Witness name: Younus Saleem

Statement No: WITN0208001

Dated: 13.11.2025

**THE NOTTINGHAM INQUIRY**

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**FIRST WITNESS STATEMENT OF YOUNUS SALEEM**

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I, Younus Saleem, will say as follows: -

INTRODUCTION

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

BACKGROUND

3. I hold MBBS, MRPsych and MBA degrees. My career is marked bytraining in forensic psychiatry and obtaining a CCST in 2003 in the same field. I have been a consultant forensic psychiatrist since September 2003. I have worked

in Broadmoor Hospital as a consultant forensic psychiatrist before I came to Nottinghamshire Healthcare NHS Foundation Trust.

4. I have been working at the Trust since June 2005. I have worked mainly in the low secure and community forensic directorate. I am a consultant with the responsibility of care of inpatients on Porchester ward at The Wells Road Centre. I also have worked as a Responsible Clinician at Bracken House for about nine months in 2018. I have further worked in the Local Mental Health Team ("LMHT") in the Stonebridge Centre in 2024 between February and April. I have also worked at LMHT at Musters Road between April and October 2024. I continued working at Central LMHT based at Highbury Hospital between October 2024 and April 2025. I have been working in the Early Intervention in Psychosis team ("EIP") since August 2025. I have worked at LMHT and EIP on a sessional basis. My main work remains at the Wells Road Centre on Porchester ward.

ROLE AND TRAINING

5. Since joining Nottinghamshire Healthcare NHS Foundation Trust in June 2005, I have consistently contributed to the consultant-level on-call rota at Highbury Hospital. My role involves providing out-of-hours psychiatric cover as part of a 1-in-14 on-call schedule, ensuring continuity of care and clinical leadership across services.
6. It is important to note that I had completed my specialty training in forensic psychiatry between August 2000 and July 2003 and was working at consultant level throughout the period from 23rd May 2020 to 20th June 2023.

INPATIENT MENTAL HEALTH SERVICE

7. The overarching clinical aim of treating inpatients detained under the Mental Health Act 1983 is to provide safe, effective, and person-centred care that promotes recovery, reduces risk, and supports reintegration into the community. Treatment is delivered within the legal framework of the Act and guided by statutory principles, NICE guidelines, and evidence-based best practices.
8. The key clinical objectives include:

    - Stabilisation of Mental State: Immediate priority is given to alleviating acute psychiatric symptoms and distress, using appropriate pharmacological and psychological interventions.
    - Comprehensive Risk Assessment and Management: Risk assessments are conducted using structured professional judgement tools. These assessments consider historical, clinical, and future risk scenarios, including risks to self and others.
    - Formulation and Delivery of a Biopsychosocial Care Plan: Treatment plans are developed collaboratively, incorporating biological, psychological, and social factors. These plans are regularly reviewed and adapted to meet the evolving needs of the patient.
    - Safeguarding and Legal Compliance: Where safeguarding concerns arise, appropriate procedures are followed in line with statutory guidance and local safeguarding protocols. Treatment is provided in accordance with the safeguards under the Mental Health Act, particularly for serious or invasive interventions.

- Respect for Patient Rights and Dignity: The Code of Practice emphasises the importance of treating patients with dignity, ensuring their autonomy is respected, and involving them in decisions about their care wherever possible.
- Adherence to NICE Guidelines: Clinical interventions are informed by NICE guidelines relevant to the patient's diagnosis and presentation, such as those for psychosis, bipolar disorder, personality disorders, and co-occurring substance misuse.
- Preparation for Discharge and Aftercare: Discharge planning begins at admission and involves multi-agency collaboration to ensure continuity of care. Section 117 aftercare responsibilities are jointly managed by NHS bodies and local authorities, as outlined in statutory guidance.

9. In practice, Nottinghamshire Healthcare NHS Foundation Trust adheres to national standards and has robust mechanisms for training, implementation, and audit of these guidelines, ensuring high-quality care for detained patients.
10. Nottinghamshire Healthcare NHS Foundation Trust (NHFT) provides a comprehensive range of inpatient services for individuals experiencing an acute mental health crisis. These services are designed to offer timely, safe, and therapeutic interventions, either on an informal basis or under the legal framework of the Mental Health Act 1983.
11. Patients in crisis are typically assessed promptly by community-based teams such as the **Crisis Resolution and Home Treatment Team (CRHT)**, **Early Intervention in Psychosis (EIP)**, or other relevant crisis services. Following assessment, if the individual meets the clinical and risk thresholds for inpatient

care, admission is considered to one of the Trust's designated inpatient units. These include:

- **Highbury Hospital** in Nottingham
- **Sherwood Oaks Hospital** in Mansfield (formerly Millbrook Hospital)

12. Admissions may occur informally (with the patient's consent) or formally under the Mental Health Act. The most commonly used sections for formal admission include:

- **Section 2** – for assessment (up to 28 days)
- **Section 3** – for treatment (initially up to six months)

13. In forensic contexts, admissions may occur under:

- **Section 37** – hospital order issued by a court
- **Section 37/41** – hospital order with a restriction order
- **Section 47/49** – transfer from prison with a restriction direction
- **Section 48/49** – urgent transfer from prison with restrictions

14. Patients admitted under forensic sections are typically cared for in secure settings such as:

- **The Wells Road Centre** (low secure)
- **Wathwood Hospital** and **Arnold Lodge** (medium secure)
- **Rampton Hospital** (high secure)

15. These services operate within the statutory framework of the Mental Health Act 1983 and adhere to national standards, including NICE guidelines and the Mental Health Act Code of Practice. The Trust maintains robust governance and training structure.

## TREATMENT, CARE AND MANAGEMENT UNDER THE MENTAL HEALTH ACT 1983

16. The primary focus of care for individuals detained under Section 2 of the Mental Health Act 1983 is comprehensive assessment. This includes evaluating the nature and severity of the mental disorder, assessing associated risks, and determining the most appropriate treatment pathway. While treatment may be initiated during this period, it is tailored to the patient's immediate clinical needs and risk profile, including risks to self or others. All interventions are delivered in accordance with NICE guidelines and within the legal safeguards provided by the Act.
17. Section 3 of the Mental Health Act is specifically intended for the treatment of individuals with a diagnosed mental disorder. The care provided under this section is more treatment-focused, with a structured plan aimed at managing symptoms, reducing risk, and promoting recovery. Treatment is guided by evidence-based practice, including NICE clinical guidelines and is regularly reviewed to ensure it remains appropriate and effective.

INVESTIGATING MENTAL HEALTH ILLNESS

18. In determining whether an individual is acutely unwell, I rely on a combination of clinical presentation, collateral history, risk assessment, and previous psychiatric records. The decision is informed by both current symptoms and contextual factors, including patterns of relapse, engagement with services, and risk to self or others.

19. A relevant example is the case of VC, who had a well-documented history with Nottinghamshire Healthcare NHS Foundation Trust, having presented multiple times since 2020. On 29th January 2022, I was consulted regarding his potential admission. VC had been assessed by the City Crisis Resolution and Home Treatment Team (CRHT) on 27th January 2022, followed by a Mental Health Act assessment conducted by Dr Lomas, Mr Manzar, and Fiona Parker on 28th January 2022.

20. Although VC did not exhibit overt psychotic symptoms at the time, his presentation was consistent with previous episodes of relapse. He was thought-disordered, delusional, and lacked insight. His guardedness and suspiciousness, combined with a history of forced entry into properties driven by delusional beliefs, indicated a significant risk to others. The assessing team noted that his calm demeanour mirrored previous incidents of serious violence and concluded that he met the criteria for detention under Section 2 of the Mental Health Act.

21. Further assessments revealed disengagement from services, non-compliance with medication, and irritability in the presence of mental health professionals. He declined to engage in meaningful discussion and was noted to lack capacity to make decisions regarding his care. Based on these factors, and in

consultation with colleagues, I agreed that VC was acutely unwell and required admission.

22. This case illustrates that while overt psychotic symptoms can make the decision to admit straightforward, they are not the sole criteria. A thorough understanding of the individual's psychiatric history, behavioural patterns, and risk profile is essential. Guardedness, suspiciousness and disengagement—particularly when consistent with previous episodes—can be indicative of acute mental illness. Admission under the Mental Health Act may be necessary even in the absence of florid psychosis, as was the case with VC.

## TREATMENT, CARE AND MANAGEMENT OF PSYCHOSIS

23. During the initial period of observation following admission, it is essential to gather a comprehensive picture of the patient's mental state, behaviour, and overall presentation. This phase is critical for establishing a clinical baseline and identifying any immediate risks or needs. Observations focus on the patient's appearance, level of self-care, and behaviour, including signs of agitation, withdrawal, or unusual motor activity. Speech patterns—such as coherence, rate, and relevance—are closely monitored, alongside mood and affect, which help determine emotional congruence and stability.

24. Clinicians pay particular attention to thought processes and content, looking for signs of disordered thinking, delusions, or suicidal ideation. Perceptual disturbances, such as hallucinations, are also noted. Insight and judgement are assessed to understand the patient's awareness of their condition and their ability to engage with treatment.

25. Behavioural changes are especially important during this period. These include alterations in sleep, appetite, and social interaction, as well as any episodes of aggression, self-harm, or non-compliance with ward routines. The patient's willingness to engage with staff and participate in assessments is observed, as is their response to redirection or de-escalation strategies.

26. Collateral information from family, carers, or community teams is invaluable, particularly when it provides context about recent deterioration or relapse. Previous psychiatric history, patterns of engagement and known risk factors are considered alongside current presentation. Risk assessments are conducted to evaluate potential harm to self or others, as well as any vulnerabilities the patient may have.

27. Physical health screening is also undertaken, and the patient's capacity to consent to treatment is assessed. All findings are documented and discussed within the multidisciplinary team to inform the initial care plan. This process is guided by NICE clinical guidelines and the Mental Health Act Code of Practice, ensuring that care is both lawful and aligned with best practice.

28. In the case of VC, following my authorisation for admission, he was seen by several mental health professionals during the initial observation period. Notably, Dr Yusuff, the on-call SHO, made a detailed entry on 29th January 2022 at 6:12pm [NHFT0000168 at p218]. During this interaction, VC was informed about the presence of a COVID-19 positive patient on the ward. He responded by stating that he had received two doses of the COVID-19 vaccine. Dr Yusuff also attempted to carry out routine investigations, including blood tests and an ECG, but VC declined. This refusal was communicated to me, and no further action was taken regarding those investigations at that time.

29. Subsequent entries provide further insight into VC's presentation. On 30th January, Mr Kadzinga documented his observations, followed by a review from the ward pharmacist, Ms Bhavi Parmer, on 31 st January 2022 [NHFT0000168]. At that point, VC was noted to be prescribed Aripiprazole 10mg tablets. Later that day, Dr Jonathan Gibson conducted a senior medical review, which included a reassessment of VC's background, mental state, and engagement. Dr Gibson consulted with Dr Thangavelu, the responsible clinician, and noted that VC appeared monotonous and guarded, with significant difficulty in establishing rapport. VC denied experiencing hallucinations and was not observed to be responding to unseen stimuli. No clear delusional beliefs were elicitable during the assessment, and he demonstrated no insight into his history of psychotic episodes.

30. There was also uncertainty surrounding the circumstances of his current admission, particularly in relation to reported incidents of hostility and hostage-taking involving peers. VC's engagement with community services had been poor, although there had been some improvement during contact with the CRHT. Dr Gibson concluded that, aside from being guarded, VC did not present with overt psychotic symptoms at that time but acknowledged that further inpatient assessment might reveal additional symptoms, as had occurred during previous admissions.

31. Given the uncertainty surrounding VC's admission, particularly previous admissions and escalating violence which was of significant concern, his guarded presentation had to be viewed within a broader clinical context. Guardedness in individuals with paranoid or psychotic disorders often reflects internal distress, fear of stigma, or residual psychotic symptoms. In VC's case,

this presentation could not be dismissed as reluctance to engage, but rather as a signal of deeper clinical complexity. His case required a careful, step-by-step approach—peeling back layers of behavioural, psychological, and interpersonal factors with patience and sustained observation to fully understand his mental state and risk profile.

32. A multidisciplinary team (MDT) meeting was held on 31st January 2022, during which it was agreed that collateral history should be obtained from VC's family and a Police National Computer (PNC) check should be completed. While I will not provide an exhaustive list of all observations made during this period, I consider the above to represent the key elements of the initial observation phase. Further commentary on subsequent observations would be more appropriately provided by other professionals involved in VC's ongoing care.

CORE ASSESSMENT

33. The core assessment serves as a foundational clinical tool designed to gather a comprehensive understanding of the patient's psychiatric history, current presentation, risk profile and treatment needs. Its primary aim is to inform a holistic and person-centred care plan, ensuring that interventions are tailored to the individual's mental health condition, social circumstances and potential risks to self or others.

34. In Nottinghamshire Healthcare NHS Foundation Trust, core assessments are routinely completed for all inpatients, including those detained under the Mental Health Act 1983 as well as those admitted informally. For detained patients, the assessment is particularly important in establishing the legal and clinical basis

for ongoing care and treatment. It is reviewed and updated regularly throughout the admission, especially during key clinical decision points such as multidisciplinary team meetings, changes in presentation, or preparation for discharge.

RISK ASSESSMENTS IN CARE PLANS

35. Risk assessments play a central role in the formulation and ongoing development of an inpatient's care plan. They are conducted regularly and are integral to understanding the patient's clinical presentation, history and potential risks. These assessments consider a wide range of factors, including a history of violence, personality disorder, offending behaviour, substance misuse, homelessness, relationship difficulties, and poor occupational functioning.
36. By identifying and evaluating these risks, clinicians are able to develop not only a treatment plan but also a robust management strategy that anticipates potential scenarios and mitigates harm. This process is multidisciplinary in nature, involving input from medical, nursing, psychological, and social care professionals. In inpatient settings such as Highbury Hospital, this collaborative approach ensures that care plans are comprehensive, dynamic, and responsive to the patient's evolving needs and risks.

MENTAL STATE EXAMINATION

37. When undertaking a Mental State Examination (MSE), the process begins with a review of the patient's clinical history to provide context for the current

presentation. The examination itself involves a structured observation and interaction with the patient, focusing on several key domains.

38. The patient's appearance, demeanour and level of cooperation are noted, including how they are dressed, their posture and their ability to maintain eye contact. Speech is assessed for rate, volume, coherence and relevance. Mood is explored both subjectively (how the patient describes their own emotional state) and objectively (how they appear emotionally during the interview).

39. The thought process is examined in terms of both form and content. Formal thought disorders may be identified through signs such as derailment, loosening of associations, or flight of ideas. In terms of content, the presence of delusional beliefs—such as paranoid, persecutory, or grandiose delusions—is explored, along with any unusual or fixed beliefs that may indicate psychosis.

40. Perceptual disturbances are assessed, including auditory and visual hallucinations, as well as passivity phenomena. The patient's cognitive function is also evaluated, including orientation to time, place, and person, and any signs of cognitive impairment, such as memory deficits or features suggestive of dementia.

41. The MSE is a vital component of psychiatric assessment and is used to inform diagnosis, risk assessment, and care planning. It is conducted systematically and interpreted in the context of the patient's history and current circumstances.

DISCHARGE PLANNING

42. When considering discharge planning for an inpatient experiencing psychosis or diagnosed with paranoid schizophrenia, several clinical and behavioural

indicators must be present to ensure the process is safe, appropriate, and sustainable. A key prerequisite is the stabilisation of the patient's mental state. There should be no evidence of acute psychotic symptoms, significant behavioural disturbances such as aggression or violence, or major side effects from prescribed medication.

43. Equally important is the development of insight. The patient should demonstrate an understanding of their mental health condition, the reasons for their admission and the necessity of ongoing treatment. This includes recognising relapse signatures and acknowledging the importance of continued engagement with services.

44. Discharge planning also requires a clear assessment of the patient's social circumstances. This includes ensuring appropriate accommodation is in place and that the patient has access to adequate support—whether emotional, familial, or community-based. Confidence in the patient's ability to adhere to supervision and monitoring arrangements in the community is essential.

45. These factors are assessed collaboratively through the multidisciplinary team, and only when these criteria are met can discharge planning be meaningfully initiated.

*History of aggression in the community and inpatient settings*

46. If there is a history of aggression—whether in the community or inpatient settings—a thorough risk assessment must be undertaken to evaluate the nature, context and potential escalation of violent behaviour. This assessment should consider historical incidents, current presentation and any known triggers. Where appropriate, liaison with external agencies such as MAPPA

(Multi-Agency Public Protection Arrangements), the police, the community forensic team, and other relevant stakeholders is essential to ensure coordinated risk management and safeguarding. This multidisciplinary approach helps inform both the care plan and any necessary legal or protective measures.

*Those who are considered to be at risk of becoming violent in the absence of treatment?*

47. Clinicians consider individuals with a known history of violence, particularly in the context of untreated mental illness, to be at heightened risk of becoming violent in the absence of appropriate treatment. In the case of VC, for example, his documented history of violent behaviour would have clearly indicated a significant risk. Therefore, he would have been regarded as at risk of further violence without timely and effective intervention. In VC's case, involvement of the family could have served as a critical protective factor when considering discharge, particularly in mitigating the risk of violence through promoting treatment adherence, emotional stability, and continuity of care in the community.

*History of violence*

48. When an individual has a history of violence, conducting a thorough and structured risk assessment becomes critically important. This assessment helps clinicians evaluate the likelihood of future violent behaviour, understand potential triggers and develop appropriate management strategies to ensure the safety of the patient, staff, and the wider community.

*With a history of non-concordance with medication.*

49. When there is a history of non-concordance with prescribed medication, it becomes essential to conduct a thorough assessment of the individual's likelihood to adhere to treatment and supervision in the community. This includes evaluating their insight into their condition, understanding of the need for medication, and willingness to engage with services. In the case of VC, for example, his previous disengagement from services and refusal to take medication raised significant concerns about his ability to maintain treatment compliance outside of a structured inpatient setting. Such factors would have been carefully considered before any decisions regarding discharge or community management were made.

*With a history of social isolation*

50. A history of social isolation is a significant factor when assessing discharge readiness, particularly in cases such as VC. Social isolation can impact a patient's ability to engage with support networks, adhere to treatment, and manage daily living independently. In VC's case, this history would have been a key consideration in determining whether he was suitable for discharge, as it raises concerns about vulnerability, risk of relapse, and the availability of appropriate support in the community.

*With a history of disengagement from treatment*

51. A history of disengagement from treatment is a significant factor when considering discharge planning. In VC's case, this pattern of disengagement

would have been carefully considered, as it raises concerns about his ability to adhere to follow-up care, maintain medication compliance, and engage with community support services. Without a clear plan to address these issues, the risk of relapse and potential harm increases substantially.

*With a history of masking psychotic symptoms.*

52. When a patient has a history of masking psychotic symptoms, it is essential to approach their self-reported experiences and observed behaviour with caution. In VC's case, this was particularly relevant, as his guarded presentation required careful clinical interpretation. Masking can obscure the true severity of the illness, making it more difficult to assess risk and readiness for discharge. Therefore, a thorough and nuanced evaluation is necessary to ensure that underlying symptoms are not overlooked.

PAST BEHAVIOUR AND FUTURE RISK

53. When assessing the potential risks, a patient may pose to themselves or others during a psychotic crisis or period of acute mental illness, clinicians rely heavily on information from the patient's history. Key factors include a previous history of violence or aggression, patterns of disengagement from treatment, non-concordance with medication, and substance misuse. Additional considerations include poor interpersonal relationships, unstable employment history, lack of routine or structure in the community, and limited psychosocial or family support.

54. These historical indicators help build a comprehensive risk profile, which informs both the clinical management plan and any necessary safeguarding or legal interventions. Understanding these elements is essential for anticipating potential deterioration and implementing appropriate preventative strategies.

INVOLVEMENT WITH VALDO CALOCANE ("VC")

FOURTH ADMISSION

55. During VC's fourth admission, my involvement was limited to providing advice in my capacity as the on-call consultant. I did not have direct, face-to-face contact with VC, nor was I a formal member of his multidisciplinary team (MDT). My role was advisory, based on information provided to me during the on-call period, and I was not involved in the ongoing clinical management or decision-making processes related to his care.

56. I can confirm that I am the originator of the entry in VC's medical records dated 29th January 2022 at 18:04 [NHFT0000168 at pp.216-217], which states as follows: *"I have reviewed Rio notes dated 29th January 2022 at 18:04.He was seen by the on call doctor in the early hours of this morning who noted that he had significantly disengaged from the services. There were reports of compliance issues with medication. He declined to engage. He is well known to the secondary mental health services with one previous admission for first episode psychosis. He declined to answer any questions. He was irritable in the presence of mental health professionals. He was also seen by Dr Lomas who has known him previously. He was of the view that he has a history of recurrent psychosis. He thought that he was a significant risk to himself and*

*others. He has a history of significant assault on police and ongoing risk to staff following last admission. He recommended detention under section two of the Mental Health Act. Earlier today when he was seen in Cassidy suite, it was noted that he was not very cooperative and refused to engage. He had been offered food and drink on numerous occasions but had declined it all. He sat on the floor in the communal area during the night and had previously declined to go to his bed space. It appears that he does not have the capacity to make a decision in regard to his ongoing assessment and treatment. I have conducted the covid risk assessment and agreed to his admission.*"

57. The purpose of my involvement in the aforementioned review was to ensure that senior consultant support was available to the frontline assessing team, who held responsibility for determining the need for admission. As part of the on-call consultant role, I was required to authorise the admission, which I duly provided to support the team's clinical decision-making.

58. My impression of VC's mental state was that he appeared guarded and presented with a significant history of mental illness and violence. What stood out to me was his non-concordance with treatment and the pattern of repeated admissions. From the documentation I reviewed prior to authorising his admission, it was evident that he demonstrated very limited insight into his condition. This lack of insight, combined with his clinical history and presentation, strongly supported the decision to proceed with admission.

59. Insight, in clinical terms, encompasses an individual's a) understanding of their mental illness, b) the associated risks, including the potential for violence and c) the need for ongoing treatment. In VC's case, he showed no appreciation of his psychiatric symptoms, did not acknowledge his history of violent behaviour,

and failed to recognise the necessity of continued treatment. This included both pharmacological and non-pharmacological interventions. His lack of insight significantly increased the risk of deterioration and underscored the need for structured inpatient and outpatient/community care.

60. I concluded that VC did not have the capacity to make decisions regarding his ongoing assessment and treatment. This view was based on a substantial body of evidence in his clinical notes, which consistently showed that he had denied the seriousness of his mental health presentation over a number of years, particularly in the lead-up to his admission in January 2022.

61. At the time, VC was unable to understand the information provided to him about his condition and treatment options. He lacked the ability to weigh the risks and benefits of the decisions he was being asked to make, and he was unable to arrive at a reasoned decision or communicate it effectively to the professionals conducting the Mental Health Act assessment and those involved in his admission. These factors led me to determine that he lacked decision-making capacity in relation to his care and treatment.

62. I reviewed VC's medical records, particularly in the lead-up to 29th January 2022. This included entries made by Dr Lomas (NHFT0000168, 20-Jan-2022 at p205; 28-Jan-2022 at pp214-215) and other mental health professionals involved in his Mental Health Act assessment (NHFT0000168, 28-Jan-2022 at p215). I also spoke with the individual who contacted me at the time, although I am unable to recall their name. I examined VC's core assessments, though I cannot now recall the exact sequence of events due to the passage of time.

63. Importantly, I reviewed the Mental Health Act assessment carried out by two independent medical practitioners—Dr Lomas and Dr Omar Manzar—who

recommended admission under section 2. In addition, I examined clinical notes recorded on RiO by the Crisis Resolution and Home Treatment Team (CRHT) and the Early Intervention in Psychosis (EIP) team (NHFT0000168, 24-Jan-2022 at p209; 24-Jan-2022 at p210; 26-Jan-2022 at p211; 27-Jan-2022 at p212; 29-Jan-2022 at p217-218. I also considered other relevant documentation and clinical entries necessary to inform my decision to authorise VC's admission.

64. My understanding of VC's diagnosis was that he was highly likely to be suffering from paranoid schizophrenia. However, I did not consider it necessary to be absolutely certain of the diagnosis at that stage. What was more clinically relevant was his presentation—marked by psychotic symptoms, a history of escalating violence, and non-concordance with treatment. These factors were more significant in guiding the decision to admit than a definitive diagnostic label.

65. It was clear that VC had a mental disorder of a nature and degree that warranted hospital-based treatment. While I did consider whether care could be safely provided in the community, I concluded that this was not appropriate. His guarded and suspicious behaviour, history of violence, and poor adherence to prescribed medication raised serious concerns about risk and safety both to himself and others. Therefore, inpatient treatment was deemed necessary.

66. I did not have direct access to VC's Police National Computer (PNC) record at the time of his admission. However, the clinical notes clearly referenced a significant history of violence, which was taken into account during the decision-making process. I was aware that, in the weeks leading up to his fourth

admission, the police had been involved in investigating allegations that VC had assaulted a housemate.

67. Despite this, I did not seek further information from the police, the Approved Mental Health Professional (AMHP) referral, or VC's housemates, as the decision to admit him did not require additional external evidence at that point. His presentation was consistent with previous episodes, and his documented history of violence, non-concordance with treatment, and aggressive behaviour provided sufficient grounds for admission.

68. I did not instruct junior doctors to obtain further information either, as it was not necessary to inform the immediate decision to bring him into hospital. However, had I been part of VC's ongoing multidisciplinary team (MDT), I would have pursued further details myself or delegated the task appropriately. I routinely access PNC records through established arrangements with relevant agencies when such information is required to support clinical decision-making.

69. I do not recall having reviewed the risk and safety assessment completed for VC on 28th January 2022 [NHFT0000191]. This assessment was undertaken some time ago. I also do not recall being involved in VC's admission, despite the recent national media coverage surrounding this case. It came as a surprise to learn, upon being contacted to prepare this report, that I was the consultant who authorised his fourth admission.

70. In the course of my work, I see a large number of patients and have limited involvement with those admitted through the on-call system. My role in such circumstances is to respond to clinical needs as they arise. At the time, my involvement was limited to assessing whether admission was appropriate for a

patient of this nature, and I assisted in making that decisionbased on the information available to me.

71. I do not recall any conversations with the nurse who updated the risk assessment, nor do I remember who initially contacted me regarding VC's admission. I have no recollection of the individual or team member with whom I discussed this case. Apart from the clinical entry recorded under my name, I have no specific memory of these interactions. It was only after reviewing the documentation provided in the bundle that I was able to confirmthat I had indeed made that entry.

72. I understood that the primary risks associated with VC wererelated to his presentation with a psychotic illness, his history of violence,and his non-concordance with treatment. It was clear to me at the time thathe posed a potential risk of harm to himself and to others. In view of this assessment, I authorised his admission to hospital.

73. In making the decision as to whether VC should be admittedto hospital, I undertook a clinical risk assessment based on the information available to me at the time. This included a review of the relevant entries in his electronic clinical record, from which I gleaned pertinent background details regarding his mental state, history of violence, and previous non-concordance with treatment. I conducted this assessment mentally, as part of my usual on-calldecision-making process, rather than through the use of a structured risk assessment tool such as the HCR-20. The use of such a formal tool would not have been appropriate or feasible in the context of an urgent admission decision.

74. At the time, the decision was necessarily driven by the immediate clinical information available and by the presenting level of concern regarding VC's

mental state and potential risk to himself and others. My mental formulation of risk, based on this information, was sufficient to support the decision that hospital admission was warranted. I did not complete or record a separate risk assessment document, as my involvement was in the capacity of the on-call consultant making an urgent admission decision.

75. Following VC's admission, I did not have any further involvement in his care or treatment during the course of his fourth admission. My role was limited to authorising his admission on the basis of the information available at that time.

76. I have been involved in cases where patients under the care of community mental health teams, following their discharge from hospital, have gone on to injure members of the public. I have also been contacted by the National Confidential Inquiry in relation to individuals who subsequently committed homicide, as I had been involved in their care at some stage.

77. To my recollection, none of the patients discharged from The Wells Road Centre under my direct care have gone on to commit homicide. However, I have been involved in the care of individuals at The Wells Road Centre who were later discharged into the community and subsequently committed offences resulting in injury to members of the public. I do not recall any such incidents occurring in recent years.

REFLECTION

78. My main reflection is that this is a deeply tragic case involving significant loss of life and distress to the victims and their families. It highlights the importance

of continual reflection and learning within mental health and associated services.

79. I recognise that, as with many complex cases, there may have been missed opportunities across systems of care and risk management. It reinforces the need for ongoing improvement in the way mental health servicesidentify, manage, and communicate risks—both within teams and across agencies. VC's case was inherently complex due to the presence of multiple uncertainties and unknowns surrounding his presentation and the circumstancesof his admission. While certain aspects, such as his history of psychotic episodes, escalating violence, and poor insight were clear and well-documented, other elements remained ambiguous and required deeper exploration. This contrast between the evident and the unclear necessitated a careful, layered approach to assessment, making the case clinically and contextually challenging.

80. It is my hope that this review process contributes to strengthening multi-agency collaboration, ensuring that information is shared effectivelybetween health services, social care, and criminal justice agencies. Such collaboration is essential in preventing similar incidents in the future.

81. I also believe that sustained investment and adequate resourcing of mental health services are crucial to enable timely, comprehensive assessments and interventions for individuals with complex needs. This should be viewed not only as a local or regional issue but as a matter of national importance.

82. From my review of the available information, it appears that mental health services endeavoured to engage appropriately with VC and to provide care within the scope of the resources, available frameworks and information available at the time. However, this case underlines the need for continued

attention to how agencies coordinate their responses to individuals who present both clinical and public safety concerns.

83. I believe that anyone with responsibility for the care of mental health patients in UK would have reflected on, and to some extent adapted, their practice following a case of this nature. It is difficult not to be affected by the tragic circumstances and the implications for clinical practice.

84. As a consequence of VC's case, I have become particularly mindful of the importance of ensuring that risk assessments are clearly documented in the clinical record, so that the rationale for decisions and the identified risks are transparent and accessible to all members of the multidisciplinary team.

85. I have not given any interviews or made any public comments regarding this matter, and I do not wish to do so.

RECOMMENDATION

86. I respectfully recommend that the Chair emphasise the importance of integrated working across all parts of the mental health system. Mental health services should not operate in silos but function as part of a single, coordinated system in which information is shared efficiently, and roles and responsibilities are clearly defined.

87. Early escalation to forensic mental health services should be actively considered in cases where there are indicators of significant risk, a history of violence, or complex clinical and social factors that exceed the remit of general mental health teams. Timely involvement of forensic services allows for more

comprehensive risk assessment, specialist input, and appropriate management planning.

88. Additionally, I believe there should be continued focus on strengthening communication between health services, social care, police and criminal justice agencies to ensure that risks are jointly understood and appropriately managed. Multi-agency collaboration—supported by clear protocols for information sharing—can play a crucial role in identifying and mitigating emerging risks.

89. Finally, sustained investment in training, supervision, and resources for front-line clinicians is essential to ensure that staff are supported in recognising, recording, and escalating risk concerns promptly and effectively.

90. Locally and nationally, I believe the effectiveness of multi-agency working can be significantly improved by fostering a culture of shared responsibility and open communication across all services involved in the care and management of high-risk individuals. Mental health, social care, primary care, and criminal justice agencies should operate as parts of a collaborative, coordinated system rather than as separate, unconnected entities.

91. Information sharing is central to this process. Agencies should be supported and encouraged to share relevant information promptly and appropriately, with clear frameworks and agreements in place to facilitate this. Professionals should feel confident and empowered to escalate concerns about individuals who present increasing levels of risk, without fear of overstepping boundaries or creating duplication. It is particularly important for the police to have a low threshold for liaising with mental health teams and sharing information regarding the risk of violence. Early and proactive communication can be critical in preventing escalation and ensuring timely intervention.

92. Regular multi-agency meetings, joint risk reviews, and clearly defined escalation pathways could strengthen collective decision-making and ensure that emerging risks are addressed proactively. Nationally, the development of consistent standards and expectations for inter-agency collaboration would help embed this approach and promote uniformity of practice across regions.

NOTE

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

Statement of Truth

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

Signature… GRO-B

Dated……13/11/2025……..

**Index to First Witness Statement of Younus Saleem**

| No. | Inquiry URN | Document Description |
|---|---|---|
| 1 | NHFT0000168 | Medical Records of VC from 24/05/2020 to 14/06/2023, Various NHFT Staff/Teams, re: Patient Record Summary |
| 2 | NHFT0000191 | Medical Records of VC dated from 28/01/2022 to 02/02/2022, NHFT, Re: Risk and Safety Assessment |