Witness Name: Sue Middleton
Statement No: WITN0283001
Dated: 18 November 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF
SUE MIDDLLETON

I, Susan Middleton, will say as follows:

1. I have been a Registered Mental Health Nurse at the Nottinghamshire Healthcare NHS Foundation Trust (the "**Trust**") since 2004. I provide this statement to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 Request dated 23 September 2025 (the "**Request**").

2. 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.

3. This statement is structured according to the topics I have been asked to address in the Request: (A) Career and role; (B) Training and system of work; (C) Interaction with VC; and (D) Reflections and recommendations.

A. Career and role

4. I have been a Registered Mental Health Nurse since 2004, after obtaining a diploma in mental health nursing from Nottingham University. I am registered with the Nursing and Midwifery Council, and I am a member of the Royal College of Nursing.

5. I joined the Trust in 2004. I spent 6 years working as a band 5 nurse on Lady Middleton ward at Highbury Hospital (the "**Hospital**"). Lady Middleton was a mixed sex 21-bed acute inpatient ward. After the hospital was rebuilt, the ward closed and I went on to work on Rowan 1, a 16-bed male inpatient acute ward. In 2009, I started working in the city Crisis Resolution and Home Treatment ("**CRHT**") team, alongside my substantive post in inpatient care. In 2010, I was seconded in the county CRHT team as a band 5 nurse. At the end of the secondment, I was offered a permanent full-time role in the county CRHT team which I accepted. As my skills and knowledge base grew, I became a band 6 clinical nurse lead within the CRHT team in 2013 and worked in this role until 2021.

6. In 2021, I started my role as an in-reach coordinator as a band 7. My job was to review and address barriers to discharging patients from acute in-patient wards. I worked in this role as a secondment for about a year. I was in that position when interacting with VC in February 2022, as I will explain in more detail below. Later in 2022, I became a band 7 Clinical Nurse Lead within the county CRHT team, a position I hold to the present day.

B. Training and system of work

7. I have been receiving various trainings in the assessment of risk for mental health patients from the Trust. Each year, we need to complete an online risk assessment training about recognising and responding to risks. We also complete an annual Breakaway training for community staff which is focused on staff safety. In addition, every three years we take part in a more comprehensive risk training, focused on staff safety and underlying causes for violence of mental health patients and recognising signs of violence and aggression. This training combines both theory and practice, and we are taught about utilising de-escalation techniques to keep the staff and others safe in a ward environment.

8. While studying for my qualification, I completed a 5-day course on the management of violence and aggression before going out on ward placements. However, it has been 21 years since studies, so I do not remember further details

about that course or which other risk assessment training I had during my studies.

9. Regarding sharing information about patients I was involved with, the CRHT teams have daily Multi-Disciplinary Team ("**MDT**") meetings led by the CRHT consultant psychiatrist. The teams use a Red-Amber-Green ("**RAG**") system to classify each patient's level of risk. Patients with a red RAG rating are seen and discussed by the team daily. Patients with amber or green RAG ratings are discussed over the week, during the afternoons in separate MDT meetings. Patients on the CRHT caseload move from red to amber to green as their situation improves and risk reduces. If at any time a patient's risk increases, any practitioner in the team can change their RAG rating to reflect this. The CRHT team also has a virtual board which highlights everyone's caseload including any relevant information. After each visit we would update the board to ensure all visits were completed on the day. This board also highlighted any risks and would advise which RAG rating the patient was on.

10. On the inpatient wards there is a handover at the end of each shift from the nurse in charge to staff taking over the shift. There is also a daily MDT meeting when the consultant psychiatrists arrive on the ward. Staff would have a discussion regarding each patient's presentation.

11. I have non-restricted access to records on RIO. I also have access to Ulysses, the Trust's incident reporting platform. Before any visit by the CRHT team or any interaction with a patient, I would read up on their daily running records on RIO and their core and risk assessments. When recording the information, I would complete a full entry on RIO and update the risk assessments where necessary. I would give verbal handovers or send emails and letters where necessary and document that this had taken place. I also took part in regular MDT meetings. I have always been able to raise concerns with either my line manager or team consultant psychiatrists. I have always felt comfortable raising concerns both in MDT meetings and in one-on-one meetings.

12. Other than VC, in 2015 I was involved in the care of one other mental health patient who killed a member of the public (their partner) when open to a community mental health team.

C. Interaction with VC

13. The Inquiry refers to a single interaction I had with VC when I joined his ward review on 17 February 2022 at 4:30pm (NHFT0000168, at pp. 250-251). My recollection of this interaction is limited and is based primarily on my RIO note. I can confirm that the note is accurate based on my ordinary practice.

14. In general, ward reviews are led by the responsible clinician or their senior registrar. The purpose of ward reviews is to review the patient's progress over the previous week, seek feedback from the patient and their family members, review their mental state, and make plans for the following week.

15. At the time, I was working at the Hospital as a CRHT in-reach coordinator, covering 5 wards with over 70 patients. My role was aimed at reviewing and addressing barriers to discharge. For example, a patient could be ready to be discharged but would not yet have an allocated mental healthcare team or a Care Co-Ordinator ("**CCO**"). I addressed such barriers and others to help facilitate early discharge when appropriate and safe with CRHT input. The patient would remain with CRHT until a local mental health team was allocated and a robust treatment plan was established.

16. I participated in VC's ward review as an in-reach coordinator. However, from reviewing VC's RIO notes now, I see that at the time VC already had a community mental healthcare team allocated, including a CCO and a consultant psychiatrist. In addition, VC's discharge plans had already been decided at a previous ward review and his provisional discharge date was set for 24 February 2022 (entries from 10 February 2022, 10:15AM, NHFT0000168, at pp. 237-240; and 14 February 2022, 4PM, NHFT0000168, at pp. 245-246). In such scenarios, where the patient already had an allocated community team and where discharge plans – including a discharge date – had already been made, there was no role I could

assist with as an in-reach coordinator. I am therefore not sure why I was invited to attend the ward review of 17 February.

17. My note from 17 February summarised the position of the community team, according to which it would have been better to place VC on a Community Treatment Order ("CTO") and depot medication, but VC was against it and wanted to take his medication orally. I made this note because I would routinely make notes regarding patients I had seen, but as mentioned, the position was that of the community team. I did not participate in VC's treatment or care, did not assess his mental state, and did not take part in his discharge plans. I noted that VC was guarded about providing his address and that his address was required to allow discharge to the community, so that the community team could monitor his mental state and concordance with prescribed medication. I did not witness VC displaying any aggression or violence, and I do not recall whether I provided any information to VC's MDT beyond making that entry in his RIO note.

18. I do not recall the specific information I had about VC prior to this interaction. Based on my routine practice, I would have reviewed his RIO notes, risk assessment, past admissions and care plans. After reviewing his RIO records now, it is likely that I would have known at the time that VC was previously in contact with mental health services after becoming acutely unwell and that he had been diagnosed with paranoid schizophrenia. I would have also known that VC was being treated with oral antipsychotic medication and was under the care of the Early Intervention in Psychosis team, and that when he was not concordant with his medication, he posed a significant risk of violence to others. I would also have known that he was previously involved with the police. I would not have needed to ask for further information from the police because I did not take part in VC's care or treatment or in his discharge plan.

19. The Inquiry has asked me a series of questions regarding the circumstances that would allow or not allow a patient diagnosed with paranoid schizophrenia to be treated within the community. In general, I would expect that patients would be considered for discharge when they present with good insight, are compliant with medication, are no longer presenting with acute psychotic symptoms, are willing

to engage with community support, and are not presenting a risk to themselves or others. I would consider a patient diagnosed with paranoid schizophrenia would need to be on a CTO if there were issues with medication concordance and they posed a significant risk to themselves or others. I would also consider that a person diagnosed with paranoid schizophrenia would require depot medication if there had been ongoing issues of concordance with oral medication.

20. Regarding VC, as I mentioned above, I was not involved in his discharge plan, I had not engaged with him prior to that ward review, and I would therefore not have been able to consider whether his presentation had improved since he was admitted (and it was not my job to do so). However, from reviewing VC's RIO records now, given his prior admissions, history of non-concordance with prescribed medication and the significant risk he posed to others when not taking his medications, it seems to me that VC's circumstances required a CTO and depot medication.

D. **Reflections and recommendations**

21. Like many others in this country, I felt sadness and disbelief when I first heard about VC's attacks. However, at the time, I did not remember that I met VC when he was admitted. Like I said above, my recollection of my limited interaction with VC is mostly based on my RIO note. I therefore have no other reflections or recommendations following his attacks.

22. I have not given any interviews or otherwise made any public comments about the actions of VC or the matters under investigation by the Inquiry.

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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: 18/10 GRO-B /2025

Index to First Witness Statement of Sue Middleton

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