Witness Name: Dr Sasitha Sasidharan

Statement No: WITN0325001

Dated: 2 December 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DR SASITHA SASIDHARAN

I, Dr Sasitha Sasidharan, will say as follows: -

INTRODUCTION

1. I am a consultant psychiatrist, formerly employed by Nottinghamshire Healthcare NHS Foundation Trust ("**the Trust**").

2. This witness statement is made to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 Request dated 23 October 2025 (the "**Request**").

3. This witness statement was drafted with assistance from the external solicitors acting for the Trust in respect of the Inquiry, with my oversight and input, following discussions in writing by email and by video conference.

PART 1: BACKGROUND

Career and Role

4. My qualifications are:

   4.1. Bachelor of Medicine, Bachelor of Surgery (MBBS) [2006]

   4.2. Member of the Royal College of Psychiatrists (MRCPsych) [2017]

5. I completed my medical degree in India in 2006. I moved to the UK and completed my Professional and Linguistic Assessments Board test (PLAB). I commenced work as a Foundation Year 1 doctor in 2008, based in Carlisle, followed by Foundation Year 2 in Ayr in Scotland. I was working full time. I took an unpaid maternity break from 2009 to 2011. I then reapplied at FY2 level and completed my Foundation training. I then took a break for one year due to family moving from Scotland to England. I then commenced psychiatry training in the East Midlands Deanery in 2013. I completed my core psychiatry training on a part-time basis between 2013 and 2019 and then moved on to higher psychiatry training on a full-time basis between 2019 and 2022.

6. I trained in East Midlands. During training I worked in different hospital in East Midlands including Highbury hospital at the Trust. During this time, I gained experience working in community mental health, crisis team and inpatient settings.

7. At the time of the events covered in this statement, I was a trainee doctor in the last year of my higher psychiatry training.

8. In 2022, I gained Approved Clinician Status under the Mental Health Act 1983.

9. In 2022 I took a consultant in Community Psychosis at the Trust, based in Mansfield for a few months, then I worked as a consultant in CMHT and Crisis team in Grantham for a year at another Trust, before returning to the Trust and worked in the City Central team as consultant CMHT until I

moved to Australia in summer 2025. I am currently unemployed and looking for job opportunities.

Early Intervention in Psychosis ("EIP") and Local Mental Health Teams ("LMHT")

10. The Trust's EIP Service Operational Policy states, "*first episode psychosis is the term used to describe the first time a person experiences a combination of symptoms known as psychosis. During an episode of psychosis, a person's perception, thoughts, mood and behaviour are significantly altered. Each person will have a unique experience and combination of symptoms. Core clinical symptoms are usually divided into `positive symptoms', so called because they are added experiences, including hallucinations (perception in the absence of any stimulus) and delusions (strongly held beliefs that are not in line with the persons' social and cultural norms), and `negative symptoms', so called because something is reduced (such as emotional apathy, lack of drive, poverty of speech, social withdrawal and self-neglect). A range of common mental health problems (including anxiety and depression) and coexisting substance misuse may also be present"* [NHFT0000460 p9].

11. In addition, it confirms that "*EIP have an important and integral role to play in supporting service users and their families/carers in a community setting. EIP is founded on an extensive and compelling evidence base which has demonstrated Early Intervention in Psychosis can contribute significantly to the amelioration of initial problems, and consequently improve long-term outcomes (Bertelsen et al., 2008; Hegelstad et al., 2012). Effective early treatment is thought to reduce the probability of the emergence of longer term "treatment resistant" symptoms, and contributes to the avoidance of the "revolving door" syndrome of repeated relapse and as suicide is highest in the first few years of First Episode Psychosis (FEP) EIP can reduce the risk of suicide*" [NHFT0000460 p3].

12. The primary goal of the EIP service is to provide early assessment and treatment to reduce symptoms, promote recovery and support social, occupational and educational needs. Support with EIP team typically lasts up to 3 years.

13. Interventions offered by the EIP service include: Comprehensive assessment; Medication; Cognitive Behavioural Therapy for psychosis; Family intervention and support for caregivers; Physical health monitoring and interventions; Supported employment and education programs.

14. The goal of early intervention programs is to help individuals achieve the highest possible level of recovery and lead fulfilling lives.

15. FEP is when people experience psychosis for the first time in their life. They are not under the influence of illicit drugs and do not have any preceding medical problems.

Treatment, care and management of patients under EIP services

16. When an individual is referred to EIP from an inpatient setting, or from any other service, the initial assessment will be a full comprehensive assessment of health and social care needs conducted by the member of staff allocated on IT system as the `Care Coordinator' for the referral. As the Operational Procedure sets out [NHFT0000460 p12-13]:

    16.1.1. After the care co-ordinator's assessment, patients will be discussed at the MDT and then allocated to a doctor. The patient is then booked into a clinic or for a home visit as appropriate.

    16.1.2. The team will look into the referral form, and the discharge summary from the inpatient ward. They also look into the risk assessments from the ward, Mental health act assessments if any. All of this information is available on the electronic notes system called Rio.

17. The CPA was designed to ensure that people with serious mental health illness receive coordinated, planned, comprehensive care, not fragmented. EIP services address a high risk, high impact group (first episode psychosis) where early, coordinated intervention can make a big difference. Because the window of opportunity is early, ensuring that the CPA mechanisms (assessment, planning, coordination, review) are embedded is critical. By delivering integrated services (medical, psychosocial, vocational, family) via a dedicated care coordinator, EIP services operationalise the CPA policy in a specialised context.

18. After a patient is accepted onto First Episode psychosis pathway provided by EIP services, the types of treatment and interventions typically offered to patients or pursued, include:

    18.1. Antipsychotic medication will be given to patients for psychotic symptoms,

    18.2. The psychologist will be providing CBT to understand about psychosis and improve insight re mental health issues.

    18.3. The Care coordinator will continue to monitor their mental health and medication compliance and address social and financial issues.

    18.4. The Care coordinator will provide psychoeducation to the patient about mental health issues.

    18.5. Family interventions will be provided by psychologists in the team.

    18.6. The crisis and contingency plan will be discussed with patient and family – by the care coordinator, during the care plan.

19. The types of observations I look for when assessing a patient are, if a patient is engaging well with the mental health team. Whether they are concordant with their medication. I will assess if they have a reduction in their psychotic symptoms and if they are functioning well. They also need to demonstrate that they have insight into their illness. Further demonstrating that they have a hope for the future.

20. When forming a view on whether an individual is acutely unwell, I rely on a combination of the following:

    20.1. Clinical observation, such as if the patient is aggressive, agitated, responding to unseen stimuli and expressing persecutory thoughts and expressing thoughts of harm to themselves or others.

    20.2. Behavioural evidence, if they start acting on their psychotic thoughts, and demonstrating agitation, aggression, and

    20.3. Risk evaluation, including risk to self/others and property compared against the individual's baseline presentation. A determination of acute unwellness is made when symptoms or functioning deteriorate to a level that compromises safety, self-care, or insight — warranting immediate clinical intervention.

21. The basis of the above is gleaned from direct observations, their medical notes and attendance at MDT meetings.

Diagnosis

22. Psychosis is a collection of symptoms which include experiences such as hallucinations, delusions, disorganised thinking, and impaired insight, accompanied by functional decline and distress, and cannot be explained by substance use or medical conditions.

23. My understanding of Paranoid Schizophrenia is based upon the definition within ICD-10 (F20.0), which requires that the individual first meets the general

criteria for schizophrenia, including characteristic first-rank symptoms or persistent hallucinations and thought disorder. The paranoid subtype is identified when the presentation is dominated by well-formed persecutory or referential delusions and/or prominent auditory hallucinations. Other functions such as affect, speech, and behaviour are relatively preserved, and negative symptoms are not the leading feature. The pattern is typically persistent and stable rather than rapidly fluctuating.

24. The general criterion for schizophrenia includes, hallucinations, delusions, thought insertion or withdrawal and passivity.

Mental State Examination (MSE)

25. When I undertake an MSE I will look at the following factors:

25.1. Appearance and behaviour, the patient's general presentation, hygiene, eye contact, psychomotor activity, and rapport.

25.2. Speech, the rate, volume, tone, and coherence.

25.3. Mood and affect, the Patient's I mood (subjective) and observed affect (objective).

25.4. Thought form and content, their coherence, and logical flow. Whether there is the presence of delusions, preoccupations, or suicidal ideation.

25.5. Perception including the presence of hallucinations, illusions, or perceptual distortions.

25.6. Cognition, I consider their orientation, attention, concentration, memory, and abstract thinking.

25.7. Insight and judgement, considering their understanding of their mental health difficulties, their compliance with treatment, and awareness of their need for help.

Care Planning

26. A "Summary & Care Plan" is created to outline a patient's needs, risks, and treatment goals, and explains how the team will support their recovery. Its purpose is to ensure coordinated, safe, and consistent care, so that everyone involved knows what interventions are in place and what to do if the person's mental state changes.

    26.1. The main aim of the Care plan is to involve patients and their facility to the care that they receive and make them aware of what is going on with the treatment.

    26.2. The patient would be given full info about their medication, outpatient clinic appointment and how often visited by care coordinator and what to do in crisis and details of the different agencies involved in their care.

27. Within the **FEP–EIP multi-disciplinary team (MDT)**, care planning is a **collaborative process**, but specific responsibilities are clearly defined to ensure accountability and consistency of care.

    27.1. The **Care Coordinator** (often a community psychiatric nurse, social worker, or occupational therapist) has **primary responsibility** for formulating the patient's comprehensive care plan.

    27.2. The care plan is formulations **in collaboration** with the patient, their family or carers (where appropriate), and the wider **MDT** — including the psychiatrist, psychologist, support worker, and other relevant professionals.

    27.3. The plan is based on the **initial assessment which is undertaken by a care coordinator** , risk management findings, and the individual's **identified goals, needs, and preferences**.

27.4. The **Care Coordinator** leads the **ongoing review and evaluation** of the plan, ensuring it remains current, relevant, and recovery focused.

27.5. The **MDT collectively** reviews the care plan during regular team meetings or case discussions, particularly following significant changes in the patient's presentation or circumstances.

27.6. The **Consultant Psychiatrist** contributes medical oversight and ensures alignment with clinical treatment and medication management.

28. When a patient has had multiple admissions under the *Mental Health Act 1983 ("MHA")* it is important that patterns in respect of their presentation are captured as part of the ongoing care planning. This is done by way of Comprehensive case reviews. Clinicians review previous admission records, discharge summaries and risk assessments to identify patterns, and incorporate the information into the care plan. They will also be discussed within any MDT discussion and with the patient.

29. Inpatient and community care planning are linked stages of the same care continuum: inpatient plans address acute needs, while community care plans provide ongoing support, recovery, and risk management, with effective handover and collaboration within the MDT ensuring continuity and safety.

Risk Assessment

30. Risk assessments provide the evidence base for inpatient care planning. They enable individualised, safe, and recovery-focused interventions, guiding monitoring and support, and informed post-discharge continuity of care.

31. Outpatient appointments in FEP–EIP are central to recovery-focused, safe, and coordinated care, providing opportunities for monitoring, treatment adjustment, risk management, and collaborative planning. The frequency of these appointments are flexible and dependent on the clinical stability of the patient. Given, the passage of time I cannot recall the assessments that would have taken place.

32. When considering the risks a patient may pose to themselves and/or others historical information can help clinicians predict risk patterns, personalise care planning, and implement relapse prevention strategies, ensuring that interventions are timely, safe, and focused on recovery.

33. Specifically, I would look for whether they have a history of non-compliance with medication and poor insight as they will be at risk of further non-compliance with medication. They will be at risk of relapse if they are not compliant with medication.

34. If there is a past history or pattern of aggression and violence, you can predict that the patient may behave in a similar way, in a situation where they are non-compliant. The patient can become aggressive and act according to their psychotic symptoms.

35. Presentations can differ in each psychotic episode, but ongoing patterns from past admissions when they were unwell can inform the clinician in relation to future risks. So that individualised care plans can be made and ensure that interventions are completed in a timely and safe manner.

36. "Insight" is the patient's awareness of their mental health condition, their understanding of their need for treatment. and recognition of symptoms and risks. These are essential for engagement, safety, and recovery in FEP and paranoid schizophrenia.

37. In FEP and paranoid schizophrenia, masking is the deliberate or unconscious concealment of symptoms or difficulties, often motivated by stigma or fear. Masking can complicate assessment and delay timely care because you don't get an accurate picture of the patient's symptoms, and it can affect the treatment and care plan.

Discharge under EIP Services

38. If a patient disengages from EIP services or refuses to engage with assessments, an EIP MDT will consider whether it is appropriate to use assertive follow up approaches. In considering the options reasons for disengagement should always be actively explored including any associated risk. Where possible the persons family or support network should also be involved and a plan put in place which covers risk, actions (time frames, contact method telephone, cold call etc, points of escalation) and this clearly documented in the risk assessment and progress notes.

39. EIP teams decide whether to follow assertive approaches by weighing risk, symptom severity, history, capacity, and contextual information, aiming to maintain safety, prevent relapse, and support recovery, while respecting the patient's autonomy wherever possible.

40. Prior to discharge, the patient must have stabilised psychotic symptoms, optimised medication management, addressed physical health needs, assessed risks, and developed initial functional and safety plans. This ensures safe transition from inpatient care to community-based recovery-focused support.

41. Discharge planning is initiated when a patient demonstrates clinical and functional stability, reduced risk, improved insight into their condition, and readiness to engage in follow-up care, ensuring a safe and recovery-focused transition from inpatient to community-based EIP services.

42. For patients with a history of violence or aggression, discharge is only considered when there is evidence of behavioural stability, effective risk management, environmental supports, and MDT consensus, ensuring safety for the individual and the community while supporting recovery-focused care.

43. Clinicians consider individuals at higher risk of becoming violent when there is a combination of past aggressive behaviour, untreated psychotic or mood symptoms, substance misuse, poor impulse control, and lack of engagement with treatment, especially when environmental stressors are present. Identifying these factors allows for early intervention, risk management, and safe care planning.

44. For individuals with a history of non-concordance, clinicians prioritise understanding barriers, restoring engagement, ensuring medication stability, and implementing robust relapse prevention strategies before discharge.

45. Ongoing monitoring and collaboration between the patient, carers, and MDT are essential to reduce relapse risk and maintain safety.

46. For individuals with a history of social isolation, discharge planning requires evidence of improved engagement, social readiness, and access to structured supports. Clinicians prioritise interventions that enhance social functioning, reduce relapse risk, and promote sustained recovery in the community.

47. For patients with a history of disengagement from treatment Clinicians prioritise assertive follow-up, personalised care, and proactive relapse prevention to maintain safety and promote recovery in the community.

48. For individuals with a history of masking psychotic symptoms, discharge planning requires evidence of sustained openness, consistency of presentation, and multi-source verification of stability. Ongoing community monitoring and therapeutic engagement are essential to reduce relapse risk and maintain safety.

49. A patient should not be considered for discharge planning when they demonstrate ongoing psychotic symptoms, poor insight, risk-taking or aggressive behaviour, non-adherence, or unstable psychosocial circumstances. Discharge is only appropriate once risks are mitigated, stability is sustained, and the patient can safely engage with community support.

50. For patients who are discharged to the care of their GP and/or any other service, the EIP MDT ensures that care and discharge planning are holistic, collaborative, and risk-informed, with a clear focus on continuity, safety, and sustained recovery. Even after discharge to a GP or other service, the EIP team maintains a supportive, coordinating, and advisory role, ensuring no gaps in care.

Community Treatment Orders

51. When a patient is under Early Intervention in Psychosis (EIP) care is placed on a Community Treatment Order (CTO), the EIP team plays a central role in ensuring the order is implemented safely, ethically, and collaboratively, balancing clinical need, legal responsibility, and recovery-oriented practice.

52. They will monitor mental health and make sure that the patient is compliant with their medication. If there are any concerns in relation non engagement will liaise with the relevant team and recall patient to a psychiatric ward.

53. When assessing whether a CTO should be implemented when a patient has experienced psychosis and/or diagnosed with paranoid schizophrenia, I consider the following factors:

    53.1. The patient has a history of relapse following non-adherence with medication or disengagement from services.

    53.2. There is limited or fluctuating insight into their mental illness, leading to repeated deterioration once discharged.

53.3. The individual responds well to treatment while in hospital but has a pattern of rapid decline when treatment is discontinued.

53.4. Voluntary engagement has proven unsuccessful despite assertive outreach and intensive support.

53.5. In such cases, a CTO provides a legal framework for continued treatment while promoting autonomy and recovery in the least restrictive setting possible.

54. A CTO may be necessary where there are ongoing risks such as:

54.1. Self-neglect, including poor nutrition, hygiene, or medication non-compliance.

54.2. Suicidal ideation or behaviour, particularly linked to psychotic symptoms or depressive features.

54.3. Reckless or disinhibited behaviour due to delusional beliefs or impaired judgement.

55. A CTO is also appropriate where there is evidence or history of:

55.1. Aggression, threats, or violence linked to persecutory or grandiose delusions.

55.2. Irritability, hostility, or agitation driven by psychotic misperceptions or command hallucinations.

55.3. Non-concordance with treatment resulting in relapse and associated risk behaviours in the community.

55.4. Deterioration of social functioning, leading to conflict or vulnerability in public or family settings.

56. If the patient has a pattern of violent behaviour linked to relapse or non-adherence, a Community Treatment Order (CTO) may be indicated to ensure treatment compliance and structured follow-up.

57. This legal framework helps manage ongoing risks while supporting gradual reintegration into the community under close supervision.

58. Clinicians consider individuals with a history of psychosis-related aggression, poor insight, and repeated deterioration off medication to be at risk of becoming violent in the absence of treatment. Proactive, structured follow-up and legally supported interventions (such as CTOs) may be necessary to ensure safety, stability, and sustained recovery in the community.

59. Patients who have a history of non-concordance with prescribed medication are considered at higher risk of relapse, deterioration, and associated risks to self or others. Clinicians take this into account when planning discharge, risk management, and ongoing care.

60. There is an increased risk of relapse with social isolation. There is an increased risk of self-neglect, poor medication adherence, and delayed help-seeking during relapse. There is a risk of exacerbation of psychotic symptoms due to lack of structure, stimulation, and social reality testing.

61. Discharge planning must ensure robust social and community support, including structured follow-up by the EIP team or social care services.

62. Focus on rebuilding social networks through recovery colleges, peer support, or vocational programmes.

63. Incorporation of psychosocial interventions (e.g., social skills training, CBT for social anxiety) into care planning.

64. Ongoing monitoring to ensure the patient remains connected, engaged, and supported post-discharge.

65. For patients with a history of disengagement, discharge is only appropriate once sustained engagement, insight, and stability are demonstrated, and clear support and monitoring systems are in place.

66. For individuals with a history of masking psychotic symptoms, discharge planning requires evidence of sustained openness, consistency of presentation, and multi-source verification of stability. Ongoing community monitoring and therapeutic engagement are essential to reduce relapse risk and maintain safety.

Non-concordance and depot medication

67. Behaviours and/or observations that would lead me to conclude that a patient poses a risk of non-concordance with medication include:

    67.1. Expressed distrust or disbelief in diagnosis, for instance maintaining beliefs of "I don't think I'm ill," or "I don't need medication".

    67.2. Minimisation of symptoms or denial of previous episodes.

    67.3. Negative attitudes toward medication, such as fear of dependence or belief it is unnecessary.

    67.4. Complaints of side effects with reluctance to discuss or explore alternative options.

    67.5. Inconsistent medication-taking behaviour (e.g., missed doses, refusal,).

    67.6. Missed appointments with prescribing clinicians or refusal of medication reviews or blood tests.

68. Poor engagement with care coordination or therapy sessions.

69. Discarding or hoarding medication, suggesting covert non-adherence.

70. The following circumstances would be factors that would lead to a consideration as to whether a patient should receive their medication through DEPOT.

    70.1. Repeated failure to take oral medication as prescribed, despite support and psychoeducation.

    70.2. Relapses or hospital admissions following medication discontinuation.

    70.3. Denial of illness, poor insight, or ambivalence about the need for treatment.

    70.4. Chaotic lifestyle or cognitive difficulties making daily oral adherence unrealistic.

    70.5. Recurrent relapses resulting in harm to self or others when medication is stopped.

    70.6. History of aggression, violence, or self-neglect linked to non-adherence.

    70.7. Patients subject to a Community Treatment Order (CTO) where consistent treatment is legally required for risk management.

71. Depot medication is considered when a patient's past non-adherence or instability has resulted in serious self-harm, neglect, or violence during relapse. It is used to maintain treatment consistency, safeguard both the patient and the public, and support recovery in the least restrictive and most therapeutic manner possible.

72. Depot medication helps with medication concordance.

73. Depot helps with regular engagement with care coordinator.

74. Depot cannot be enforced in the community without a legal framework like CTO.

75. Depot helps to maintain recovery and thus in turn reduce the risk of harm to himself and others.

PART B: VALDO CALOCANE'S ("VC") TREATMENT

Pre-Home Visit

76. On 10th August 2021, I reviewed VC during a home visit. I do not recall having ever had any interaction with VC prior to 10th August 2021. The purpose of the visit was to review his mental health. *[NHFT0000168 p158-159].* After the home visit a follow up letter was sent to VC and his GP, to advise them of my findings, and plan, which included follow up for his GP. [WITN0325002]

77. On 10 August 2021, I was ST6 General Adult Psychiatry trainee (last year of higher training before becoming consultant). I believe that I had been working in the EIP service for less than a month, as the changeover for training rotations was on Wednesday, 4th of August 2021. As a trainee, I was working under supervision with Dr Tuhina Lloyd (Consultant Psychiatrist). I was working full time, and home visits to review a patient's mental health were a regular part of my role in the team. I think that I would have regular home visits every week. (I cannot recall exact numbers or frequency as no minimum or maximum numbers were in my contract.)

78. The home visit on 10th August 2021 was my only interaction with VC, and unfortunately, I do not recall the interaction. Therefore, the remainder of this statement is based on my usual practice, and what is recorded in the Trust's electronic notes ("**RiO**").

79. An entry dated 9th August 2021 at 8:53am in VC's RiO [NHFT0000168 at p.157] by Dr. Tuhina Lloyd states: *"[VC] did not attend his clinic appointment at*

noon today. His CPN feels he might be relapsing so she will book him in for a home visit with my ST6 Sasitha."

80. I cannot recall how this task was relayed to me. As Dr Lloyd and I shared a room, she would sometimes just tell me verbally or let me know after an MDT that there was an urgent visit I needed to complete that day. For other pre-booked visits, the secretaries would place it in my diary. The fact that I visited the next day does not necessarily reflect a particular urgency, it may have been that the following day happened to be my home visit day, and I had availability. The fact that he was not seen until the following day suggests to me that he was not in crisis and in need of same day attention.

81. In the EIP setting, the frequency of psychiatric contact was dynamic and needs-led, increasing during acute phases and reducing gradually as recovery progressed. This flexible approach supported early detection of relapse, effective medication management, and collaborative recovery planning with the wider multidisciplinary team (MDT).

82. My usual practice is to review all relevant documents available on Rio before seeing a patient, however I cannot recollect the specific incident. I usually check the notes and find out about the patient, about their past history, about what medication that they are on, and how they have been doing until the day that I go and see them. I would usually check the Progress Notes (the running record of interactions with the patient), discharge summaries, summary and care plan documents, risk and safety assessments, and Mental Health Act assessments. I would usually spend about half an hour reviewing a patient's notes, seeking to cover their full history to get an overall idea of what was going on, but also paying closer attention to the most recent entries to see what has been going on in the last few days.

83. I cannot recollect speaking to VC's nearest relative, but it was recorded in my notes following the home visit that VC had told me that he is in close contact with his mum. He speaks to her over the phone regularly and that She had not raised any concerns about his mental health.

84. My usual practice is to discuss with care-coordinator before reviewing a patient. It is recorded in my notes that I visited VC along with the care coordinator.

85. I cannot recollect my meeting with VC, so cannot say what steps I took to ensure that my understanding of the background to VC's admissions was accurate and up to date. It is my usual practice to go through all the available relevant notes before my visit or clinic review.

86. My understanding is that it is the responsibility of everyone involved in his care to ensure that VC's MDT had an accurate and up to date understanding of his psychiatric and forensic history.

87. I have set out my understanding of the following incidents prior to reviewing VC on 10th August 2021:

87.1. VC's first arrest on 24 May 2020- I have no recollection of whether I knew this before reviewing VC. However, on reviewing the RIO notes for the purpose of drafting this statement, I can see that VC was arrested by police for criminal damage as he kicked his neighbour's door [*NHFT0000168 p 2*].

87.2. VC's second arrest on 24 May 2020- I have no recollection. of whether I knew this before reviewing VC. However, on reviewing the RIO

notes for the purpose of drafting this statement, I can see that VC was arrested for smashing his neighbour's door. The neighbour was reported to be fearful of her life and jumped from the first-floor window. [*NHFT0000168 p 3*].

87.3. VC was detained at 136 suite by the police on 13 July 2020- I have no recollection of whether I knew this before reviewing VC. However, on reviewing the RIO notes for the purpose of drafting this statement, I can see that The Police were contacted by residents of a flat near to Valdo's. Valdo had been banging on the door and when someone opened it, he immediately forced his way in, attempting to push past the resident. He was restrained on the floor by a number of residents until Police arrived. This is mentioned in the progress notes in Rio.

87.4. Whether or not VC had a history of acting aggressively and/or violently - I have no recollection of whether I knew this before reviewing VC. However, on reviewing the RIO notes for the purpose of drafting this statement, I can see that VC can be aggressive when he is acutely unwell with psychotic symptoms. This is mentioned in the progress notes in Rio as above.

88. I cannot comment on what my understanding was of the risks associated with VC's condition and presentation was at the time as I have no recollection of reviewing him.

89. In my day-to-day practice, I do read all the relevant notes before seeing a patient. Following review, I record my notes which includes risk assessment undertaken during my review.

90. As I cannot recollect reviewing VC, I cannot say what my understanding was of the reason why I was asked to undertake a home visit, nor what issues I understood were being raised in respect of VC and by whom. However, as per RIO notes on the 9th of August 2021, his CPN was worried about relapse of his mental health problems as he did not attend his clinic appointment with Dr

Tuhina Lloyd on 9th August 2021 [NHFT0000168 p157]. Hence a home visit was arranged with me on 10th August 2021.

Home Visit 10 August 2021

91. I attended the home visit with VC's CPN Claudia Birtles (Care coordinator), who was someone who knew VC already. I would have discussed with her VC's diagnosis, the reason for seeing him, what medication he was on, and what were his risks.

92. I would have made some handwritten notes during the review and then typed my entry onto RiO following the visit, as set out at [NHFT0000168 p158 – 160]. All references to my entry on RiO relate to those pages. .

Medication

93. In relation to medication, I recorded that "*He reported that he is compliant with his medications and no side effects reported*". When people say that they are complying with medication, we tend to trust what they are saying unless they show signs otherwise, for example symptoms such as signs of relapse, like if they are agitated or aggressive, if they are not looking after themselves, they are not functioning well or they're neglecting the personal hygiene, or they're not sleeping".

94. As per my RIO notes:

"Valdo reported that he has been doing fine. He spends time by going to work and engaging in studies. He works in a warehouse which is going well. The workplace has not raised any concerns about his mental health. He is able to concentrate alright. He continues to enjoy watching movies. He has been eating alright. He has been sleeping alright. He is planning to return to university from October which he is looking forward to. He feels hopeful

towards future. He denied active suicidal thoughts or plans. He denied active thoughts of harm to others. On asking about voices, he reported that they have become faint, and he is no longer distressed by it. He last heard voice was few weeks ago. He denied having any delusional thoughts".

95. Based on the above VC was functioning well. There was no agitation or aggression during the review. He was hopeful towards his future. He was not acutely unwell. There were some residual psychotic symptoms like hearing voices however he reported the voices have become faint and he is no longer distressed by it. He was not seen responding to any unseen stimuli during the entire interview. He did not express any delusional thoughts. Although he had some residual psychotic symptoms like hallucination, they were not affecting him. He was able to function well, and he was no longer distressed by it. It is worth noting that a lot of patients that we see have residual psychotic symptoms, that they can cope with.

96. He was willing to continue to take oral medication. He reported good compliance with medication. There was no reason to suspect non-compliance with medication at the time of the review.

Insight

97. I have recorded in the RIO notes that "*he reported that he does not believe he has mental health problems however he is happy to follow medical advice. He is willing to continue to take medication*". VC had therefore acknowledged to me that he was still hearing voices, but he was also denying that he had mental health problems. His insight into his mental health was therefore limited. This is a concern because there is a risk of non-compliance with medication in people who have limited insight (however, we also see patients with limited insight who say that they don't believe in mental health illness, but they are happy to continue to take medication).

98. However, during my review, there was no reason to doubt his medication compliance, VC was functioning well, showed no agitation or aggression, and

was not seen responding to unseen stimuli during the interview. He did not express delusional thoughts or thoughts of harm to himself or others.

99. Therefore, the plan was to continue to monitor his mental health by EIP and to encourage him to have psychotherapy to improve his insight. The only way that we can monitor someone in VC's position (informal patient in the community without CTO) is to continue to monitor his mental health by EIP to see whether there were any signs of relapse. If there had been, at that point we would involve the crisis team. At the stage that I saw VC; there was no indication that we needed to involve the crisis team.

100. Later on in the entry, I have also recorded that "*We discussed about the importance of compliance with medication to prevent a relapse, which he agreed.*"

Police involvement

101. As set out above, I have no recollection of what I knew about VC's past forensic history at the time I conducted the home visit, but I would have read his records and discussed him with the CPN before the visit. From reading the notes in preparation for this witness statement, my understanding is that he was offered a conditional caution for damaging neighbour's door. I have recorded following my review with VC on 10 August 2021 that he declined the offer of a conditional caution. VC said that he has been offered few sessions as part of the programme, but he did not want to do this. This was discussed with his solicitor and police. VC is aware that this could potentially lead to a criminal record. VC wants to contest the case in court. I cannot recall anything further than what is recorded in this entry.

Mental State Examination.

102. I have recorded the findings of my Mental State Examination of VC as follows:

"MSE- He was casually dressed and well kempt. He initially did not agree for the assessment as he reported speaking to someone on phone. However, he agreed when we offered, we are happy to wait for him to finish his conversation. He made good eye contact. There was no agitation or aggression. His speech was normal in rate, tone and volume. There was no flight of ideas. His mood was subjectively and objectively euthymic. There was no formal thought disorder. The voices have become faint, and he is no longer distressed by it. He was not seen responding to unseen stimuli. He denied active suicidal thoughts or plans. He denied active thoughts of harm to others. He was oriented to time, place and person. He reported that he does not believe that he has mental health problems however he is happy to follow medical advice. He is willing to continue to take medication."

103. "Flight of ideas" is where people are acutely unwell, they will jump from one subject to another and their thoughts will not be coherent. In VC's case, he was coherent, and he was able to hold a conversation with me.

104. Overall, this Mental State Examination shows that whilst he had some residual psychotic symptoms, he is no longer distressed by the voices and is experiencing no delusional thoughts. He is functioning well, and he is not acutely unwell, although he has limited insight.

105. In relation to whether VC could have been masking psychotic symptoms. It is a challenging question as I have no recollection of the assessment. My Rio entry does not indicate that there was any evidence of masking of his symptoms during this review. He seemed stable on oral medications.

106. I have recorded that my overall impression was that: "his mental health has remained stable".

107. As set out above, he was functioning well. There was no agitation or aggression during the review. He was hopeful towards his future. He reported sleeping well. He reported eating alright. He was not acutely unwell. There were some residual psychotic symptoms like hearing voices however he

reported the voices have become faint and he is no longer distressed by it. He was not seen responding to an unseen stimulus during the entire interview. He did not express any delusional thoughts. Although his insight was limited, he was willing to continue to take oral medication. He reported good compliance with medication. There was no reason to suspect non-compliance with medication at the time of the review.

Risk Assessment.

108. I have recorded under "risks" :

> "Risks- Risk of ending life is low as he denied active suicidal thoughts or plans, feels hopeful towards future and he is willing to engage with mental health services.
>
> He denied active thoughts of harm to others."

109. I came to this conclusion because VC was not aggressive. He was not agitated. He engaged well with the interview, and he was not acutely unwell. He was looking forward towards future. He denied any thoughts of harm to himself or others, and he was not seen responding to unseen stimuli, although he has limited insight, he was willing to continue to take medication. There was no reason for me to suspect that he had thoughts of harming others.

110. As per my RIO notes, there was no reason to suspect non-compliance with medication. He was functioning well. He was not acutely unwell during my visit. I would have come to this conclusion as I had visited VC along with the care coordinator who is aware of his baseline presentation and after assessment agreed that his condition was stable.

Plan

111. The plan made was to continue to monitor his mental health by EIP and to encourage him to engage with psychotherapist to improve insight.

112. I have recorded in the notes and set out in the letter to VC and his GP:

"Plan- No change in medication.

He will continue to get support from EIP.

To encourage him to consider psychotherapy to improve his insight about his illness.

Please could GP monitor his bloods and ECG as part of annual physical health monitoring for patients who are on antipsychotics."

113. The first two points were to continue the existing plan: there had been no indication to change medication, and it was necessary for EIP support to continue so that VC's CPN could continue to monitor his mental state to see if there were any signs of relapse. I added in about psychotherapy due to his comments about not believing that he had a mental illness. I believe I would have asked his CPN, who was with me at the visit, to take this forward. The GP monitoring of VC's physical health is something that is required in all patients who are on antipsychotic medication.

Diagnosis

114. At the beginning of my RiO entry for this home visit, I have stated "Diagnosis: First Episode Psychosis". This diagnosis was already in his notes and was maintained while he was still under the care of EIP for the same reason as per previous Rio entries on 15/03/2021 (page 148 of NHFT000168) and entry on 01/04/2021 (p 145/146). First Episode psychosis diagnosis will be given to those patients who develops psychotic symptoms for first time in their life. They will be referred to EIP and assess their psychopathology during their stay with EIP. This allows EIP to make a definite diagnosis before they get discharged from EIP. My understanding is that VC never had mental health problems prior to 2020. Hence, he was given a diagnosis of First Episode Psychosis under EIP care.

115. I understand that VC's Discharge Summary by his inpatient consultant records that VC had paranoid schizophrenia [NHFT0000222]. The diagnosis of paranoid schizophrenia would not have made a difference to his treatment as he was on oral antipsychotic which is also the treatment for schizophrenia.

Post-Visit

116. After the visit, I added my entry to RiO, as above, the entry would have been considered within the review of his care and treatment plans.

117. I usually discuss with supervising consultant after seeing a complicated patient especially as this was allocated to me by Dr Lloyd. However, I cannot recollect what I have discussed. I cannot recollect attending MDT meetings in respect of VC following this review.

118. I have no recollection of seeing VC again and there is no evidence on Rio notes given to me about further review by me.

119. During my consultation, I have taken into consideration his history of aggression, violence and risk of masking psychotic symptoms and lack of insight. Given his stable condition at that time as he was functioning well, no acute interventions or changes were felt necessary. However, given his history of lack of insight, plan was made to continue to monitor his mental state by EIP and to encourage him to attend psychotherapy to improve his insight.

120. I have not given any interviews or made any public comments related to VC.

121. *I* have not been involved in the care of another patient who has killed or seriously injured a member of the public.

Recommendations

122. I would recommend that adequate risk assessment training for all the clinicians working in mental health team is provided.

123. I consider that improved Communication and Information Sharing within local teams would be beneficial. Further adequate risk assessment training for all the clinicians working in mental health team.

124. Nationally consider that the National Training and Competency Standards should be improved.

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: 02/12/2025

Index to First Witness Statement of Dr. Sasitha Sasidharan

No.	URN	Document Description
1.	NHFT0000460	Early intervention in Psychosis Service Operational Policy
2.	*NHFT0000168*	Medical Records of VC from 24/05/2020 to 14/06/2023, Various NHFT Staff/Teams, re: Patient Record Summary
3.	NHFT0000222	Discharge Summary
4.	WITN0325002	Letter to GP Dated 15 October 2021