

Witness name: Benedict James di Mambro

Statement No: WITN0247001

Dated: 13.11.2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF BENEDICT JAMES DI MAMBRO

I, Dr Benedict James di Mambro, will say as follows: -

INTRODUCTION

1. I am a consultant psychiatrist with the Crisis Resolution and Home Treatment Team within the Nottinghamshire Healthcare NHS Foundation Trust, Nottingham.
2. This witness statement is made to assist the Nottingham Inquiry (the "Inquiry") with the matters set out in the Rule 9 Request dated 23 September 2025 (the "Request"). This witness statement was drafted on my behalf by the external

solicitors acting for the Trust in respect of the Inquiry, with my oversight and input, following discussions in writing by email and by video conference.

BACKGROUND

3. My professional background and experience are as follows:

Qualifications

BMBS University of Nottingham (Jun 2000)

MRCPsych Royal College of Psychiatrists (Dec 2005)

MMedSci Masters in Clinical Psychiatry, University of Nottingham (Jun 2006)

Professional organisations.

General Medical Council 4715320

Royal College of Psychiatrists 810992

Clinical Experience.

Aug 2000 Surgical Junior House Officer in Surgery and Urology

Mr. Rigg, City Hospital, Nottingham

Feb 2001 Medical Junior House Officer in Old Age Medicine and

Endocrinology

Dr. Snape, Kings Mill Hospital, Mansfield

Aug 2001 Medical Senior House Officer in General Medicine

Barnstaple Hospital, Barnstaple

- Oct 2001 Surgical House Officer in Renal Medicine
Christchurch University Hospital, Christchurch, New Zealand
- Dec 2001 Surgical House Officer in Rehabilitation Medicine
Christchurch University Hospital, Christchurch, New Zealand
- Feb 2002 Surgical House Officer in General Medicine
Christchurch University Hospital, Christchurch, New Zealand
- Aug 2002 Senior House Officer in General Adult Psychiatry
Dr. Doody, Nottinghamshire Healthcare NHS Trust, Nottingham
- Feb 2003 Senior House Officer in General Adult Psychiatry
Dr. Boks, Nottinghamshire Healthcare NHS Trust, Nottingham
- Aug 2003 Senior House Officer in Old Age Psychiatry
Dr. Jones, Nottinghamshire Healthcare NHS Trust, Nottingham
- Feb 2004 Senior House Officer in Learning Disability Psychiatry
Dr. Mukherjee, Nottinghamshire Healthcare NHS Trust,
Nottingham
- Aug 2004 Senior House Officer in Rehabilitation Psychiatry
Dr. Park, Nottinghamshire Healthcare NHS Trust, Nottingham
- Feb 2005 Senior House Officer Liaison Medicine
Dr. N. Holden, Nottinghamshire Healthcare NHS Trust,

Nottingham

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| Aug 2005 | Senior House Officer Crisis Resolution Team Dr. M. Sherman, Derbyshire MH Services NHS Trust, Derby |
| Apr 2006 | Specialist Registrar General Adult Psychiatry Dr. I. Medley, Nottinghamshire Healthcare NHS Trust, Nottingham |
| Sept 2006 | Specialist Registrar Perinatal Psychiatry Dr. M. Oates, Nottinghamshire Healthcare NHS Trust, Nottingham |
| Aug 2007 | Specialist Registrar General Adult Psychiatry Dr B. Ferguson, Lincolnshire Partnership Foundation Trust |
| Aug 2008 | Specialist Registrar General Adult Psychiatry Dr. E. O'Regan, Nottinghamshire Healthcare NHS Trust, Nottingham |
| Jun 2009 | Consultant Perinatal Psychiatrist & Clinical Teaching Fellow Nottinghamshire Healthcare NHS Trust, Nottingham |
| May 2013 | Consultant Perinatal Psychiatrist & Associate Clinical Subdean Nottinghamshire Healthcare NHS Trust, Nottingham |
| May 2015 | Consultant Psychiatrist |
| to date | Crisis Resolution and Home Treatment Team Nottinghamshire Healthcare NHS Foundation Trust, Nottingham |

ROLES AND TRAINING

4. My current role is as a consultant psychiatrist working for two Crisis Resolution and Home Treatment Teams (CRHT), namely City and County South, in Nottinghamshire Healthcare NHS Foundation Trust.
5. The functions and duties of a consultant psychiatrist are dependent upon the team one is working for. However, there is an overarching function of all consultants to provide clinical leadership. Within CRHT, consultant psychiatrists contribute to MDTs to help understand formulations, guide treatment options, manage risk and ensure progression of care. The consultant will offer supervision to the team, including nurses and junior doctors, to support assessments of mental health difficulties, risk management and delivery of effective care.
6. The consultant will undertake clinical assessments for Mental Health Act assessments, more complex cases, cases where formulation or diagnosis is unclear, cases where there is concern about an underlying organic pathology or a comorbid physical health condition, cases associated with significant risk or in cases where progress is not being achieved. The consultant will undertake assessments on wards, in police custody, in people's homes and in the community. Where possible, the assessment will be carried out with family or carers present. Collateral history from family or carers is routinely undertaken within the assessment of mental health disorders.
7. During mental health assessments it can be challenging to gather desired information and there is only a very limited role for objective testing. The consultant in CRHT is required to undertake risk-benefit decisions, which sometimes can be with only limited information. The consultant has an

- important role in contributing to the governance of the team, including learning from serious untoward incidents, key performance indicators delivery, service delivery, service development and supporting clinician's career progression. During the period covered in this inquiry, there were three consultants working across the two CRHT teams with clinical commitments, comprising of either 900 to 2000 shifts or 900 to 1700 shifts, determined by a rota covering Monday to Friday. An additional weekend rota had been discontinued some years prior.
8. I hold an additional role within Nottinghamshire Healthcare NHS Foundation Trust in the Population Health Unit (PHU), which aims to contribute to wider healthcare system improvement through the provision of technical, statistical, clinical and public health expertise. I have interests in data analysis and computer coding; the focus of my role in the PHU is to support the development of analyses for health inequalities and clinical outcomes in the Trust.
 9. I hold a further role within Nottinghamshire Healthcare NHS Foundation Trust offering clinical supervision to the Primary Care Mental Health Team. A colleague and I offer ad hoc supervision to this team to discuss individual patient prescribing, formulation and pathway queries from the mental health nurses working in Primary Care. The time commitment for this role is minimal.
 10. Through my training as a junior doctor, which included the completion of a Masters in Clinical Psychiatry, I received taught sessions and supervision relating to the management of patients subject to the Mental Health Act and in relation to the assessment of capacity. As part of my role as a consultant psychiatrist, I am section 12 approved, which requires completion of an Approved Clinician course, delivered by a recognised body, every five years.

The focus of this training is the implementation of the Mental Health Act in clinical settings.

11. Training is available through the Trust's e-learning offer on both the Mental Health Act and Mental Capacity Act, which requires regular completion. I am required by my membership of Royal College of Psychiatrists to complete 30 hours of peer reviewed clinical Continuing Professional Development per year, the focus of which will change from year to year.
12. The assessment of capacity is part of my routine clinical work. Discussions about a person's capacity and potential utilisation of the Mental Health Act occur on a daily basis as part of a multidisciplinary team meetings (MDT). Issues around capacity and the role of the Mental Health Act in an individual's care are frequently discussed at Trust organised Case Presentations and Journal Clubs. Due to the nature of my work in CRHT, I undertake Mental Health Act assessments several times per week. The Mental Health Act assessment will usually occur with another doctor and an Approved Mental Health Professional (AMPH), during which I will explore the issues around capacity and criteria for applying a section of the Mental Health Act, both of which will be documented in an individual's electronic patient record and if completed in a medical recommendation for a section of the Mental Health Act. Documentation will be read by fellow clinicians and medical recommendations scrutinised by the Trust's Mental Health Act office.
13. To my knowledge, I have not been involved in any other incident where a patient has killed or seriously injured a member of the public.

Involvement with and knowledge of Valdo Calocane (“VC”)

JUNE 2020

14. Prior to 16 June 2020, I believe that I had a verbal discussion with Dr Faizal Seedat, consultant psychiatrist, about the discharge pathway for VC from his admission to Rowan 1, Highbury Hospital. If my recollection is accurate, we discussed that due to VC being uncertain about where he wished to live, Dr Seedat requested follow-up with CRHT rather than with the previously planned Early Intervention in Psychosis team (EIP), which would have been the expected pathway. I agreed to the referral to CRHT. I cannot recall the date of the conversation or level of detail of VC's case we discussed. Samantha Woodings, Band 6 Nurse, attended a Ward Round on 15 June 2020 at Rowan 1, Highbury Hospital, to agree a plan for follow-up on discharge for VC [NHFT0000168 p45]. I am likely to have been aware that the appointment was planned.
15. VC was referred to CRHT on 11 June 2020 [NHFT0000168 p37] in preparation for discharge from Highbury Hospital with the aim of CRHT providing follow-up in the community. Given that VC was uncertain as to whether he intended to remain in Nottingham or move to Birmingham, a referral to EIP services had been delayed, which appeared appropriate. CRHT offered a telephone appointment the day following discharge.
16. CRHT operate a team held caseload, with a consultant psychiatrist being on duty each day (Monday to Friday) and the duty consultant holding clinical responsibility. Though I was named as VC's consultant in the community at the point of discharge, it is arguably more accurate that the three CRHT consultants (myself, Dr Ben Lomas and Dr Mike Skelton) held that responsibility.

NHFT0000023, p1). At the point of discharge, I was unaware that I had been named as the community consultant. However, I would not have expected to be informed about a referral to CRHT that I was named on. All referrals to CRHT are discussed with a Band 6 or 7 clinician. The CRHT clinician has access to the electronic patient record and will discuss any concerns about a referral with a senior colleague. I would have been available to discuss VCs care as required. CRHT interface with inpatient services. If required, CRHT will discuss with the inpatient Responsible Clinicians prior to discharge or review an individual patient prior to discharge. However, routinely CRHT consultants will pick up cases through MDT or through supervision. As per previously stated, the role of the consultant within CRHT, which would be as the community consultant, is to ensure effective care is being offered, manage risks, monitor for signs of deterioration and ensure that care is progressing.

17. To my knowledge, at the point of discharge I was not sent discharge summary. NHFT0000023. However, the discharge summary would be available to me through the electronic patient record. Due to CRHT having a team held caseload, I would not have expected to be included in the distribution list and would not be concerned by not being included in the distribution list. This was so, especially as CRHT had attended the discharge planning meeting.

18. The discharge summary was addressed to "Dear Dr". I am uncertain as to whether this was specifically addressed to me or not. This may have been meant to be received by the General Practitioner who received the discharge summary. In addition to a discharge summary, I have access to the electronic patient record which would provide greater clinical detail. I would not rely on solely a discharge summary to provide ongoing care.

19. Though I did not receive the letter at the point of discharge, I was subsequently made aware of the incident that led up to the admission, where VC entered neighbour's flat. I considered that this was significant as VC had undertaken a concerning behaviour in response to psychotic symptomatology. I also learnt that that behaviour had resulted in a serious injury to a member of the public.
20. At the stage that I learnt of these happenings, I should say that considerations of ongoing plan to mitigate risks remained dependent upon VC's current symptoms, concordance with treatment, crisis planning and engagement, particularly relating to the service's ability to detect signs of relapse. This is primarily an assessment of contemporaneous presentations. I was unaware of any other risks regarding VC at this point.
21. Following discharge, VC's initial appointment was with Isabel Fairbrother, Band 6 Nurse. To my knowledge, I did not have a discussion with Isabel Fairbrother about her interaction with VC on 18 June 2020. My first direct involvement as recorded in the electronic patient record was with VC on 19 June 2020 and I attended the MDT on that date -[NHFT0000168 p50]. The purpose of the MDT is to review the care being offered, identify concerns, discuss aspects of an individual's care and plan care moving forward. CRHT operate with a RAG system (Red-Amber-Green), which indicates the frequency of contact, level of concern or complexity and frequency for MDT discussion. Red RAG will be discussed daily in MDT and generally the individual will have daily contact with the team. Amber RAG will be discussed weekly in MDT and the individual will have contact with the team 2 to 3 times per week. Green RAG indicates preparation for discharge, a Band 7 clinician will review progress weekly and the individual will likely have contact with the team once per week. Each day,

approximately 20 Red RAG cases across both teams will be discussed each morning. Additionally, approximately 30 Amber RAG cases across both teams will be discussed in the afternoon.

22. The MDT has access to the electronic patient record. In addition, where possible, the MDT will include discussion with clinicians who have had recent contact with the individual. MDT documentation occurs only within the 'Progress Notes' section of the electronic patient record. The MDT documentation for 19 June 2020 [NHFT0000168 p50] and 26 June 2020 [NHFT0000168 p53] were a reflection of the issues in VC's case at that time and were not intended to be a comprehensive documentation of his presentation. At the time of these MDTs, I personally had had no clinical appointments with VC. MDT documentation should be considered alongside documentation from other clinical appointments. The level of detail of documentation is dependent upon the complexity, risks, recent developments and required planning. In my opinion, the documentation was sufficient for the presentation at that time.

23. VC was experiencing a first episode of psychosis (FEP), which requires specialist input from EIP. Specialist input is required at the earliest opportunity to improve outcomes in psychosis by reducing the duration of untreated psychosis, reducing severity of symptoms, reducing risk of relapse, potentially reducing neuronal changes, establishing therapeutic relationship to promote future engagement, undertaking psychoeducation and reducing potential social harm. EIP would offer a care co-ordinator (CCO), a consistent worker, and expertise in the assessment and management of psychosis for VC for up to the next three years. The aim for CCO was to establish a therapeutic relationship

with VC which would support onward engagement and care. CRHT offer a 24 hour a day service and are not able to offer a consistent worker.

24. Dr Faizal Seedat, consultant psychiatrist, sent an email to the CRHT consultants on 22 June 2020. This occurred, to my understanding, after Dr Seedat received an email from VC's mother, who expressed concern that the initial contact following discharge had occurred over the phone rather than face-to-face due to the pandemic. Dr Seedat contacted the team to reiterate that contact with VC needed to be undertaken face-to-face due to VC not being forthcoming with information about his symptoms or experiences [[NHFT0000168 p51]. Through my own experiences in CRHT, I am aware of the limitations of remote consultations, particularly in providing care for people experiencing psychosis. From Dr Seedat's email, I suspect that the need for face-to-face contact had been discussed prior to discharge and CRHT should have undertaken the initial contact face-to-face. Through the pandemic, the delivery of care was required to substantially change and CRHT were undertaking a combination of remote and face-to-face appointments. For people experiencing symptoms of psychosis, CRHT would not have relied solely on remote appointments to deliver an episode of care as CRHT are aware that people will not necessarily disclose the symptoms they experience due to their level of insight or beliefs. Dr Ben Lomas, consultant psychiatrist, who was on duty for CRHT that day, relayed the information from Dr Seedat to the CRHT team and a face-to-face appointment was arranged for the following day.

25. At the point of discharge, VC was uncertain about where he wished to live in the future. However, on 23 June 2020, VC indicated that he intended to stay in

Nottingham at least in the short-term [NHFT0000168 p52]. A referral had been made to EIP services in Nottingham on 12 June 2020 (was 'in place') which was the appropriate pathway as he was remaining in Nottingham. At the appointment on 23 June 2020, VC reported that psychotic symptoms had lessened but were still present. Risks were considered, including his ability to mask symptoms, risk of violence and aggression and non-concordance. The reported improvement in symptoms suggested that antipsychotic treatment had been of some assistance to VC and that VC was likely concordant with treatment. It was positive that VC had engaged in a conversation about his symptoms which would guide ongoing treatment plans and assessment of risk.

26. At the assessment on 23 June 2020 [NHFT0000168 p52], VC's presentation required ongoing treatment but did not require ongoing intensive home treatment with CRHT and his risks were suitable for ongoing management by EIP. RAG rating was reduced to Green (discharge planning). My interpretation of this assessment was that there remained ongoing symptoms of psychosis and a risk of relapse, which would be associated with an increase in risk to others. However, VC required a longer-term approach to manage his mental health difficulties, which EIP were best placed to deliver. In my opinion, it was an appropriate juncture in VC's care to introduce the team who would be providing longer term care and who had the expertise to address ongoing symptoms. Continuing with care being provided by CRHT would require the involvement of multiple clinicians which would most likely be detrimental to future engagement with services. To ensure continuity of care, a joint appointment was arranged, at which CRHT and EIP clinicians would make an assessment together and agree a plan for ongoing care with VC. The planned

transfer of care to EIP was discussed at MDT on 26 June 2020 [NHFT0000168 p53]. A joint appointment between EIP and CRHT occurred on 30 June 2020 [NHFT0000168 p54] and it was agreed to transfer care to EIP.

AUGUST 2021

27. I had no involvement in VC's care between 26 June 2020 and 2 September 2021. VC was referred to CRHT on 31 August 2021 due to concerns about a deterioration in mental state, previous risk incidents and difficulty with engagement. A Mental Health Act assessment had been unsuccessfully attempted on 1 September 2021.

28. On 2 September 2021, I attended VC's property for the purpose of conducting a Mental Health Act assessment [NHFT0000168 p164]. Prior to attending the assessment, I accessed the electronic patient record to gain an understanding of both historic and recent events. From the records, VC's presentation was consistent with a relapse of a psychotic disorder. During an episode of relapse of a psychotic disorder, the individual often experiences similar symptoms and intensity of symptoms as the first episode of psychosis. If an individual presented as a risk of any type during the first episode of psychosis, that risk is likely to be again elevated during the relapse. VC was likely experiencing a relapse of a psychotic disorder, due to difficulties with engagement, acceptance of treatment and previous risks associated with psychotic symptoms admission was indicated. It appeared likely that admission would require a Mental Health Act assessment as VC was unlikely to agree nor likely have the capacity to consent to admission.

29. When we attended the property, there was no answer the door. It was noted that it was VC's birthday in the coming days, which I felt increased the likelihood

that he may have had plans booked, including seeing family members. I recall that myself, Dr Omar Manzar, consultant psychiatrist, and Jen Shaw, AMPH, discussed the case and agreed that a Mental Health Act assessment was required and services needed to locate VC. The AMPH agreed that she would contact family. I personally did not speak to family members. We agreed that if not located, a further Mental Health Act assessment would be attempted, aiming for early in the morning to increase the likelihood of finding VC at home. The AMPH contacted VC's mother and due to level of concern, a further Mental Health Act assessment was attempted that afternoon with Dr Ben Lomas, consultant psychiatrist.

30. I was made aware of the events that occurred during the process of the Mental Health Act assessment on 3 September 2021 through discussion with Dr Ben Lomas, consultant psychiatrist. However, I'm unable to recall whether that discussion occurred on the same or the following day. My recollection of that conversation was that VC had perpetrated a serious assault on a police officer when VC came into contact with police. I recall discussing the uncertainty as to whether the assault related to psychotic symptomatology, a reaction to the police presence or in response to a perceived threat of incarceration. I was aware that VC had been admitted under a section 2 of the Mental Health Act and placed in seclusion on Cassidy Suite at Highbury Hospital.

31. Seclusion is utilised to manage risks and behaviours of an individual admitted to mental health ward detained under the Mental Health Act. Seclusion is most commonly utilised to manage the risk that an individual poses to others. Seclusion is the highest level of inpatient care that community mental health services are able to routinely access at the point of admission. Given the

assault that occurred, in my opinion, initially managing VC in seclusion was necessary to manage the risk posed to staff and other patients on the ward. The care of individuals in seclusion is regularly reviewed and seclusion is continued for the shortest time possible, which is in keeping with the principle of the least restrictive option. VC had been conveyed to the Cassidy Suite (136 Suite), under section 135(1) of the Mental Health Act. He was subsequently detained under a section 2 of the Mental Health Act. Due to concerns about the risks he presented to others, VC required a Psychiatric Intensive Care Unit (PICU) environment and seclusion. On 3 September 2021, no seclusion bed was available, therefore a decision was taken to 'step up' the Cassidy Suite bed and use as a seclusion room.

32. The CRHT consultant on duty holds the Responsible Clinician role for individuals who are 'stepped up' to the Cassidy Suite (136 Suite). In that capacity, I carried out a medical review of seclusion for VC on 7 September 2021 and 8 September 2021. The purpose of the medical review of seclusion is to assess an individual's mental state, risks, need for continued seclusion, physical health and collaboratively review plan of care. Reviewing an individual's care is best undertaken in collaboration with the individual and where possible including the individual's support network. As part of this review, a discussion about the individual's rights under the Mental Health Act would be undertaken.

33. On 7 September 2021 VC remained in seclusion on the Cassidy Suite. Multiple unsuccessful attempts had been made to source a PICU with seclusion capacity, though this delayed the transfer of VC from the Cassidy Suite it did not alter my approach or decision-making. I attended the Cassidy Suite to

undertake the medical review of seclusion [NHFT0000168 p181], staff nurse was present, I attempted to engage VC in conversation about his mental health, current needs, assess current risks and agree a plan with VC. VC gave only brief answers and it was clear that VC wished to demonstrate that he had no difficulties in his life that required involvement of mental health services. I attempted to engage with VC using open and closed questions. I attempted to change topic of conversation but could not achieve any meaningful engagement. VC denied having any current or historic mental health difficulties. I attempted to describe my understanding of recent events. VC denied that these events ever occurred. VC appeared aware that he was detained under the Mental Health Act but again could not engage in conversation on the topic. From the preceding day's entries in the electronic patient record, my interaction with VC, including the difficulty in engaging conversation, appeared consistent with previous assessments. I documented that VC was engaging "only superficially." This was in reference to both engagement with assessments and plan of care. Poor engagement decreases the reliability of the assessment undertaken and concordance with the plan of care, particularly in the longer term.

34. My opinion on 7 September 2021 was that VC's presentation was consistent with a relapse of psychosis. From reading through the electronic patient record, the relapse likely occurred after non-concordance with antipsychotic treatment. VC required ongoing treatment with antipsychotic medication to treat the psychotic relapse and manage risks. Initially, that medication should be offered orally but if declining, antipsychotic medication was to be given by intramuscular (IM) route. Given my knowledge of VC's case, I anticipated that IM medication

would be required initially to initiate treatment. Due to the difficulty in engaging VC in meaningful conversation, it was difficult to assess the efficacy of the treatment offered. Though VC presented as being calm and there had been no further aggression on Cassidy Suite, it was my opinion that given the severity of the assault and that the assault had occurred with little warning, continued seclusion and a PICU was required. Due to difficulty with engagement, I was unable to carry out a formal assessment of capacity with relation to decisions about treatment. In the reference on 7 September 2021, I said it was “*difficult to envisage how [VC] can be safely stepped down from seclusion without a PICU*” [NHFT0000168 p181]. To clarify, this referred to the decision of whether to continue the admission in a PICU or a General Adult ward environment and did not relate to the decision of whether to continue seclusion. Staffing levels can be increased on Cassidy Suite to manage risks posed.

35. On 8 September 2021 I carried out a further medical review of seclusion on Cassidy Suite [NHFT0000168 p185]. Olivia Musonza, Staff Nurse, and Sophia Mutonono, Staff Nurse, were present at the review. Over the previous 24 hours, VC had remained calm and staff had been able to enter his room without incident. VC had continued to decline oral medication. He had previously required the administration of IM medication under restraint. However, he had in the previous 24 hours accepted IM medication without the need for restraint. At interview, I recall that VC was slightly more engaged with our conversation. However, he remained guarded. I again attempted to engage VC in a conversation about his care. I attempted to discuss abstract concepts of psychosis and how psychosis can potentially impact on an individual’s life. VC explained that he had never experienced any symptoms of psychosis. I again

attempted to discuss with VC incidents where there had been concerns about VC's risks to others; VC denied any incidents relating his neighbours ever occurred, thus I was unable to explore these further. I was aware of the details of the incidents involving his neighbours, which were an indication of a change in behaviour in response to psychotic symptoms that would be associated with increased future risk whilst experiencing psychotic symptoms. VC did acknowledge that there had been an incident with the police. It remained difficult to explore any subject in detail.

36. VC briefly referred to the interaction between NHS and police, which was likely consistent with previously documented persecutory beliefs. Most likely, this was an expression of persecutory delusions, which is itself, a symptom of psychosis. Throughout the interview VC was guarded and did not display insight into his mental health difficulties or the incidents associated with risk. I was mindful that VC may have been dismissing all concerns to achieve a reduction in the restrictions placed on him. It was also possible that he held beliefs about my motivations as I worked for the NHS, so as a consequence, he was choosing not to engage in the assessment. VC appeared more agreeable with working with mental health services but continued to not see a need for medication or continued hospital treatment. VC denied that he was a risk to himself or to others. However, given the difficulty engaging in the assessment, previous history, current presentation and recent assault, VC continued to require treatment for his mental health disorder in a PICU environment.

37. As previously stated, I attempted to discuss the incidents relating to his neighbours, which VC denied ever occurred. Regarding the incident with the police, I was unable to engage in follow-up questions on. I was asking these

questions specifically in relation to risk and trying to explain to VC why he was in hospital and currently in seclusion. Unfortunately, I cannot recall the words VC used. However, his answers were brief and dismissive of concerns.

38. My opinion on 8 September 2021 remained the same as the previous day. It was that VC's presentation was consistent with a relapse of psychosis, secondary to non-concordance with antipsychotic treatment. There did appear to be an improvement in his presentation, though engagement in the assessment process and care planning remained challenging. Given that there had been no further incidents of aggression or agitation whilst in Cassidy Suite, staff had been able to enter his room and he was agreeable to work with mental health services - the decision was taken to end seclusion. Ending seclusion would reduce the restrictions placed on VC, allowing him access to additional areas on the Cassidy Suite, including an enclosed outdoor space. However, he would remain restricted to the Cassidy Suite. This was discussed and agreed with nursing colleagues present. Risks to others remained elevated. However, it appeared appropriate to manage ongoing risks with continuous observations and increased staffing levels on Cassidy Suite. In my opinion, this was in keeping with minimising restrictions on VC's freedom of action. It was likely that VC's decision-making continued to be influenced by psychotic symptoms, including limited insight. Thus, it was likely at that time that VC's capacity to decide venue of care and treatment options was impaired. Ending seclusion and continuing with the plan for continued admission to a PICU was, in my opinion, the minimum restrictions required to safely manage VC's care at that time.

39. At both my meetings with VC, I attempted to engage VC in the care planning process. This was challenging. My opinion was that treatment with an antipsychotic medication was in VC's best interests. VC did not agree. Given that VC had presented with a further relapse of a psychotic disorder, I was aware of the need to engage him in the care planning process for both the short and longer term. During previous admissions, antipsychotic treatment had resulted in an improvement in his mental state. Therefore, the focus of my assessments was on short-term planning. Longer-term planning would need to be considered as his mental state improved to enable VC to have greater involvement. I was aware that unfortunately, it is not always possible to develop a collaborative care plan, and in such instances, a best interest decision is required on how care should be taken forward. At the time of my appointments with VC, my focus was on achieving an improvement in mental state to enable to him engage with decisions about his care.

40. Short-acting IM antipsychotic medication administration can be associated with excessive sedation, exacerbation of pre-existing physical health conditions and cardiovascular or respiratory collapse. Due to these risks, additional physical health monitoring (respiratory rate, pulse, blood pressure, level of consciousness and temperature) is sought in the hours following administration, initially every 15 minutes for the first hour and then hourly until the individual is ambulatory. IM antipsychotic can be given without undertaking the additional physical health monitoring if the patient is refusing the monitoring or attempting to undertake the monitoring would pose a risk to the staff and/or patient; in such scenarios, a risk-benefit decision is taken. In the case of VC, antipsychotic treatment was indicated and he was declining oral antipsychotic

treatment. Additionally, he was declining physical health observations. It was my opinion that due to his mental health presentation, age, past medical history, evidence of a decline in mental state and risks to others, IM antipsychotic treatment was indicated even if additional physical health monitoring could not be undertaken. Antipsychotic treatment and IM haloperidol had been initiated on 3 September 2021. When I reviewed VC on both 7 September 2021 and 8 September 2021 it was my opinion that it was appropriate to continue the treatment plan of offering oral antipsychotic medication and to administer IM antipsychotic medication if declining.

41. I offered to speak to VC's family but VC did not give consent. The care planning options that I was considering on 7 and 8 September 2021 did not necessitate involvement of family members but would have been desirable. Though my opinion was that most likely VC's capacity to make decisions about his mental health care was impaired, I had insufficient information to make a considered opinion on whether his capacity to make the decision to not allow me to speak to his family was in fact impaired. Therefore, I respected his wishes and did not contact VC's family. Since I was unable to adequately engage VC in conversation, my actions would have been contradictory to VC's wishes and I would have been unable to discuss the reasons for my actions being against his wishes. It appeared more appropriate to continue with treatment and for discussions to occur about involving family to be revisited as his mental stated improved. Staff on the Cassidy Suite updated VC's mother on the evening of 8 September 2021.

42. During both my assessments with VC, he had refused oral medication, denied confronting his neighbours, denied symptoms of psychosis or the need for

hospital admission. Given the close temporal relationship (consecutive days) between these assessments, I would see that the similarities in VC's responses to questioning as relating to his mental state at the time and would not conclude that these were necessarily fixed views. To understand whether these views were fixed, further assessment would be required as his mental state improved. In addition, there would need to be exploration of VC's premorbid perception of mental health disorders and treatment of mental health disorders which were not possible to explore during my meetings due to level of engagement.

43. Covid-19 testing was undertaken as the result was required prior to transferring VC to a different hospital, Cassidy Suite staff were aware of the test and the need to pass the result on to Cygnet Hospital. I cannot recall that I received information relating to a PCR result for Covid-19 for VC dated 10 September 2021. NHFT0000057. During that period, testing for Covid-19 was routinely occurring and I expect that I would have only responded to such a result if it had been positive. In VC's case, the Covid-19 test was negative. I do not recall having any discussions with any other clinicians about the test or its result. I was asked to comment on whether I was surprised that VC had accepted Covid-19 testing, presumably as engagement with other assessments had been challenging or VC had declined. The Covid pandemic had been a source of great anxiety for the population; thus I am not surprised that VC accepted this test. VC may have viewed that the Covid-19 testing was in his interests, whereas he may have viewed other assessments and investigations as relating to his mental health care and not being as much in his interests. In addition, on 10 September 2021 when the swab was taken, there appeared to be some improvement in engagement and VC was accepting of oral medication. It's

possible that VC may have just been more accepting of other investigations on that day. VC was discharged from CRHT on 8 September 2021.

JANUARY 2022

44. VC was referred to CRHT following a Mental Health Act assessment undertaken by Dr Mike Skelton, consultant psychiatrist, on 19 January 2022. The reason for referral was in relation to possible relapse, concerns over medication concordance and risks associated with a relapse.
45. Through my role as duty consultant for CRHT I participated in two MDTs whilst VC was under the care of CRHT. VC was placed on Red RAG and CRHT were seeing daily to support medication concordance. VC's care was reviewed daily in MDT with the most senior clinician present that day. The role of the MDT is outlined in paragraph 21. MDT discussions are only documented in the 'Progress Notes' section of the electronic patient record. In my opinion, the content of the MDT documentation on 24 January 2022 [NHFT0000168 p210], and 26 January 2022 [NHFT0000168 p211], was sufficiently comprehensive for the purpose of the MDT. Tricia Denham (Band 7 Nurse), Rachel Masterson (Band 7 Nurse) and Ben Clements (Trainee ACP) were present at these MDT's.
46. At the time of the MDTs, I was aware of my previous involvement in VC's care, the plan from his PICU admission, recent police involvement and interactions with community services. I had access to the electronic patient record. I cannot recall whether I had any additional discussions about VC outside of the MDT.
47. My understanding of VC's presentation at that time was that he had a history of psychosis, engagement in community had become more difficult, VC had discontinued medication, there was evidence supporting a relapse of a psychotic disorder and he had previous increase in risk to others when

experiencing psychotic symptoms. The Mental Health Act assessment had been conducted, VC was subsequently referred to CRHT for medication concordance and ongoing monitoring of mental state and risks. Due to risks when experiencing psychotic symptoms, if VC was not engaging with CRHT or not accepting antipsychotic treatment, CRHT would move towards seeking hospital admission. During the time that VC was under the care of CRHT, additional information was obtained that VC had not been keeping up his university studies and due to his behaviour, he was potentially facing eviction from his accommodation. On the 25 January 2022, CRHT had failed to meet with VC to oversee medication [NHFT0000168 p211]. This had been discussed with Dr Mike Skelton, consultant psychiatrist. Further attempts were to be made to contact on 26 January 2022 [NHFT0000168 p211-212], and MDT discussed a plan for requesting a Mental Health Act assessment if VC failed to attend the planned contact. Within the MDT documentation, I stipulated that police presence would be required, due to the previous assault on a police officer during a previous Mental Health Act assessment. At both MDTs, I maintained VC's care on Red RAG which required daily discussion in MDT, in VC's case daily contact with CRHT and medication concordance. Due to VC's history, I was aware of the potential for him being not forthcoming with information about any mental health difficulties, that he may experience a relapse of psychosis which would be associated with increased risks and that he may not accept medication. I therefore was of the opinion that VC require frequent review of his mental state and risks, in addition to regular oversight by a senior colleague in CRHT through the MDT.

48. Medication concordance is undertaken to support an individual with initiating or continuing medication, usually for an individual with difficulties with insight into their own mental health difficulties. The individual is observed taking the medication and information from that interaction is reviewed at the daily MDT, for example it was noted that VC was not accepting a drink of water when swallowing tablets, which might suggest that he was not swallowing the tablet. The reason for maintaining Red RAG was that there had been no evidence of improvement in mental state or engagement, there remained concerns about concordance with medication, risks to others remained unchanged and risk of admission remained significant. VC was being seen in a public place as he had declined appointments at his home address, which would be the usual practice for CRHT. In addition, VC attending an outpatient appointment on a daily basis would be impractical for VC and likely not sustainable.

49. VC attended his appointment on 26 January 2022 [NHFT0000168 p212]. My recollection was that if VC were to engage with services and accept antipsychotic treatment then it would be appropriate to continue with community treatment as VC's psychotic symptoms had seemingly previously been effectively treated with antipsychotic medication. I was also aware of his history of non-concordance and difficulties with engagement, which if could not be overcome would require hospital admission, at the time this appeared the most likely outcome.

50. On 27 January 2022 due to ongoing concerns about whether VC was swallowing the antipsychotic medication, a Mental Health Act assessment was requested [NHFT0000168 p213]. During the assessments with CRHT, VC had presented as being guarded and engagement in assessing mental state had

remained difficult. A Mental Health Act assessment was conducted on 28 January 2022 resulting in admission to hospital. I had no further involvement in VC's care [NHFT0000168 p215].

INPUT INTO OTHER INVESTIGATIONS

51. Concerning the investigation into the questions sent by the families of VC's victims, I received the questions (below) on 1 October 2024. NHFT0004798. I was invited to attend an interview on 10 October 2024, which I attended. NHFT0004839. I had not been asked to give a written response to the questions. Prior to the interview I familiarised myself with the care offered to VC as documented in the electronic patient record, including my own and CRHT involvement. I did not make notes prior to/during/after the interview.

Questions for Dr Ben Di Mambro CRHT

Involvement – CRHT 19.06.2020 and 19.01.2022

49. What actions were taken following missed appointments/ failures to engage?

52. What concerns were raised by the community staff in relation to Calocane's condition and what actions were taken as a result?

53. If staff were raising concerns, who were they raising concerns to?

68. Details of the concerns raised, and the risk mitigation considered (relates to compliance with medication).

69. Details of efforts made to ensure that Calocane was treatment compliant.

75. Calocane's presentation has been described as guarded. Was consideration ever given to the possibility that he was masking symptoms and failing to disclose information in order to be discharged?

85. What were the Calocane family made aware of in relation to his diagnosis?

94. Did any clinicians attempt to support criminal charges in relation to Calocane?

52. As previously stated, I attended the interview on 10 October 2024 with Dr Anna Hiley and Dr Jason Read. I answered the questions from the perspective of my own and CRHT involvement. Notes were taken during the interview by Dr Anna Hiley and Dr Jason Read. Unfortunately, I cannot recall my exact answers to the questions asked, but I recall that the specified questions (above) were asked. My answers to the questions were in keeping with my responses set out in this witness statement. Concerning Question 94, I recall that I was unaware of attempts to support criminal charges against VC.

RECOMMENDATIONS

53. As previously stated, VC was admitted on 3 September 2021 to the Cassidy Suite due to there being no available PICU with a seclusion facility. I am uncertain whether an admission directly to a PICU on 3 September 2021 would have altered the care offered during the admission or subsequently.

54. From my clinical involvement in VC's care, I would not look to make any additional recommendations.

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

Benedict di Mambro

Dated: 13/11/2025

Index to First Witness Statement of Dr Benedict Di Mambro

| No. | Inquiry URN | Document Description |
|-----|-------------|---|
| 1 | NHFT0000168 | Medical Records of VC from 24/05/2020 to 14/06/2023, Various NHFT Staff/Teams, re: Patient Record Summary |
| 2 | NHFT0000023 | Medical report of Dr Ibrahim, Hakam, NHFT Re: Inpatient Discharge Summary of Valdo Calocane |
| 3 | NHFT0000057 | Medical Records of VC Dated 10/09/2021 Re: Specimen – Nose and Throat Swab NFT, Department of Clinical Microbiology |
| 4 | NHFT0004798 | List of questions for Dr Ben Di Mambro CRHT from Letter of concern/complaint received by Valdo Calocane's victim's families |
| 5 | NHFT0004839 | Email from Samantha Cobb [NHFT] to Anna Hiley [NHFT], Justine Rosser [NHFT], Theresa Dorey [NHFT] and others Re: VC interviews 9/10 October |