Witness Name: Dr Helena Aziri

Statement No: WITN0229001

Dated: 14 February 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DR HELENA AZIRI

I, Dr Helena Aziri, will say as follows: -

Introduction

1. I am a locum Consultant Psychiatrist.

2. This witness statement is made to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 Request dated 13 October 2025 (the "**Request**").

Background

3. I have been asked to set out my treatment of Valdo Calocane (VC) following his admission to Priory Hospital Arnold in October 2021.

Career and role

4. I am a locum Consultant Psychiatrist currently practicing within the NHS. My medical career began in 2007, after I completed the final state examinations at the Faculty of Medicine, Comenius University, in Bratislava, Slovakia. I have

since continued my practice in the UK, where I have been working since 2012.

5. I obtained my postgraduate qualification, the MRCPsych, in 2023. Additionally, I am approved by the Secretary of State under Section 12(2) of the Mental Health Act 1983, authorizing me as a specialist in the assessment and treatment of mental disorders.

6. Prior to starting to work in my current role as a Consultant Psychiatrist, I was employed as a speciality doctor in Priory Healthcare, between 2019 and 2021. At this time, I was based at Priory Arnold hospital. During my employment as a Specialty Doctor at the Priory Hospital, my role was to provide day-to-day medical care and psychiatric treatment to inpatients experiencing acute or severe mental health crises, under the supervision of the Consultant Psychiatrist (Responsible Clinician). I worked closely with the multidisciplinary team — including nursing staff, psychologists, occupational therapists and social workers — to ensure safe, effective, and recovery-focused care in accordance with the Mental Health Act 1983 (MHA), its Code of Practice (2015), and relevant NICE guidelines.

Inpatient Mental Health Services

7. The broad clinical aim of providing treatment to a patient in an acute mental health unit is to ensure their safety, stabilise their mental state, and support recovery through a combination of medical, psychological, and social interventions. Care is provided within a multidisciplinary framework, with an emphasis on risk assessment, formulation, and collaborative care planning.

8. For a patient detained under the MHA 1983, the primary objectives are to treat the patient's mental disorder in the least restrictive manner consistent with their health and safety, and the protection of others. Treatment is provided under the legal framework of the MHA, which allows for necessary interventions when the patient lacks capacity or declines treatment, while ensuring that statutory safeguards and reviews are in place.

9. For a voluntary (informal) patient, treatment is based on consent and collaboration. The aims are similar in terms of clinical outcome — symptom relief, stabilisation, and recovery — but all care is provided with the patient's consent, and they retain the right to leave hospital if they wish, unless a risk assessment indicates that detention may be required under the MHA to ensure safety. Across all settings, the overarching aim is to promote recovery, reduce risk, and facilitate safe discharge with appropriate community support.

10. My understanding of the general procedure and scope of Priory inpatient services is that these units provide 24-hour care, assessment and treatment for individuals experiencing acute mental illness or crisis. The primary aims are to:

    - ensure patient and public safety;
    - stabilise the patient's mental state;
    - address the underlying mental disorder using evidence-based interventions; and
    - facilitate recovery and discharge in the least restrictive and most therapeutic environment possible.

11. All patients are reviewed regularly by medical staff, nursing staff provide continuous observation and support, and care is guided by the principles of

risk management, least restriction, patient involvement, and recovery orientation.

Caring for Patients under Section 2

12. When caring for patients detained under Section 2, the clinical objective is to undertake a full assessment of the person's mental disorder, risk profile, and treatment needs within the 28-day detention period. This includes:
    - carrying out a comprehensive mental state and physical examination;
    - initiating appropriate treatment where indicated;
    - monitoring response and side-effects; and
    - making an early determination regarding discharge or further treatment under another legal framework (for example Section 3).
13. Treatment under Section 2 can be given without consent, in line with the MHA 1983 Part IV and the Code of Practice, but consent is always sought wherever possible. If ECT were to be considered, the requirements under Section 58A would apply. Patients are informed of their rights under Section 132, and access to an Independent Mental Health Advocate (IMHA) is offered.
14. Care during this period follows NICE NG10 (**WITN0229002**) for de-escalation and safety, and multidisciplinary reviews are held at least weekly.

Caring for Patients under Section 3

15. When caring for patients detained under Section 3, my role as a Specialty Doctor was to provide day-to-day medical input under the supervision and direction of the Consultant Psychiatrist (Responsible Clinician). Section 3 authorises detention for the purpose of treatment for a mental disorder for up to six months initially, renewable if the criteria continue to be met. My responsibilities included:
    - conducting regular reviews of the patient's mental state and risk

profile;

- prescribing and monitoring medication in accordance with the Consultant's treatment plan and NICE guidance relevant to the diagnosed condition (for example, schizophrenia, bipolar disorder, or severe depression);
- monitoring for side-effects and arranging necessary physical health investigations;
- supporting the implementation of psychological and occupational therapy interventions; and
- documenting progress, capacity assessments, and any changes in presentation in the medical records.

16. Consent for treatment was reviewed regularly by the medical team. If the patient had capacity and consented, a T2 certificate was completed by the Responsible Clinician. Where the patient lacked capacity or refused treatment, the Consultant would request a Second Opinion Appointed Doctor (SOAD) to authorise treatment via a T3 certificate, as required under Part IV of the MHA.
17. Voluntary patients were admitted with their consent and were free to leave the ward at any time, unless risk increased to a level warranting MHA assessment.
18. Care was collaborative and based on shared decision-making. Treatment followed NICE guidelines relevant to the patient's condition, and the same standards of physical health monitoring, medication review, and risk assessment were applied as for detained patients.
19. If a voluntary patient expressed a wish to leave but significant concerns existed about their safety or the safety of others, I or the duty doctor would assess whether the criteria for detention under Section 5(2) or formal MHA

assessment were met.

Working with other NHS hospitals and independent healthcare providers

20. During my time working as a Specialty Doctor at Priory Hospital Arnold, the inpatient service functioned as part of the wider system of mental health care provision, working closely with NHS Trusts, commissioners, and community teams to ensure safe, coordinated and legally compliant care for patients.
21. Priory Hospital Arnold operated as an independent sector provider but admitted patients whose treatment was commissioned and overseen by the NHS. Most admissions were arranged through local NHS Trusts or Integrated Care Boards (then CCGs), often following referral from an NHS acute or crisis service when local NHS beds were unavailable or where Priory offered a more suitable therapeutic environment.
22. We worked in partnership with NHS inpatient units, community mental health teams (CMHTs), and crisis resolution/home treatment teams (CRHTTs) to maintain continuity of care. Regular communication took place through discharge planning meetings, Care Programme Approach (CPA) reviews, and liaison with care coordinators and community psychiatrists.
23. When a patient was transferred to or from an NHS or another independent hospital, clinical handovers were completed using standardised documentation, medication reconciliation, and risk information sharing, consistent with NICE NG53 (2016): **WITN0229003**.

Acute mental health units

24. An acute mental health unit such as Priory Hospital Arnold provides short-term, recovery-focused care for adults experiencing a mental health crisis that cannot be safely managed in the community. The aim is to stabilise symptoms, manage risk, and prepare for safe discharge or step-down.

25. In contrast, a Psychiatric Intensive Care Unit (PICU) caters for patients who pose a greater risk of harm to themselves or others, require higher levels of observation and security, or whose disturbed behaviour cannot be safely managed in an open acute setting. PICUs operate with higher staff-to-patient ratios, enhanced security measures, and more restrictive environments.

26. Acute wards often serve as a step before or after a PICU admission, depending on clinical progress.

The role inpatient service providers, particularly independent providers, have in the context of the Care Programme Approach ("CPA").

27. Under the CPA framework, the responsibility for care coordination lies primarily with the patient's community-based care coordinator, usually employed by the NHS Trust.

28. However, inpatient providers — including independent hospitals — have an essential role in contributing to and implementing CPA plans during admission.

29. At Priory Hospital Arnold, CPA principles were embedded in care planning. The multidisciplinary team contributed to CPA meetings, updated risk assessments, and formulated discharge and aftercare plans in collaboration with the NHS care coordinator and Responsible Clinician.

30. The Priory's role was therefore collaborative and time-limited, focusing on safe treatment during the inpatient phase and supporting the patient's transition back to NHS-led community services upon discharge.

Factors which indicate a diagnosis of Psychosis

31. In clinical practice, psychosis is a broad term describing a condition in which a person loses contact with reality, typically through disturbances in perception, thought, or belief. Diagnosis is based on the presence of characteristic symptoms, their duration, and the impact on functioning, as described in ICD-

10 (F20–F29) or ICD-11 classifications, and informed by NICE guideline CG178: Psychosis and schizophrenia in adults (2014, updated 2023) (WITN0229004).

32. Key features indicating psychosis include:

- Delusions: fixed, false beliefs not in keeping with cultural norms (e.g. beliefs of persecution, reference, or grandiosity);
- Hallucinations: sensory experiences without external stimuli, most commonly auditory (e.g. hearing voices);
- Disorganised thought or speech: incoherence, derailment, or thought blocking;
- Grossly disorganised or abnormal behaviour: agitation, bizarre posturing, or catatonic features;
- Negative symptoms: social withdrawal, reduced motivation, blunted affect, or poverty of speech.

33. Psychosis is diagnosed when such symptoms are persistent and cause significant impairment in functioning, and are not attributable to an organic cause, substance misuse, or a mood disorder with psychotic features.

Factors which indicate a diagnosis of Paranoid schizophrenia

34. Paranoid schizophrenia is a subtype of schizophrenia as defined by ICD-10 (F20.0) — though ICD-11 has moved away from subtypes and instead describes "schizophrenia spectrum disorders." At the time of my work with the Priory (between 2019–2021), ICD-10 criteria were in routine use.

35. The diagnosis of paranoid schizophrenia was made when a person presented with:

36. Prominent delusions (typically persecutory, referential, or grandiose in nature);

- Frequent auditory hallucinations, often in the form of voices

commenting or conversing;

- Relative preservation of affect, cognition, and volition, meaning the person might appear organised and articulate despite psychotic beliefs;
- Absence of prominent disorganised or catatonic features; and
- Duration of at least one month of characteristic symptoms (as per ICD-10).

37. Assessment involves a detailed history, mental state examination, corroborative information from carers or professionals, and exclusion of organic or substance-induced causes. Diagnosis is supported by longitudinal observation of symptoms and functional decline, often confirmed through multidisciplinary formulation.

Treatment, care and management of patients experiencing psychosis

Circumstances where PICU patients are referred or 'stepped down' to an acute inpatient ward at Priory Hospital Arnold

38. During my time at Priory Hospital Arnold, patients were transferred or "stepped down" from a Psychiatric Intensive Care Unit (PICU) when their level of risk and behavioural disturbance had sufficiently reduced such that they no longer required high levels of security, observation, or physical containment.

39. Typically, this occurred when:

- the patient's acute agitation, aggression, or behavioural dysregulation had settled;
- rapid tranquillisation or continuous one-to-one nursing was no longer necessary;
- there was improved insight, engagement with treatment, and a willingness to participate in ward activities; and

- risk to self or others could be safely managed within an open acute environment.

40. The aim of such transfers was to continue recovery and rehabilitation in a less restrictive setting, consistent with the Mental Health Act Code of Practice (2015) principle of least restriction. The decision was usually agreed jointly between the PICU team, the receiving Consultant Psychiatrist at Priory, and the commissioning NHS Trust, following a multidisciplinary discussion and risk review.

41. When accepting a patient transfer or new admission, I would expect a comprehensive referral pack to be provided before admission, typically including:

    - A recent psychiatric assessment or medical summary, including diagnosis, presentation, and rationale for admission or transfer;
    - Details of the legal status under the MHA, including copies of detention papers and consent-to-treatment forms (e.g. Section 2/3 documentation, T2/T3 forms, nearest relative details);
    - A risk assessment and management plan, including recent incidents, safeguarding concerns, or forensic history;
    - A current medication chart and summary of previous treatments, side-effects, and response;
    - Relevant physical health information (past medical history, allergies, investigations, and any current physical issues);
    - Social and background information, including contact details of next of kin, care coordinator, and any community services involved; and
    - Copies of recent CPA or discharge summaries if transferring from another unit.

42. This information would ensure that the Priory team could provide safe and continuous care, with an accurate understanding of the patient's history, risks, and treatment needs.

43. It was standard practice to clarify details directly with the referrer (usually an NHS clinician, bed manager, or care coordinator) if any information in the referral was incomplete, unclear, or appeared inconsistent with the patient's presentation on arrival. This might include clarification about recent incidents, risk triggers, or medication changes.

44. If a patient had received treatment from other services (for example, previous inpatient units, community mental health teams, or crisis teams), it was standard to request relevant background information — particularly if the current presentation raised questions about historical diagnosis, adherence, or prior response to treatment. Such liaison was typically coordinated by the ward team.

45. If a patient had been admitted following or in connection with criminal behaviour — for example, if detained by police under Section 136 of the MHA or transferred from custody — the admitting team would normally request relevant police information to clarify the nature of the incident, any ongoing investigations, and any conditions or restrictions. This would usually be arranged through the referrer or the local liaison officer, with consent or appropriate legal basis.

46. Where risk to others was suspected but information was incomplete, we would seek further details from the police or the referring service to ensure that risk assessment and management planning were based on accurate, up-to-date information.

Factors involved when determining observation levels for an inpatient

47. When determining the appropriate observation levels for an inpatient, risks to self and to others are taken into consideration, such as:

48. Risks to self:

- Suicidal ideation or intent, including any plans, means, or recent attempts;
- Self-harming behaviour, including cutting, ligaturing, burning, or head-banging;
- Risk arising from psychotic symptoms, such as command hallucinations or delusional beliefs that might lead to harm;
- Severe depression, hopelessness, or withdrawal;
- Vulnerability or impulsivity, including risk of absconding or non-compliance with medication;
- Physical health concerns, such as severe malnutrition, poor fluid intake, or risk of collapse due to medication side effects or substance withdrawal.

49. Risk to others:

- Aggression or violence, whether verbal, physical, or directed towards staff or peers;
- Threatening or intimidating behaviour, often linked to persecutory delusions or paranoia;
- Sexual disinhibition or boundary violations;
- Risk of property damage or fire-setting;
- History of offending or antisocial behaviour, particularly if related to mental illness;
- Substance misuse or behaviours that place others at risk.

50. Each of these factors was considered alongside protective factors (e.g. engagement,

insight, family support) and environmental factors (e.g. ward dynamics, triggers, staffing levels).

Observation levels

51. Observation levels were increased when there was:
    - Evidence or disclosure of suicidal or self-harming intent;
    - New or escalating aggression or hostility towards others;
    - Rapid deterioration in mental state, for example increased agitation, paranoia, or disorganisation;
    - Significant medication changes associated with altered consciousness or behavioural instability;
    - Acute stressors, such as bad news from family or tribunal outcomes;or
    - Return from leave if the patient appeared intoxicated, distressed, or disengaged.
52. Observation levels were reduced only after a period of stability, where the patient demonstrated:
    - Improved insight and engagement with treatment;
    - Sustained absence of risk behaviours or triggers;
    - Cooperative behaviour and willingness to seek staff support when distressed; and
    - A multidisciplinary agreement that a lower level of observation was safe and appropriate.
53. All changes were documented, communicated at nursing handovers, and reviewed daily or more frequently if required.
54. When reviewing or adjusting observation levels, I relied on direct observation, nursing reports, and mental state examination findings, looking for:
    - Improved mood, reduced anxiety or agitation;

- Diminished psychotic symptoms, especially reduction in command hallucinations or persecutory beliefs;
- Consistent engagement with staff, therapy, and medication;
- Improved self-care and social interaction on the ward;
- Calm, cooperative behaviour, with ability to express distress appropriately;
- Conversely, any withdrawal, irritability, agitation, refusal of medication, or re-emergence of psychotic symptoms would prompt reconsideration of risk and possible increase in observation.

55. Adjustments were made jointly with the nursing team and reviewed by the Consultant Psychiatrist, ensuring that observation levels were responsive, proportionate, and continuously risk-informed.

56. During the initial period of observation following admission, the focus is on obtaining a comprehensive understanding of the patient's presentation, risks, and baseline behaviour. This is a critical phase, as risk can fluctuate significantly during the early stages of admission — particularly following a crisis, sectioning, or medication changes.

57. At Priory Hospital Arnold, this process involved close observation and frequent multidisciplinary review, guided by the Priory's Admission and Observation Policy, the Mental Health Act Code of Practice (2015), and relevant NICE guidelines (including NICE NG10: **WITN0229002**, and NICE NG53: **WITN0229003**.

I. Information gathered at the point of admission

58. On admission, I would review or confirm:

- The referral documentation, including mental health act papers, medical summaries, risk assessments, and care plans;

- The circumstances leading to admission, such as relapse, self-harm, aggression, or non-engagement with community services;
- Any recent stressors, such as bereavement, loss, or conflict;
- Medication history, including recent changes, side-effects, or issues with adherence;
- Physical health information, allergies, and substance use;
- The patient's own account of their difficulties and perceived needs.

59. This information formed the basis for the initial clinical formulation and determination of observation level and engagement plan.

II. Observations and presentation during the first hours and days

60. During the first 24–72 hours, the following features were regarded as particularly significant and closely monitored:
    - Mental state: mood, speech, thought content (including delusions or suicidal ideation), perceptual disturbances, and level of insight;
    - Behaviour: cooperation with staff, compliance with medication, agitation, pacing, irritability, or withdrawal;
    - Interaction with others: ability to engage appropriately with staff and peers, or any hostility or avoidance;
    - Level of arousal: restlessness, sleep pattern, appetite, and level of fatigue;
    - Response to medication or signs of intoxication, withdrawal, or sedation;
    - Emotional lability: tearfulness, anxiety, or signs of distress;
    - Physical presentation: hygiene, nutrition, hydration, and any evidence of self-injury or physical illness.
61. Nursing staff documented these observations at regular intervals, and I would

review them during medical assessments and ward rounds, particularly if any change was noted.

III. Behavioural or clinical changes prompting review

62. During the early admission period, I paid particular attention to changes that might indicate escalating risk or deterioration, such as:

- Emergence or intensification of suicidal or self-harming behaviour;
- Sudden withdrawal or isolation after initially engaging;
- Increased agitation or aggression, verbal or physical;
- Refusal of medication or meals;
- Heightened psychotic symptoms, such as hearing voices commanding self-harm;
- Disinhibited or unpredictable behaviour;
- Expressed hopelessness, fear, or paranoia.

63. Any of these changes would prompt a review of the observation level, additional medical review, or multidisciplinary risk discussion.

Capacity assessments

64. Capacity assessments are an integral part of routine clinical care and conducted in accordance with the Mental Capacity Act 2005 (MCA), its Code of Practice, and the MHA 1983 and Code of Practice (2015) where relevant.

65. The guiding principles are that capacity is decision-specific, time-specific, and must always be presumed unless there is reason to doubt it.

1. Circumstances in which capacity assessments are carried out

66. Capacity assessments were undertaken whenever there was reason to question a patient's ability to make an informed decision, for example:

- On admission, where the patient's consent to treatment, admission, or sharing information was uncertain;

- Before initiating or continuing treatment, particularly medication changes, electro-convulsive therapy (ECT), or physical health interventions;
- When a patient refused treatment or expressed a wish to leave hospital while detained or voluntary;
- If there was fluctuation in mental state, such as acute psychosis, mania, depression, or cognitive impairment that might affect understanding;
- Prior to decisions about leave, discharge, or risk behaviours;
- When a patient's presentation or level of insight changed significantly during admission.

67. In practice, many detained patients retained capacity for some decisions but not others. Therefore, assessments were repeated as the clinical situation evolved.

2. Process of assessing capacity

68. Capacity was assessed using the two-stage test set out in the MCA (Sections 2 and 3):

Stage 1 – Diagnostic test:

69. Determining whether the person has an impairment or disturbance in the functioning of the mind or brain (for example, due to psychosis, mania, depression, intoxication, or organic illness).

Stage 2 – Functional test:

70. Assessing whether that impairment means the person is unable to:

1. Understand the relevant information about the decision;
2. Retain that information long enough to make the decision;
3. Use or weigh the information as part of the decision-making process; and

4. Communicate their decision (by any means).

71. The assessment is decision-specific — for instance, a patient may have capacity to consent to medication but not to discharge planning if insight and risk appraisal are impaired.

72. As a Specialty Doctor, I routinely conducted capacity assessments regarding medication consent, information sharing, and leave, documenting the rationale, discussion, and outcome clearly in the notes.

73. For complex or disputed cases, the assessment would be reviewed or repeated by the Consultant Psychiatrist (Responsible Clinician).

3. Outcomes and actions following assessment

74. If a patient was found to have capacity, their decision was respected even if it appeared unwise, in keeping with the MCA principles.

75. If lacking capacity, decisions were made in the patient's best interests, considering their past and present wishes, views of carers, and the least restrictive alternative.

76. Where refusal of treatment by a detained patient was concerned, the MHA framework (e.g., Section 58/58A, SOAD involvement) was applied as appropriate.

77. Capacity was reviewed regularly, especially when mental state changed or when new decisions arose.

Mental State Examination

78. A Mental State Examination is a structured, observational and conversational assessment of a patient's psychological functioning across multiple domains.

79. As a Specialty Doctor, I used the MSE to identify symptoms of mental disorder, assess risk, and monitor changes in presentation throughout admission, ensuring decisions about treatment and observation were based

on accurate, up-to-date clinical information.

Key domains of the Mental State Examination

80. The standard domains I assessed included the following:

a. Appearance and behaviour

- General appearance, hygiene, grooming, clothing, and physical health.
- Eye contact, posture, psychomotor activity (agitation, retardation), and any abnormal movements.
- Level of cooperation, engagement, or hostility.
- Signs of intoxication, withdrawal, or physical illness.

b. Speech

- Rate, volume, tone, and fluency of speech.
- Relevance and coherence.
- Any pressure or latency in speech suggesting mania or thought blocking.

c. Mood and affect

- Subjective mood: how the patient describes their emotional state.
- Objective affect: observed emotional expression — e.g. flat, blunted, labile, congruent/incongruent with content.
- Presence of anxiety, irritability, or elation.

d. Thought form (process)

- Organisation, flow, and coherence of thought.
- Evidence of flight of ideas, loosening of associations, tangentiality, or thought blocking.

e. Thought content

- Presence of delusions, overvalued ideas, preoccupations, or obsessions.

- Themes of guilt, worthlessness, persecution, grandiosity, or reference.
- Risk-related thoughts — suicidal or homicidal ideation, self-harm urges, or harm to others.

f. Perception

- Presence of hallucinations (auditory, visual, tactile, olfactory, gustatory).
- Nature of voices or experiences (e.g. commenting, commanding).
- Presence of illusions or depersonalisation/derealisation.

g. Cognition

- Orientation (time, place, person, situation).
- Attention, concentration, and short-term memory.
- Basic assessment of intellect, often through conversation or formal testing if indicated.

h. Insight and judgement

- Awareness of illness, acceptance of need for treatment, and understanding of consequences.
- Ability to make informed decisions and recognise risk.
- Judgement about safety, relationships, and compliance with care.

Supporting information and contextual factors

81. In addition to direct examination, I took into account:

- The history of presenting illness and recent behavioural observations from nursing staff;
- Information from family or carers regarding recent changes in functioning;
- The patient's response to medication or substance use;
- Cultural or linguistic factors that might influence presentation.

Risk assessments

82. Risk assessment for inpatients at Priory Hospital Arnold was a continuous, multidisciplinary, and formulation-based process aiming to ensure the safety of the patient, other patients, staff, and the public. As a Specialty Doctor, my role was to contribute clinical assessment and interpretation of risk factors, review them regularly with the Consultant Psychiatrist, and ensure that observation levels and treatment plans were responsive to any emerging concerns.

83. The assessment aims to:

- Identify current and historical risks of self-harm, suicide, aggression, neglect, or vulnerability;
- Formulate an understanding of why and when those risks occur (the "dynamic formulation");
- Implement and document management plans to reduce or mitigate those risks; and
- Enable ongoing review and communication of changing risk levels across the multidisciplinary team.

84. At Priory Hospital Arnold, formal risk assessments were undertaken:

- On admission – as part of the initial assessment and formulation;
- After any significant incident or behavioural change (e.g. self-harm, aggression, deterioration in mental state);
- Before granting or renewing leave from the ward;
- Prior to discharge or transfer;
- Following tribunal hearings, family visits, or stressful events that could alter risk; and
- Whenever new information emerged that might change the overall risk formulation.

85. In addition to formal reviews, risk was continuously monitored through day-to-day observation, nursing reports, and ward reviews.

86. Risk assessment was a multidisciplinary process involving input from:

- Nursing staff, who provided continuous observation, incident reports, and behavioural monitoring;
- Medical staff (Consultant and Specialty Doctor), who contributed clinical formulation, diagnostic understanding, and medication review;
- Psychologists, who offered structured formulations and psychometric assessments where available;
- Occupational therapists and support workers, who contributed observations from group sessions and ward activities; and
- Care coordinators or social workers, who provided community and background context, including safeguarding or forensic history.

87. Each discipline provided unique insights into risk patterns, triggers, and protective factors, which were synthesised into a unified risk management plan.

88. Formal risk assessments were reviewed at least weekly during ward rounds and after any incident or notable change in presentation. However, dynamic risk assessment occurred continuously — nursing staff reported changes at each shift handover, and any significant development was discussed promptly with medical staff.

89. The frequency of review increased when risk was elevated — for example, following a suicide attempt, new delusional beliefs, or an escalation in aggression — and reduced as stability improved.

90. Risk assessments were conducted using a combination of:

- Structured clinical tools, such as the Priory risk assessment

framework, which incorporated historical, clinical, and situational factors; and

- Professional judgement, informed by multidisciplinary discussion and direct clinical assessment.

91. The assessment process considered both immediate (dynamic) and historical (static) risk factors, for example:

Static (historical) risks:

- Previous suicide attempts or self-harm;
- History of violence or offending;
- Past trauma, substance misuse, or significant losses;
- Chronic mental illness and patterns of relapse.

Dynamic (current or changeable) risks:

- Current suicidal or violent ideation;
- Recent stressors or triggers (e.g. bad news, relationship breakdown, tribunal outcomes);
- Mental state (e.g. command hallucinations, agitation, hopelessness);
- Engagement, insight, and response to treatment;
- Access to means or opportunities for harm;
- Ward dynamics and peer interactions.

92. Information was gathered from the patient, staff observations, incident reports, and collateral sources (family, referrers, or community teams).

93. The findings were documented in the patient's notes and care plan, and where indicated, risk management strategies were implemented — such as increased observation, environmental safety measures, medication review, or closer engagement by staff.

Aim and purpose of a care plan

94. A care plan is a structured document that outlines the agreed goals, interventions, and responsibilities for a patient's treatment, recovery, and risk management while in hospital and beyond. Its primary purpose is to ensure that care is individualised, coordinated, and consistent across the multidisciplinary team, and that it reflects both clinical needs and the patient's own preferences. Care planning is guided by the Care Programme Approach (CPA), the Mental Health Act Code of Practice (2015), NICE NG53: **WITN0229003**, and relevant Priory policies.

95. When formulating a care plan, the following factors are considered:

- Clinical diagnosis and formulation, including underlying causes, triggers, and maintaining factors;
- Current mental state and presenting symptoms;
- Identified risks to self or others and protective factors;
- Patient's strengths, goals, and preferences, including cultural and social background;
- Legal status (detained or voluntary) and relevant statutory safeguards;
- Input from the multidisciplinary team (nursing, psychology, occupational therapy, social work, and medical staff);
- Family or carer involvement, where appropriate and with consent;
- Physical health needs and comorbidities; and
- Safeguarding or social factors, such as housing, employment, or support networks.

96. The approach is collaborative, with the patient involved as far as possible in setting realistic and recovery-oriented goals.

Review frequency

97. Care plans are reviewed regularly and dynamically throughout admission.

- Formally, they are reviewed at least weekly in ward rounds, and updated following any significant change in presentation, risk, or treatment.
- Informally, they are revisited during daily nursing handovers and multidisciplinary discussions.
- A comprehensive review occurs prior to discharge to ensure that community follow-up arrangements are in place and the plan remains current.

98. All changes are documented and communicated to the team to ensure consistency of care.

Scope of a care plan

99. A care plan typically covers the following areas:

- Diagnosis and formulation summary;
- Treatment plan (medication, psychological interventions, occupational therapy);
- Physical health monitoring and general medical care;
- Observation and risk management strategies;
- Goals for recovery and discharge planning;
- Social and environmental needs, such as housing, benefits, family contact, and meaningful activity;
- Patient's views, preferences, and consent;
- Crisis management plan, including early warning signs and relapse indicators.

100. The care plan therefore provides a comprehensive framework for all aspects of inpatient care.

Multiple admissions into inpatient care

101. For patients with multiple admissions, clinicians review historical records, previous care plans, and risk assessments to identify recurring patterns in presentation, triggers, and response to treatment.

102. This may include:

- Early warning signs of relapse;
- Common stressors or situational triggers;
- Response to particular medications or psychological approaches;
- Typical risk patterns (e.g. self-harm following leave, deterioration after medication non-adherence).

103. This longitudinal understanding informs a relapse prevention strategy, which is integrated into the current care plan.

104. In practice, I would review the electronic notes and previous CPA documentation, discuss relevant history with the community care coordinator, and incorporate key learning points into the current plan.

Inpatient care planning and care planning following discharge

105. Inpatient care planning is directly linked to care planning in the community.

106. The inpatient plan focuses on stabilisation and short-term safety, while the post-discharge plan (under CPA or equivalent) ensures continuity of care and relapse prevention.

107. Prior to discharge:

- A CPA or discharge planning meeting is held, attended by the inpatient team, the community care coordinator, and where possible the patient and family.
- The care plan is updated to include aftercare arrangements under Section 117 (where applicable), medication, follow-up appointments, and crisis contact details.

- This discharge plan is shared with the community mental health team (CMHT) and general practitioner.

108. Risk assessments are an integral part of care planning.

109. Findings from the initial and ongoing risk assessments directly inform:

- The level of observation and engagement required;
- Environmental and procedural safeguards (e.g. removal of ligature risks, supervised leave);
- Therapeutic interventions tailored to risk-related behaviours (e.g. coping strategies for self-harm); and
- Contingency plans in case of deterioration or crisis.

110. Risk information is regularly updated within the care plan so that all staff have access to current and relevant safety information.

111. In practice, the care plan and risk assessment are reviewed together to ensure that interventions remain proportionate, evidence-based, and aligned with the patient's evolving needs.

Leave plans

112. Leave was always considered a therapeutic and rehabilitative intervention, aimed at supporting recovery, testing progress, and promoting safe transition to community life, while ensuring patient and public safety.

1. Establishing leave for detained patients

113. For detained patients, leave from the ward required formal authorisation under Section 17 of the MHA by the Responsible Clinician (Consultant Psychiatrist).

114. Key factors considered included:

- Current mental state and stability of symptoms (e.g. residual psychosis, mood disturbance, impulsivity);

- Insight and engagement with treatment, including willingness to return after leave;
- History of compliance and previous behaviour on or after leave;
- Level and type of risk to self or others, including absconding or substance misuse risk;
- Protective factors, such as family support or supervision during leave;
- Purpose of leave (therapeutic, social, escorted/unescorted, community testing, home visit); and
- Legal and safeguarding context, such as restrictions under Section 41 or Ministry of Justice conditions, if applicable.

115. Leave plans specified:

- Duration and frequency of leave;
- Whether it was escorted, accompanied, or unescorted;
- Supervision arrangements and location;
- Any specific conditions, such as abstinence from substances, curfew times, or contact limitations.

116. All decisions were documented on the Section 17 leave form, recorded in the patient's notes, and communicated to nursing staff before implementation.

2. Leave for informal (voluntary) patients

117. Informal patients were legally free to leave the ward, but leave was still planned and risk-assessed to ensure safety. The same clinical considerations applied: mental state, risk of self-harm or relapse, support available, and insight. Where risk appeared elevated, the team might discourage leave temporarily, or if necessary, consider an assessment under the MHA if the patient insisted on leaving unsafely. Leave for informal patients was therefore a collaborative decision, based on discussion with the patient and ongoing risk

evaluation.

3. Review and amendment of leave plans

118. Leave arrangements were dynamic and reviewed regularly:

- At least weekly during ward rounds;
- After each period of leave, once staff had obtained feedback on the patient's presentation, compliance, and risk behaviours;
- Immediately following any incident, such as delayed return, intoxication, deterioration in mental state, or risk escalation; and
- Whenever there was clinical improvement, allowing for gradual extension of leave privileges.

119. Nursing staff documented the patient's behaviour and feedback from family or carers following each leave episode, and I would review this information to determine whether leave could safely continue, be extended, or should be suspended.

120. During my time as a Specialty Doctor at Priory Hospital Arnold, reviews of risk assessments and care plans were undertaken collaboratively within the multidisciplinary team, with particular emphasis on the observations and input of nursing staff and healthcare assistants who had the most direct, continuous contact with patients. Their daily observations on mood, engagement, self-care, sleep, appetite, and behaviour—along with any incidents or changes in presentation—were recorded in the clinical notes and shared verbally during handovers, morning meetings, and ward rounds. I routinely reviewed these entries and sought verbal updates from the primary nurse or nurse in charge before assessing patients, ensuring that medical and risk decisions were based on current and accurate information. Observations from other team members, such as psychologists, occupational therapists, and support

workers, were also discussed at multidisciplinary meetings and incorporated into ongoing risk formulations and care plans.

Clinical and medical treatment expected to be carried out prior to a PICU patient being 'stepped down' to an acute mental health unit

121. Prior to a patient being 'stepped down' from a Psychiatric Intensive Care Unit (PICU) to an acute mental health ward, I would expect that the most acute phase of psychosis and behavioural disturbance has been stabilised through a combination of medical, psychological, and nursing interventions. Typically, this means that the patient has received adequate assessment, treatment, and monitoring to ensure that risks can be safely managed in a less restrictive environment. From a medical perspective, this would usually involve the initiation or optimisation of antipsychotic medication, either oral or depot/long-acting injectable, with clear evidence of partial or full response, tolerability, and adherence. The patient should have undergone physical health monitoring, including baseline investigations such as ECG, full blood count, metabolic profile, and side-effect screening in line with NICE guidance (CG178: Psychosis and schizophrenia in adults). Where necessary, rapid tranquillisation should have been completed and no longer required, and the patient should not be in need of one-to-one observation or continuous restraint. Psychologically, the patient should demonstrate some improvement in insight and engagement, reduced agitation, and the ability to participate in ward routines and discussions about care. Behaviourally, there should be evidence that violence, aggression, or self-harm risks have significantly diminished and that the patient is able to comply with boundaries, medication, and staff direction. Multidisciplinary review and agreement between the PICU and receiving team are essential to confirm readiness for transfer, ensuring

that both the clinical rationale and risk management plan are clearly communicated. In summary, step-down from PICU to an acute ward occurs when the patient's psychotic symptoms are partially stabilised, risks are manageable without intensive security, and ongoing treatment can continue in a standard therapeutic environment aimed at recovery and discharge planning.

Clinical and medical treatment expected to be carried out on a person experiencing psychosis, prior to discharge.

122. Before considering the discharge of an inpatient experiencing psychosis, it is essential that the patient has received and responded to a course of treatment to ensure stability, safety, and readiness for ongoing care in the community. From a medical standpoint, this includes establishing a clear diagnosis and treatment plan, ensuring that antipsychotic medication has been initiated, titrated to a therapeutic dose, and shown to be effective and well tolerated, with appropriate monitoring for side effects and adherence. The patient should have achieved a sustained improvement in mental state, with resolution or significant reduction of positive symptoms (such as hallucinations and delusions) and improved insight, thought organisation, and self-care. Risk assessment should confirm that risks to self and others are manageable in the community, and that the patient is able and willing to engage with follow-up services and comply with medication. Multidisciplinary input is essential, including confirmation from nursing staff, psychologists, and occupational therapists that the patient is functioning at a level consistent with safe discharge. A comprehensive discharge plan must be in place, addressing medication supply, crisis management, and social support, with a clear follow-up arrangement through the community mental health team or under Section

117 aftercare where applicable.

When discharging an inpatient experiencing psychosis, Specific criteria or considerations for patients:

a. With a history of aggression in the community and inpatient settings;

123. Discharge requires sustained evidence of non-aggressive behaviour, good impulse control, and constructive management of frustration or conflict on the ward. Staff must be confident that triggers are identified and a risk-management plan is in place for community follow-up.

b. Who are considered by clinicians to be at risk of becoming violent in the absence of treatment;

124. Discharge is considered only if the patient demonstrates consistent acceptance of medication, insight into the need for ongoing treatment, and community mechanisms—such as depot administration, care-coordinator oversight, or CTO conditions—are in place to ensure adherence.

c. With a history of violence;

125. A thorough risk review is essential, confirming no current intent, hostility, or behavioural precursors, and that the risk can be safely managed through supervision and engagement with community teams.

d. With a history of non-concordance with medication;

126. Sustained compliance during admission, understanding of the purpose of medication, and willingness to continue treatment post-discharge are prerequisites. Long-acting injectable antipsychotics or supervised medication may be considered.

e. With a history of social isolation;

127. Discharge planning includes ensuring community support, social inclusion strategies, and follow-up contact to monitor engagement and wellbeing.

f. With a history of disengagement from treatment; and

128. Evidence of sustained participation in ward activities, therapy, and collaboration with the team is required, alongside a structured follow-up plan and crisis contact details.

g. With a history of masking psychotic symptoms.

129. Discharge is approached cautiously, with corroboration from multiple staff over time to ensure consistency of presentation, absence of covert symptoms, and collateral information from family or previous services to verify stability.

Risks posed by the factors set out at (a)-(g) above?

130. Each of the factors listed in (a)–(g) above, presents specific clinical and safety risks that must be carefully assessed and managed before discharge.

131. Patients with a history of aggression in the community or inpatient settings are at increased risk of re-escalation of violent or threatening behaviour, particularly when exposed to stress, substance use, or loss of structure after discharge.

132. Those considered at risk of becoming violent in the absence of treatment carry the danger of rapid relapse and loss of behavioural control should they discontinue medication or disengage from services; this can lead to serious assaults, criminal justice involvement, or readmission under the Mental Health Act.

133. A history of violence indicates enduring vulnerabilities such as impulsivity, low frustration tolerance, or antisocial traits, which may persist even when the acute episode has resolved. Such patients require careful monitoring and structured supervision to mitigate the potential for future aggressive or offending behaviour.

134. Patients with a history of non-concordance with medication are at heightened risk of relapse of psychosis, which can re-activate delusions, hallucinations, increasing danger to themselves or others and reducing the protective effect of pharmacological treatment.

135. Those with social isolation may lack practical and emotional support to recognise early warning signs or seek help, leaving them vulnerable to neglect, self-harm, relapse, or exploitation, and to deterioration going unnoticed until risks become more obvious.

136. A history of disengagement from treatment poses the risk of loss to follow-up, treatment discontinuation, and delayed intervention during relapse, which can result in emergency readmission, self-neglect, or aggression arising from untreated psychosis.

137. Patients with a history of masking psychotic symptoms can appear superficially stable while still experiencing delusional thinking or command hallucinations. This poses the risk of covert relapse or unanticipated violent or self-harming acts, as the true level of illness may be underestimated.

Behaviours and/or observations where a patient remains a risk to themselves and/or others and not to be considered for discharge

138. Behaviours or observations suggesting that a patient continues to pose a risk to themselves or others, and therefore should not yet be considered for discharge, include any evidence of ongoing instability, impaired insight, or unmitigated risk behaviours.

139. Clinically, this would encompass the persistence or re-emergence of psychotic symptoms such as persecutory or command hallucinations, delusional beliefs that could prompt harmful actions, or severe thought disorder impairing reality testing and judgement. Signs of low mood,

hopelessness, or active suicidal ideation, self-harming behaviour, or verbal expressions of wanting to die indicate continued risk to self.

140. Likewise, agitation, hostility, verbal or physical aggression, or threatening behaviour toward staff or peers demonstrate unresolved risk to others. Other warning indicators include non-concordance with medication, concealment or refusal of treatment, poor insight into illness, and lack of recognition of the need for ongoing support.

141. Behavioural changes such as withdrawal, isolation, irritability, or unpredictable mood shifts may also signify rising risk, particularly when accompanied by reduced engagement or deterioration in self-care, sleep, or appetite.

142. If a patient continues to require high levels of observation, frequent de-escalation, or restraint, or if staff remain uncertain about their ability to manage frustration or distress safely, discharge would be premature.

143. Similarly, if there are concerns from nursing staff or the multidisciplinary team that the patient's presentation fluctuates, or that risk factors identified in previous incidents remain unaddressed, further inpatient treatment is indicated.

144. In summary, ongoing psychotic symptoms, impaired insight, behavioural instability, poor engagement, or active risk indicators are clear reasons to conclude that a patient remains unsafe for discharge until further stabilisation and sustained improvement are demonstrated.

Handover to community mental health teams following discharge

145. When a patient is discharged from Priory Hospital Arnold, I would expect a comprehensive clinical handover to be provided to the relevant community mental health team (CMHT) to ensure safe and continuous care.

146. This would include:

- A clear discharge summary outlining the diagnosis, relevant psychiatric and medical history, and the reason for admission;
- A detailed account of the treatment provided during admission, including medication prescribed (name, dose, route, frequency, and duration), any recent medication changes, and response or side effects observed;
- The current mental state at discharge, including residual symptoms, level of insight, and compliance with treatment;
- An updated risk assessment and management plan, identifying current risks to self or others, known triggers, early warning signs of relapse, and protective factors;
- A copy of the individual care plan, including relapse prevention and crisis management strategies;
- Details of any legal status under the Mental Health Act (e.g. Section 2, Section 3, Section 117 aftercare) and associated responsibilities for follow-up;
- Information on physical health status and outstanding investigations or follow-up needs;
- Social and safeguarding information, including accommodation, family or carer involvement, and support arrangements;
- The date and details of the next planned community appointment, responsible care coordinator, and crisis contact numbers; and
- Where relevant, a summary of family or carer communication, including advice given and contact arrangements post-discharge.

147. This information is normally sent securely to the patient's care coordinator,

GP, and other involved professionals on the day of discharge or shortly thereafter. As a Specialty Doctor, I contributed to preparing the medical section of this documentation, ensuring that the CMHT received accurate and complete clinical information to facilitate safe continuity of care and effective community follow-up.

Explanations of insight, masking and needs led basis in respect of patients who are experiencing or have a history of psychosis

Insight

148. "Insight" refers to the patient's awareness and understanding of their mental illness, its effects, and the need for treatment. It encompasses recognition that their experiences or beliefs are due to a mental health condition rather than external reality, acceptance of the need for medication or professional help, and acknowledgment of how their illness impacts their behaviour and functioning. A patient with good insight can usually identify early warning signs of relapse and seek help appropriately, whereas poor or absent insight — common in psychotic disorders — can lead to treatment refusal, relapse, or risky behaviour due to lack of awareness of being unwell.

149. Insight is assessed through direct clinical interview, observation, and corroborative information. Objective factors include:

- The patient's explanation of their experiences — whether they attribute hallucinations or delusions to mental illness or external causes;
- Consistency between reported beliefs and observed behaviour (for example, whether the patient takes precautions based on delusional ideas or accepts reassurance from staff);
- Medication adherence and engagement with treatment, indicating awareness of the need for ongoing care;

- Acceptance of diagnosis or past episodes of illness and recognition of early warning signs;
- Collateral information from nursing staff, family members, and community teams about prior patterns of compliance, relapse, and attitude toward treatment;
- Review of historical notes and CPA documentation, which often reveal whether the patient has previously shown fluctuating insight or denial of illness.

150. These objective data help determine whether insight is full, partial, or absent, and whether it is improving with treatment.

Masking

151. "Masking" (of symptoms) describes a situation where a patient conceals or minimises their psychotic symptoms, either deliberately or subconsciously. This may occur because of mistrust, fear of detention, embarrassment, or limited awareness of illness. Masking can make the person appear superficially stable and cooperative while they continue to experience hallucinations, delusions, or disordered thoughts. This creates a clinical risk because staff may underestimate the level of illness or danger, leading to premature reduction in observation, leave, or discharge. Detecting masking relies on careful, repeated assessment, collateral information, and multidisciplinary observation over time.

152. Judgements about masking are based on discrepancies between self-report and independent observations. Clinicians look for:

- Behavioural inconsistencies, such as guardedness, avoidance of certain topics, or emotional incongruence when describing symptoms;
- Reports from nursing staff or HCAs noting signs of responding to

unseen stimuli, mumbling, or preoccupation despite denial of hallucinations;

- Collateral accounts from family, carers, or previous treating teams indicating the patient's typical presentation when unwell;
- Patterns in historical records, such as repeated instances where deterioration or aggression occurred soon after appearing settled;
- Psychological formulations or structured assessments, where available, identifying defence mechanisms or minimisation; and
- Multidisciplinary discussion, ensuring that all staff perspectives are considered before concluding that masking is occurring.

Engaging on a "needs led" basis

153. Engaging on a "needs-led" basis means the patient interacts with staff or services only when they perceive an immediate or practical need, rather than engaging consistently in ongoing treatment or recovery work. Such patients may approach staff for specific requests (e.g. medication, meals, discharge discussions) but otherwise remain withdrawn or avoid therapeutic interaction. This behaviour can indicate limited insight, ambivalence toward treatment, or residual psychotic thinking, and it often requires proactive engagement strategies to maintain therapeutic alliance and monitor emerging risk.

Identifying future risks from a patient's history

154. The following 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 deteriorate, relapse, experience a psychotic crisis or become acutely unwell:

155. Previous episodes of mental illness: nature, duration, and severity of past psychotic or mood episodes; whether deterioration was sudden or gradual;

and what clinical or environmental factors preceded relapse.

- History of self-harm or suicide attempts: methods used, intent, frequency, circumstances, and triggers (such as loss, conflict, or command hallucinations), as well as the patient's response to past interventions.
- History of violence or aggression: incidents of physical or verbal aggression, assaults, property damage, or threats, including the context (e.g. during psychosis, intoxication, or frustration with services), and any identifiable warning signs or precipitants.
- History of substance or alcohol misuse: links between intoxication or withdrawal and exacerbation of psychotic symptoms or disinhibition.
- Response to previous treatment and medication adherence: effectiveness of past medication, side effects leading to discontinuation, and patterns of non-concordance that increased risk.
- Forensic or criminal history: arrests, convictions, or police involvement related to violence, threats, or disorderly behaviour when unwell.
- Social and relational history: stability of housing, employment, and relationships; presence or absence of supportive networks; and episodes of social isolation or vulnerability to exploitation.
- Triggers and stressors: identifiable situations that have previously precipitated deterioration, such as bereavement, substance relapse, conflict, or loss of structure.
- History of engagement with services: previous cooperation or disengagement, missed appointments, or rapid decline after discharge, which can signal risk of non-engagement in future crises.
- Medical and neuropsychiatric history: head injury, cognitive

impairment, or neurological conditions that may affect impulse control or insight.

- Family history: particularly of psychosis, suicide, or violence, which may indicate genetic or learned risk factors.

Discharge planning

156. Discharge planning for psychiatric inpatients is a multidisciplinary and structured process aimed at ensuring safe, continuous care and minimising the risk of relapse or harm following discharge. Formulation of a discharge plan involves the entire multidisciplinary team (MDT). This includes the Responsible Clinician (Consultant Psychiatrist), who has overall responsibility for clinical decisions; the Specialty Doctor, who contributes ongoing medical and risk assessment, reviews medication, and helps prepare the discharge summary; nursing staff, who provide detailed observations and reports on the patient's functioning, engagement, and self-care; psychologists and occupational therapists, who contribute therapeutic perspectives and assessments of coping skills, functioning, and readiness for community living; and the social worker or care coordinator, who liaises with community services, housing, and family or carers. The community mental health team (CMHT), including the allocated care coordinator, is usually involved in discharge planning meetings before discharge to agree aftercare and follow-up arrangements. Where relevant, family members or carers are also consulted with the patient's consent.

157. Once a patient is discharged to the care of community mental health services, direct medical responsibility transfers to the community psychiatrist and care coordinator. However, there may be short-term clinical involvement from the inpatient team to ensure a smooth transition — for example, providing

advice, clarifying medication changes, or responding to queries from the CMHT or GP. In some cases, the inpatient doctor may be contacted to provide clinical context or historical information if issues arise shortly after discharge, but ongoing care and monitoring become the responsibility of the community services.

158. After discharge, the community mental health team (CMHT), under the governance of the local NHS Trust, holds responsibility for ensuring that the discharge plan is implemented and maintained. If the patient has been detained under Section 3 of the MHA, this includes provision of Section 117 aftercare, which is a joint duty between the local NHS and the local authority. The CMHT is responsible for ensuring follow-up appointments are attended, medication is continued, and support arrangements are in place, while the GP and other relevant services (e.g., housing, substance misuse teams) contribute to the broader plan. The inpatient service remains responsible for ensuring that all relevant information is handed over clearly at discharge, and that the plan is comprehensive, realistic, and understood by the receiving team.

Community Treatment Orders ("CTOs")

159. A CTO would be considered when there is a significant risk of relapse leading to self-harm, neglect, suicide, or violent behaviour, particularly where these risks are historically linked to non-compliance with medication or disengagement from services. It is especially indicated when deterioration could occur rapidly after discharge, or where relapse has previously resulted in serious consequences such as assaults, self-injury, or re-admission under emergency detention.

160. Where repeated or severe aggression has occurred during relapse, and

the patient's stability is contingent on medication adherence, a CTO provides a mechanism for close supervision and early recall should aggression re-emerge.

161. If the clinical team believes that the patient would become violent or threatening when unwell and there is a realistic risk of disengagement post-discharge, a CTO ensures continuity of treatment and swift intervention to prevent harm.

162. A sustained or serious history of violence indicates enduring risk factors that may not resolve with short-term stability. A CTO offers structured monitoring and accountability, reducing the likelihood of recurrence.

163. This is one of the strongest indications for a CTO. Where previous relapses were precipitated by stopping medication, and there is limited insight or reliability, a CTO allows treatment conditions (including depot antipsychotics) to be maintained and reviewed under statutory authority.

164. Patients living alone or lacking supportive networks are at greater risk of unnoticed deterioration. A CTO provides a legal framework to ensure regular contact with clinicians and early detection of relapse.

165. Where patients have a pattern of missing appointments or avoiding services, a CTO enables structured follow-up and facilitates rapid recall if they withdraw from care.

166. If a patient has previously presented as superficially well while concealing delusions or hallucinations, a CTO allows ongoing observation and formal powers for recall should concerns re-emerge, ensuring that apparent stability is verified through consistent engagement.

Non-concordance and depot medication

167. Behaviours or observations suggesting that a patient poses a risk of non-concordance with medication typically relate to attitudes, insight, past behaviour, and current engagement. In patients with psychosis or schizophrenia, these indicators often emerge gradually and require careful observation and multidisciplinary input.

168. Clinically, I would consider a patient at risk of non-concordance when they show limited or absent insight into their illness — for example, expressing beliefs that they are not mentally unwell, that medication is unnecessary, or that staff are attempting to harm or control them. Verbal reluctance or avoidance of discussions about treatment, minimising the need for medication, or attributing improvement to non-medical factors may also indicate potential non-adherence. Observable behaviours include refusing or delaying doses, cheeking or concealing tablets, frequently requesting medication changes without clinical basis, or complaining of exaggerated or inconsistent side effects.

169. Historical factors are highly predictive: a previous pattern of stopping medication after discharge, repeated relapses linked to discontinuation, or documented resistance to depot or oral treatment. Nursing observations such as withdrawal from staff, irritability during medication rounds, increased secrecy, or sudden change in attitude toward treatment can also signal risk. Patients who lack insight but remain superficially compliant may need closer monitoring to detect covert non-adherence.

170. Additional risk factors include substance misuse, which may reduce motivation to take prescribed medication; cognitive impairment or disorganisation, affecting ability to remember doses; and social isolation, where no support network exists to encourage adherence.

Depot treatment

171. Depot treatment is indicated when non-adherence could lead to rapid deterioration, resulting in psychotic relapse, self-neglect, self-harm, or violent behaviour. Patients with limited insight may stop oral medication as soon as they feel better, increasing risk of re-emergent delusions, hallucinations, or disorganised behaviour that could endanger themselves or others. Where past relapses have led to aggression, suicide attempts, or serious social breakdown, ensuring consistent treatment via depot injection can significantly reduce these risks and maintain community stability.

172. If aggression has repeatedly coincided with stopping or refusing oral medication, depot treatment provides assurance of continued pharmacological cover and reduces the risk of future violent incidents.

173. Where clinicians believe that untreated psychosis would likely lead to threatening or violent behaviour, depot administration allows close monitoring and recall to hospital if symptoms re-emerge, making it a safer discharge option.

174. A sustained or serious pattern of violence during relapse supports the need for a depot, as this provides consistent symptom control and prevents the cycle of deterioration, risk escalation, and re-admission.

175. When a patient has a history on non-concordance with medication, it is one of the strongest indications for depot therapy. When a patient has previously discontinued oral treatment, missed doses, or demonstrated ambivalence about medication, depot administration ensures adherence and enables early identification if treatment is declined.

176. Patients without regular family or social contact may lack external support to encourage compliance. Depot treatment provides structured contact with

services and helps maintain engagement and safety.

177. Where patients have a pattern of avoiding appointments or community follow-up, depot medication reduces reliance on self-motivation and ensures continuity of care between reviews.

178. If a patient has previously concealed delusional or hallucinatory experiences while appearing superficially well, depot treatment mitigates the risk of covert relapse, as treatment remains consistent even when insight fluctuates.

Annex B: Questions in Respect of VC's Treatment

Transfer to Priory

1. Given that it has been 4 years since my involvement with this patient, I am unable to recall explicit details regarding any interactions I had with him or involvement with his transfer or admission. From the notes made available to me, it would appear that I first saw him in the ward review on 7.10.2021. I was not always involved in the scrutiny of new referrals to Bestwood ward. It is also possible that for part of his admission I was off due to school holidays (October 2021).
2. From the attached files I can see that we received transfer information and discharge summary. The main reason for transfer was the fact that he improved in his mental state, presented as settled and compliant with treatment. There have been no episodes of violence or aggression since his admission to Cygnet and therefore he was "stepped down".
3. In relation to Cygnet providing a discharge notification [CYGN0000015] and discharge summary [CYGN0000012], I am unable to comment on when the documents were received and when I first saw them. I believe I have been

informed of the admission at the time (this would have been around 7.10.2021 or the day before).

4. I am unable to comment what I would have identified as the most pertinent information at the time (this would have been referral documents and risk assessment), given the length of time since I left my role in Priory.
5. In relation to VC's *"Keeping Safe"* care plan [PAGR0000023] and background regarding the circumstances of VC's admission, the source would have been documents provided by Cygnet – the referral and discharge summary. Priory Healthcare also had read-only access to RIO, the electronic information system used by Nottinghamshire Healthcare.
6. In relation to VC being able to engage in the admission process and have a good understanding of his reason for admission, I believe this would have related to his cooperativeness in the initial clerking by the admitting doctor and the rationale he was able to provide regarding the events leading to admission. This has also been documented in the nursing admission entry by Emilia Parton (PAGR0000017).
7. As to the comment "*he admits that these were thoughts he was having at the time and appeared to be a symptom of his illness*", I don't recall this and cannot see further details in the provided documents.
8. As to the comment that VC had "*engaged well with the team*" whilst at Cygnet Victoria House, I am unable to comment what the team from Cygnet meant by their comment (as stated in the documents that I had available).

Initial assessments and plans

9. I was not present on VC's admission to Priory.
10. I believe that the risk assessment was done based on the referrer's information by the admitting doctor.

11. The key concerns arising from each of the risks seemed to reflect the circumstances around the admission (by which I mean documented events prior to admission and documented progress in the referring unit) and the fact that the patient was stepping down from PICU. Non-adherence with treatment appears here as the main risk, followed by risk of violence, absconding and self-neglect.

12. In relation to the *referral checklist that was completed on 1 October 2021 [PAGR0000005], and the background information that set out "Historically when unwell he has force [sic] entry into his neighbour's houses under the influence of his psychotic experiences, though no violence has resulted",* I presume there was no previous violence despite the interference with neighbours in the past, however I don't know the details. At this point in time I cannot access this patient's notes on RIO as I'm not authorised to do so.

13. I am unable to comment if the risk assessment or any part of it copied across from information provided by Cygnet, as this was completed by the admitting doctor. However, it is usually informed by the most recent risk assessment from the sending hospital.

14. In relation to the risk management plan that was included in the referral checklist, I don't recall being involved in the formulation of this plan, however these plans would be usually completed by the person accepting the patient and completing the forms.

15. The various aspects of this plan and reasons for them are set out below:

i. Physical Health Screening

16. On admission, VC would have received a comprehensive physical health assessment including examination, blood tests, ECG, and COVID screening. This would ensure that any underlying medical issues were identified early,

would provide a safe baseline for prescribing psychotropic medication, and support infection-control protocols as per the Trust policy.

ii. Observation Levels

17. Based to VC's presentation on admission, he would have initially been placed on intermittent nursing observations (four per hour), with adjustments made according to assessed risk. This would enable close monitoring of his safety and behaviour while allowing flexibility to increase to 1:1 or reduce as his risk stabilised.

iii. Restricted Access to Items

18. VC would have had restricted access to potentially harmful objects as part of risk management. Staff would have explained the rationale for these restrictions and how he can gradually regain access through safe and cooperative behaviour, reinforcing trust and responsibility in his recovery process.

iv. Capacity, Rights, and Advocacy

19. As VC's capacity to consent fluctuated, staff would ensure his legal rights were explained and that he had access to an Independent Mental Capacity Advocate (IMCA) or legal representative. This would protect his autonomy, support informed decision-making, and ensure compliance with the MHA.

v. Daily MDT Handover

20. VC's presentation and management would be discussed in daily MDT handovers, allowing all disciplines to share observations and agree on any adjustments to his care plan. This would promote coordinated, consistent, and timely clinical decision-making.

vi. Psychological Input

21. The psychology team would offer both individual and group interventions

focused on insight, substance-use psychoeducation, and relapse prevention. This would support VC's understanding of his mental illness, strengthen coping strategies, and reduce the likelihood of future relapse.

vii. Weekly MDT Review and Medication

22. VC's mental state, treatment progress, and therapy needs would be reviewed weekly by the full MDT. Medication would be titrated appropriately, ensuring both clinical efficacy and tolerability, while longer-term therapy goals would be agreed collaboratively.

viii. Named Nurse and 1:1 Sessions

23. A named nurse would be allocated to VC to provide continuity and a therapeutic relationship. They would facilitate at least one dedicated 1:1 session weekly, offering emotional support, monitoring progress, and helping him engage with his overall treatment plan.

ix. Occupational Therapy Activities

24. The Occupational Therapy team would engage VC in structured ward and community-based activities, aiming for around 25 hours weekly. This provides routine, builds confidence and social skills, and supports functional recovery and readiness for discharge.

x. Liaison with CCO and Family

25. The MDT would maintain close liaison with VC's Care Coordinator (CCO) and, with his consent, involve his relatives in weekly reviews and discharge planning. This would ensure continuity between inpatient and community care, strengthen support networks, and facilitate a safe, well-planned discharge.

26. It is standard for the observation level of "four intermittent nursing observations within an hour" for new admissions for the first 24 hours.

27. Psychological input was expected to help VC develop insight into his mental

illness, understand the impact of substance use, and strengthen coping and relapse-prevention strategies through structured one-to-one sessions. Progress was to be evaluated through ongoing formulation, observed changes in engagement and behaviour, and feedback shared at weekly MDT reviews. Where VC showed limited engagement, the team would explore underlying reasons such as anxiety or poor insight, adapt the approach using motivational techniques or shorter, more informal sessions, and review the plan within the MDT to maintain therapeutic engagement and continuity of care.

28. Substance misuse was mentioned amongst other things, but was not as a focus. This can be a significant factor in one's disengagement and relapse and not always disclosed by patients.

29. Occupational therapy input was expected to support VC's recovery by promoting structure, routine, and engagement in meaningful activities that enhance daily living skills, confidence, and social interaction. Progress was to be assessed through his participation, motivation, and functional improvement observed during sessions, with regular feedback shared in MDT reviews. These observations would inform adjustments to his therapeutic plan and contribute to discharge readiness and community reintegration.

30. I am unable to comment if there are other measures to reduce risk that could have been included in this plan.

31. A care plan was prepared for VC on his admission, this would have been updated regularly, in the attached documents (PAGR0000021).

32. I consider that the Priory's "Admission, Transfer and Discharge" policy [PAGR0000033] was adequately followed in relation to VC's admission.

Clinical reviews

33. From the attached files, I can only conclude that I was probably present during his ward review on 7/10/2021 as I have recorded his diagnosis on the electronic system used by Priory. I am also named in the ward round document from 21/10/2021.

34. I am unable to confirm my attendance at other ward rounds or reviews, as these took place some time ago. It is also possible that I was on leave during that period due to school holidays, as I had young children at the time.

35. Given that these events occurred four years ago, I am unable to reliably recall the details of VC's presentation during specific ward rounds. I therefore cannot provide an accurate account of his communication style, level of engagement, or changes in presentation over time. My responses to the questions listed would be speculative and not supported by contemporaneous documentation. Any accurate information regarding these aspects should therefore be drawn from the clinical records and MDT notes available from that period.

36. As these ward rounds took place around four years ago, I am unable to recall the specific feedback provided by nursing, support, or other staff at the time. While multidisciplinary feedback would typically have been obtained verbally during ward rounds and informed the ongoing care plan, I cannot accurately comment on the content, tone, or evolution of that feedback without access to contemporaneous records. Any reliable account of staff observations or concerns should therefore be drawn from the documented MDT notes and ward round summaries from that period.

37. I have been looking for notes of VC's ward rounds on 4, 7 and 14 October 2021 and I cannot locate them. As I left Priory Healthcare four years ago, I am unable to comment further on this.

Risk assessments

38. A risk assessment would have been completed as an additional document alongside with MDT review/ ward round. MDT reviews were documented in a specific part of the electronic system.

39. Ward round assessments are conducted to review a patient's current mental state, risks, engagement, and response to treatment, and to make decisions about ongoing care and observation levels. As the events took place approximately four years ago, I cannot recall the specific discussions or rationale for any downgrades in VC's case. Generally, such decisions are made collectively by the MDT based on observed improvements in presentation, stability in behaviour, and consistent engagement, while also considering the patient's historical risk profile. Any detailed account of the assessments or changes made should therefore be derived from contemporaneous clinical documentation. I haven't been able to extrapolate more following the review of the available documents.

40. In relation to the section of the form on "Risk Formulation" provided at each ward round, the repetition of the same risk formulation across ward rounds likely reflected that there had been no significant change in VC's overall risk profile during those reviews. In practice, the same formulation may be retained when the risk factors, presentation, and management plan remain consistent, with updates recorded elsewhere in the clinical notes or MDT summaries. It is possible that the section intended to document the rationale for the assigned risk level was used primarily to summarise the background to admission rather than provide a detailed narrative at each review. Any contemporaneous record of the specific rationale behind VC's risk assessment would be expected within

the MDT notes, daily progress entries, or risk assessment forms completed during his admission. The absence of a local support network in Nottingham would have been a relevant psychosocial factor, as limited family or community support can increase vulnerability, hinder discharge planning, and affect engagement with aftercare services both during admission and following discharge.

Risk management plans

41. In relation to the Risk Management Plan on 4 October 2021:

"*Observations - L2, 2 checks*

PRN meds - Lorazepam, Promethazine

Leave - escorted grounds leave and community leave with 01 staff

Access - restricted access to sharps, normal clothing, has access to mobile /PC"

42. The plan outlines measures to ensure patient safety while supporting recovery. Level 2 observations indicate regular checks at set intervals, allowing staff to monitor VC's wellbeing while granting a degree of independence. PRN ("as required") medication provides an option for short-term relief of agitation, anxiety, or insomnia. Escorted leave allows therapeutic exposure to the community in a controlled and supported manner, reducing institutional dependency while maintaining safety. Restricted access to sharps mitigates self-harm risk, while normal clothing and access to personal devices promote dignity, autonomy, and engagement.

43. "L2, 2 checks" refers to level two observations, meaning staff check the patient at least twice per hour. Observation levels are adjusted according to ongoing

risk assessment; a reduction from four checks per hour to two typically reflects an improvement in mental state, risk awareness, and stability, as agreed by the multidisciplinary team.

44. "PRN" stands for pro re nata (Latin for "as required"). Lorazepam, a benzodiazepine, and Promethazine, an antihistamine with sedative properties, are commonly used to manage acute agitation, anxiety, or sleep disturbance. These medications offer short-term symptom control without committing the patient to continuous sedation or long-term prescription.

45. Escorted leave enables gradual reintegration into normal environments under supervision, serving both as a therapeutic intervention and a safety measure. It allows staff to assess VC's behaviour and coping outside the ward and to monitor any emerging risks before progressing to unescorted leave.

46. Additional measures—such as increased engagement with psychology, enhanced nursing observations, or temporary environmental restrictions—could be considered if risks warranted them. Their absence in this plan suggests that, at that stage, VC's presentation and behaviour were assessed as sufficiently stable to manage with the existing precautions, which balanced safety with recovery-oriented care.

47. The risk management plan changed on 14 October 2021, I assume this is attributable to settled presentation on the ward and uneventful utilisation of escorted leave.

48. I am unable to comment on why the risk management plan did not change from the ward round on 4 October 2021. .

Care plans

49. In reference to VC's care plans in relation to "Keeping Connected"

[PAGR0000021]; "Keeping Healthy" [PAGR0000022]; "Keeping Safe" [PAGR0000023] and "Keeping Well" [PAGR0000024], I believe these plans would first be formulated by admitting nurse or the named nurse at the time.

50. The care plan that is dated 21 October 2021 is presumably the date of the latest update.

51. This is a standard way of creating care plans in Priory Healthcare.

52. VC's "Keeping Safe" care plan [PAGR0000023] included the following objective set by the MDT:

"*The MDT would like Valdo's level of risk to decrease.*
His current risks are;

- *Non-compliance*
- *Violence and aggression*
- *Psychosis*
- *Paranoia*
- *Harassment of neighbours*"

53. The identified risks reflected VC's presentation and history at the time of admission. *Non-compliance* referred to his previous disengagement from mental health services and inconsistent adherence to prescribed medication, which had contributed to relapse and behavioural disturbance. *Violence and aggression* were considered current risks due to reports of threatening or hostile behaviour prior to admission, often occurring in the context of psychotic symptoms and substance use. *Psychosis* and *paranoia* were included as active clinical features, given VC's presentation with delusional beliefs and mistrust of others, which heightened the potential for unpredictable or defensive reactions. *Harassment of neighbours* was recorded as a manifestation of his illness in the community, linked to disinhibition, impaired insight, and persecutory ideas.

54. During his admission, these risks would have been reviewed and monitored through daily nursing observations, MDT handovers, incident reporting, and formal weekly MDT reviews. Reductions in risk would typically be evidenced by improved engagement, adherence to treatment, absence of aggressive incidents, and a more stable mental state with reduced psychotic or paranoid features. Although I cannot recall the specific progression in VC's case, any observed improvement would have informed ongoing risk formulation and decisions regarding observation level, leave, and discharge planning. The MDT would have considered both the reduction in acute risk and the need for continued support post-discharge to maintain stability and engagement with services.

55. VC's "Keeping Well" care plan [PAGR0000024] included the following "*Needs/Goals as expressed by patient":*
    - *"To be compliant with medication*
    - *To have a balanced diet*
    - *I hear multiple voices which subsided previously but came back under stress.*
    - *I have been informed that it is called psychosis.*
    - *I will like to switch to Aripripazole.*
    - *The only problem I have is salivation".*

56. It is likely that these statements were recorded during an early-stage formulation or care planning discussion with VC, though I cannot recall the specific conversation or date given that the admission occurred approximately four years ago. The goals expressed appear consistent with those typically discussed during admission, particularly the wish to be compliant with medication and to address side effects. Their significance lies in VC's partial engagement and some degree of insight into his illness — recognising that he experienced voices and identifying this as psychosis suggests some awareness of his mental health condition, even if limited.

57. When VC stated that he had "been informed that it is called psychosis," I would interpret this as a factual acknowledgment rather than full acceptance; it may reflect intellectual understanding of the diagnosis without full emotional or experiential insight. His comment that "the only problem I have is salivation" likely refers to hypersalivation, a common side effect of some antipsychotics. This complaint suggests that he attributed his difficulties primarily to medication side effects rather than to the underlying illness, which can indicate limited insight and externalisation of the problem. In the context of his presentation, risk, and admission history, it would be clinically significant that VC minimised his symptoms, as this could impact treatment adherence and engagement, and would therefore require continued monitoring and psychoeducation by the MDT.

58. In relation to the needs and goals as assessment by the MDT, which included understanding VC's warning signs and triggers, given the passage of time, I am unable to recall the detailed discussions regarding VC's early warning signs or triggers. From general clinical practice, such factors would usually have been understood by the MDT based on his presentation and history, likely including non-adherence to medication, increased suspiciousness, and deterioration in mental state or functioning. These issues would ordinarily have been addressed through regular review, observation, and psychoeducation about relapse prevention and risk awareness.

59. I cannot specifically recall the extent to which VC himself recognised his warning signs or triggers. Any understanding would have been assessed through discussion and his engagement with the team, though, in my experience, such insight can fluctuate depending on symptom severity and

response to treatment.

60. Similarly, while VC expressed some willingness to take medication, I cannot confirm how fully he understood its importance for long-term stability. The MDT would typically have taken such factors into account when planning discharge, ensuring follow-up with community services and emphasising adherence, but I cannot recall the specific approach used in his case.

Diagnosis

61. I considered a paranoid schizophrenia diagnosis for VC as this has been long established. He fulfilled the criteria for his diagnosis so there was no need for an alternative. If for instance, an alternative diagnosis had been made, such as psychosis, the management of the condition would remain the same.

Capacity

62. Given that these events occurred approximately four years ago, I cannot recall the specific details of VC's capacity assessments or who carried them out. In general, a patient's capacity at Priory Hospital Arnold would have been assessed by the responsible clinician or medical team during admission and reviewed as needed, particularly in relation to consent to treatment, medication, and care planning. The information from Cygnet was likely provided as part of the admission handover or referral documentation, summarising that VC's capacity had previously fluctuated but appeared more stable at the point of transfer.

63. I do not specifically recall assessing VC's capacity on admission, though this would ordinarily form part of the standard admission process. From the documentation cited, it appears that VC was later assessed as having capacity to consent to his medication regime and, subsequently, full capacity at the time of discharge. These findings would have been based on his ability to

understand, retain, and communicate information about his treatment, as well as his consistent engagement and presentation during ward reviews (PAGR0000017, PAGR0000021, PAGR0000022, PAGR0000023, PAGR0000024, PAGR0000025).

64. VC's capacity would have been taken into account throughout his admission in determining how decisions about treatment were made — ensuring that he was supported to consent to medication, participate in care planning, and understand his rights under the Mental Health Act (MHA). Where capacity fluctuates, decisions are reviewed regularly and recorded accordingly, but I cannot recall the precise discussions or timings in this case (PAGR0000017, PAGR0000021, PAGR0000022, PAGR0000023, PAGR0000024, PAGR0000025).

Medication

65. VC's medication and dosage were established prior to his transfer from Cygnet. The attached documents suggest that he was compliant during his admission in Priory (PAGR0000017, PAGR0000021, PAGR0000022, PAGR0000023, PAGR0000024, PAGR0000025).

66. The provided documents stated that he preferred a change to aripiprazole and was compliant with it (PAGR0000017, PAGR0000021, PAGR0000022, PAGR0000023, PAGR0000024, PAGR0000025).

67. I am unable to comment on why VC wanted to change his medication and can only assume that it was due to side effect profile.

68. Haloperidol was changed to aripiprazole, although I cannot provide details. This was in the form of oral tablets. The medication was changed, I presume, based on his preference, which is often the case, to ensure better and more

long-standing compliance (especially if there are undesirable side effects, e.g.muscle rigidity, tremor, restlessness, sexual dysfunction etc.

69. I don't recall any changes regarding compliance, toleration or side effects of the medication, however from the information provided it would seem that VC was compliant with the new treatment and tolerated it well.

70. TTO was referenced in the "Discharge entry" in VC's care record *[PAGR0000025].* "TTO" means "To Take Out" medication—a supply provided on discharge to bridge the period until community prescribing is in place. In this case, VC was issued 14 days' TTO aripiprazole to ensure immediate continuity of antipsychotic treatment after leaving the ward, reduce relapse risk during transition, and allow time for the GP/CMHT to continue prescribing. Fourteen days is a commonly used window in inpatient practice to cover weekends/administrative delays, support adherence with clear written instructions, and monitor early tolerability in follow-up. While I cannot recall the specific discussion from four years ago, the rationale would have been continuity of care, risk mitigation, and alignment with the agreed treatment plan at discharge.

MHA detention

71. I do not recall being involved in the decision relating to VC's discharge from s.3 MHA detention.

Leave

72. Given the time that has passed, I do not recall the specific discussions or decisions around VC's periods of leave. In general, unescorted or extended community leave would only be authorised following multidisciplinary team (MDT) review, once the patient had demonstrated sustained mental state

stability, engagement with treatment, and safe behaviour on the ward and during previous escorted leave. Such leave is an important part of rehabilitation and recovery, allowing staff to assess a patient's ability to manage safely and responsibly outside the hospital environment.

73. From the records, it appears that VC utilised his community leave appropriately and returned as expected, which would have been viewed as a positive indicator of stability, reliability, and readiness for discharge. Staff would ordinarily observe his presentation on return—looking for signs of distress, anxiety, or relapse - and record these in daily notes. The fact that no concerns were documented suggests that his leave was uneventful and that he remained settled.

74. In terms of management and discharge planning, successful use of leave would have supported the MDT's view that VC could safely transition to community care, while still maintaining regular review before final discharge. Although longer periods of leave temporarily reduce direct observation opportunities on the ward, they serve as a practical test of the patient's capacity to cope independently, which is an essential step in assessing discharge readiness.

Priory Policies

75. Given that these events took place approximately four years ago, I cannot comment in detail on the full application of the Priory's Assessment, Diagnosis & Treatment policy in VC's case. However, based on the documentation available, the key elements of that policy — including comprehensive assessment on admission, formulation of a care plan, multidisciplinary review, and ongoing monitoring of mental state and risk — appear to have been followed. I am not aware of any specific deviations from policy, though I cannot

verify the consistency or completeness of all required documentation. If any procedural steps were not fully adhered to, this may have reflected the clinical context at the time, such as the need to prioritise immediate risk management or the patient's engagement level, rather than intentional omission.

76. To the best of my recollection, and based on the available documentation, the key principles of the Priory's Care Programme Approach (CPA) / Care & Treatment Planning policy appear to have been followed in VC's case. This included the development of care plans addressing his risks, needs, and goals; regular multidisciplinary team (MDT) reviews; and coordination with external agencies to support discharge planning. I am unable to comment on every procedural detail given the passage of time, but there is no indication that any significant aspects of the CPA framework were omitted. If any elements were not fully completed - such as documentation of community follow-up or formal CPA review timings = this may have reflected clinical priorities, time constraints, or the patient's engagement at that stage rather than a deliberate departure from policy.

Insight and engagement

77. I understand that in VC's 1 October 2021 [PAGR0000008] and 4 October 2021 risk assessments [PAGR0000009] it was noted that *"Patient is engaging with staff. He requested to know when he will be discharged, but willing to stay to get better."*

78. I cannot recall the specific circumstances surrounding these entries, but such comments would ordinarily be based on nursing and multidisciplinary team (MDT) observations of VC's interactions, attendance at reviews, and general cooperation with ward routines. The note that he was "engaging with staff"

likely reflected that he was communicating appropriately, responding to support, and participating in care planning discussions.

79. VC's request to know when he would be discharged, combined with an expressed willingness to "stay to get better," would generally be viewed as a positive indicator of engagement and partial insight. It suggests some awareness of his need for ongoing treatment, even while expressing a natural desire to leave hospital. This balance between curiosity about discharge and acceptance of the need for further care is common in recovery phases of inpatient treatment.

80. The statement that VC was "willing to stay in hospital" would therefore have been based on his verbal communication and behaviour at the time—cooperating with staff, accepting medication, and not displaying resistance to admission. While I cannot confirm the precise conversation, such documentation would typically indicate that he was settled, compliant, and engaging constructively with the team's treatment plan.

81. I understand a nursing admission assessment was conducted on 1 October 2021 by Emelia Parton [PAGR0000017] which notes that VC commented on his insight into his mental health, recognition of his psychosis and acceptance to take medication. I cannot recall if these comments were shared or reported to me, however these notes were available in the electronic record so I would have access to them at the time. As explained previously, some notes suggest that he had a degree of understanding on his mental health issues.

82. I understand that VC's 14 October 2021 risk assessment [PAGR0000011] included the following comment:

"Patient is engaging only on needs basis, remains guarded - likely to be personality - keen to be discharged and appears to be minimising the severity

of illness"

83. VC's 21 October 2021 risk assessment [PAGR0000012] included the following comment:

"Presenting as relaxed, engaging better during ward review, showing insight but appears to be in denial of the severity of illness"

84. Given the passage of time, I cannot recall the specific discussions or observations that led to these entries. However, the note that VC was "engaging only on a needs basis" and "remains guarded" would typically indicate that he interacted with staff when necessary but was cautious, limited in self-disclosure, and somewhat defensive in communication. Such guardedness can be characteristic of enduring personality traits or a protective interpersonal style, rather than solely a symptom of acute psychosis. The reference to this being "likely to be personality" suggests that the clinician perceived a stable, trait-based pattern of interaction, rather than transient illness-related suspicion.

85. By 21 October 2021, the comment that VC was "engaging better" and "showing insight" likely reflected observed improvements in cooperation, openness, and awareness of his illness or treatment needs. However, the simultaneous note that he appeared "in denial of the severity of illness" indicates partial insight—he may have acknowledged being unwell but continued to underestimate the seriousness or potential consequences. In clinical terms, "minimising" generally refers to downplaying symptoms or risks, while "denial" implies a more entrenched lack of recognition; both would have been relevant to risk management and discharge planning, as they affect concordance and relapse prevention.

86. Although I cannot recall the specific MDT discussions at the time of discharge,

it would have been standard practice to acknowledge ongoing limited insight as part of risk formulation. This would typically be managed through continued psychoeducation, close follow-up with community services, and clear communication of the importance of treatment adherence. Insight and engagement would have been key factors in determining observation levels, leave, and readiness for discharge, and any residual concerns would have informed the aftercare plan and communication with the care coordinator.

87. Other than what had been documented during his stay in Priory, I would not be able to comment further about VC's engagement with occupational therapy or psychology.

88. I cannot recall the specific actions taken in VC's case, but generally, where a patient is reluctant to engage with occupational therapy or psychology, the MDT would explore the reasons for non-engagement and adapt the approach accordingly. This might include informal conversations to build rapport, offering shorter or more practical sessions, or linking therapeutic work to the patient's personal goals, such as preparing for discharge. Nursing staff and the named nurse would provide encouragement and reinforce the benefits of participation during daily interactions. The psychology and occupational therapy teams would also review and adjust their strategies in MDT discussions to promote gradual engagement, with progress monitored and revisited throughout the admission.

89. In general, lack of engagement with therapeutic interventions such as occupational therapy or psychology can present certain risks or concerns. These include reduced opportunity for the patient to develop coping strategies, limited insight into their condition, poorer relapse prevention, and diminished readiness for discharge or community reintegration. Non-engagement may

also indicate ongoing symptoms, low motivation, or limited trust in staff, all of which can impact recovery.

90. I cannot recall the specific details of VC's engagement, but based on the documentation, it appears that his participation was variable, and there may be different reasons for this, e.g. fluctuations in mental state, changing motivation etc.

91. VC's engagement with staff and other patients during his admission, would have been included in the available correspondence from Cygnet. I cannot recall what his engagement was with staff in Priory.

92. I cannot recall due to the length of time that has passed since then, if any encouragement was given to VC if he was not engaging with staff or peers.

93. A lack of engagement with staff or peers can give rise to a number of clinical and risk-related concerns in the inpatient setting. In general terms, when a patient does not engage, it becomes more difficult to assess their mental state accurately, monitor risk, and build the therapeutic alliance necessary for effective treatment. However, I'm afraid I cannot recall such details from the time when I was involved in VC's care.

Family engagement

94. I am unable to recall whether VC gave consent for his family to be contacted, or any conversations with VC's mother, wider family or care coordinator, during his stay at Priory. While this would be part of routine practice, unless this had been documented at the time, I am unable to recall such details.

Violence and aggression

95. In relation to the entry made on VC's care record on 10 October

2021, where he brought a hammer in his rucksack, From the provided documents I can see that this was mentioned in ward round notes, however I am unable to recall if anything else was discussed other than what was documented. While this would certainly have been a concern, I am unsure to what level of detail this was discussed in the ward review, and whether or not the ward round notes reflected the entirety of such conversation.

96. From the available documents, it appears that towards the end of his admission, VC's behaviour had been calm, cooperative, and stable, with no evidence of aggression, hostility, or threatening behaviour toward staff or peers. His mental state had improved, with a reduction in psychotic symptoms and no indications of imminent risk.

97. It was anticipated that any ongoing risk would be addressed through consistent engagement with the CMHT, adherence to prescribed medication, and regular psychiatric review.

VC's delusional beliefs

98. The type of persecutory and technology-related delusional beliefs described in VC's records were familiar to me from general clinical experience with psychotic and paranoid presentations. Such beliefs are not unusual in schizophrenia.

99. I cannot now recall the precise details of VC's presentation, as this was around four years ago.

100. I do not now recall whether VC researched or sought support for his beliefs online, and I have no recollection of any information at the time suggesting that he did so.

Depot medication

101. VC's medication was not administered by depot at any time prior to his

discharge because this was not discussed and approved as treatment plan.

102. I don't recall if conversations with VC's community treatment team took place, generally or in relation to depot medication. This would have been routine practice. Sometimes, however, community teams are not in the position to attend each individual ward review.

103. Commencing depot medication would not necessarily have required a request from VC's community treatment team. It is however, good practice to have input from the community team regarding the treatment and discharge planning.

104. VC had a good response to Aripiprazole due to his settled presentation and reduction of psychotic symptoms.

105. I was not the decision maker at the time, although in hindsight I would not rely on VC's confirmation that he would continue taking his medication on discharge, given the historic non-compliance.

106. In hindsight, further steps in relation to depot medication could have been taken and it would be a logical step to take. I cannot comment as to why this was not the case four years ago.

Discharge and ongoing treatment

107. VC's "Keeping Connected" care plan [PAGR0000021] included the following comment in relation to his discharge plan:

"*Valdo was admitted on 1st October 2021 as a step down from PICU. He made very good progress during his admission to PICU so now on an acute ward, Valdo will be supported to work towards an appropriate discharge plan.*"

108. I assume the comment that VC had made "very good progress" at Priory Hospital would be related to his generally settled presentation with no florid psychotic symptoms.

109. VC's care record [PAGR0000025] on 4 October 2021 stated: *"Discharge to Beacon Lodge was discussed and Valdo was keen on this option"*.

110. Beacon Lodge is a 12-bed step-down residential service commissioned by Nottinghamshire Healthcare NHS Foundation Trust and delivered by Turning Point.

111. The service's purpose is to provide a transitional environment: the individual is no longer in acute crisis but still needs structured support (medication management, risk monitoring, life-skills work, social inclusion) before fully returning to community living.

112. I am unable to recall why Beacon Lodge was being considered, what steps were taken or why VC was discharged to the community and not to Beacon Lodge. There may have been various reasons for this at the time, such as lack of beds, prioritization of patients who were deemed living in unsuitable conditions in the community etc. Sometimes patients decline the offer to be discharged to a step-down accommodation.

113. I understand that each of VC's risk assessments – 4 October 2021 [PAGR0000009], 7 October 2021 [PAGR0000010], 14 October 2021 [PAGR0000011], and 21 October 2021 [PAGR0000012] – included the following comment: "*May be able to mask symptoms to get discharged*".

114. I assume this would have been documented previously based on historic experience.

115. I am unable to comment on how this risk was taken into account in relation to VC's discharge planning or the possibility that VC may be able to mask his symptoms to get discharged. This would usually be taken into account in the process of risk assessment and be monitored.

116. The usual expectation following discharge, would be for a patient to have a

follow-up care arranged by their local mental health team after the discharge.

117. Upon discharge, I drafted a discharge summary which commented *"Engaging with staff. Understands he has been unwell and is getting better. He is keen on being discharged but happy to continue treatment as an in-patient."*

118. The comment "Engaging with staff" would have been based on MDT feedback. The comment *"Understands he has been unwell"* was formed on the basis of conversations with the team.

119. I provided the following *"Summary of Progress on Ward and incidents during admission":*

"Relatively brief admission. Valdo has settled well on the ward. He engaged in some of the offered actives. Medication was changed to aripiprazole, which he tolerated better. No psychotic features noted, nor risks to self or others noted."

120. I considered VC's admission to be relatively brief as it was shorter than four weeks. I assume his admission was brief because he settled very quickly following his admission to Priory and therefore it was assumed he could continue his recovery in the community.

121. I do not recall the precise details of my clinical notes regarding VC, as this was approximately four years ago, but I can explain the general clinical context and basis for the comments recorded at the time. The phrase "*settled well on the ward*" would have been based on observations from nursing staff and my own reviews, indicating that VC had adjusted to the ward environment, was calm, cooperative, and not exhibiting disturbed or agitated behaviour. It would reflect that he was sleeping, eating, and engaging appropriately, with no behavioural incidents or signs of distress.

122. The comment *"engaged in some of the offered actives"* would have referred to VC's partial participation in ward-based occupational or recreational

activities, as noted by nursing or occupational therapy staff. It suggests that while he was not fully socially active, he accepted some therapeutic engagement, which was viewed as a positive sign of stability and recovery.

123. The comment *"tolerated* [Aripiprazole] *better"*? would have been based on clinical observation and VC's self-report, together with nursing feedback, that he was complying with medication and not experiencing significant side-effects such as akathisia, restlessness, or sedation. It indicates an improvement in tolerability compared to any previous antipsychotic trials or earlier reports of side-effects.

124. The comment *"No psychotic features noted, nor risks to self or others noted"* would have reflected that, at the time of review, VC's mental state examination did not reveal active psychotic symptoms — no evidence of delusions, hallucinations, thought disorder, or marked paranoia — and that he was presenting as calm, settled, and free from overt risk behaviours such as agitation, hostility, or self-harm. It was intended to document an absence of acute symptoms or imminent risk, not to suggest that all background risk factors were absent.

125. I do not now recall all the precise details of VC's presentation and discharge, as this occurred four years ago, but based on the review of the available documentation, his discharge to the community was considered appropriate at the time. By late October 2021, VC's mental state appeared stable, he was compliant with medication, and there were no overt psychotic symptoms or aggressive behaviours observed on the ward. His risk of violence was regarded as low, provided that he remained engaged with treatment and follow-up.

126. VC was treated in line with accepted standards of care: receiving

antipsychotic medication, regular medical and nursing reviews. In retrospect, one additional consideration might have been whether a Community Treatment Order (CTO) could have further supported adherence and provided a legal framework for recall if he disengaged after discharge. However, at the time, VC was engaging with the team, taking medication voluntarily, and not presenting with active risk behaviours, so a CTO may not have met the proportionality threshold under the Mental Health Act. On that basis, no further coercive or restrictive actions were taken.

127. I did not have any further contact with VC after his discharge on 22 October 2021.

Recommendations

128. I believe the Inquiry should recommend stronger joint decision-making at discharge for high-risk patients, with clear communication between inpatient and community teams, and consideration of Community Treatment Orders where there is a history of violence or non-adherence. Consistent post-discharge monitoring and contingency planning would help prevent relapse-related incidents.

129. Multi-agency working could be improved through better information sharing and structured collaboration between NHS, independent providers, social care, and the police, ensuring that key risk information and responsibilities are clearly communicated and acted upon across all services.

Statement of Truth

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

Signed: GRO-B

Dated: 14.02.2026

Index to First Witness Statement of Dr Helena Aziri

No.	Inquiry URN	Document Description
1	CYGN0000012	Report dated 11/10/2021, compiled by Tania Engel Re: Discharge Summary of: Valdo Calocane
2	CYGN0000015	Medical records of Valdo Calocane from 11/09/2021 to 01/10/2021, Cygnet Re: notification of discharge/transfer to be sent on day of discharge
3	PAGR0000005	Priory Hospital Arnold, Referral Checklist form of Valdo Calocane
4	PAGR0000008	Risk Screening form of Valdo Calocane dated 01.10.2021
5	PAGR0000009	Risk Screening form of Valdo Calocane dated 04.10.2021
6	PAGR0000010	Risk Screening form of Valdo Calocane dated 07.10.2021
7	PAGR0000011	Risk Screening form of Valdo Calocane dated 14.10.2021
8	PAGR0000012	Risk Screening form of Valdo Calocane dated 21.10.2021
9	PAGR0000017	CARE notes form of Valdo Calocane
10	PAGR0000021	Medical records of Valdo Calocane, from 14/10/2021 to 21/10/2021, Nottingham University Hospitals NHS Trust
11	PAGR0000022	Care Plan form for Valdo Calocane.
12	PAGR0000023	CARE notes form of Valdo Calocane
13	PAGR0000024	Medical Records of Valdo Calocane, from 07/10/2021 to 21/10/2021, Nottingham University Hospitals NHS Trust
14	PAGR0000025	Medical records of Valdo Calocane, from 01/10/2021 to 27/10/2021, Nottingham University Hospitals NHS Trust
15	PAGR0000033	Policy Document, re: Admission, Transfer and Discharge, Priory Healthcare
16	WITN0229002	NICE NG10- Violence and Aggression.
17	WITN0229003	NICE NG53 (2016): Transition between inpatient and community settings, Priory's Admission and Observation Policy, the Mental Health Act Code of Practice (2015), and relevant NICE

		Guidelines.
18	WITN0229004	NICE guidance (CG178: Psychosis and schizophrenia in adults)