Witness Name: Sharon Heath
Statement No.: WITN0292001
Dated: 19 November 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF
SHARON HEATH

I, Sharon Heath, will say as follows: -

1. This statement is provided to assist the Nottingham Inquiry ("the Inquiry") and responds to the Rule 9 requests dated 13 October 2025. It will cover my interactions with VC between 2019 and 13 June 2023.

2. It was drafted on my behalf by the external solicitors acting for the Trust in respect of the Inquiry, with input from counsel, with my oversight and input, following discussions in writing, by email and by video conference.

Career and Role

3. I have the following qualifications:
    - Registered Nurse Mental Health awarded by University of Nottingham, September 2014

- Leadership & Management Diploma and Apprenticeship, Level 5, awarded by Corndel Ltd.
- Non-Medical Prescriber, awarded by Sheffield Hallam University, August 2025

4. I have experience within a private healthcare rehabilitation setting over a period of 9.5 years for complex mental health needs both as a care assistant then as a registered nurse. I qualified as a registered nurse in September 2014, 6.5 years into this period.

5. I joined the Nottinghamshire Healthcare NHS Foundation Trust ("NHFT") as a registered nurse in September 2017. I initially worked on the inpatient wards: B2, a mixed gender, 24-bed, acute mental health ward at Bassetlaw Hospital and then on Lucy Wade, a 16-bed, female, acute mental health ward at Millbrook Hospital.

6. In 2019 I became a community mental health nurse within the Ashfield Local Mental Health team. I joined the Early intervention in Psychosis service in 2020.

7. I was then successful in securing a new role as a Clinical Team Leader within the South Early Intervention Psychosis team ("South EIP Team") in December 2021. This, as the name suggests, is a clinical role. I subsequently secured a secondment opportunity in December 2022 as the Team Leader. The Team Leader is a managerial rather than clinical role and does not involve seeing patients directly. In June 2024 I was made

permanent Team Leader for the South Early Intervention Psychosis Team, a post I retain to this day.

8. At the time of the interaction with VC, I was a Clinical Team Leader within the South Early Intervention psychosis team ("EIP Team") based at the Stonebridge Centre, Cardiff Street, Nottingham, NG3 2FH, part of the Nottinghamshire Healthcare NHS Foundation Trust ("NHFT"). The EIP service covers all of the Nottinghamshire area and is divided by the localities of the North team which covers the areas of City North, City Central, Mid Notts, Bassetlaw and Newark. The South team covers the areas of City south, City East, Rushcliffe, Broxtowe and Hucknall and Gedling areas. Each of the five local groups in North and South EIPs have a small remote team attached to them which are based alongside the Local Mental Health teams to be able to support that locality with the management team having the oversight of all the five bases in the different areas. The City South Base within the South EIP was responsible for a lot of Nottingham University and Nottingham Trent University students. At the material time it had responsibility for VC.

Training and system of work

9. As part of my nursing qualification carried out between 2011 and 2014, I was allocated different placements within the NHFT areas. During that time, I received risk assessment training from a variety of mentors including mentors at the Mid Notts Crisis Team based at the Millbrook site. This training was provided as follows: when a new individual came either on the ward or to the crisis team, a risk assessment would be carried out. In all cases we would

discuss with the individual any past risks to themselves or others; we would also look at the referral that had been sent and, if the individual had had previous engagement with mental health services, consider what had been logged on the RiO system. As a student I was not able to complete risk assessments on the system myself, but where possible, I would spend the time with my mentor or other qualified staff whilst they completed this. There was no formal risk assessment training completed during study days at the University but with all training being given by the different mentors during my practice hours.

10. I joined NHFT in 2017 and part of my mandatory eLearning courses was an eLearning course on risk assessment which was completed. I do not recall any other formal risk assessment training having been provided at that point within the NHFT. I relied on my previous experience from working in the private sector as a registered nurse and completing risk assessments and any practice of risk assessments I had observed or been involved in as a student nurse within NHFT placements.

11. The training I received in 2022 from January until the end of September 2022 is as follows:

    a. Safeguarding supervision – 11th January 2022
    b. ASD training – 18th February 2022
    c. HLS training – 7th June 2022
    d. MVA training – 14&15th June 2022
    e. SeRiOus incident training – 29th & 30th June 2022
    f. Inquest training – 8th July 2022
    g. Sickness absence and wellbeing – 27 July

h. Understanding Psychosis & Bipolar – 13 & 15th September

I also completed all mandatory E-learning training

12. Patients were generally referred to the EIP by a GP, crisis teams or inpatient wards. Additionally, where GP support was within a university context, a referral could come from the University Mental Health Team or from Nottingham Talking Therapies. Referrals would generally include information regarding the presenting issues and symptoms: for example, the individual reporting hearing voices, being paranoid and/or having any suicidal thoughts, at the point the referrer had seen them. Some referrals would include a significant amount of detail, including historical risks and information about patient presentation; others would include minimal information. In cases where minimal information was available for an individual, the allocated staff member would look on the RiO system for any historical information, go back to the referrer to try and gain further information, or would discuss with the patient during the initial screening/triage call or initial face-to-face assessment to build a picture what was happening to an individual.

13. Patient records within adult mental health services are held on the RiO system. In a community health setting, patient information was shared via a RiO number and a brief handover of the patient. Throughout my time at NHFT, I was able to access the RiO system only for the local partnership, ie adult mental health. There were other RiO services for forensic teams and other care groups, but I did not have access to these. Previously, when I was a CPN (2019-2021), I was able to access patient records via the health and social care portal which could provide insight into a patient's GP records. However, this was not always

helpful: on occasions when a practitioner would attempt to log into the portal, no information would be recorded, or the last update would be shown from a significant time previously. The portal I believe at that time was updated by the primary care staff. Prior to dealing with a patient and/or attending a multi-disciplinary team ("MDT") meeting I would typically read documentation on RiO from the first contact for any new referral. I would consider the uploaded referral to gain insight into the referral reason and then look at any risk assessments, any care plan and any other core documents. This would include the core assessment which has other factors documented such as family history of mental health illness, an individual's social circumstances, any allergies and also any other agencies involved in the individual's care. I would also, where appropriate, look at any uploaded documents from any other services in order to consider whether the individual might be appropriate for the EIP pathway.

14. Care coordinators ("CCOs") work as part of an MDT to develop and implement care plans, assess needs and review progress. They are responsible for undertaking assessments to understand an individual's mental health condition, social circumstances and overall needs. This may involve gathering information from the individual, their family and other relevant professionals. Based on this assessment they collaborate with the individual to create a personalised care plan. The plan outlines specific interventions, support and services required to address the individual needs to promote their recovery.

15. CCOs decide which of their patients to discuss in MDT meetings so it is not always clear which patient will be discussed at any MDT. As a senior staff member, I would only find out which patient was to be discussed when the

meeting commenced: no prior details were given from CCOs prior to the meeting taking place. I would always attempt to look at any RiO notes during the MDT meetings, but this would need to be managed alongside listening to the discussion taking place within the MDT.

16. My practice when supporting a patient and having a discussion within an MDT was to document the discussion and the plan from the meeting in the patient's running RiO records. The responsibility to document discussions within the MDT during the time that VC was under NHFT's care was that of the CCO or the person bringing the individual to be discussed at the MDT. No other system was in place at that time; there was no robust audit process in place to ensure the documentation was completed and no managers would go back on the documentation to ensure this had been completed. The process of documentation was not enforced by any managers at this time and it would be completed dependent on the staff member and their practice.

17. A summary care plan is a plan of an individual's care whilst under a team. It includes a summary of an individual's presenting issues/symptoms and a plan of care setting out how the team will provide appropriate support.

18. The aim of a summary care plan is to provide a brief background of the patient to any reader. The care plan is developed in collaboration with the patient and their family or loved ones and its aim is to set out what care will be provided by the service. This includes the interventions offered by the EIP: what medication the individual has been prescribed, what the dose is, the frequency of providing the medications to the individual, i.e, weekly/two weekly and whether it has

been prescribed by e.g. NHFT or the individual's GP. The summary care plan also included any social inclusion interventions identified and how the EIP team would support with this, for example: attending weekly football, spending time with the community support worker on a weekly basis, providing support with shopping. The summary care plan also noted any family or loved ones involved in the individual's care, including a point of contact and relevant details; whether they were accepting of carer support and been offered a carer's assessment; whether they had been offered access to the carer education and support programme and if so how often these contacts would be taking place.

19. There is a static summary care plan form **[WITN0292002]** that provides a space for a pen portrait of the individual, a space to record a diagnosis if appropriate, whether or not they are on the CPA or have a relevant status within the MHA. There is a section titled "care plan": it includes provision to record an advance statement and a space to record whether or not there are any doubts regarding their mental capacity to consent to the care plan. It also includes a blank space for a CCO to complete a care plan. There is then space for recording any unmet needs, any planned medication and any crisis/contingency/safety planning. Details of the CCO and any relevant emergency contacts are also recorded.

20. The section for care planning contains no prompts: as a result, each practitioner records the care plan in their own style. A risk assessment is completed separately. This contains a large number of prompts. It is held on the individual's RiO notes in connection with the summary care plan. A copy of VC's summary care plan is exhibited as **[NHFT0000198]**.

21. Where a patient has had multiple admissions under the Mental Health Act 1983 ("MHA 1983") this should be highlighted within the risk assessment area and summary of the care plan, including any plans for any factors to reduce risk. VC's previous MHA admissions can be seen recorded in the Care Plan details on p.3 of his Care Summary Plan **[NHFT0000198]**. Care plans are now updated on an annual basis, with robust audits and reports taken weekly in place.

22. The summary care plan should also be updated when there is a change of team, for example from inpatient to community or crisis to community; additionally, it should be updated where there is a change of presentation. This would include any new plans regarding patient care.

Care Planning

23. Inpatient care planning involves a medical model of medications, observations levels, and details of a patient's formal status under the MHA 1983, any records of PRN medication, and a patient's risks to others or themselves. It will also set out details of any restraint procedures/policies that will be employed while the patient is an inpatient.

24. In contrast, in a community setting, a care plan – while looking at risk to self and others and medications etc – will also focus on the social inclusion aspect of a patient's life, including matters such as housing, employment support, activities to build up community engagement etc.

25. During the time that VC was under NHFT's care, when an individual first presented to NHFT as an inpatient, the relevant community service was sent a referral and, on receiving the referral, the EIP team would arrange with the ward to attend the individual's ward rounds. At the material time, the EIP team would complete an assessment looking at the individual's symptoms and looking to see if that individual met the criteria for the EIP team. If the individual was already known to NHFT, as VC was, the CCO would request an invitation to join their ward round as soon as possible following admission.

26. When receiving a referral from an inpatient or crisis setting, the EIP team now uses a trusted assessor approach: this means that a patient who has been assessed by a consultant psychiatrist is not subject to a second assessment. Rather, a member of the EIP team attends ward rounds and begins the process of getting to know the individual to start building a relationship. If the individual is already under the EIP team and has had an inpatient admission, the allocated care coordinator will attend ward rounds. This is in order that any suggestions or concerns around being able to support the individual in the community are shared and a robust discharge plan for the individual can be developed. Once the individual is ready for discharge, the ward agrees a date for that discharge and informs the CCO.

27. Risk assessments are used in the development of the inpatient care plan to look at how an inpatient team can keep the patient and others safe within that environment for the time they are an inpatient. They are also used in the development and formulation of a patient's care when they are discharged from

the inpatient service and for the purpose of providing ongoing support within a community mental health team.

28. I refer the Inquiry to the Mental Health Clustering Tool (previously HONOS PbR), completed regarding VC on 10 August 2022 [**NHFT0000179**]. The purpose of this document is to analyse a patient's presentation for the two previous weeks. It looks at all aspects of their social functioning and considers their difficulties from an "historical" perspective. It is intended to inform a patient's care around their needs as well as identifying any risks so that a CCO can consider how these might be either reduced or minimised and what factors can be identified that will reduce risk.

29. The purpose of a HONOS PbR is for the clinician to be able to identify the needs of an individual and how the team can support the individual with those needs, it also analyses whether the interventions being provided for that individual are working for them and whether they are on the correct pathway or if any changes are required in their care.

Managing Risk

30. Prior to 2022 when I was in the role of staff nurse then charge nurse I felt I was able to raise and escalate any concerns I had around my patients to my line managers.

31. In 2022 I began a new role in a new locality as clinical lead within the EIP. As clinical lead I was in MDTs with my line manager, Emma Robinson, ("ER") Team

Leader. Accordingly, in circumstances where I had concerns about an individual, in most cases ER would have been privy to those concerns by virtue of being in the same MDT. In circumstances where she was not present at an MDT, I would share concerns with my service manager, Kelly Simpson ("KS"). I do not recall having concerns about patient risks at that time that I escalated save for one patient that I discussed with ER over the summer of 2022.

32. In terms of discharge planning, in my role as a staff nurse and charge nurse within inpatient services from 2017 to 2019, I was involved in the discussions with the MDT regarding discharge planning. These involved ward doctors, support staff, family members, community staff if relevant and the patient to discuss how they were doing and then discuss a plan to work towards for the patient's discharge. I was involved in the community aspect of discharge planning from 2019 onwards. In this context, if I had any concerns about risks posed to other by patients with whom I was involved, I would report them to the relevant consultant psychiatrist within an MDT at which my line manager was also present. I felt comfortable doing that.

33. When the ward rounds were completed, my practice was to follow up any actions or complete referrals needed to the community teams such as Local mental health teams or crisis teams. This included providing a summary of the individual's stay on the ward, any risks identified on the ward and any documented risks from previous admissions or incidents. I would also provide an ongoing plan of what had been agreed during the ward round and, if I had not completed all of the ward round tasks, these would be placed in the ward diary for other staff nurses to follow up on the next shifts.

34. The ward round MDTs on an inpatient ward are different to MDTs in the community. On an inpatient setting, the patient, the patient's families/carers and any community team professionals are invited and present alongside the staff from the ward which includes, support staff, one of the staff nurses, a medic and any students from either medical or nursing background, the ward MDTs would also have interpreters, housing or social workers invited. Within the EIP MDT for a community setting, it is different. The only people present are the professionals involved in a person's care: the care coordinators of that team, a member of the team management, consultant psychiatrist or junior doctor and the other team professionals such as peer workers, community support workers, CBT therapists, pharmacist prescribers, advanced practitioners and employment support workers.

35. Regrettably, VC is not the only mental health patient with whom I have had an involvement who, following discharge to the community has killed or seriously injured a member of the public. In my role as clinical team leader and team leader within the South EIP, I have been involved with two other such patients: one in 2023, and another in 2024.

Interactions with VC

I. VC's Fourth Period in Community Care: 24 February 2022-23 September 2023

36. During the period February 2022 to December 2022, I was the Clinical Team Leader within the EIP Team South. From December 2022 to September 2023,

I was seconded to the post of Team Leader EIP South. In both roles I covered all five areas of the EIP South.

37. In my role within the EIP team I attended meetings whenever possible around my other commitments. Reasons for nonattendance would include sickness, annual leave, attending training or needing to visit patients at the time an MDT was scheduled.

38. In my role as Team Leader I was responsible for 5 teams within the city and County South EIP. As a result, I was invited to attend up to five MDTs each week. I have reviewed a paper diary I have retained from 2022 in which it was my practice to tick or cross meetings I attended or did not attend. I note that from 6 January to 23 September 2022, I attended 22 MDTs within the City South Team alone.

39. I have considered VC's patient record summary **[NHFT0000168]**. I note that I am recorded as the originator of an entry on pp.270-271 completed at 1.17pm on 23 September 2022. This entry refers to a discussion that took place within the MDT on 22 September 2022 and I was informed that as no contact has been made with VC, a decision has been made within the MDT team meeting to discharge him back to his GP with a view to the GP referring him back to services in the future if needed.

40. I do not recall attending the MDT meeting on 23 September 2022 and I do not know who was present in that meeting. Routine MDT team meetings were held

between 9 and 10.00 for Rushcliffe team and then between 10.30 and 11:30 for the city south team on a Thursday. It was not the EIP South Team's practice at that time to take a minute of all MDTs or to record attendees. It had previously been my practice when based in the EIP North to make a note of who was in an MDT. As a CPN at EIP North we would have a morning "huddle" between staff members of the team and a MDT where an administrative member of staff was present; I had a structure that I adopted where I could record who was present at MDTs, what discussion was had and what the plan would be.

41. When I moved to the South EIP – where VC was placed - practices were different and it was not general practice to record who had been present at an MDT.

42. A colleague has subsequently informed me that I was not present at the MDT of 23 September 2022. I have referred back to a paper diary that I kept at the time which I exhibit as **[WITN0292003]**. I note that there is a reference to the MDT with a cross placed next to it: this was my practice when I had been unable to attend a particular event or meeting and I infer from this that I was not present at the MDT on 23 September 2022. I can confirm that this is the only mention of VC in this diary.

43. I do not recall this particular day. I had joined the team in January 2022 and, in August 2022 I had very recently returned from an extended period of annual leave. I have gone back to the rota for that day which I exhibit here **[WITN0292004]**: I note that the care-coordinator ("CCO") at the time, Gary

Carter ("GC"), was absent on sick leave. I can only assume – because I do not recall – that I was asked or volunteered to help with the paperwork, first by filling in the reference on VC's notes to the MDT, and then by sending an email to our administration staff to generate a discharge letter.

44. This was not unusual practice: where an individual appeared to be disengaging, we would send an email to admin to generate a covering letter which would be sent to the patient's GP along with the core assessment, risk assessment, and care plan. **[WITN0292005]**.

45. I have been referred to the EIP Operational Policy that was in force on 22 September 2022 **[NHFT0000460]**. As I was not present at the MDT, I cannot comment on whether or not it was considered or otherwise referred to at the MDT. I am also familiar with the Policy on DNAs that was in force at the material time **[NHFT0000417]**. Again, given I was not present at the MDT I cannot comment on whether or not it was considered or referred to.

Knowledge of VC

46. I did not know VC personally at this time. in my role as Clinical Team Leader, I was only made aware of specific patients if their care coordinator brought them up for discussion at an MDT. VC's care coordinator was Claudia Birtles ("CB") until May 2022: I did not supervise her and I did not have any conversations with her about VC at this time. VC did not feature in supervision between me and a CCO until Gary Carter took over as his CCO in May 2022.

47. My understanding of VC's psychiatric history at the time of my joining the team was very limited. In January 2022 he had been under the team for nearly 2 years. There were conversations around non engagement with the team and I was aware of a conversation regarding possible non-compliance with medication. This appeared to be an ongoing pattern for VC from discussions within MDT.

48. I was initially observing the City South MDT discussions. I recall that VC was discussed at a number of MDTs but I am unable to recall which MDTs VC was discussed at, and at what length and have no documentation to refer to. I did not supervise his previous care coordinator, CB; who therefore did not request to discuss VC with me or raise any risks of concerns that I recall. His subsequent CCO, GC, only discussed VC with me on one occasion during supervision on 27th July 2022. GC provided me with an update explaining that VC was not out the country which had been previously thought but, that after a call with VC' mother, she had confirmed that VC was actually in Nottingham and the plan was for GC to attempt to visit with the team Community support worker (CSW) Paul Williams (PW). No risks or concerns were raised at this point around VC. Accordingly, I did not have any in-depth conversations around VC, his presenting, or ongoing presentation during supervisions with GC.

49. VC had a diagnosis of First Episode of Psychosis when first presenting to the EIP team in 2020. I recall that VC's diagnosis changed to one of schizophrenia. I believe this was due to symptoms he continued to display and from the reviews with the consultant psychiatrist(s) during MDT discussions.

50. In terms of forensic history or prior involvement with the police, my only knowledge was that which was shared during MDTs and in supervision with GC, where I recall that it had been discussed that VC had required the use of restraint and a taser when arrested under section 136 MHA to be taken to a place of safety.

51. I do not know whether any member of VC's MDT attempted to make contact with his nearest relative or any other family member at this time save that I note from the running RiO records, that contact was made with VC's mother on 31 August 2022 and a plan to arrange a visit was made. There is no further documentation regarding whether or not this visit took place or whether discharge was discussed with VC'S family.

52. The discussion around discharge for an individual is the responsibility of the CCO or, in their absence, the staff member to whom this responsibility has been allocated: discussions would have been taking place over a few weeks or months prior to a final decision being made. I have located an email sent by Abigail Parsonage on 8 September 2022 setting out the cover that was required during GC's absence **[WITN0292006]**. It was sent to other members of the City South including four CPNs, requesting cover during GC's period of absence. I am not aware whether or not that cover was arranged.

53. From consulting my 2022 paper diary I can confirm that I attended 22 MDTs out of a potential 38 in total with the City South EIP team from 6th January 2022 to 23rd September 2022. I am unable to say at which of the MDTs VC was discussed due to there being no documentation recording this information.

Gary Carter

54. From January 2022 until December 2022, I supervised GC as part of my role as Clinical Team Leader, I then continued to supervise him in my role of Team Leader until August 2024. GC was VC's care-coordinator ("CCO") from around 13 May 2022 until VC's discharge on 22 September 2022.

55. I have been referred to an entry made by CB on 28 April 2022 at 11am **[NHFT0000168, at p.266]** in which it is recorded that, following a risk assessment and discussion in MDT, it had been "agreed that it would be appropriate to transfer VC to a new CCO, preferably 2 CPNs". I recall this recommendation being made: I do not recall the specific preference for 2 CPNs but I do not have any reason to doubt CB's entry. I recall a discussion was held within the MDT to transfer from previous CCO CB to GC as the new CCO. I can recall that the discussion around this was that VC was not engaging with CB and that there had been some delusional thoughts around CB being in a conspiracy with the NHS. It was felt by the MDT that a new CCO was a good opportunity to continue to engage VC and to look at also introducing a community support worker who was from a more similar cultural background to ensure any cultural aspects or barriers to engagement were supported and respected.

56. I have been referred to an investigation that was carried out into GC for which I was interviewed on 13 December 2024 **[NHFT0004905]**. I note that on p.23 of the transcript I am asked whether or not CB's pregnancy was a relevant risk factor – I confirmed that it was. One of the reasons for moving VC from CB's

care was that she was due to leave on maternity leave, but it was also considered that VC had some delusional feelings towards her and that it would be a good opportunity to transfer to a new CCO to continue to aid VC's engagement with the team. I would note that this investigation was completed after I had had access to the records and the full risk assessments so I may have answered with knowledge of the risks after the event. I can confirm that the contents of this interview is accurate and there is nothing I would like to amend.

57. In my role as GC's supervisor, I did not review any of GC's documentation. This was normal practice. Prior to the Covid epidemic there had been a practice of carrying out documentation audits by way of 10 random audits from EIP South every quarter. However, this practice had been stood down by NHFT following Covid and there was no robust documentation audit in its place at that time.

58. I did not receive any formal training or induction for my role of clinical team leader nor did I have any formal handover of the supervision process of what I should or should not be looking for in terms of documentation. When in a supervision with GC I would follow a supervision template **[WITN0292007]** as a guide to what I was asking GC. The supervision guide looks at the wellbeing of staff, any leave, caseload numbers: it was the opportunity for GC to request to discuss any issues or concerns or to escalate anything around his caseload patients or within his work or personal life which might be affecting his role.

59. I have been referred to an entry in the transcript **[NHFT0004905 at p.8]**: in which I said

"...GC only brought Patient V to supervision once, after he had discussed him in an MDT environment-where they were saying that they believed that Patient V had left the country. We had a supervision after that during which he informed me that he had spoken with Patient V's mother, who had informed him that Patient V was still in the country, in Nottingham."

60. Patient V is of course VC. This remark refers to GC wanting to update about a patient. We were not generally given details of which patients would be discussed prior to a supervision. I was not given details of who GC was wanting to discuss in supervision prior to the supervision. I did not raise any concerns following this supervision which was on 27 July 2022: GC was updating me to say that he had spoken with VC's family and that they had confirmed that VC was in Nottingham. GC explained he was going to attempt contact with VC. No concerns were raised by GC around risk or any issues he might have had. On completing supervisions, all staff are sent a copy of their supervision notes and asked if they want any amendments: these could be additions or other changes. I did not receive anything back from GC, so I assumed he was happy with the content documented.

61. I do not recall asking around any issues with VC independently but when GC attended supervision with me, I would ask around patients on his caseload and I would expect him to raise any issues with me around patients on his caseload. As a manager, I relied on care coordinators to approach me with any issues or difficulties they were having with a patient either in supervision, an MDT meeting or by asking to speak with me or another manager.

62. I had monthly meetings, combining managerial and clinical supervision, with all CCOs unless they were absent or I was absent from work. This was standard practice albeit that CCOs could request to have clinical supervision with another appropriate staff member such as a psychologist or an ACP or a CPN. I was not aware of GC choosing that option: I carried out both his managerial and clinical supervisions. Clinical supervision training was provided by way of E-learning. There was no formal training for managerial supervision given to me when starting the Clinical team leader role. I was responsible for supervising approximately 18 CCOs and support workers at this time.

63. There were some discussions within the supervision around GC working out of hours and weekends. This was raised because of safety concerns: it was a risk to his own safety but also the safety of the patients as we are a 9-5 service with out of hours support provided by another team. This was also discussed with GC from the team leader of EIP, Emma Robinson, at that time as this was a recurring issue, but I was not involved in those discussions or meetings.

64. I believe I had around 7 monthly meetings with GC from January to September 2022. GC was VC's CCO during the last months of this period. GC did not raise any concerns with me around VC disengaging or any risk associated with VC during supervisions. I was away on leave for the majority of August 2022, returning on the 25th August 2022. GC was off work on carer's leave from 25th to 2nd September; he returned to work on 5th September 2022 and then went on sick leave from 6th September until 25th September. Accordingly, GC did not have any opportunity to raise anything with me regarding VC. I have no

knowledge of whether GC had raised any concerns or had discussions with the Team Leader, ER, in my absence.

65. I did not discuss any plan with GC for attempts to re-engage VC within a supervision due to no issues being raised with me. It is usual practice to update all documents by the care coordinator when having any new patient even if transferred from a different care coordinator and also on a change of a patient's presentation and after discussions within MDTs of any new plans of care. Unfortunately, no documentation audits were in place at this time. VC's care plan and risk assessment were not updated: this would not have been picked up during the audits because there was no active audit process in place. GC was off work when I returned from my annual leave in August 2022; I had no discussions with him at that time around updating documents prior to the discharge.

66. I have been referred to the following exchange in the transcript of the investigation into GC **[NHFT0004905, at p.21]**:

> "[Interviewer]: Why was Patient V rarely discussed in supervision, despite numerous entries on RiO between May-July 2022, indicating that he was failing to engage and not responding to attempts to contact with him?
>
> [You]: [VC] was discussed in MDT on a frequent basis and it was better practice to discuss it there so that his Responsible Clinician and the whole team are aware of what's going off, rather than me just relying on GC sharing information with me."

67. I recall conversations within MDT discussions around VC's non – engagement. When I joined the team in January 2022 there were already references to VC not engaging with the team and that a consideration for discharge had been made. I can see this having had access to VC's running records and having considered them in retrospect: it is documented on 17th January 2022 by the consultant psychiatrist after the 5th missed appointment with them. **[NHFT0000168, p.203]**. This appeared to be a pattern with VC. I was new to the team and was learning about several patients within the service. I had not met VC or been involved with the team when he was first referred so relied heavily on others who knew him for information during MDT discussions.

68. I am not able to give accurate information around MDT discussions to attempt to engage VC due to the absence of documentation in the RiO notes. I understand assertive outreach to mean that individuals who are difficult to engage and have higher risk factors have a number of weekly visits by a CCO. Historically I believe NHFT did have an assertive outreach time; however, I am not aware of one having been in place during 2021-2022.

69. I have been referred to an entry in the transcript of the investigation into GC in which I commented on the chaotic nature of same of GC's record keeping, particularly his RiO entries **[NHFT0004905, pp.11-14].** I had not reviewed the quality of GC's record keeping previously: I only became aware following the VC incident when I was required to look at cover because GC was absent from work. I would not be able to clarify if the notes written by GC contributed to any lack of clarity or understanding of VC's presentation and /or condition at the

time, as I only reviewed the notes after the VC incident. Looking at them now and reflecting on the notes, there is not a lot of detail: I would have expected there to be more information in the notes. Whether or not this would have made a difference to how VC was treated I cannot say.

70. I have been referred to VC's medical records which show that the last update to his "*Summary & Care Plan*" was carried out on 14 February 2022 at 13:02 [NHFT0000198] while VC was still under the care of inpatient services at Highbury Hospital (Redwood 1 Ward).

71. The person responsible for updating VC's summary and care plan after being an inpatient is the CCO at the time of discharge which would have been CB. I did not review the care plan at any stage. It was usual practice for the care coordinator to update the summary care plan or it could be updated in the CCO absence if the treatment and care changed by another qualified staff member, no other safety netting was in place at that time.

72. VC's CCO, CB, was also responsible for updating his risk and safety assessment following discharge from inpatient setting. It was usual practice for the care coordinator to update the risk and safety plan; alternatively, this could be updated by another qualified staff member if the presentation and /or risks changed in the CCO's absence: no additional safety netting was in place that I am aware off. I did not review the risk assessment and safety plan at any stage. That was normal practice. As a Clinical Team Leader it was not part of my practice to review the individual records of the patients within my team.

73. I have been referred to VC's medical records which show that the last update to VC's "*Mental Health Clustering Tool*" was carried out on 10 August 2022 at 13:04 **[NHFT0000179]**. This document records that VC has a "3 = *moderately severe*" historic problem with "*agitated behaviour / expansive mood*". Again, the responsibility for ensuring the mental health clustering tool has been carried out is a patient's current care coordinator. The purpose of this document is to provide an overview of the patient's presentation showing any changes which have occurred in the previous two weeks, it is updated on an annual basis or when a change in presentation of the patient.

74. On reviewing VC's notes related to patient reviews between 24 February 2022 and 22 September 22 by the EIP team City South, I consider and on reflection that I would expect more attempts to see VC to be made. If coming out of an inpatient setting, I would expect the individual to be seen weekly unless there were a clear rationale for another timeframe. I can see it is documented that a discussion was had in the outpatients appointment on 14th March 2022 with the Consultant Psychiatrist Dr Tuhina Lloyd ("TL") and CCO CB (**NHFT0000168**, **p.263**) around the frequency of contact and how VC was wanting his contact to be as low key as possible but still engaging with the team. It was agreed for two weekly contact to continue, with a further outpatient appointment with the consultant psychiatrist in June (3 months from the March appointment). I am unable to see whether this later appointment took place or was booked by CCO GC from the progress notes but can see an appointment was made for the 1st of August 2022 with the Consultant Psychiatrist which was 5 months later. It is

difficult to say if appropriate contact was made with VC in line with his care and treatment as the last EIP summary care plan was dated 29th June 2021 so may not be an accurate reflection of his needs in 2022.

75. The frequency on this summary care plan was to have two weekly contact with the CCO but the care and treatment for VC may have changed following an admission to hospital and would need to have been updated to reflect any new care and treatment plans. On reflection and looking back at the notes, I note that there were a lot of attempted telephone contacts which had been unsuccessful, and that medications were not being collected from the City South EIP team. It also appears that there were minimal interactions and documentation suggesting non-compliance with medications: VC was not collecting his medication and was reporting he still had medications after the due date of the next medications. On reflection, more attempts at unannounced visits, telephone contacts attempted with mum and liaison with other agencies would have been appropriate at that time to try and find VC's location and assess his mental state and presentation.

76. I have been referred to NHFT's "*Level 2 Comprehensive Investigation Report*" **[NHFT0000451]** and in particular a reference at p.22, paragraph 68 where it is commented that GC as CCO had a caseload of over 20 patients over the summer of 2022

77. In June 2022 GC's caseload was reported by GC as being 19 during supervision **[WITN0292008]**. No issues were raised around his caseload size with me during this supervision. In July 2022 during supervision GC reported his

caseload size to be 18 patients. He did not raise any issues around his caseload size during this supervision or on any other occasions. – I am unable to confirm what CG's caseload size was during August of 2022.

78. I recall the caseload sizes were slightly higher than the nationally suggested of 15/16 at this time however this was due to the high student population at this EIP base and the amount of referrals to the City South Team. Usually in June at the end of the university term end, numerous students would return to their hometowns for the summer and their care would be handed over to their home EIP teams as per the shared care arrangement between the two services. Contact would then be on a minimal basis often of around one contact per month from the Nottinghamshire City South EIP team to the patient and home EIP team. I would not, however, be able to confirm if this was the case for GC and how many of his caseload were shared care students at that time.

79. On reflection, caseload size may have contributed to gaps in the decision-making process for GC, but as no concerns were raised to me by GC of this nature at that time during our supervisions or on any other discussions I can recall. I am unable to say if GC holding a caseload of this size contributed to any gaps in the decision-making process of VC for GC. I note that he was offered additional support in June 2022 which he declined. At our supervision in July 2022, he reported feeling ok and that his work-life balance was ok. **[NHFT0004909]**

80. I did not personally review or have any interactions with VC. I do not recall discussing VC's risk with any other colleagues except when being present within the MDT meetings I attended and VC was discussed in those meetings.

Reflections

81. I have reflected on whether having VC reported as a missing person as suggested in the RiO records in early August 2022 would have allowed some liaison with the police around historical and current risks as identified in the risk documents and whether, if this was not possible, we might have considered an MHA assessment but as we did not have a confirmed address for VC this may not have been a possibility.

82. Discussions and liaison with other agencies such as forensic colleagues and the police would have been appropriate to help support and manage VC care and treatment in a community setting if a confirmed address had been found.

83. I have also reflected that I may not have been the most suitable person to request the discharge letter be created and that perhaps the discharge of VC could have waited until VC's CCO, GC had returned from sick leave or that a staff member who had known VC within the team may have been better suited to complete a discharge letter had this still been the decision of the MDT. I have also reflected on whether contact with VC's family and GP should have been attempted again before a final decision in order that they could have had an opportunity to voice any concerns or worries.

84. I write this reflection in hindsight and with access to all the information provided within the medical records and documents.

85. I have changed the way I practise since the VC attacks, the team I lead now ensures an MDT entry is written in the RiO records. This is the responsibility of the CCO or the person raising the patient at the meeting. The entry is then audited to ensure that it is complete. An MDT template **[NHFT0004754]** is used by staff to ensure all aspects of a patient's care and risks discussed are recorded as well as who is present at the MDT. Staff are encouraged to use a clinical note template for their RiO records following visits, with guidance on what to include and what the expectation is in each of the entries. **[NHFT0004753, NHFT0009954]**

86. During MDT discussions there is now an action log that is devised to ensure actions are followed up and the action log is checked at the start of the following MDT by the chair of the MDT meeting, - usually a member of the management team or senior staff member.

87. A robust audit system is now in place with several audits around a patient's care completed monthly by the team's CTL and TL. **[WITN0292009]** In addition to this, a weekly meeting called SafeNow is attended by each team's CTL or TL. Here, a report identifies any documentation that has expired within the annual basis of 12 months or when going from one team to another team to ensure the current team updates the care plan, core assessment and risk assessment documents. The team CTL or TL have overall oversight of documentation.

88. During supervisions with staff members a review of a single patient's RiO notes is now completed looking at all the documents including RiO note entries **[WITN0292007]**. This sample is then considered in order to determine whether there is a quality and clear plan of care for the patient, whether the patient has been discussed within an MDT within the last 6 months, whether the recommended templates are being used for MDT and clinical RiO entries. Risk assessments and core assessments are also scrutinised to ensure they contain a good quality of information, that they are from the current team and CCO and also looking at outcome measures such as the HONOs and ensuring this has been updated. If any issues are highlighted within these audits, a staff member's entire caseload is then reviewed and, if required, the informal process around capabilities/conduct is discussed with the service manager and TL. They will then consider whether a performance improvement plan should be implemented following meetings with the staff member involved.

89. The EIP South team has now introduced morning huddles and both North and South have introduced risk meetings which allow the escalation to team leaders or more senior colleagues for support, allowing a better oversight of any risk or disengagement issues of each individual within either area. This allows the managers who are working over 5 different bases across the city and county south of Nottinghamshire and attending 5 MDTs per week to meet. Meetings to liaise with police or forensic colleagues have also been implemented for managers or CCOs to attend to allow more collaborative working with some individuals who present with more risks to themselves or others.

90. I have not made any public comments or interviews about actions of VC or the matters under investigation by the inquiry.

91. I do not feel that I am able to suggest recommendations to the chair of the Inquiry. I do feel the added resource of psychologists and a designated medic within the EIP team would help with the formulation of an individual's care and ongoing risks to enable staff to continue to provide a high standard of care to this client group within a community setting.

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: 19th November 2025

Index to First Witness Statement of Sharon Heath

No.	Inquiry URN	Document Description
1	WITN0292002	Static Summary Care Plan Form
2	NHFT0000198	VC Summary Care Plan
3	NHFT0000179	VC Mental Health Clustering Tool, 10 August 2022
4	NHFT0000168	Medical Records of VC from 24/05/2020 to 14/06/2023, Various NHFT Staff/Teams, re: Patient Record Summary
5	WITN0292003	Sharon Heath diary entry, 23 September 2022
6	WITN0292004	Staff rota, August 2022
7	WITN0292005	Email re discharge, 23 September 2022
8	NHFT0000460	EIP Operational Policy, in force 22 September 2022
9	NHFT0000417	Policy on DNAs in force in September 2022
10	WITN0292006	Email from Abi Parsonage re GC cover, 8 September 2022
11	NHFT0004905	Interview with Sharon Heath as part of GC investigation
12	WITN0292007	Supervision template
13	NHFT0000451	NHFT Level 2 Comprehensive Investigation Report
14	WITN0292008	June 2022 supervision meeting with GC

15	NHFT0004909	July 2022 supervision meeting with GC
16	NHFT0004754	MDT template
17	NHFT0004753	Clinical note template
18	NHFT0009954	Clinical note template guidance
19	WITN0292009	Note Audit Supervision Template