

Witness Name: Emma Louise
Robinson

Statement No.: WITN0315001

Dated: 26 November 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF EMMA ROBINSON

I, Emma Louise Robinson, will say as follows: -

- 1.This statement is provided to assist the Nottingham Inquiry (“the Inquiry”) and responds to the Rule 9 request dated 15 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 my oversight and input and assistance from counsel, following discussions in writing, by email and by video conference.

Career and Role

3. I have worked for Nottinghamshire Healthcare NHS Foundation Trust (“NHFT”) from October 2000 to the present day. I am a Registered Mental Health Nurse: I have a Diploma in Nursing and in addition to a Diploma in Psychosocial Interventions which I completed in 2006.

4. I started my nursing Career on the 22nd October 2000. I started as a D grade nurse (band 5) at Broomhill House which was an inpatient rehabilitation facility for patients experiencing severe and enduring mental illness. I then progressed to a band 6 clinical team leader role in 2003.

5. In June 2013 I was seconded to work as a clinical team leader at Highbury Hospital where I remained until June 2014. I returned to Broomhill House as the manager (band 7) in June 2014. In 2015 Nottinghamshire Healthcare closed patient beds across the Trust and Broomhill House closed. I continued in my Band 7 role as part of the Early Intervention in Psychosis (“EIP”) Team for Nottingham City and County South.

6. In 2019 the Local Mental Health teams were formed: the stand alone EIP team was disbanded, and the pathway was put into the Local Mental Health Teams. I became the manager (Band 7) for the City North Local Mental Health Team.

7. In 2019 The Trust decided that the EIP pathway was not working in the Local Mental Health Team and wanted to bring back the stand alone EIP service. I

left City North Local Mental Health team to develop the EIP Service and to manage EIP City South Team.

8. In December 2022 I left the EIP team and secured a Modern Matron Secondment (Band 8a) at the Wells Road Centre, a low secure forensic in-patient hospital in Nottingham. In June 2023 I was asked to cover the Service Manager position at Wells Road: this post became permanent (Band 8a) in 2024. I am currently working in the same position.

9. My roles at NHFT have included: being a staff nurse and some of the brief duties included being a care co-ordinator for patients, writing care plans and risk assessments, and reviewing; liaising with multiagency teams and working with patient families; attending multi-disciplinary meetings; administering medication; completing audits and checks of the unit.

10. My clinical lead roles have involved deputising for the Team Managers, completing team rotas, supervising staff, completing appraisals, overseeing performance measures, responding to complaints and concerns, role modelling for junior staff.

11. As Team Manager for Broomhill House, City North Local Mental Health Team and the EIP Teams, I was responsible for oversight of the Team's performance, budgeting, and ensuring the team provided safe and effective care. My role also involved carrying out supervisions and appraisals; addressing complaints; meeting with patients' families; attending multi-disciplinary meetings; facilitating

meetings; liaising with Senior Management such as Kelly Simpson who was the service manager and Tracey Taylor who had operational oversight; escalating concerns like waiting lists or staffing issues including discussing clinical issues providing emotional and well-being support for staff. I was the line manager to the clinical staff in the team and was not directly involved in patient care. I managed the staff that worked with the patients: I was in a managerial role while my staff performed a clinical role.

12.As matron, a role I have undertaken from December 2022 to June 2023 I was involved in quality oversight for five wards including reviewing care plans, quality audits, responding to CQC regulations and ensuring staff are working to the CQC standards of care. I am also responsible for managing investigations and complaints; ensuring appropriate training is in place for staff; writing quality improvement plans and providing evidence for actions; attending senior meetings, and escalating concerns. I am also required to maintain a presence on the wards and to attend ward meetings.

13.I was a team manager from 2019 to December 2022 in the Early Intervention Team. Subsequently, from December 2022 until June 2023, I held a Matron Role at the Wells Road Centre, also part of NHFT, from June 2023 to present I moved to a service manager role at the Wells Road Centre.

14.As Team Manager at the EIP, a role I carried out from 2019 to 2022 I was responsible for line managing five ward managers and having operational oversight of the wards including holding the wards financial budgets; supporting

the managers in service reviews and inspections; having oversight for the ward's performance; carrying out staff training, appraisals, sickness monitoring, recruitment and monitoring conduct and capability. I was also responsible for ensuring patient safety and good standards of care. Throughout this time I worked closely with the quality Matron, a post responsible for the quality of patient care like, ensuring CQC standards are upheld and for addressing patient safety issues complete audits and quality improvement plans; I also attended meetings with senior managers and governance meetings.

Early Intervention in Psychosis Service and role of Team Leader

15.I refer the Inquiry to the EIP Service Operational Policy [NHFT0004012]. This sets out the circumstances in which an individual would be referred to the EIP, namely:

- People with a first episode or first presentation of psychosis with a maximum of 3 years duration of untreated Psychosis.
- People aged between 14 and 65.
- People who have not received treatment for psychosis with antipsychotic medication that commenced over 12 months ago.
- People registered with GP practices covered by the seven CCGs within Nottinghamshire (people resident outside of the CCG¹ boundaries will be assessed on a case by case basis).

¹ Now ICB.

16.The aim of the service is to assess and treat patients with a first episode of psychosis. This is to ensure that interventions are offered early in order to

improve patient outcomes and prognosis. The aim is to improve health outcomes for the individual and reduce future hospital admissions. The function of the EIP team is to deliver the care and treatment of the pathway in line with the Royal Collage of Psychiatrists Quality standards and National Institute for Health and Care Excellence (NICE) Standards. The aim is also to work with patients in the least restrictive way and in the least stigmatising setting; with an emphasis on working with distressing experiences rather than diagnosis and ensuring that the pathway is oriented towards recovery.

17.As the policy sets out (see p.18 **[NHFT0004012]**), for service users experiencing a first episode of psychosis, the team may treat the individual with medication. Preference will be for low dose atypical antipsychotic medication, as per low dose prescribing protocol for people with a first episode psychosis.. Service users will be provided with information about the pros and cons of different medications and the efficacy of medication and potential side effects should be explained and regularly reviewed. Initial commencement of medication should be reviewed within six weeks as part of the assessment of physical health needs.

18.The policy sets out (see p.18 **[NHFT0004012]**), that service users with a diagnosis of schizophrenia who have been tried unsuccessfully on two atypical antipsychotics may be offered Clozapine. Evidence-based psychological

interventions, such as Cognitive Behavioural Therapy for Psychosis (CBTp), and family interventions are offered as a first line treatment to all service users. Patient Outcome Measures are used (HONOS (Health of the Nation Outcome Scales), DIALOG outcome scale (a structured tool designed to measure patient reported outcomes and experiences) and Question about Process of Recovery (QPR) when the patient first enters the service and then during their time on the pathway, physical health care of the patient is also monitored (physically monitored) as they are usually new to medication and side effects are monitored, psycho education for individual patients and carers is also the offer of the pathway. Diagnosis where appropriate, emotional support and social engagement are all offered to a patient. Education and Occupation support is an offer on the pathway. A care co-ordinator is allocated within the first two weeks of assessment.

19. On considering VC's records, I note that he appears not to have engaged in any of these activities.

20. The EIP would work in a proactive way to try to engage the patient to reduce the risk of the patient being lost in services and potentially experiencing a longer duration of untreated psychosis. The team followed a flexible approach to engaging the patient in their care. Treatment was provided in accordance with the NHFT EIP Policy **[NHFT 0004012]**.

21. In terms of monitoring, each individual accessing the service would be allocated a Care Co-Ordinator ("CCO"). The role of CCO was to monitor patients on the

EIP pathway by attempting to build a therapeutic relationship of trust with the patient in order for the patient to be open and transparent about their experiences of Mental Health Symptoms. The CCO would already have an initial understanding of signs and symptoms from completing an initial assessment with the individual – which would be done within the first two weeks of receiving the referral. An agreement would be made between the CCO and the patient in terms of what level of engagement would be useful for the patient, times of visits calls etc. The CCO would provide the patient with their work mobile number in case the patient wanted to get hold of them. (There was no duty worker In the EIP team) Some patients also preferred to text to communicate opposed to phone calls. The Care- Coordinator would also be in regular contact with the patient's family or friends if consent was given. The frequency of contact was dependent on the patient's need and the severity of symptoms the patient was experiencing. For example, somebody new to the pathway may require more frequent contact than a patient who was well and was ready to be discharged. If a patient was exhibiting symptoms of relapse, then more visits may be required or the intervention of daily visits from the crisis team.

22.As part of the monitoring, the CCO would ask the patient about their experiences, symptoms, severity, and frequency. They would also look for other cues, i.e. a patient being incongruent during a conversation responding to unseen stimuli, evidence of negative symptoms, and thought disorder for example.

23.The CCO would see the patient regularly in an Multi-Disciplinary Team (MDT) review. The patient would also have Care Programme Approach (CPA) reviews and appointments with their Responsible Clinician. The CCO would also use feedback from a family member or friend as a way of monitoring and would also use the outcome measures again with the patient in terms of measuring patient progress.

Monitoring and Management of medication concordance

24.The management and monitoring of concordance with medication was more difficult for community patients than patients in an inpatient setting due to the patients not being observed taking their oral medication.

25.The CCO would ask patients in the first instance if they were regularly taking their medication and would talk to the patient about any side effects they are experiencing. They would also be monitoring if there was a change in presentation of the patient, i.e appearing to become unwell. A patient may demonstrate this by an increase in symptoms. This could be an indication that a patient is not taking their prescribed medication; however, it could also mean the dosage or the medication may need to be adapted. Family and friends may give feedback to the CCO about any concerns. Sometimes the medication is taken to the patient by the CCO and for some patients they may come to the team base to pick it up. When a CCO delivers the medication to the patient's address, they may also monitor the patient in their own environment and there are signs that they are not attending their activities of daily living. For example,

a patient may be highly functioning, and there is a decline in functioning. This could be a sign that a patient is not being medicated. There would be discussions about the patient's presentation in MDT Meetings and plans put into place if more monitoring was required. I.e. changing a prescription from monthly to weekly medication allowing the CCO to be monitored more closely.

26. The EIP operational policy addresses the service's response to disengagement at Appendix 2 [NHFT0004012, P.24]). Reasons for disengagement should always actively be explored, including any associated risk. Where possible, a person's family should be involved and a plan put into place which covers risk and actions, and this should be documented in the risk assessment and running records. This policy ran alongside the Trust Procedure 01.08a Merged Do Not Attend/cancellations [NHFT0004725] and Management of patients who fail to engage with services or seek to Disengage from Care in an Unplanned Way Procedure. This includes the CCO taking their concerns to an MDT, contacting other agencies such as the GP, Housing departments etc, a letter being sent to the person's home address and phone contact, document attempts in the patient's running records. The MDT should consider the use of a CTO. If the patient's whereabouts are known and risk has been assessed, the team should consider a Mental Health Act assessment/Mental Capacity Act assessment. The CCO should take advice from other professionals. The MDT should consider the involvement of the police. Where a patient verbalizes that they do not wish to engage, and risks are low, all attempts should be made to engage the patient in options of other support. If a patient expresses a wish to

selfdischarge, the question of their mental capacity to make such a decision must be assessed.

Disengagement from the Service

27.From my experience, as a first response where there was no risk concern, e.g. a service user had simply gone on holiday or there was a family emergency which meant they had missed an appointment, the CCO might call to check in but otherwise, the EIP response would be relatively minimal.

28.If disengagement progressed, the CCO would then increase the frequency with which they tried to engage that individual, initially by phone; they would then message the patient, and attempt contact each day. If the patient had given consent, the CCO would contact any known family members; they would also carry out a cold call visit to the person's home to see them.

29.In the continued absence of contact, the EIP would consider whether to request that the Police carry out a "safe and well" check. We would also write to individuals and their GPs and discuss their cases in MDT.

30.In circumstances where a patients appears to have disengaged entirely and we are worried that they are relapsing and becoming unwell, we would involve the Crisis Team. We would consider the use of a s.136 suite as a place of safety where appropriate, whether there should be an assessment under the MHA

1983 with a view to inpatient admission and potential use of a Community Treatment Order (CTO); in certain circumstances we might contact the police using 999.

31. Where patients are non-concordant with oral medication, depot medication would also be considered. This would usually be commenced in an inpatient setting. Some patients request a depot injection but as a service we would generally encourage oral medication as the least restrictive option. Patients who had come from an acute ward were more likely to be placed on a depot: a depot can be commenced in the community with the patient's consent; if, however, a patient is not consenting, a patient must be under a CTO in order for depot medication to be commenced.

32. A CTO would be used in EIP after consideration of a patient not engaging with their treatment. We do not see many patients on CTO's because a lot of our patients respond to treatment and engage with the service. For those that do not, then a CTO can be considered when the patient has been detained in hospital. This would only come from a Section 3 or Section 37 of the Mental Health Act. A patient is placed on this in an inpatient setting on discharge to a community setting

33. A patient would not be considered suitable for EIP treatment when they were:

- Outside the age range 14-65 [NHFT0004012]
- A person who has severe learning and communication difficulties which render them unable to benefit from the service

- Organic diagnosis, e.g. Huntington's diseases, Parkinson disease, dementia
- People that have an extensive forensic or offending history and are deemed to be at high risk of re-offending would be better served by community forensic services.
- People whose psychotic symptoms clearly occur only in the context of acute intoxication. When a clear link is observed between cessation and remission of symptoms with cessation of drug and alcohol use within 7 days.
- Those that have already served a 3-year EIP service and have been discharged.
- For those who have already been in contact with mental health services for non-psychotic conditions such as anxiety/depression and where current referral for psychosis is a new emerging phenomenon. If a service user has been on all antipsychotic medication for another condition for over 12 months, the referral will not usually be accepted. But exceptionally when it can be shown that a low dosage regime has been used, this may be accepted on a case-by-case basis.
- People that have been assessed as experiencing psychotic symptoms for the first time as a result of pre-existing and long standing chronic mental health problems such as recurrent depression and bipolar disorder, individuals with personality disorder who might experience hallucinatory voices encouraging self-harm or perceptual abnormalities representing historic trauma

Working with community health services

34. The first EIP team acted as a standalone service; city, county and south working as one team in one base. The Trust subsequently wanted the pathway in Local Mental Health Team (LMHT) model however EIP was not meeting the national standards as a pathway, and it agreed to separate the pathway and have a stand-alone team again.

35. We worked in the same bases as our community mental health services. We would often discuss the referrals as they came in to discuss the appropriateness and if the referral would be an EIP referral. The two services may also be present in each others' MDTs if a patient was being referred to the community teams at the end of the three year service.

36. When the EIP was reconfigured as a standalone team, it was reconfigured into five geographic patches: one team but five bases – seen as a standalone team but based in the same place as LMHT services.

37. This worked well but was challenging as demand on LMHT was different to our EIP team. LMHT colleagues may have 20-25 patient caseload, but the EIP team would be much smaller. Once staffing numbers were established, we did not have waiting lists.

38. Waits in LMHT meant they could not always accept discharge from EIP and others service were prioritized as EIP had a CCO. For example, a patient on a

ward needing discharge with a CCO would be prioritised over a patient that already had one in the community.

39. In terms of working with inpatient services, CCOs were present at ward rounds.

As Team Leader, I was not in these meetings as it was not appropriate in my role. Cooperation was generally good but there were occasional administration frustrations – e.g. ward rounds being cancelled and wasted journeys.

40. Weekly meetings were held across each of the five EIP patches in the South.

These were attended by CCOs, some of the support workers² equivalent to role of Health Care Assistant Worker, a medic ie a psychiatrist, and either clinical lead or Team Leader. Nursing students also attended occasionally as did psychologists and peer support workers. The MDTs were smaller than in an inpatient setting; their purpose was to share the views of everyone involved in an case, pooling their experience and relevant backgrounds: this also provided an opportunity to share risk and expertise across the MDT so no one practitioner was alone in deciding on a patient treatment. MDTs also provided an opportunity to plan ahead for individuals' care, to review their risks and to process feedback from CPA reviews, tribunals and other relevant sources. Each CCO would discuss any patients they wished to and raise any issues of concern. It was usual practice for a CCO to discuss every patient on their caseload but at different levels of detail, depending on the particular patient and their particular needs. As an MDT we would review patients and we would then

² Support workers are the unqualified staff in the team. They work with the nurses and would help deliver care plans and also would visit the patients.

discuss what interventions might be appropriate and what we as a service could offer.

41. Each individual's risks were discussed in the context of their MDTs and CCOs would write up their assessments: I do not recall there being separate risk assessment meetings.

Roles and Responsibilities of a Team Leader

42. As Team Leader, I was responsible for finance and budgeting for the EIP North in addition to:

- a. recruitment;
- b. performance and KPI monitoring – e.g. meeting national standards and team delivery
- c. appraisals, oversight of mandatory training for the team
- d. supervision of team
- e. complaints at team level
- f. supporting team on daily basis
- g. Managing sickness

43. It was also my responsibility to develop and maintain a team culture and to look after the health and wellbeing of my staff.

44. At the time that I held the role of Team Leader there was no clinical matron input into the EIP Service: both matrons and operational leads were subsequently introduced to the team and the Team Leader is no longer responsible for that aspect of work.

45. During my time as Team Leader, I would attend MDTs for the purpose of making decisions about patient care. Before the clinical lead was in place I attended most of the MDT meetings; once she was in place I attended less frequently as we shared the responsibilities of the MDTs.

46. Critical decisions were made as a team: difficult matters were escalated to me; I in turn could escalate them to senior managers. We did not make decisions in isolation.

47. My role as Team Leader did not involve inquiring into a patient's records. It was not my practice to look into a patient's Rio records, unless specifically invited or required to do so – this might happen if there was a national standards audit or if a referrer or other professional from another agency needed information. If a patient had been referred to EIP I would read the referral and sometimes look to see if there was further information for the patient in the patient records – for example if they had commenced treatment or were known to services. I would access records if documenting clinical activity or if I needed information and if I was triaging referrals. Ordinarily I wouldn't be accessing records every day. There was no audit programme in place for reviewing Rio records in EIP.

48. Supervision was provided in both directions: I attended monthly supervision sessions with Kelly Simpson, Service Manager and before that time it would have been Vidah Adamson who was the previous Strategic Lead. I also attended supervision sessions with 35 practitioners during the relevant period. This number reduced approximately by half when Sharon Heath, Clinical Team Leader, came into post and I remained the Team Manager.

49. Supervisions were carried out in accordance with a template: this provided space for recording issues such as staff wellbeing, performance, training compliance, appraisals, caseload as well as any issues with patients, any risks and any safeguarding problems. It was up to each CCO which individual to bring to supervision on a monthly basis.

Expectations of CCOs

50. In terms of expectations I had of CCOs, as a Team Leader, I would expect them to be responsible for the monitoring of patients; contacting them through various means such as phone calls, text messages, home visits, or visits in the community depending on where the patient wanted the visit conducted. I would expect such contacts to have been for around an hour. In terms of frequency, this would depend on the individual patient and the level of risk and engagement.

51. As set out above, CCOs were also responsible for managing medication concordance in patients. This would involve, in first instance, asking patients if they were taking medications regularly; asking them about any side effects, and

monitoring if there was any change in presentation or symptoms of becoming unwell. I would also expect CCOs to engage with a patient's family and friends, if appropriate, for feedback on their medication concordance. CCOs were also responsible at times for delivery medication to patients which would provide an opportunity to monitor them in their home environment. With regard to arranging for a patient to receive medication by way of depot injection, this would be the role of the CCO. They would usually inform the patient leading up to when the depot is due; diarise the dates and make arrangements with the patient for it to be administered. They would record this on the medicine card and also document this in the patient running records.

52. Another CCO duty was the devising of care plans. An initial care plan was devised at the point that a patient was accepted onto the EIP pathway. Best practice thereafter was for ongoing patient involvement; in circumstances where patient engagement was minimal, CCOs were expecting to devise care plans without patient input.

53. Patient engagement is a fundamental standard however, when dealing with patients with serious mental health problems or patients that are not willing to fully engage, the team have to work dynamically. That may mean engagement with family/ carers; alternatively, it may be a nursing prescription of what is being delivered and offered that is documented.

54. A care plan should be reviewed on a monthly basis or as a patient's needs change. It is based on a person's individual needs and what is required for their

recovery, while some aspects might be similar across a number of individuals – eg aspects of daily living, social functioning, risk, physical healthcare, mental state, medication and support networks, other care plans may be more personalised.

55.If a patient was not engaging or was not concordant, their care plan might reflect this by providing points of contact: ie means by which the patient could reach help if they wanted it; details on any particular tools the patient would find helpful to help the team engage in their care. It might also include details of other services the patients may engage with. It would also include details on crisis planning, in particular relapse signatures and early warning signs. Relapse signatures are unique and personal early warning signs to an individual, including thoughts feelings and behaviours.

Discharge is unique to each patient but there are a number of pathways that this would normally follow. Firstly, the patient would finish the three years with the EIP Team and be discharged back to the care of their GP. Secondly, after three years, the patient would be referred to the Local Mental Health Team for ongoing support and monitoring. Thirdly, not all patients require the full threeyear pathway and are discharged with GP support. There are discharges between Trusts, this is especially key to this team as they picked up the Nottingham Student population. Where disengagement is a factor, the patient would be taken to the MDT and the following would be considered. Good practice would be to have contact with the patient's family or linked person to seek an update, contact any other involved agency (probation/ local authority for example) and take all reasonable steps to contact the patient. The MDT

would review the actions taken and make the final recommendation for discharge at which point the GP and patient would be notified.

MDT Meetings

56.CCOs also had a key role to play in MDT meetings. In the EIP North there was an administrative member of staff who would take a relevant minute. At the time that VC was cared for, there was no such role in EIP South.

57.Each MDT meeting would last around 1.5 hours and would involve discussion of around 20-30 patients. The CCO would be expected to make notes but there was no policy in force at the time requiring a minute to be taken. I am no longer in the service so I cannot say if this has changed.

58.I would also expect CCOs to be responsible for liaising with consultants and clinicians in the community health team either via weekly MDT meetings or more frequently if they considered a patient to be at risk of relapse. The consultant role in MDTs was not a full-time post at that time but given it was a member of staff who worked at the trust, access was available via the Trust.

59.In the event a CCO had concerns about a patient, I would expect them to escalate those concerns to the Team Leader or the Clinical Lead or to raise the issue in supervision.

Patient Attendance

60.If a patient did not attend an appointment (“DNA”) it was the responsibility of the CCO to phone the patient to see if they were ok. Generally, they would all and ask the patient to call them back if the phone went to voicemail. The CCO would then attempt to make another appointment. The CCO would not contact anyone else for one missed appointment.

61.I have been referred to two policies: NHFT0000417 and NHFT0004725. NHFT0000417 was in force from November 2018 to October 2021 (“the 2018 policy”); NHFT0004725 was in force from September 2021 to February 2024 (“the 2021 policy”). Both policies define DNAs as “Patients who have been informed of, or who agreed their appointment/visit date and who, without notifying the department/service, did not attend for their appointment/visit. This also applies to non-attendance at arranged visits with the community team. This may be an initial appointment, outpatient clinic or an appointment for on-going care” (NHFT0000417, p.4 o 16; NHFT0004725, p.4 of 11).

Care Coordinator role in CTO

62.Responsibility for arranging a CTO did not lie with the EIP. A CCO might raise their views as to why a patient would benefit from a CTO, but it is not part of their role to action / do paperwork / recall patient. They would, however, write a CTO care plan. As Team Leader it was also not part of my role to arrange for a patient to be placed on a CTO or to arrange for them to receive a depot injection of medication.

Assessment of risk

63. Assessing risk would initially come from the CCO and the responsible clinician. However, risk was regularly discussed within an MDT. A risk assessment is carried out when the patient is new to the service in accordance with the EIP SOP [NHFT0004012, P.12]. The risk assessment should be updated as the risk changes and should be reviewed in CPA reviews and as risk changes. Generally care plans should be reviewed monthly; updated yearly or updated when the risk of a person changes.

64. Both historical and current risk are considered in risk management. The nature and severity of the individual's diagnosis and treatment will also be considered. Information provided by the patient and others (usually family, friends, and other agencies) is also taken into consideration and helps inform the risk assessment. Risks are managed by monitoring of the patient: this includes monitoring medication concordance and mental state. The EIP team will also be in contact with family and friends to help to ascertain risk and relapse signatures of a patient.

65. Typical patient risks include harm to self or others. We also worked with patients that were at risk of suicide, drug and alcohol misuse. There were also patients that had no risk of behaviours.

66. It was the responsibility of the CCO to gather information from the patient, family and friends, previous agencies involved with the patient, and any previous

records. All of this information would help inform the risk management plan. The controls were the same whether the patient presented a risk to themselves or to others.

67. The patients, their families or other external agencies would sometimes report an increase level of risk. This information would usually go to the CCO who also may have observed an increased level of risk. The increased level of risk would be determined from a change in the person's presentation and their historical risk would also be taken into consideration also. The CCO and/or the Responsible Clinician would assess the level of risk. They would update the risk assessment with any change to risk. There was an expectation that the patient would be reviewed by the Responsible Clinician if their risks appeared to be increasing. If a patient's risks were considered to have increased, thought would be given to whether there should be an increase in visits from the CCO or the Crisis Team; hospital admission and/or an assessment under the Mental Health Act 1983 would also be considered by the CCO and/or the EIP team generally.

68. During my time as Team Leader, risk assessments were available via the Trust Risk management plan which was on Rio. I cannot recall any other tools available to the EIP by which risk assessments were produced.

69. I received risk training by NHFT throughout my career which started in 2020. This took the form of internal Risk Management Training provided by NHFT. I

cannot recall having training on the Royal College of Psychiatrists' publication, the assessment and management of risk to others (College Report 201).

70. Where a member of the EIP had concerns about the risk of harm posed by a mental health patient to members of the public these would be raised in a variety of forums, depending on the immediacy of perceived risk. Concerns could be raised in MDT discussions which would also provide a means of alerting the relevant medic; they could also be raised with line managers; a Mental Health Act 1983 assessment could be carried out.

71. Where a patient is under the care of the Trust and there is an immediate risk to the public, a MHA assessment would be called for and the police called. If the patient is a risk to the public but it is not related to their mental illness, this would be referred to the police.

72. If a patient was assessed under the MHA but found not to be detainable, the Crisis Team would become involved for more intensive monitoring: it had the ability to monitor a patient once or twice a day, particularly with medication concordance. Where there were concerns of an immediate risk to the public, we would raise concerns via the 999 service. If there were concerns of risk, unrelated to a mental health condition, police involvement would be sought.

73. Similarly, where there were concerns that a patient was relapsing, the EIP Team/ CCO would increase the frequency of visits to the patient and speak to

their family or friends. There would also be a review in MDT and consideration would be given to a referral to the Crisis team.

74. Where there is a concern about possible forensic mental health needs, the team can refer to the Forensic Community Team for assessment, advice or for a takeover of care. Where a forensic inpatient bed is required, that would be led by the crisis team and the bed management team and MDT, including a psychiatrist. This referral is through IMPACT where referral criteria are clearly set.

Mental Capacity

75. Any necessary assessment of an individual's mental capacity was carried out by their Responsible Clinician where appropriate, or by the member of the team responsible for the relevant decision upon which capacity fell to be assessed. There is a presumption of capacity under the Mental Capacity Act 2005 so we would assume a patient has capacity unless there is a reason to think otherwise. Where there is a question over a patient's capacity to make any relevant decision – to consent to treatment, for example - a formal capacity assessment would be carried out.

76. I received mandatory training on both the Mental Health Act 1983 and the Mental Capacity Act 2005 from NHFT.

Information Sharing

77. In terms of information sharing, each patient's social circumstances, including the question of contact with their family, is unique to that patient. We would only share information with a patient's consent unless risk indicated that sharing without patient consent was necessary and therefore lawful.

78. As a result, some patient's families might be present at all contacts, some at set review times and there may be times when this is withheld from the service.

79. I was not aware of any barriers to the sharing of information relevant to clinical treatment and risk assessment that limited the effectiveness of multiagency working.

80. Where we were concerned that a patient posed an immediate risk to themselves or to others, we would share our concerns with the police; we triaged care with police to rag rate risk. There was occasional frustration that the Police would fail to tell us that a patient had been arrested.

81. In terms of sharing information with a patient's family, the EIP would attempt to do so by consent. Alternatively, we would discuss the issue in the MDT. We also work with carers in relation to psychoeducation which could be done without consent as it did not require the sharing of confidential information. We also openly encourage families to come forward if there are any concerns and again, this can be treated confidentially. We also would review family contact if this was withheld as we recognise the importance of involving the family.

82. Where a patient withdrew consent to sharing information with their family, There would be a discussion at MDT as to whether the patient has capacity to consent to the sharing of their confidential information or not. If they had the requisite capacity, and did not agree to their information being shared, we would not share information with their family. We encourage the patient about the importance of having a support network around the individual. This would not prevent us from sharing information with, eg the police, or the family in certain circumstances, if we had relevant concerns of risk to the patient or to others.

83. We also consider the family dynamics and the relationship with the family, any abuse history and whether the family member wanting information is also the abuser.

84. If a patient is detained under the MHA, the AMHP may contact the person's Next of Kin as part of the detention process. The EIP could provide information to the family about what we offered as a service and education around how to support their relative.

85. Information was shared with third parties such as the police, local authorities, the GP, and independent healthcare organizations through phone calls, letters, emails. While some private providers had read-only access to Rio, there was an expectation that the CCO would maintain contact with private providers and ensure a link was maintained between them and the EIP.

Related experience

86.I have on one other occasion, in 2024, been involved with a mental health patient who, following discharge, went on to kill/seriously injure a member of the public

Chronology of Events

87.I had one face to face interaction with VC to hand over medication I cannot recall when this was. I had no other further interaction with him.

88.I can recall that I handed medication to VC at the Stonebridge Centre. I cannot recall the precise date. This was unusual in my then role of Team Leader; I would only be required to hand over medication if a CCO was ill or on a visit. There were only six CCOs in the EIP South Team and no duty workers: there was no duty system unlike the LMHTS.

89.When meeting an individual in such circumstances, I would normally engage them in generic questions about how they were feeling, general observations, e.g. nonverbal cues.

90.MDT meetings took place weekly on a Thursday morning for 1.5 hours: as set out above, there was no formal administrative support. At the time of VC's discharge, I covered five EIP teams across the EIP South. I had a clinical lead in post and so did not attend every meeting covering five EIP teams. However, I tried to attend regularly, balancing my diary commitments and other managerial responsibilities with attending.

91. Supervision was carried out monthly with CPNs. When Sharon Heath ("SH") took on the role of clinical lead in December 2021, we split supervision of the 35 staff between us. SH took on Gary Carter's supervision from February 2022 onwards. I was responsible for supervising Claudia Birtles until her maternity leave in August 2022. My supervision of CB included discussions about VC. When GC took over, I would expect SH to have discussed VC with GC as required.

92. I documented these supervision sessions by handwriting on the supervision template which was then put into their personal folders. Unfortunately, I did not keep robust records of all of my supervision sessions and this included this time frame. I have reflected and worked with my line manager to ensure that I do now keep robust records.

93. I can recall CB raising issues about VC as his CCO. She raised issues about his difficulty in engaging and about trying different ways to build a therapeutic relationship. I recall she expressed that she had a sense of "unease" about him. He had not made any verbal or physical threats towards her and I couldn't decide whether CB's unease was because CB was pregnant.

94. It is routine in mental health services to support pregnancy risk assessments in any event, and it is not uncommon to move patients to other workers at times or to advise practitioners not to attend certain locations. CB last saw VC on the 29th April 2022 and his care was then transferred to GC.

95. I recall that both VC's CCOs, CB and GC, and others present at MDTs reported that it was difficult to engage VC. Advice was given that cold calls should be attempted; letters, contacting family, telephoning VC etc. I was not in every meeting. But at those at which I was present, we (meaning me, other nurses, support workers and the MDT team Consultant) would consider what an individual's likes and interests are and try and engage patients on these issues rather than 'just' talking about symptoms and medication. Mental health nurses would be observing non verbal behaviours at the same time: when observing for signs and symptoms of mental health we often look for non verbal behaviours such as if some is responding to unseen stimuli or there are delays in their responses during a conversation, either of which could indicate that an individual is responding to visual or auditory hallucinations.

96. I have been referred to the interview carried out by NHFT in January 2025 **[NHFT0004883]** at which I reported that CB reported VC to have been guarded in his presentation. I cannot now recall this conversation. There were periods of time when it was reported that VC engaged and collected his medication. Although I referred in that interview to having met VC "once or twice", on reflection I believe I only met him once. I have not been able to recall or to find a record of the exact date. My memory is that he arrived on time, was polite, courteous, and quiet. Our interaction was brief as he did not want to talk.

97. My recollection is that VC was initially diagnosed as experiencing a period of first episode psychosis. It subsequently transpired that he was in fact

experiencing more of an enduring psychosis (paranoid schizophrenia). I believe that his engagement was sporadic in that there were times when he did engage; times when he did not, noting that engagement can mean different things – engagement in activities, taking and collecting medication. VC was quiet when I met him and consideration of the records suggests this was his usual presentation.

98. In terms of his insight and compliance, I did not have direct contact with VC beyond a single medication collection so I rely on the reports of others. I understand he exhibited fluctuating levels of insight as well as fluctuating compliance: I can recall that he reportedly did take his medication when he was on an inpatient ward. From considering his Rio records, I understand that there was a potential risk to others based on his behaviour, particularly his behaviour involving other students given the incident in which he broke into a flat.

99. I have been referred to the following records

- a. an entry on 9 October 2020 at 3.25pm **[NHFT0000168, at p.135]** in which Abi Parsonage (**Community Psychiatric Nurse**) refers to intending to email me regarding VC. While I am referred to by name in this entry, I believe the supervisor Abi Parsonage in fact she spoke to is likely to have been Sharon Heath. I have searched my inbox in order to locate the email from Abigail Parsonage and it does not appear I received this email.

- b. an entry by Ms Kehinde Hasson on 15 October 2020, at 1:11pm [NHFT0000168, at p.135] in which she refers to a telephone call with VC's mother, Celeste and notes: "*[Celeste] asked if someone from the has make a contact with [VC], on looking at the entries Abi and Anthony make a cold call last week and was not at home. Email to Emma to follow up this week as Abi/Claudia on leave...'*." I cannot recall receiving an email from Miss Hassan and I do not believe I had any contact with Celeste.
- c. An entry by CB dated 19 April 2022, at 9:00am [NHFT0000168, at pp.264-265] in which she writes: "*Discussed phone call with Team Leader Emma Robinson. We agreed given the historical risks of violence and aggression and hostage taking, home visits were not appropriate unless absolutely necessary and it would be better to continue with plan to offer appointments at the Stonebridge Centre*". I believe this entry to be accurate. I recall that VC's risks were risks to others and not a risk of harm to self. He was not known for taking illicit substances or using alcohol. At that time his CCO was a pregnant worker, so consideration was given to this and we were trying to find different ways to engage him in his care. The risk he posed was also a factor in deciding for him to be seen at the team base. With regard to the decision that he should not be visited at home "*unless absolutely necessary*", it wasn't uncommon for us to have patients that visited in the base due to risk behaviours. The majority of patients were seen in their home environments, however

there were also a lot of patients we would see in base or if we visited them in their home we would visit in pairs due to risk.

100. With regard to the decision to change VC's care-coordinator from CB to GC, this was in part because CB felt uneasy, and it did not feel safe to see him at his home address and also that CB may have been pregnant. It was also in part because, he had already worked with a female - and switching to a male worker, GC, was another way of attempting to engage VC. GC was appointed as VS's CCO as a way of trying to engage him differently; it was hoped that, through transitioning to working with a male CCO, VC might have engaged a little more in terms of some common ground. We also knew that there were times that he was hard to engage and GC worked well with the more assertive outreach patients. I recall that CB did raise that VC made her feel uneasy, but I am not aware of other female members of staff reporting themselves to have been scared of VC.

101. I cannot recall if I had the conversation with GC to work with VC, or if it was his supervisor, Sharon Heath. My usual responsibility would have been to have an overview in the team who had capacity to take patients on their caseloads, to assess the skill mix in the team and to make decisions around whether patients needed to be moved across to different CCOs for different reasons. This was usually determined by feedback from the CCOs themselves or from their clinical lead. GC would have some responsibility for the decision to take VC onto his caseload. I cannot recall any objections being made. I cannot recall

what GC's caseload was at this time but the EIP's practice at that time meant we would have taken his numbers into consideration and if he was due to discharge any patients also looking at capacity of numbers. We would have also looked at skill mix.

102.I have been referred to an MDT meeting on 28 April 2022, at which it was noted that it would be preferable to have two community psychiatric nurses for VC [NHFT0000168, at p.266]. I can recall that I was aware that the plan was to move him over from CB to GC; I was not aware of a plan for him to have two CCOs: the entry was made by CCO CB.

103.I have also been referred to an entry on 4 August 2022, at 2:40pm [NHFT0000168, at p.270] in which GC noted a cold call visit to VC's presumed address and recorded: "[VC] has a history of giving false addresses so I will take this situation back to Dr Lloyd and Emma on Monday. To consider – discharge to GP? Report as a missing person?"

104.I have reflected on this entry: I cannot recall this exact conversation. I can remember conversations in general about him not engaging and missing his prescribed medications in MDTs. I recall that we did not feel he would meet the threshold for a missing person as he had been in contact with his sister and he had also put a request in for his medical records. We had discussions in the MDTs about discharge as attempts were made by his CCO and other workers to engage him in his care. As above, there were conversations held about the appropriateness of contacting the police. There was nothing to suggest he was

unwell, and we knew he had been in touch with his sister and, from the handover, from his mother, and he had also made a request to access his medical records. I believe we had conversations in meetings prior to discharge about the use of the Mental Health Act however there was no evidence he was unwell. We could not assess him as he had disengaged. He was an informal patient at the time he had disengaged.

105. I note the entry on 9 August 2022, at 3:59pm **[NHFT0000168, at p.270]**: an entry in the notes by CB stating that VC had requested access to his notes and that I would be dealing with the request in addition to a further entry on 18 August 2022, at 11:20am in which GC noted that VC had applied for access to his documentation and notes and it had been submitted to me **[NHFT0000168]**. I recall that I passed this request on to psychiatrist, Dr Tuhina Lloyd and the information governance office who dealt with information requests. I do not believe that I had contact with VC about this issue.

106. I am aware that an MDT meeting was held on 22 September 2022 **[NHFT0000168, at pp.270-271]** at which it was decided that VC would be discharged. I cannot recall if I was present at the discharge meeting, nor can I recall whether GC was present at the meeting. I can say however, that usual practice was that there would have been discussions about discharge at previous MDT and the views of VC's RC and CCO would have been sought.

107. I have been referred to the NHFT Carter Conduct interview in which I remarked at **[NHFT0004883, at p.15]**

“We knew, to some extent, that he was okay – or we believed (in hindsight obviously – now it’s a different thing) he was okay. He’d been in contact with his family and he’d also asked for access to his records. So, it felt that he had the capacity to do things and make decisions.”

108.I have reflected on this and consider the basis of the belief that VC was ok was that there was no concern raised that he was not ok. At the time of discharge, he was an informal patient. We could not assess capacity or mental state as the team could not locate him. We could not provide treatment as we could not locate him. I understood that he had been in contact with his mother over the phone a few weeks prior to discharge. There was nothing escalated to me to suggest that his mother was concerned about the conversation she had with him. There was no information coming into the team to suggest he was unwell and required a Mental Health Act Assessment.

109.I now know that there was a bench warrant issued by Nottingham Magistrates Court on 22 September 2022 regarding VC’s failure to attend court. I was not aware of this fact until after the events of 13 June 2023. Had I known of this fact, or any other similar information, it would have been discussed further in the MDT meeting and I would have escalated it to my superior for advice.

Investigations

110.I have been referred to three previous investigations into VC:

- a. interview by the NHFT on 8 January (year unspecified) **[NHFT0004708]**

- b. interview with Theemis Consulting [TCLT0000755].
- c. transcript of interview in the conduct investigation into GC [NHFT0004883].

111.I would like to make the following observations:

- a. TCLT0000755- page 15 1st paragraph reads *“it just felt like we had lost him altogether, but yeah in answer to your question it was risk, and it was just about us not having capacity to see him, and see how he was”*
I did not mean to imply that we did not have the capacity to see him in the sense that we lacked the necessary resources: rather, I meant that he had disengaged so that we were unable to locate and assess him.
- b. NHT0004708 – Under the heading Depot/CTO I stated that a number of staff thought *“they weren’t worth it”*. This was wrongly worded and I would like to correct this. When I refer to a number of staff this was not specific to EIP staff but experience of feedback from a number of roles I have worked in. What I intended to convey by this remark was that it can be very difficult and challenging to coordinate a recall due to the patient’s level of availability and engagement if serving a warrant and having an inpatient bed available all at the same time.

Reflections & Recommendations

112.The NHFT’s Level 2 investigation [NHFT0000451] comments that too much emphasis was placed on complying with VC’s priorities for his education. I do not believe there was reluctance. The EIP service ethos is to attempt to work

closely with the patient to identify how we can support them and engage them whilst considering least restrictive practice and not stigmatizing patients with labels. We always had to balance the patients' needs and what they wanted in terms of therapy and pharmacological treatment so to keep them engaged with service and balance that with helping the patient to stay well taking into consideration risk to self and to others.

113.I can confirm that while I was aware about concerns about the disproportionate overuse of Mental Health Act restrictive measures with black African and black Caribbean patients publicised in the context of Mental Health Act Reform, this did not impact on the decisions around VC's care.

114.I would like to acknowledge all of the families, victims and those injured in the tragic events that happened on June 13th 2023. I am sorry for the devastating impact that this has had on your lives.

115.When working as a team, we had some challenges in the structure of the team in terms not having a risk rag rating meeting. This is a meeting which would involve the team meeting daily to highlight patients that were becoming unwell or not engaging and we would discuss what escalations were required. We also worked without a duty system. A duty system is to have an allocated member of staff daily to take calls that were for the team or for any queries. The duty member of staff would also follow up any outstanding patient work. Although we had CBTp therapists we did not have a psychology provision for the patients

or the staff. The staff would often use psychology to discuss complex patients and help with formulation to care.

116. We set up the team during covid which changed the way we worked and we had to learn how to adapt to a new environment. I recognise that record keeping was poor in terms of the multidisciplinary meetings and no set agenda in terms of having a set template.

117. I would like to give assurances that patients were discussed in every MDT and the team worked very hard to try to engage VC in his care.

118. I left the team in December 2022 so cannot comment on the changes to the service since I left. However, I do understand that some changes have been made. On my part there were times when supervisoion was not documented and I am sorry for this, and I have changed my practice in this respect. As a nurse with the background of 25 years' experience the events in June 2023 will never leave me.

119. I am sorry for all the lives that have been impacted by this tragedy.

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: _____ 26.11.25 _____

Index to First Witness Statement of Emma Robinson

No.	Inquiry URN	Document Description
1	NHFT0004012	Policy Document, Re: Early Intervention in Psychosis Service Operational Policy of NHFT
2	NHFT0004725	Policy document Re: 01.08a Merged Do Not Attends (DNAs)/Cancellations & Management of Patients Who Fail to Engage with Services or Seek to Disengage from Care in an Unplanned Way Procedure, Nottinghamshire healthcare NHS FT
3	NHFT0000417	Policy Document, Re: Cancellations and Management of patients who fail to engage with services or seek to disengage from care
4	NHFT0004883	Record of Interview for Emma Robinson [NHFT] dated 13/01/2025
5	NHFT0000168	Medical Records of VC from 24/05/2020 to 14/06/2023, Various NHFT 6 Staff/Teams, re: Patient Record Summary
6	NHFT0004708	Record of Interview for Emma Robinson, dated 8th January [Unknown Year]

7	TCLT0000755	Record of interview of ER (EIP team leader at NHFT) by Theemis dated 14/06/2024
8	NHFT0000451	Report dated 15/06/2023, compiled by Jackie Craissati, Joanne Parry, Rachel Lees, NFT, Re: Level 2 Comprehensive Investigation Report