, I am commenting that his level of psychosis then was accompanied by such fury and paranoia, that he believed he could and should fight attempts to give him oral medication, hence the need for IM injections. I would have known from experience that haloperidol is a quick acting reliable antipsychotic medication, as I commonly used it, and it was in the Trust's Rapid Tranquilisation Protocol [WITN0207011]. I would therefore expect to see some improvement after its use, perhaps after three

days. Once it began to reduce his agitation, and reduce the psychosis even a little, I would expect that he would then be able to appraise his situation better, and realise that opposition to the treatment at that point was futile, and it would be better to take oral medication, rather than one or more daily injections, to reduce not only any discomfort from the needle, but also the discomfort from a team of nurses having to pin him down to do this. Acceptance of oral medication would not mean he had regained capacity to consent to treatment or admission, and would not mean that that the psychosis had reduced necessarily to any great extent, but it did mean it had eased a little, enough to allow him to better appraise the situation. It did not infer more than that.

124. VC was in seclusion from Friday 3 September 2021 to Wednesday 8 September 2021 at the Cassidy Suite. Over that weekend, the responsible clinician would have been the on-call consultant psychiatrist. On the weekdays, the duty CRHT consultant was the responsible clinician, which was: me on 6 September, and Dr Ben Di Mambro on 7 and 8 September. Whilst seclusion medical reviews were carried out by a variety of grades of doctor, it would be the responsible clinician who would have overall responsibility for VC's care and treatment; this responsibility continued after seclusion was terminated on 8 September 2021. An example of this is a note on 9 September by Ms Sophia Mutono, CPN, that I had denied VC his request for section 17 leave to go home unescorted, and pack his belongings, as his contract for his accommodation had ended on the 6 September [NHFT0000168 p186].

125. The use of the duty CRHT consultant psychiatrist to act as responsible clinician for patients in either or both of the two rooms at the Cassidy suite, and for the Cassidy suite to be changed from its usual use as a section 136 assessment

suite was intended only for emergencies and not to be routine practice. VC was there from 3 to 11 of September 2021, which was longer than would have been desirable, and this was due to there being no internal male PICU beds, nor could an external PICU bed be found until then. Dr Di Mambro noted on 7 September 2021 that VC had been declined by 14 PICUs [NHFT0000168 p181].

126. The records show that on 4 September 2021, VC's "Risk and Safety Assessment" was completed by Miss Busayo Ajewole, nurse, [NHFT0000193] and updated by Ms Olivia Musonza, nurse, on 8 September 2021. Within the details of risk to others, it records that on 31 August 2021, VC was relapsing and had stopped taking his medication and also notes "*no evidence of any aggression.*" Under the heading "Risk Formulation", it notes that VC was "*very paranoid and suspicious, not willing to resume treatment. Nil insight, does not believe he has ever been unwell / was not psychotic*."

127. The individual practitioners completing this "Risk and Safety Assessment" would have been responsible for ensuring that the risk formulation as accurate. I cannot see that this document includes any update for the MHA assessment of 3 September 2021 during which police were significantly assaulted. It does contain an update dated 8 September 2021 which references seclusion, which would suggest that was needed due to physical violence, as per the MHA Code of Practice (26.103). An experienced clinician might therefore consider there should be further relevant information regarding this.

128. I have been asked whether the formulation of VC's Risk and Safety Assessment would have changed if the information regarding the incidence of aggression preceding his third admission had been included. Whilst it was

generally the role of nurse staff to formulate the "Risk and Safety Assessments", in my opinion, it would likely not have made any difference whilst the patient was assessed and treated at Highbury Hospital. This was due in part to the use of the Rio patient management software system, which had strengths and weaknesses. Clinicians would primarily use the Progress Notes section of Rio, where clinical plans and formulation were written directly. My experience was that Progress Notes were faster, more detailed and were up to date than information in the Rio templates. The Progress Notes would allow me to see which clinician made the entry and be less potentially confusing than a collaborative document such as the "Risk and Safety" form, which required not only updating of the chronology of risks, but to update the overall risk formulation. As those tasks derived from the Progress Notes, there was a risk that they might not be up to date.

129. There were detailed plans, including risk assessment and formulation, entered into the Progress Notes during this episode, such as the plan set out by Dr Lomas, CRHT consultant psychiatrist on 3rd September 2021 [NHFT0000168 p168], to commence seclusion, request a PICU bed, commence haloperidol 5mg bd and to use IM if he refused etc. VC's care followed this plan and updates in the Progress Notes.

130. For the purposes of the Inquiry, I have reviewed the chronology of relevant risk assessments. The risk information in relation to the incidence of violence at the MHA assessment was not added to the Rio "Risk and Safety Assessment" until an update by EIP CCO Miss Claudia Birtles on 18 January 2022 [NHFT0000192, p2]. Its omission did not affect the plan for transfer from the

Cassidy Suite, Highbury Hospital to a PICU, following the MHA assessment, as clinical plans would have been based on the Rio Progress Notes entries.

131. I have also reviewed the subsequent inpatient private hospital admissions; documents from both hospitals' evidence knowledge of the incident of aggression preceding his third admission. The Cygnet hospital risk assessment on the discharge summary of 1 October 2021 [NHFT0000268, pp 1-2] notes that they were aware of the risk upon admission: "*Prior to admission to Albert ward there was a high risk of violence and aggression, [VC was] nursed in seclusion for a week prior to transfer, he required CS gas and repeated firing of Tazers to subdue him sufficiently to be removed to the Cassidy Suite, and mechanical wrist and ankle restraints to transport him even after being CS gassed and tazered. Due to extreme levels of violence and aggression, physically assaulting a police officers (sic) by punching him on the face and attempting to assault other (sic), an emergency shout for support went out from Officers on scene executing the S135 warrant, dictating that they were being assaulted and needed extra support*." The Priory hospital discharge summary of 24 October 2021 [NHFT0000068 p1] records knowledge of the same risk history: "*He had previously been on admission at Cygnet Victoria PICU ward where he had spent about 3 weeks on section 3 of the MHA. His admission was preceded by an episode of psychosis. He recounts hearing male and female voices in his head telling him someone is being raped next door. This made him act by barging into his neighbour's apartment thereby causing them distress. There was associated history of violence and aggression. He had had to be de-escalated by police officers who he assaulted in the process. Tasers and gas had to be used to keep him under control.*

*Subsequently, he was sectioned under 136 and moved to Cassidy Suite at Highbury Hospital. Once at Highbury, Valdo spent a period of time in seclusion due to violence and aggression*." Despite the Trust "Risk and Safety Assessment" form not being updated for these risks, this suggests the external hospitals became aware of these risks by other means e.g. the Rio Progress Notes, verbal liaison with Trust staff or referral forms.

132. Regarding subsequent community care at the Trust following the above inpatient admissions, he was discharged to EIP, who would have had access to his full Rio notes and discharge summaries. I would not therefore expect that omission affected VC's care planning there. I note that his CCO later updated the Risk and Safety Assessment form on 18 January 2022, the day before the MHA assessment that I took part in. The assessment from that MHA recognised his past history of aggression when unwell and made a plan for daily medication concordance. When we had subsequent concerns about VC, he was detained on section 2, MHA on 28 January 2022. One of the assessors, Dr Lomas, recorded the history of significant assault on the police, which he had himself witnessed on 3 September 2021.

133. Whilst I conclude that the omission of this specific incident in the "Risk and Safety Assessment" as discussed in preceding paragraphs, did not change VC's formulation or care planning, it highlights a weakness in the Trust's clinical recording system, Rio. This is a concern as it could affect other patients' care. I am personally aware currently in my role as Clinical Director of community mental health services, since 1 September 2025, of the need for remedial steps to address deficiencies in our Rio system, and I am personally working with colleagues to improve parts of that. However, at present there is

no automatic way for the Rio system to update forms such as the "Risk and Safety Assessment" automatically from the Progress Notes or vice versa. I understand that the Rio company is working to improve the system. In the meantime, we will be reviewing our existing system to mitigate this risk as best as possible, and consider if needed, appropriate alternatives.

134. In summary, this "Risk Assessment" did not fully capture the risks relevant to VC, however the Rio Progress Notes did fully capture the risks, particularly the plan and risks documented by my CRHT consultant colleague Dr Ben Lomas on 3 September 2021, following the MHA assessment. VC's treatment plan was based upon the Rio Progress Notes, including Dr Lomas making a referral to a PICU, instituting haloperidol (an effective rapid acting antipsychotic medication which can also be given by injection, if oral medicine is refused) and commencing seclusion. The formulation, risk assessment and plan on the Progress Notes met the RCPsych's guidance "Good Practice Guide for the Assessment and Management of risk to others" [NHFT0015099] in my view, but the Risk and Safety form did not with regards to assessment – in particular with regards to a general principle on p.9 of that document: "Has the assessment and management plan been adequately recorded?"

**Transfer to Cygnet Hospital, Darlington**

135. VC was transferred to Albert ward, PICU, Cygnet Victoria House, Barton Street, Darlington, County Durham, DL1 2LN, on 11 September 2021 for continued treatment. The need for a PICU bed was made clear by Dr Lomas on 3 September 2021 [NHFT0000168, at p.167], noting his extreme violence and likely psychosis. On subsequent days in seclusion, when myself and Dr Ben Di Mambro, reviewed VC in seclusion, there was no sufficient change in

presentation to warrant a change to the plan set out by Dr Lomas until 8 September when Dr Di Mambro ended seclusion.

## III. VC's third period in community Care – Stonebridge centre, NHFT (22 October 2021 – 28 January 2022)

**Discharge from Priory**

136. VC's third Admission consisted overall of: seclusion on the Cassidy Suite at Highbury Hospital; a transfer to a PICU at Cygnet Hospital, Darlington; and then a transfer to Priory Hospital, Arnold, Notts. He was discharged from Priory Arnold on either 22 October 2021 (per EIP CPN Abi Parsonage's clinical note [NHFT0000168 p193-194]) or 24 October 2021 (per the Priory discharge summary p1).

137. Miss Abi Parsonage, EIP CPN, recorded in the notes on 22 October 2021 that she called the Priory Arnold for details of VC's ward round the previous day. Her notes of this conversation are:

> "*Valdo was discharged this morning, mum rang and was annoyed she had not been informed. Neither had we. I asked them what he had been discharged on medication wise they did not know. I asked them if they had sent the discharge summary to Claudia, they stated not yet as the ward has been busy. I will ring crisis to see if they can do a 3 Day F/U over the weekend. Claudia (CCO) is back Monday but she will then only have M/nday to complete*." [NHFT0000168 p194].

138. She then recorded a summary of her telephone call to the CRHT, which stated that CRHT would be unable to complete a 3 Day follow up (follow up within 72 hours) over the weekend *"due to [a to lack of} capacity from taking an influx of*

*referrals in from GP and crisis's over the weekend. CCO to complete Monday.*"
[NHFT0000168, at p.194]

139. CRHT's triage system would be for an experienced CPN (typically band 6) to discuss relevant aspects of the request with the referrer, and consider what the most appropriate level of support should be. Outcomes might include providing advice or signposting to other services, if more appropriate, to considering what level of response CRHT should plan for, or if escalation to potential hospital admission or an MHA assessment were required. If the triage nurse needed more support, this could be sought from the more senior band 7 nurse or the duty CRHT consultant psychiatrist. Regarding triage priorities, CRHT would prioritise high risk, acutely unwell people in the community first, and plan on how best to allocate resources such as for planned home visits with medication and the level of staff seniority needed. Regarding resources available, there would be less resources at the weekend, including no regular duty consultant psychiatrists. CRHT would and should have minimum standards regarding information about referrals. In this case, I understand there was no discharge summary from the Priory Hospital, Arnold. This would be a significant concern to CRHT as a discharge summary would be considered a prerequisite for a safe transfer from a hospital to CRHT, particularly an external one, as CRHT would not be able to see its records. As CRHT had not been consulted by the Priory in advance of the discharge, nor received a discharge summary, the triage nurse may have considered that the Priory were not unduly concerned about the need for CRHT support, but this would be only an inference, as the CRHT triage nurse name is not mentioned, nor did they make a separate entry on Rio. Miss Abi Parsonage's note

references that the request to CRHT seems to have been for a 3-day follow-up only. In the end, a plan was agreed by EIP with VC for him to receive a telephone call on the following Monday, which would fulfil the requirement for a 72-hour follow-up.

140. Regarding CRHT's service capacity, CRHT was considerably stretched when I was a consultant there (2019 to 2024). The team was hardworking, tightly integrated, and generally very experienced and was doing its best to cope with the pressures. In my view, it by and large prioritised the needs of the most severely ill people, including people with schizophrenia, and was a caring team that would frequently go the extra mile. It was able to punch above its weight regarding the resources it had available, and was perhaps the cornerstone of the Trust's adult mental health service. Regarding whether there were any issues regarding CRHT's capacity to undertake their work towards the end of 2021, broad themes such as the impact of the COVID-19 lockdowns, and the increasing pressure on linked stakeholders in the NHS (GPs, LMHTs, inpatient wards) increased pressure on CRHT. Whilst the COVID-19 lockdowns had lifted by this point, COVID-19 resulted nationally in exhaustion and burnout particularly to front-line staff, and CRHT were the most front-facing large community team in the Trust during the lockdowns, and would have been particularly affected. Regarding seasonality, the months of October to December are typically less intensive regarding demand, than spring and summer months. It is difficult to recall clearly that period, as it was four years ago.

**NHFT's review of adult and older adult crisis services**

141. Following the events of summer 2023, the Trust commissioned a review of its adult and older adult crisis services [NHFT0000462]. One of the findings within this report was as follows:

> *"Intensive ward in the community model of care can be best delivered where the fidelity of the model is supported by capacity. None of the CRHT had a clear threshold on what is their maximum capacity (caseload). While flexibility on managing an expanding caseload is a testament to the resilience within the team there is little thought around capacity and 'flow'. Patient flow is further affected by delays in finding beds at the high acuity end and delays on discharging to the community team at the low acuity end*" [NHFT0000462, pp.5-6].

142. It is difficult to comment on this as I was not personally interviewed by the authors or involved with the report. Specific issues such as maximum capacity (caseload) across CRHT services would be within the remit of operational and nursing management for those areas, and the Inquiry could request further information from colleagues there. The report covers several CRHT teams across the Trust, and I can only comment on my experience of the Nottingham City and Notts. County South teams. The report does not unfortunately evidence what it judged maximum capacity (caseload) to be in the period, including the latter part of 2021 and whether it considered that had been exceeded. Whilst it shows some informative graphs, such as markedly increasing self-referrals from 2019, when this became permitted, it does not show relevant data to address this question around capacity, which would require average caseload data, average staffing numbers and metrics on what

would be considered a safe ratio range. The caseload data stated for Nottingham City, are that month-end caseload referrals, from an unknown starting point until August 2023, were between 41-82, and for November 2023-February 2024 were between 100 to 147. This would be a 101% increase, based on the mode. However, this data does not help address this issue, as the starting point is not mentioned, and the month-end numbers might not reflect the average pattern during those months. For Notts. county south CRHT, the report states that caseloads were stable since September 2022, but does not provide further data to assist with assessing if this was within the team's staffing capacity in that period. Furthermore, it would not cover the period of relevance above, of winter 2021.

143. I can say that at the clinical team level, team members were acutely aware of how stretched they were, and wished it were otherwise. My experience was that we were aware of capacity problems, but did not feel we had much influence over this. There were longstanding insufficient numbers of hospital beds, particularly since the closure of two psychiatric wards at QMC in 2012. It was sometimes challenging to transfer care back to LMHTs, which appeared progressively weaker over time. Furthermore, there was a marked increase in self-referrals from people not already open to secondary care. Despite being frontline experienced CRHT consultants, we did not have adequate influence regarding budgets for staffing, for example. There was considerable effort by the team to maintain so-called 'patient flow', and overall, there was intense pressure on CRHT due to resource constraints. By late 2021, there had been a prolonged period of intense pressure on CRHT due to the COVID-19 lockdowns, as CRHT had to compensate for reductions in capacity in other

NHS services, such as primary care and LMHTs. Compensatory strategies attempted by those services, such as remote working via telephone calls and online video calls, were frequently insufficient to assess acutely mentally ill people, where body language is the largest part of communication. Consequently, CRHT, had a marked increase in workload, as the main frontline secondary care mental health service still seeing people face to face.

144. In summary, as I was not interviewed nor consulted by the authors of the report and there is insufficient information in it regarding caseload management during that time, as I discuss above, it is very difficult to comment.

145. The relevant demands requested of CRHT by Miss Parsonage, EIP CPN, was the request for a 72 hour follow-up. VC had been discharged from the Priory hospital, Arnold, without discussion with EIP. This made it difficult for them to meet the standard of a 72 hour follow-up, as it relied upon his usual CCO being able to do that on her return to work on Monday, the last eligible day within 72 hours. It would be standard practice for a hospital ward to discharge to the patient's longer term community team, unless there were specific concerns that required CRHT. VC's care does not appear to have been harmed by this, as the 72-hour follow-up was completed by his usual EIP CCO, Miss Claudia Birtles, on Monday 25 October 2021.

146. CRHT was next contacted on 18 January 2022, by EIP (by inference, this was Miss Adele Pinder, EIP CPN) [NHFT0000168 p203], to discuss whether an MHA was required. This followed an alleged assault by VC on a flatmate. Miss Victoria Green, the senior CRHT Band 7 nurse who was gatekeeping, recorded an entry 2 hours later, which stated that it was appropriate for the EIP CPN to request a MHA assessment, with police present [NHFT0000168 p204]. This

led to an MHA assessment the next day, 19 January 2022, during which I was present with colleagues. This was therefore a swift response.

147. CRHT were next required to provide care following the outcome of the MHA assessment of 19 January 2022 (which I discuss in detail below at paragraphs 151-158), namely daily medication concordance on Red RAG. This was intensive home treatment, and I would not have instituted that plan, if I had significant concerns about the team's ability to safely deliver it [NHFT0000168 p205]. The evidence from the CRHT entries is of a swift response: my CRHT Nottingham City colleague Emma Gregory, CPN recorded my referral within an hour [NHFT0000168 p205] on the Rio progress notes; VC's medication was prescribed on a CRHT paper community card [WITN0207012] within an hour by my colleague Dr Sandy Taylor; furthermore there is a practical summary for CRHT the next day from my consultant colleague Dr Ben Lomas, indicating a clear understanding of the need for prompt active care [NHFT0000168 p205]. CRHT engaged with VC daily in this period, evidenced concerns, and gathered information of relevance, and liaised with the university. This led to a discussion on 27 January 2022 between Jo Baker, CRHT CPN and me, which led to another MHA being called [NHFT0000168 p213]. This was a swift, intense period of appropriate care by CRHT, during the 8 days from the MHA assessment of 19 January 2022.

148. During his third period under community care, VC was under the care of EIP from 22 October 2021, until 19 January 2022, when CRHT took over his care primarily.

149. I understand from the records, and as summarised for me by the Inquiry, that (prior to my involvement on 19 January 2022), that within 1 month of discharge

from the Priory Arnold, that VC's CCO, Miss Claudia Birtles, CPN, appears to have raised concerns about his willingness to engage with mental health services [see, for example NHFT0000168 at p.199]. By 16 December 2021, VC was exhibiting anger and aggression towards Miss Birtles [NHFT0000168 at p.201] and staff at the Stonebridge centre noted that he had a "hostile edge to him" when he attended to collect his medication [NHFT0000168 at p.202]. By 10 January 2022, he is recorded to have missed four appointments with his community consultant psychiatrist, Dr Tuhina Lloyd, and his treatment team did not know if he was taking his medication [NHFT0000168 at p.202]. On 17 January 2022 VC had missed his 5th appointment with his consultant psychiatrist, Dr. Tuhina Lloyd, and she noted: "*Consideration will need to be given to discharge as Valdo has essentially disengaged and we have not been able to monitor him.*" [NHFT0000168, at p.203]. On 18 January 2022, VC was reported to have assaulted two of his housemates in their shared accommodation. The following information was received by Ms Ellie Turner at the university in an email from the student who was allegedly assaulted, and recorded by Miss Adele Pinder, EIP CPN, following a telephone call with Ms Turner.

> "*The student who I was assaulted by and who trapped me in the flat and physically wouldn't let me and my flatmate Ryan, leave is called Valdo… The police came to my accommodation and dealt with the situation, but unfortunately, although he had intent to hurt me, I stopped him by grabbing him and holding him, stopping them from arresting him as i didn't sustain any injuries. This has caused me a lot of stress as he is*

*still present in the flat and he doesn't seem the most stable of people*" [NHFT0000168 at p.203].

150. Swiftly after this, on the morning of 18 January 2022, I infer that it was Miss Pinder, EIP CPN, who spoke with CRHT and then requested a MHA assessment [NHFT0000069].

**MHA Assessment 19 September 2022**

151. On 19 January 2022, VC was brought to the Cassidy 136 suite at Highbury Hospital, after a warrant was executed at his student accommodation. Present at his student accommodation were Dr Omar Manzar, Roseanna Crane, AMHP, 15 police officers, and 3 members of staff, as described in the AMHP report [NHFT0000069 p.4]. VC was compliant in getting into the ambulance, escorted by police. This was in marked contrast to the MHA assessment of 3 September 2021, when he seriously assaulted a male police officer and needed to be subdued with CS gas and multiple discharges of a Taser.

152. I assessed VC at the MHA assessment at the Cassidy 136 suite, in my capacity as an independent medical practitioner, alongside Dr Manzar and Ms Roseanna Crane, AMHP. Observing was Miss Melanie Davies, Cassidy 136 suite RMN. Ms Crane's AMHP report [NHFT0000069 p.2] noted the following:

"*Valdo's engagement with his mental health team has been limited. Abi (covering CPN) reports Valdo as being guarded and suspicious on his last two contacts with the LMHT in November and December. Abi questions if Valdo was fully well when discharged.*"

"*Dr Manzar raised that he felt uncomfortable undertaking the mental health act assessment without police presence. Dr Manzar and I had a discussion with Valdo about his willingness to engage in the MHAA. Valdo stated he would comply, however Dr Manzer [sic] stated that Valdo was highly unpredictable as he had assessed Valdo previously in the past. It was concluded that two police officers would stay*." [NHFT0000069 at p.5].

"*Valdo accepted the prompt to take a seat on the Cassidy Suite bed. After introductions, Valdo engaged in the assessment. Through prompting Valdo described the events with the flatmate as being an altercation between housemates regarding the rotor [sic] for the bathroom cleaning. Valdo stated that this was a verbal altercation that did become physical in a '40 second scuffle'. Valdo states he normally gets along with this person and does not have any ill feelings towards him at the moment. Valdo was not initially able to recognise the link between this incident and the worries about his mental health. However with prompting with Dr Skelton Valdo was able to make the link between his behaviour becoming more agitated and aggressive, and a decline in his mental health. Valdo stated he had been taking his medication as prescribed. Rosie mentioned that the CPN team states that he would have run out by now. Valdo countered that he had not been taking the prescribed amount as he misunderstood the tablets the 20mg instead of 10mg, however has been taking 20 mg for the last two weeks. Valdo stated he understood if he did not take his medication, that he may end up in a similar situation as last year (reference previous admission). Valdo stated he did not feel he had psychosis, nor now or before. Valdo stated he had not been engaging with his community team as*

*he was time limited due to his studies. Valdo was able to make the link, with prompting, between staying well and engaging with his team and being able to successfully complete his studies. Valdo did agree to a community treatment plan with the crisis team. Valdo's main emphasis was on wanting to complete his studies, and continue with his revision as he is currently in the middle of his exam period*." [NHFT0000069 at p. 5]

"*Professionals discussion – The professionals discussion was short due to Dr Manzer [sic] having another commitment elsewhere, and the assessment initially being delayed by the discussion with police. All professionals agreed that Valdo could benefit from a hospital admission. Dr Manzer [sic] and Dr Skelton advised that they felt the community plan was most suitable based on the interview, balanced also with Valdo being in the middle of his exam period. Rosie could see the balance of the argument of for and against however as it was mutually felt that a community plan is least restrictive and Valdo's presentation does not present to the degree it has previously, Dr Manzar and Dr Skelton both having previous acquaintance. It was agreed that Valdo would be offered a community plan with the crisis team. This would be daily visits for medication concordance*." [NHFT0000069, p. 5].

153. The criteria for detention under the MHA is set out in the MHA Code of Practice, paragraphs 14.4 and 14.5. Paragraph 14.4 states: "A person can be detained under section 2 only if both the following criteria apply: the person is suffering from a mental disorder of a nature or degree which warrants their detention in hospital for assessment (or for assessment followed by treatment) for at least a limited period; and that they ought to be so detained in the interests of their own health or safety or with a view to the protection of others". Paragraph 14.5

states that for detention under section 3, 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."

154. My clinical note [NHFT0000168, p205] of 19 January 2022 summarises my conclusion, which was that CRHT daily medication concordance was appropriate at that point, whilst recognising that the overall picture suggested he was relapsing. Contributory factors to the decision not to detain him under the MHA and instead to commence a plan of CRHT daily medication concordance would have included that he was calm during the assessment, and for example, sat on his bed when requested. This was in marked contrast to 6 September 2021, when I last assessed him, in seclusion, and I was unable to safely interview him inside his room (para. 122 above). My clinical note recorded the recent altercation at his home and that police attended, but did not arrest him. There was therefore insufficient evidence to use this as evidence for detention under the MHA, although I noted that it was part of a picture suggesting he was relapsing. He was guarded during the MHA assessment, and it was not possible to elicit positive symptoms of psychosis (such as hallucinations or delusions), despite my trying. I considered altering his current antipsychotic medication at that time (aripiprazole 20mg), but he was unwilling to countenance this. His refusal to consider an alternative antipsychotic medication would not have been grounds for detention, he had been discharged from his most recent hospital admission (the Priory Arnold)

on that medication, and it was continued by his EIP team, which suggested that they had believed it to be effective. Whilst I noted his insight overall was *'relatively low'*, this was higher than when I had previously assessed him on 6th September 2021, by way of comparison. He was willing to accept resumption of his medication (and took aripiprazole 20mg at the Cassidy suite following the assessment) and to accept CRHT daily medication concordance, and it was made clear that if he did not accept that, that he would be admitted to hospital. There was insufficient evidence to justify degree under the MHA (degree refers to the current manifestation of the disorder (paragraph 14.6 of the Mental Health Act Code). These factors favoured a trial of intensive daily CRHT medication concordance, and I noted "*if it becomes clear he is not engaging or further risks become apparent, we will look at admission*." This strategy was in keeping with the MHA Code of practice: paragraph 14.7 states that before it is decided that hospital admission is necessary, that consideration be given to whether there are alternative means of providing the care and treatment which the patient requires, including consideration of whether there might be other effective forms of care or treatment which the patient would be willing to accept. Paragraph 14.9 of the MHA Code of Practice also states that factors to include in consideration are whether other methods of managing the risk are available. Alternatives to detention under the MHA may include, as stated in paragraph 14.11 of the MHA Code of Practice: "management in the community – e.g. by a crisis and support team…"

155. My practice in preparing for a MHA assessment would be to gather as detailed a picture of the person being assessed, as possible. This would include a review of the Rio medical records. On this occasion, my memory is that there

was also a discussion between Dr Lomas and me regarding VC's case, before the assessment. This was due to Dr Lomas becoming aware as duty consultant that an MHA assessment of VC was forthcoming, and he was keen to share his first-hand knowledge of VC from prior assessments, given his concern – particularly as he had witnessed the policeman being assaulted seriously by VC on 3 September 2021 at a prior MHA assessment. Regarding the issue of VC's medication, it is difficult for me to be precise on the information I reviewed, given the passage of time. My understanding at that time was that he had been prescribed aripiprazole 20mg daily. Regarding other medicine choices, I would have been aware from my prior seclusion review of 6 September 2021 that he had previously received haloperidol 10mg daily. I would have raised the issue with VC of seeking a change in medication from aripiprazole, as my clinical experience was that it was not as reliable as other antipsychotic medication choices, including haloperidol. However, at that point, as there was evidence that VC had not been concordant with the prescribed aripiprazole 20mg dose (he stated he had been taking 10mg), it was not immediately possible to assume that there was treatment failure regarding that medication and dose. Therefore the plan was formed to continue it, as this appeared to be the least restrictive option.

156. Consideration was given to the possibility that VC was misleading us, regarding his concordance with medication, and his willingness to engage with community treatment. This is a common clinical problem to address at MHA assessments for several disorders, but particularly for patients with schizophrenia. I formulated my plan to take account of this and recorded "*CRHT can monitor – if it becomes clear he is not engaging or further risks*

*become apparent, we will look at admission*" [NHFT0000168 p205]. This was based upon my noting that his insight was relatively low and that he seemed to not have been well concordant with medication. The subsequent entries from home treatment by CRHT support that the team were able to follow this plan and that there was a high degree of professional scepticism about his medication concordance, and this led to another MHA assessment, eight days later.

157. As noted above in paragraph 152, the AMHP report notes VC as saying that he "*did not feel he had psychosis".* This contributed to my statement that "*his insight overall into his condition and risk of relapse given the admission earlier in the year is relatively low in my view*." [NHFT0000168, p205]. We would have considered this, alongside all the other evidence at the time in determining the outcome. Insight is on a spectrum, as I have discussed above in paragraphs 37 and 122. This informed the community plan for CRHT daily medication concordance, and it was hoped that by VC accepting daily medication of aripiprazole 20mg, witnessed by the CRHT, that he would regain insight.

158. I concluded that VC did not pose any imminent risk to himself or others [NHFT0000168 at p.205]. As discussed above at paragraph 154, VC was calm; his calmness was not only during the MHA assessment when I observed him, but earlier in the day, when police attended at his home, when the warrant was served, and was in marked contrast to the MHA assessment of September 2021, when he had seriously assaulted police. I did consider the possibility that this calmness could change and noted his past history of aggression when unwell and that in recent days his flatmate had been worried about him. Regarding risks to self, the most likely risk would have been of further

deterioration in his mental health, and was accounted for by the proposed plan of CRHT intensive daily medication monitoring, and with VC taking aripiprazole 20mg at the Cassidy suite after the MHA assessment.

**Diagnosis of Paranoid Schizophrenia**

159. I have been asked whether in the course of treating VC under the care of the CRHT and/or in the course of undertaking the MHA Assessment on 19 January 2022, I was aware that VC had been diagnosed with paranoid schizophrenia, and the impact that would have on his care and treatment. My recollection of events and documents is affected by the fact that over four years have elapsed since then, as well as the impact of the atrocities, publicity and my reading documents as part of the Trust's internal review. Nevertheless, I hope the following comments help the Inquiry.

160. I was aware that VC had a chronic psychotic disorder, and I reference him previously being in hospital, in my note of 19 January 2022. [NHFT0000168 p205]. I had also previously seen him acutely ill with psychosis at my seclusion review of 6 September 2021. My recollection is that on the day before the MHA assessment of 19 January 2022, Dr Lomas and I had a detailed discussion about his case, as we were aware that one of us would likely be attending an imminent MHA assessment regarding him and given the past risks, Dr Lomas was keen to share his first-hand knowledge of VC, in case he should not be on duty when the MHA would occur. My recollection of events is hazy given the passage of time, but it was my habit before MHA assessments to read relevant medical entries such as the recent discharge summaries from Cygnet and the Priory, which stated that VC had a diagnosis of paranoid schizophrenia. It was also the case that I was CRHT duty consultant on 3 August 2020, less than

one week after he was diagnosed as having 'likely schizophrenia' by Dr Seedat, which I discuss above at paragraph 78. My recollection is that during our discussion, Dr Lomas and I considered whether affective symptoms were a component, based on his grandiosity at the MHA assessment of 3 September 2021. We may also have discussed Dr Burri's impression of 7 September 2020, that it was a likely affective psychosis. Whilst events are too remote to be confident, we discussed whether therefore schizoaffective disorder was appropriate.

**Referral to CRHT**

161. On 19 January 2022, VC was referred to CRHT [NHFT0000208]. The referral document completed by my CRHT colleague, Mrs Emma Gregory, CPN, states that I was the referrer. Whilst I do not recall the details, there is a Rio entry of 19 January 2022 by Mrs Gregory, noting the referral received from me [NHFT0000168, p205]. She would then have completed the referral document. It is likely that I either telephoned Mrs Gregory from the Cassidy Suite or spoke to her in person, as CRHT was no more than 10-minute walk at most.

162. Under "Current Concerns", the referral notes [NHFT0000208] "*MHA ax [assessment], relapse of psychosis, non-concordance with medication, risk of losing his uni [university] place*." The section which asks "Has a Risk assessment been completed" is left blank. Although the form was completed by Mrs Gregory, and therefore I cannot comment on why it is blank, the referral form would have been superseded by the Rio Progress Notes, which summed all of the relevant information, including events and risks leading to the MHA assessment on 19 January 2022. I discuss the Rio system issues in detail above at paragraph 133. Mrs Gregory did note the recent risks in her Rio

progress note of the same day: "*2 person visit initially until further ax [assessment] of risk; Recent hostage situation; Hx [History] of being admitted to PICU*" [NHFT0000168 p205]. The referral form likely had an administrative purpose, for CRHT to record the beginning of a patient contact, and was more important for external referrals, where we did not have Rio Progress Notes. For internal patients, the clinical information is on the Rio Progress Note in detail, hence the brief notes to action the referral urgently.

163. I have been asked why I determined on 27 January 2022 that another MHA assessment was required [NHFT0000168, p. 213]. This decision was recorded in a progress note by Miss Jo Baker, CRHT CPN. It followed her meeting with VC, during which he refused a drink with his medication, and she was unsure if he took the medication, as he walked off when she was attempting to watch his concordance. She recorded "*On return to the office I have had a discission with Dr Skelton. Plan: 1. MHA to be called. 2. Telephone call to Ellie Turner (university) to discuss*" [NHFT0000168, p. 212].

164. There were likely several factors contributing to our decision, of which medication non-concordance was one. Although I did not make a note of the conversation, I suspect that I would have seen from nurse Baker's description, on 27 January 2022, that VC was lacking insight and capacity to a significant degree. There was a consistent pattern of non-engagement with CRHT. VC had lied about his university accommodation, saying his flatmates were still with him, whereas we knew from the concerns expressed by Ellie Turner, that the university wished to evict him and were concerned for the safety of the other students. As VC would become homeless if evicted, CRHT support could not safely then take place, and so CRHT home treatment would no longer be

the "least restrictive option" per the MHA, and hospital admission would be needed to deliver treatment. Mrs Tricia Denham, CRHT Band 7 CPN had noted at MDT with me two days earlier, on 25 January, that potential eviction *"could be a seriously destabilising factor."* [NHFT0000168 p210]. This was also consistent with increasing concerns from 25 January 2022. I would also have considered that nurse Baker was very experienced, and able to take appropriate therapeutic risks, and therefore this was a signal that home treatment was no longer possible, and that an MHA assessment was needed again.

165. Later that day of 27 January 2022, nurse Baker recorded "*Spoken with Dr Skelton, decided that warrant will be needed to conduct mental health act assessment*." [NHFT0000168 p. 213]. I would have been aware of VC's extreme violence at the MHA assessment on 3 September 2021, that a warrant was considered needed 8 days earlier for the MHA that I attended, and that we now considered that he had further deteriorated. I might also have considered that without a warrant, he might not have allowed an MHA assessing team entry to his home. I might also have been prompted by the note by my CRHT consultant colleague, Dr Di Mambro, who noted on 26 January 2022 "*If not engaging today, will need to request MHA which will require police presence*" [NHFT0000168 p211].

166. On the next day, 28 January 2022, Dr Ben Lomas and Dr Omar Manzar undertook a MHA Assessment [see NHFT0000070 at pp. 7-11]. The detailed clinical progress note on Rio by Dr Lomas stated: "*Section III was discussed, but the balance of the assessors felt that further assessment was required*

*given the lack of clear psychopathology currently. We agreed to recommend detention under section II*".

167. It is difficult to provide opinions on other health professionals' decisions, especially with hindsight, and knowledge of the later atrocities perpetrated by VC. Such an opinion would presuppose that I could put myself in their place. There is also a degree of subjectivity for assessors, in determining whether section 2 or section 3 of the MHA should be applied, when considering detention. Furthermore, to the best of my knowledge, there has been a growing relative proportion of section 2 recommendations nationally, compared to section 3 recommendations, linked to several factors. I'm therefore not able to offer a view on this, unfortunately ,and would suggest further information be sought from the three participants at that MHA assessment.

168. I have never been involved in the care of any other mental health patient who following discharge or whilst under a CMHT, has killed or seriously injured a member of the public. I was shocked by the atrocities, and my heart goes out to the families of those who died or were injured. I can still recall the collective grief of the community in Nottingham at the vigil. It was a further shock for me to later learn that this was perpetrated by a former patient of our team, and someone I had assessed and treated.

**Recommendations**

169. I believe that had VC been cared for consistently by the same consultant psychiatrist during both inpatient and his community care, and had there been sufficient mental health beds, to have enabled him to have been admitted to

the same ward on each occasion, that there would have been a much greater chance that the true nature of his schizophrenia could have been recognised and that he could have received appropriate treatment. The fragmented system of a different consultant and teams in inpatient care, crisis care, community care, with further fragmentation induced by private hospital admissions, caused a fragmentation of knowledge about VC and damaged his care. Unfortunately this system remains commonplace, both in Nottinghamshire and nationally. I would recommend that the Chair recommend to the Government that mental health patients are accorded the same level of funding that patients received for physical care, which is an issue that the Royal College of Psychiatrists has campaigned for since 2015, in its "Parity of Esteem" campaign. Mental illness inpatient beds have fallen by 24% since 2010/11 in England, whilst inappropriate out of area mental health placements is now higher than in 2016, when the Government set out a target to eliminate them (BMA: Mental health pressures in England) [WITN0207013, pages 16 - 20]. The present fragmented system appears based upon a 2005 report by the Royal College of Psychiatrists, which was in response to member burnout, predicted shortages of psychiatrists and the continuing demand for mental health services (New ways of working for psychiatrists: Enhancing effective, person-centred services through new ways of working in multidisciplinary and multi-agency contexts) [WITN0207014]. An unintended consequence of these changes is that the community consultant psychiatrist, with whom the patient is expected to spend most of their time in treatment, often does not witness or treat the patient's severest symptoms, as patients are acutely assessed and treated much more by either CRHTs or inpatient

teams. As community teams come under more pressure, the opportunity also for those community consultant psychiatrists to attend emergency MHA assessments and have a voice at a critical time, is reduced. This present system makes treatment less consistent, and more difficult for the psychiatrist to witness at first hand treatment responses and side effects over the long term. This has significant consequences for the patient with a long-term disorder like schizophrenia, where it is the nature of the disorder, that most will stop their medication within two years. It also makes it more difficult for the consultant psychiatrist to assess if a patient's desire to reduce medication is due to genuine side effects, preference, or developing loss of insight. Because nursing teams are different in inpatient and community, the consultant psychiatrist is best placed to bridge that gap and help provide consistent care. Because the MHA presupposes consistency e.g. that the nature of a disorder is understood when considering potential detention, I recommend that there should be a single consultant psychiatrist looking after the same area of patients, who when they need admission, go to the same ward (a sectorised model). The present model which uses a CCO to bridge that inpatient/community gap is not as effective, despite best intentions. The old sectorised system, which I am describing, had several advantages including that a consultant psychiatrist was enabled to learn quickly from their mistakes. If a patient were discharged by a consultant psychiatrist, but quickly relapsed, then that same psychiatrist would have to reconsider what to change regarding treatment: e.g. for a patient with schizophrenia, whether a CTO with a depot was needed, and/or if the patient needed more social support (which a section 117 would support). The problem is that the same issues that existed in 2005

and that led to the present fragmented model remain – a grossly underfunded psychiatric system, with insufficient staff, insufficient hospital beds, insufficient investment into psychiatric research etc. A return to a sectorised model (but adequately funded) would also help GPs with a single point of clear senior psychiatric contact. Because the psychiatric system does not operate in a vacuum, a prerequisite for success is that other key stakeholders in the public sector system are also adequately funded, such as primary care, social care, and the police.

170. It caused me great concern in preparing this statement, to see many parallels with the case of Christopher Clunis killing Jonathan Zito in 1992. Clunis was a young Afro-Caribbean man with schizophrenia, floridly psychotic, not taking his medication and was found guilty of manslaughter due to diminished responsibility and detained to a maximum-security hospital. "The Report of the Inquiry into the Care and Treatment of Christopher Clunis, 1994", [DHSC0000160], noted similar problems to today: insufficient mental health beds, insufficient section 12 approved doctors, tendencies to care and treat the acute episode of illness, without also providing long term care etc. The authors commented: *"We could understand how it was very possible to think that Christopher Clunis was well, if discussion with him was superficial and short lived. We found in our interview with him that it was only after some time that he began to demonstrate bizarre ideas and thoughts."* [DHSC0000160, paragraph 41.1] This bears remarkable parallels to VC's case. It reinforces my view that only if VC were to have had a consistent consultant psychiatrist in both inpatient and community, with consistent nursing teams, with adequate resources to include the ability to engage with him assertively in the

community, that there would have been an opportunity to build a consistent therapeutic relationship and linked treatment plan.

171. Regarding multi-agency working, I would recommend that AMHPs are co-located in the same premises as the CMHTs for whose area they cover. This would enhance relationships, information sharing and increase the possibility for community consultants to attend MHA assessments on their own patients. I would also recommend that appropriate shared IT information be facilitated, so that AMHPs could see relevant NHS information and that mental health professionals could see relevant social care information, to enable him a more holistic picture of the patient. Regarding this issue for the police, whilst there are potentially conflicting issues such as the patient's right to confidentiality, security and legal issues, it would be helpful if information could be appropriately shared as easily as possible between the police and the NHS, so that appropriate actions could be taken, particularly in the case of patients that disengage from health services, such as some people with serious disorders, such as schizophrenia.

**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 Dr Michael Skelton, Consultant Psychiatrist

Dated: 23 November 2025

## Index to First Witness Statement of Dr Michael Skelton

| No. | Inquiry URN | Document Description |
|---|---|---|
| 1 | NHSE0000042 | Policy Document RE: Acute inpatient mental health care for adults and older adults, NHS England |
| 2 | WITN0207003 | Royal College of Psychiatrists 'Standards for Inpatient Mental Health Services 2019' |
| 3 | DHSC0000007 | Policy Document, Re: Mental Health Act 1983: Code of Practise, Department of Health. |
| 4 | WITN0207004 | NHS England – Care Programme Approach (CPA) |
| 5 | NHNB0003187 | Policy Document, Re: Practice Guidelines for Crisis Line Response and Crisis Resolution and Home Treatment Teams, Royal College of Psychiatrists |
| 6 | NHNB0004953 | Report dated 01/09/2019, compiled by NHS England and NHS Improvement and the National Collaborating Centre for Mental Health Re: The Community Mental Health Framework for Adults and Older Adults |
| 7 | WITN0207005 | World Health Organisation, The ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines. [Pp. 3, 22-43, 84, 86-96] |
| 8 | WITN0207007 | British Medical Journal, 'How to approach the mental state examination' (BMJ 2017; 357: j1821) |
| 9 | NHSE0002386 | Guidance, Re: Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services, NICE |

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| 10 | NHFT0015099 | Royal College of Psychiatrists Good Practice Guide for the Assessment and Management of risk to others |
| 11 | WITN0207008 | New England Journal of Medicine, 'Effectiveness of anti-psychotic drugs in patients with chronic schizophrenia' (2005) 353:1209-1223 |
| 12 | NHSE0002718 | Policy Document, Re: Crisis and acute mental health services, NHSE |
| 13 | NHFT0000981 | Policy Document, Re: Operational Policy, Mid Notts Crisis Team, by NHFT |
| 14 | NHFT0006966 | Policy Document, Re: Crisis Resolution and Home Treatment (CRHT) Teams Standard Operating Procedure (AMH Greater Notts, Mid-Notts & Bassetlaw), NHFT. |
| 15 | WITN0207009 | CRHT Service specification |
| 16 | WITN0207010 | 'Mental Health Crisis Care Concordat' (HMRC, 2014) |
| 17 | CQCM0016063 | Policy Document/Guidance, Re: core Crisis Resolution Team Fidelity Scale Version 2, Camden and Islington NHS FT (Date Unknown) |
| 18 | NHFT0000168 | Medical Records of VC from 24/05/2020 to 14/06/2023, Various NHFT Staff/Teams, re: Patient Record Summary |
| 19 | NHFT0000030 | Medical Records of VC dated between 28/07/2020 - 29/07/2020, compiled by Nottinghamshire Healthcare NFT, Re: City Crisis Resolution Home Treatment Team Internal Referral |
| 20 | NHFT0000222 | Medical Records of VC dated 31/07/2020, NHFT Re: Discharge summary - Version 2.2 |

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|---|---|---|
| 21 | NHFT0000195 | Medical Records of VC dated 15/07/2020, Nottinghamshire Healthcare NHS Foundation Trust, Re: Risk and Safety Assessment |
| 22 | NHFT0000181 | Medical Records of VC from 31/07/2020, NHFT, re: Mental Health Clustering Tool |
| 23 | WITN0207002 | 04.04 (Issue7) Seclusion Longer Term Segregation – January 2020 |
| 24 | CYGN0000085 | PICU Gatekeeping Referral Form dated 03.09.2021 |
| 25 | WITN0207011 | Use of Medication in Rapid Tranquilisation |
| 26 | NHFT0000193 | Medical Records of VC dated from 04/09/2021 to 08/09/2021, Nottinghamshire Healthcare NHS Foundation Trust Re: Risk and Safety Assessment |
| 27 | NHFT0000462 | Review Report [Unknown date & Author], Re: Nottingham CRHT and associated Crisis Service review |
| 28 | WITN0207012 | CRHT paper community card |
| 29 | NHFT0000069 | AMHP Report - Referral and Assessment dated 19/01/2020, compiled by Roseanna Crane, Nottingham City Council Re: Valdo Calocane |
| 30 | NHFT0000208 | Medical Records of VC dated 19/01/2022, NHFT, re: CRHT Referral |
| 31 | NHFT0000070 | Form H3 - Regulation 4(4) and (5) Mental Health Act 1983, Sections 2, 3 and 4 - Record of detention in hospital of Valdo Calocane |
| 32 | WITN0207013 | 'BMA: Mental health pressures in England' |

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| 33 | WITN0207014 | Royal College of Psychiatrists, 'New ways of working for psychiatrists: Enhancing effective, person-centred Services through new ways of working in multidisciplinary and multi-agency contexts' (2005) |
| 34 | DHSC0000160 | Report of inquiry into Chris Clunis |
| 35 | WITN0207015 | NHS England, 'Terminology and classifications' |
| 36 | NHSE0000252 | NHS England Care Programme Approach Position Statement 2022 |
| 37 | WITN0207016 | Lancet 2019 Meta-analysis anti-psychotics schizophrenia |
| 38 | NHFT0000192 | Risk and Safety Assessment update by EIP CCO Claudia Birtles on 18 January 2022 |
| 39 | NHFT0000268 | Cygnet Risk Assessment - discharge summary (redacted) |
| 40 | NHFT0000068 | Discharge Priory City South (redacted) |
| **41** | **NHFT0000130** | **Service Guide: Adult Mental Health Acute Inpatient Wards** |