THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DR AUSTIN NWAWUEZE

I, **Dr Austin Nwawueze,** of West Park Hospital, Edward Pease Way, Darlington DL2 2TS, will state as follows:

INTRODUCTION

1. I am a Locum Consultant Psychiatrist currently working at West Park Hospital, Darlington, part of the Tees Esk and Wear Valleys NHS Foundation Trust. I have held this post since February 2025.

2. I am approved for the purpose of Section 12 (2) of the Mental Health Act of 1983.

3. I have been a qualified medical practitioner since 2011, when I graduated with MBBCh from University of Calabar, Nigeria. Upon graduation in 2011, I did my compulsory 1 year internship in a private hospital in Lagos Nigeria, where I had the opportunity to work under the supervision of a professor of Psychiatry, which broadened my interest and desire to know more about the specialty and consider a career in psychiatry during my post graduate years.

4. Between 2012 – 2019, this passion remained unfulfilled whilst I continued working as a medical officer in emergency and occupational medicine in Nigeria, I continued to nurse a desire for supporting people with mental health needs and difficulties.

5. Following migration to England in winter of 2019, I decided that I would chase my dream of a career in Psychiatry. I was very interested in the safeguards that applied to the practice of Psychiatry in the UK as this was very different to the situation in my home country Nigeria.

6. My first hand experience of Psychiatry came in March 2020 when I began working as a specialty doctor in the independent sector (Cygnet Healthcare) working directly under the supervision of two Consultant Psychiatrists (Dr Kalina Shoilekova and Dr Gbolagade Akintomide) working into an Acute Mental Health ward as well as a Psychiatric Intensive Care Unit ('PICU').

7. I left Cygnet Health care in November 2023, deciding to work as a locum for the NHS, I worked as a specialty doctor for Navigo Health and Social Care CIC (Community Interest Company) in Grimsby between November – December 2023 before joining Tees Esk and Wear Valley NHS Foundation Trust as a specialty doctor from December 2023 – March 2024. I then took up a post as an Associate Specialist for the States of Guernsey from April – July 2024. Upon obtaining my section 12 approval in June 2024, I returned to the UK in a Locum Consultant Psychiatrist role for Cornwall Partnership NHS Foundation Trust from July 2024 – December 2024. I then returned to Tees, Esk and Wear Valleys NHS Foundation Trust in December 2024 as a Locum Consultant Psychiatrist at Roseberry Park Hospital before being transferred to West Park Hospital, my current role.

8. I obtained my membership of the Royal College of Psychiatrists in September 2024.

9. I make this statement following a request for a witness statement by the Nottingham Inquiry, by letter dated 1 October 2025. I understand that the Nottingham Inquiry's terms of reference are to investigate the circumstances that led to Valdo Calocane ('VC') killing three people and seriously injuring three others on 13 June 2023. The Inquiry requires me to produce a witness statement, setting out my involvement in VC's treatment, along with the matters referred to in the Annex to the Inquiry's letter dated 1 October 2025.

10. At the time that VC was admitted to Cygnet Victoria House between 11 September 2021 and 01 October 2021, I worked as a Specialty doctor covering both the acute and PICU male wards along with my Specialty Doctor colleague, Dr Tania Engel.

11. The facts and matters set out in this statement are within my own knowledge, unless otherwise stated, and I believe them to be true. Where necessary I have

referred to those records made by myself and others which form part of the medical records for VC. Where I refer to my own notes I do so on the basis that they were made contemporaneously with the events I describe. Where I refer to records made by others, I do so on the basis that I would have referred to the relevant records as is my usual practice, whenever I had any clinical involvement with VC. Where I refer to information supplied by others, the source of the information is identified; facts and matters derived from other sources are true to the best of my knowledge and belief.

12. At the outset I wish to convey my sympathy to all those affected by the tragic events of 13 June 2023, and my sincere condolences to the families and loved ones of those who lost their lives.

INPATIENT MENTAL HEALTH SERVICES

13. At the time that VC was admitted to Cygnet Victoria House on 11 September 2021, I was a Specialty Doctor. I note from the records that I met VC on one occasion during a ward round on 28 September 2021, chaired by VC's Responsible Clinicians ('RC') Dr Kalina Shoilekova. Whilst I cannot recall, I was probably providing cover for VC's assigned Specialty Doctor, Dr Tania Engel.

14. To provide more context, when I worked at Victoria House, we had patients under teams which meant that they had a particular Specialty Doctor overseeing their care under the guidance of a Consultant Psychiatrist/RC. In this case, VC was under Dr Tania Engel's team supervised by the RC, Dr Kalina Shoilekova (Consultant Psychiatrist). In the circumstances both Dr Engel and Dr Shoilekova would be better placed to address appraisal of processes and risk formulations regarding VC as he was in their team and my involvement was limited to attending one ward round.

15. I consider that the broad clinical aim of providing treatment in an acute mental health unit is to stabilise individuals experiencing acute episodes of mental illness, such as psychosis, mania, or severe depression; by the timely administration of evidence-based interventions, including pharmacological treatment and

psychological support. Risk management is a central component, ensuring the safety of both the patient and others through structured clinical observation and risk assessments. Comprehensive biopsychosocial assessments are conducted to inform diagnosis and guide treatment planning. Therapeutic engagement should be initiated early, with a focus on building rapport and delivering interventions that support recovery. Care is ideally recovery-oriented, aiming to promote autonomy and facilitate reintegration into the community. Discharge planning begins at the onset of admission, ensuring continuity of care and support post-discharge. These aims are supported by NHS England guidance [URN NHSE0000515], NICE condition-specific guidelines [URN, NHSE0000539], and the Royal College of Psychiatrists' standards for inpatient care [URN, NHSE0002308], which emphasise personalised, least restrictive, and therapeutic approaches.

16. In relation to a PICU, the clinical focus is on managing patients who present with high levels of risk due to behaviours such as aggression, self-harm, or severe psychotic symptoms. The aim is to provide intensive supervision and rapid stabilisation through enhanced therapeutic input. Care is delivered by a multidisciplinary team, including psychiatry, nursing, psychology, occupational therapy, and social work, ensuring a holistic approach to treatment. PICU admissions are typically short-term, with the goal of returning patients to less restrictive environments as soon as clinically appropriate. Patient and carer involvement in care planning is actively encouraged to support recovery and empowerment. The Royal College of Psychiatrists' PICU standards and the National Association of Psychiatric Intensive Care Units (NAPICU) guidelines provide a framework for best practice, outlining criteria for admission, care planning, physical healthcare, and safeguarding. These standards ensure that care in PICUs remains therapeutic, recovery-focused, and proportionate to the level of clinical need.

17. The overarching clinical aim for patients detained under the Mental Health Act 1983 is to provide lawful, necessary, and proportionate treatment that addresses the risks posed to the individual or others. Treatment must be delivered in accordance with the principles outlined in the Mental Health Act Code of Practice (2015), which emphasises dignity, least restriction, and patient empowerment. Clinicians must

ensure that patients' rights are upheld, including access to advocacy services and legal recourse through tribunals. Therapeutic interventions should be evidence-based and aimed at recovery and rehabilitation, with a focus on enabling patients to regain autonomy and prepare for discharge. The use of the least restrictive options is a legal and ethical imperative, and Section 17 leave is utilised as part of the rehabilitation process, not as a suspension of detention. NICE Guideline CG136 [URN, NHSE0002386] on service user experience and the Care Quality Commission's regulatory standards further reinforce the importance of patient-centred, rights-based care in this context.

18. Based on my understanding, working knowledge from my time at Cygnet between March 2020 and November 2023, and the policies provided by Cygnet Health Care in preparation of my report for this inquiry - specifically the Transfer and Discharge Policy (CYGN0000112), Individual Risk Assessment and Management Policy (CYGN0000114), and Family and Carer Involvement Policy (CYGN0000117), Cygnet's inpatient services are designed to support individuals experiencing acute or severe mental health crises through structured, multidisciplinary care. These services aim to stabilise mental health symptoms, manage risk, and facilitate recovery and reintegration into the community. The approach is expected to be person-centred and includes comprehensive risk assessments, collaborative care planning, and early discharge preparation. Family and carers are actively involved in the care process, subject to the individual's consent and capacity.

19. For individuals detained under Section 2 of the Mental Health Act 1983, my understanding is that Cygnet provides care focused on assessment and initial treatment over a period of up to 28 days. Upon admission, a multidisciplinary team conducts a thorough risk assessment using tools such as the Daily Risk Assessment (DRA), Short-Term Assessment of Risk and Treatability (START), or PICU and Acute Risk Assessment (PARA), depending on the service type. These assessments inform observation levels and therapeutic interventions. A care plan is developed collaboratively with the individual, and where consent is given, carers are invited to participate in ward rounds and multidisciplinary team meetings. Discharge planning begins early, and if the nearest relative requests discharge, Cygnet follows the statutory 72-hour notice procedure, during which the

Responsible Clinician may issue a barring report if discharge is deemed unsafe. All decisions are expected to be documented in accordance with Cygnet's records and Mental Health Act policies.

20. For individuals detained under Section 3 of the Mental Health Act, which allows for treatment for up to six months, my understanding is that Cygnet's procedures include risk assessments being regularly updated which inform ongoing care planning and leave arrangements. The multidisciplinary team plays a central role in delivering care, with regular CPA meetings held to review progress and assess readiness for discharge. Carers are considered integral to the care team and are involved in planning, service audits, and satisfaction surveys. Discharge under Section 3 requires a CPA review and a thorough risk assessment. The RC must be satisfied that discharge is safe, and Section 117 aftercare planning is coordinated with community services. If the nearest relative requests discharge, Cygnet follows the legal process, including issuing a barring report if necessary, i.e. if the dangerousness criteria are satisfied, and informs the relative of their right to appeal to the First-tier Tribunal. Upon discharge, a two-week supply of medication is generally provided (based on the individual risks especially as it pertains to risk history of significant overdoses on prescribed medications), and contingency plans are established to manage potential relapse.

21. In my opinion, Cygnet's procedures align with statutory guidance and best practice standards, including the Mental Health Act Code of Practice, NICE guidelines (such as NG53 on transitions between inpatient and community settings), and Department of Health guidance on risk management. The policies also reflect the principles of the Care Programme Approach and Care and Treatment Plan frameworks, and uphold standards set by regulatory bodies such as the Care Quality Commission (CQC) and Healthcare Inspectorate Wales (HIW).

22. Based on my understanding and the Cygnet policies referenced at paragraph 18 above, the relationship between inpatient services at Cygnet Victoria House and other mental health services or agencies is collaborative, structured, and governed by statutory frameworks such as the Mental Health Act and the Care Programme Approach (CPA). Cygnet Victoria House works closely with NHS hospitals and

other independent healthcare providers to ensure continuity of care, safe transitions, and effective discharge planning. Transfers between units, whether NHS or independent, are ideally planned and discussed in CPA or Care and Treatment Plan (CTP) review meetings. These meetings involve the individual, carers, advocates, funding authorities, and multidisciplinary clinical teams. When transferring detained individuals, Cygnet ensures that all legal documentation under the Mental Health Act is properly scrutinised and accepted by the receiving provider. The RC at the originating hospital usually retains oversight unless a formal discharge and reassignment of responsibility occurs.

23. I understand that the treatment and management provided by Cygnet Victoria House differs from other services in several ways. As an independent provider, Cygnet offers structured inpatient care with a strong emphasis on risk assessment, multidisciplinary collaboration, and family involvement. Cygnet's model includes tools such as the Daily Risk Assessment (DRA), START, and PARA to monitor and manage risk dynamically. Other independent providers may follow similar models but vary in their use of specific tools and frameworks. Crisis Resolution Teams (CRTs) operate in the community and aim to prevent hospital admissions by providing intensive home-based support during acute episodes. Community Mental Health Teams (CMHTs), on the other hand, provide longer-term support, care coordination, and follow-up for individuals with enduring mental health needs. These teams are essential in post-discharge care and in fulfilling Section 117 aftercare obligations. In contrast, inpatient services like those at Cygnet Victoria House focus on stabilisation, risk containment, and therapeutic engagement during acute phases. The inpatient setting allows for close monitoring, structured interventions, and rapid response to deterioration, which community teams are not routinely structured to provide.

24. A PICU, such as Albert Ward at Victoria House provides short-term, highly supervised care for individuals who pose a significant risk to themselves or others due to severe mental illness. PICUs are designed for patients who cannot be safely managed in general acute wards due to behaviours such as aggression, self-harm, or extreme distress. The environment is more secure, and staffing levels are higher to allow for intensive therapeutic input and close observation. In contrast, acute

mental health units cater to individuals experiencing crises that require inpatient care but who do not need the level of containment provided by a PICU. Acute units focus on assessment, initial treatment, and recovery planning, with the aim of discharging patients to community services as soon as clinically appropriate.

25. Inpatient service providers, including independent providers like Cygnet, play a central role in the CPA. They are responsible for initiating and coordinating CPA meetings, ensuring that care plans are developed collaboratively, and that all relevant parties—including the individual, carers, community teams, and funding authorities—are involved. Cygnet's policies emphasise early discharge planning, comprehensive documentation, and the identification of aftercare needs under Section 117 of the Mental Health Act. Independent providers are expected to uphold the same standards as NHS services in implementing the CPA, including risk assessments, care coordination, and communication with external agencies. They also have a duty to ensure that transitions between services are safe, well-documented, and legally compliant.

Treatment, care and management of patients experiencing psychosis

26. In relation to risk assessments, I note that Cygnet has the Individual Risk Assessment and Management policy (CYGN0000114), which sets out the approach to risk assessments for inpatients, including those experiencing psychosis, and is expected to be comprehensive and structured focussing on safety, therapeutic engagement, and recovery.

27. The aim of conducting risk assessments is to enable staff to make informed clinical judgments that protect both the individual and the public. These assessments are designed to identify potential harmful events, evaluate their likelihood and impact/severity, and guide the development of care plans that reduce and manage these risks effectively. They also support safer working practices and improve clinical outcomes by informing appropriate interventions.

28. Risk assessments are conducted for every service user upon admission and are reviewed regularly throughout their stay. They are also updated following significant changes in presentation, incidents, or at scheduled care plan reviews.

Additional assessments may be triggered by formulations, ward rounds, CPA meetings, or when there is a change in risk behaviour or mental state.

29. The process is multidisciplinary, involving input from the clinical team, including nurses, psychologists, occupational therapists, psychiatrists, and other relevant professionals. The individual receiving care is also involved wherever practicable, along with their family or carers. The process includes feedback from previous care providers, policing agencies and safeguarding professionals when necessary.

30. Risk assessments are reviewed at agreed timeframes, which vary depending on the service type and individual needs. For example, when I still worked in Cygnet in acute and PICU settings, tools like the PARA had target review periods of every two weeks (but often weekly during ward rounds) or following incidents. Daily Risk Assessments (DRAs) were completed every 24 hours to monitor immediate risks. START assessments were used in longer-term settings and reviewed periodically.

31. Assessments are conducted using structured tools such as the DRA, START, and PARA. These tools capture both immediate and historical risks. Immediate risks are assessed through daily monitoring of behaviours such as self-harm, aggression, self-care and engagement. Historical risks are considered through structured judgment tools that evaluate patterns of behaviour, previous incidents, and underlying psychological mechanisms. The assessment includes identifying predisposing, precipitating, perpetuating, and protective factors. A formulation is developed to explain the individual's risk profile and guide the care plan.

32. A risk reduction plan is a component of the individual's care or support plan that aims to change the balance between risk and safety. It is informed by the risk assessment and reflects the individual's current presentation. The plan includes strategies to mitigate identified risks, promote recovery, and support positive risk-taking. It is formulated collaboratively with the individual and the clinical team, considering the person's capacity, strengths, and preferences. The plan also includes contingency measures and crisis planning to address potential escalation of risk.

33. The aim and purpose of a care plan is to provide a structured, personalised framework for assessing, managing, and supporting an individual's mental health needs during inpatient treatment. The care plan is designed to ensure safety, promote recovery, and facilitate continuity of care across different stages of treatment, including discharge and community follow-up. The approach to formulating a care plan is usually determined by several factors such as the individual's diagnosis, current mental state, risk behaviours, history of engagement with services, and personal preferences. It incorporates both clinical observations and the patient's own views, such as his preference for oral medication over depot injections. The care plan also reflects multidisciplinary input, including nursing staff, the responsible clinician (RC), occupational therapists, psychologists and the wider MDT including their community teams where applicable.

34. Care plans are reviewed regularly to ensure they remain responsive to the patient's evolving needs. This ensures that the care plan remains dynamic and clinically relevant.

35. The scope of a care plan is broad and would normally include risk management strategies, treatment and medication plans, physical health care, occupational therapy, legal status under the Mental Health Act, discharge planning, and contingency measures.

36. Where a patient has had multiple admissions, clinicians ensure that patterns in presentation and condition are captured by documenting historical behaviours and responses to previous treatment. This historical context informs current risk assessments and treatment strategies, allowing for a more tailored and anticipatory approach to care.

37. The relationship between inpatient care planning and care planning following step-down or discharge is one of continuity and coordination. The discharge plan includes goals for stabilisation, medication compliance, and engagement with ward rounds. It also involves inviting the community care coordinator/key worker or their designated nominee to participate in discharge planning, ensuring that the transition to community services is smooth and that aftercare needs are met. This reflects a collaborative approach between inpatient and community teams. Risk

assessments play a central role in the formulation and development of an inpatient's care plan which inform decisions about observation levels, medication strategies, leave permissions, and contingency planning. These assessments are regularly reviewed and integrated into the care plan to ensure that interventions remain proportionate and effective.

38. When reviewing risk assessments and care plans, the observations of nurses, healthcare assistants, and other staff are integral to the risk assessment and care planning process. Their input is actively incorporated into both the formulation and ongoing review of risk management strategies and care plans. Observations made by frontline staff are used to gather information about specific risk behaviours, changes in mental state, and other factors that may influence risk. These observations are essential for identifying early warning signs, evaluating the effectiveness of interventions, and informing decisions about observation levels, medication, and therapeutic engagement. Cygnet's Individual Risk Assessment and Management policy emphasises that care plans will be ineffective if observations and engagement do not take place effectively (CYGN0000114).

39. Staff observations are communicated during shift changes, ward rounds, and daily multidisciplinary team (MDT) meetings. This ensures that all relevant personnel are aware of current risk factors and can contribute to a shared understanding of the individual's presentation. The risk assessment and associated care plan are treated as a multidisciplinary task, reflecting the collective input of the team, including nurses, support workers, and clinicians. Tools such as the Daily Risk Assessment (DRA) were used to capture and record staff observations in a structured format. These tools would allow for visibility of decision-making and help determine the daily management plan for everyone. The DRA, for example, included categories such as self-harm, aggression, physical health, and engagement, all of which rely on staff observations to assess risk levels (CYGN0000114).

40. Prior to a patient being stepped down from PICU to an acute mental health unit, several clinical and medical treatments must be carried out to ensure the patient is stable and safe for transfer. These treatments are particularly focused on managing psychosis and associated risks. The patient must be stabilised through

appropriate pharmacological treatment aimed at reducing psychotic symptoms and ensuring the patient is not a risk to themselves or others. Behavioural and risk management strategies must be implemented and monitored. This dynamic monitoring ensures that any deterioration in mental state is promptly addressed. Physical health monitoring is a critical component of treatment. These measures help detect any adverse effects of medication and ensure overall physical wellbeing. Additionally, psychological and occupational therapy support is provided to promote engagement and recovery usually tailored to the nature and/or degree of the mental disorder. This helps assess functional abilities and readiness for step-down care. Finally, discharge planning and multidisciplinary coordination are essential

41. Based on Cygnet's 'Individual Risk Assessment and Management' [CYGN0000114], transitioning a patient experiencing psychosis from a PICU to an acute mental health unit requires careful clinical judgment, informed by structured risk assessments, behavioural observations, and multidisciplinary input.

42. Before a patient is considered ready for step-down, they must demonstrate a reduction in acute risk behaviours, such as aggression or self-harm, and show signs of stabilisation in their mental state. This includes improved engagement with treatment, particularly medication compliance, and the presence of protective factors such as therapeutic relationships and responsiveness to interventions. These indicators are assessed using tools like the Daily Risk Assessment (DRA), the PARA tool, and the START framework, which evaluate both current and historical risks and help inform care planning.

43. For patients with a history of aggression in the community or inpatient settings, transition is only considered when aggression has subsided, and the patient has shown consistent behavioural improvement. Protective factors must be in place, and the individual may demonstrate some degree of insight and cooperation with staff. Observation levels may be gradually reduced if no incidents occur.

44. Patients who are considered at risk of becoming violent in the absence of treatment require sustained compliance with their treatment plan and a reduction in risk

behaviours. Risk assessments must confirm that the likelihood of violence is low under current conditions, and contingency plans must be in place to manage any future relapse or disengagement.

45. For individuals with a history of violence, the decision to step down requires a detailed formulation that considers predisposing, precipitating, and perpetuating factors. Transition is appropriate only when the individual is no longer considered high risk and there is clear evidence of behavioural change and therapeutic engagement.

46. Patients with a history of non-concordance with medication should demonstrate adherence to their prescribed regimen and a willingness to engage with clinical staff. The care plan should include strategies to manage future non-compliance, and the patient's response to medication must be monitored closely.

47. For those with a history of social isolation, indicators such as increased engagement with staff, participation in structured activities, and involvement in occupational therapy are important. Transition is considered when the patient begins to interact meaningfully with others and shows signs of reintegration.

48. Patients with a history of disengagement from treatment require consistent participation in ward rounds, therapy sessions, and care planning. Risk assessments should reflect improved collaboration and reduced resistance to treatment.

49. Finally, individuals with a history of masking psychotic symptoms require careful observation and repeated assessments to ensure their presentation is authentic. Collaboration with community teams and families is essential. Clinicians must be confident that the patient is not concealing symptoms that could lead to deterioration. Transition is only appropriate when the risk of concealed symptoms is low and the patient has demonstrated transparency and stability.

50. The decision to transition from PICU to an acute unit must be defensible, collaborative, and based on a shared understanding of risk. It must be documented thoroughly, communicated across the multidisciplinary team, and supported by a robust care and risk management plan.

51. Each of the factors to consider prior to step down discussed above pose distinct risks that must be carefully evaluated before transitioning a patient experiencing psychosis from a PICU to an acute mental health unit.

52. A history of aggression in the community or inpatient settings presents a risk of harm to others, particularly if the aggression is linked to untreated psychotic symptoms or poor impulse control. Such individuals may require enhanced observation and structured interventions to prevent escalation. If aggression re-emerges in a less secure setting, it could compromise the safety of staff and other patients.

53. Patients who are considered at risk of becoming violent in the absence of treatment pose a significant challenge. The risk here is that any lapse in medication adherence or therapeutic engagement could lead to rapid deterioration and potentially dangerous behaviour. These individuals require robust care plans with contingency measures and close monitoring to ensure treatment continuity.

54. A history of violence, especially if linked to psychosis, increases the likelihood of recurrence under stress or during relapse. This risk must be mitigated through detailed formulations that identify triggers and protective factors. Without adequate safeguards, stepping down such patients prematurely could result in serious incidents.

55. There are several types of behaviours and observations that may indicate a patient remains a risk to themselves or others and therefore should not be transitioned to an acute mental health unit or considered for discharge. A very important one being the presence of persistent or escalating aggression, whether verbal or physical, directed at staff, other patients, or themselves. If a patient continues to exhibit threatening behaviour or has recently been involved in incidents requiring restraint or rapid tranquilisation, this suggests that their risk level remains high and they may require continued intensive supervision.

56. Another concern is non-compliance with medication, particularly if the patient has a history of refusing treatment and/or lacks insight into their condition. If the patient is not reliably taking prescribed medication and there is evidence of deterioration

in their mental state such as increased paranoia, hallucinations, or disorganised thinking, this would be a strong reason to delay transition or discharge.

57. Disengagement from care planning or therapeutic activities is also a significant risk factor. If the patient is unwilling or unable to participate in ward rounds, one-to-one sessions, or occupational therapy, it may indicate poor insight, low motivation, or unresolved symptoms. This disengagement can lead to relapse or increased risk behaviours if the patient is moved to a less intensive setting. Social withdrawal or isolation, especially if it is accompanied by suspiciousness or avoidance of staff, may suggest that the patient is still experiencing psychotic symptoms. If the patient is not interacting appropriately with others or is unable to maintain basic routines, this could compromise their safety and wellbeing in a less structured environment.

58. Masking of symptoms is another critical factor when considering step down. If staff suspect that the patient is concealing psychotic experiences such as hallucinations or delusional beliefs, this may undermine the reliability of clinical assessments. Without a clear understanding of the patient's mental state, it is unsafe to reduce the level of care. Additionally, lack of identified protective factors, such as therapeutic relationships, family support, or coping strategies, increases the risk of relapse or harm. If the patient does not have a stable discharge plan or community support in place, they may struggle to maintain progress following discharge.

59. Based on the Cygnet policies, 'Transfer and discharge' (CYGN0000112), Notification of Discharge/Transfer (CYGN0000015) and Discharge Summary ("CYGN0000112) and my own experience, I would expect a comprehensive set of information is provided to the receiving acute mental health unit when a patient is transferred. This ensures continuity of care, risk management, and informed clinical decision-making.

60. The discharge documentation would usually include full patient identification details such as name, date of birth, NHS number, date of admission and discharge, and the patient's legal status under the Mental Health Act. It also specifies the RC and the referring doctor, which helps the receiving team understand the legal and clinical context of the transfer. A diagnosis (working or confirmed diagnosis) is

required along with a summary of the patient's mental state examination at discharge. This includes observations on self-care, affect, insight, and the presence or absence of psychotic symptoms.

61. Detailed risk assessments including both historical and current risks with specific details should be provided to help the acute unit prepare appropriate safety measures. Medication details should be clearly outlined, including regular prescriptions and PRN medications with dosages; addressing the patient's history of non-compliance, current compliance status, and any refusal of depot injections. This information is critical for maintaining treatment continuity and managing future risks. Physical health status is usually included, with ECG results, NEWS scores, and full blood chemistry and endocrine profiles. This ensures the receiving unit is aware of any physical health concerns and can assess the patient's fitness to travel or tolerate ongoing treatment.

62. The discharge summary also provides a detailed psychiatric and social history, including the circumstances of admission, previous episodes, forensic history, and social background. This helps the acute unit understand the patient's broader context and tailor interventions accordingly.

63. Finally, the discharge plan includes the name and contact details of the receiving facility and care coordinator, along with a crisis contingency plan. Additional instructions are provided for the GP to continue monitoring the patient under NICE guidelines for psychotropic medication. Altogether, this information equips the acute mental health unit with a full clinical, legal, and psychosocial profile of the patient, enabling safe and effective continuation of care.

64. In the context of patients experiencing or with a history of psychosis, the following terms are commonly used in clinical assessments and care planning:
    - "Insight" refers to a patient's awareness and understanding of their mental health condition. It includes recognition that they are unwell, understanding the nature of their symptoms (such as hallucinations or delusions), and acknowledging the need for treatment. A lack of insight is common in psychosis and can lead to non-compliance with medication and disengagement from services.

- "Masking of symptoms" describes a situation where a patient attempts to conceal or downplay their psychotic experiences, either consciously or unconsciously. This can occur due to fear of stigma, mistrust of services, or a desire to avoid treatment. Masking can make it difficult for clinicians to accurately assess the patient's mental state and risk level and may result in premature discharge or inappropriate step-down in care.
- "Engaging on a needs-led basis" means that the patient interacts with staff or services only when they perceive a personal need, rather than participating consistently in therapeutic activities or care planning. This type of engagement may indicate limited insight, poor motivation, or residual symptoms, and can affect the reliability of clinical assessments.

65. To assess insight, clinicians rely on objective factors such as the patient's verbal statements, behaviour, and consistency in acknowledging their condition and treatment. Independent sources of information may include previous psychiatric records, input from family or carers, and observations from the multidisciplinary team. Insight is often assessed during mental state examinations and through structured interviews.

66. Determining whether a patient is masking symptoms involves careful observation over time, collateral information from previous care providers, and comparison between reported experiences and observed behaviours. For example, a patient who denies hallucinations but appears distracted or responds to unseen stimuli may be masking. Clinicians may also consider inconsistencies in the patient's narrative or reluctance to engage in discussions about their mental health.

67. When identifying the types of risks a patient might pose in the event of deterioration, relapse, or acute crisis, several aspects of their history are relevant. These include previous episodes of aggression or violence, history of self-harm or suicide attempts, patterns of non-compliance with medication, forensic history, and prior use of emergency interventions such as seclusion or restraint. Social factors such as isolation, lack of support, and disengagement from services also contribute to risk. Additionally, the nature and content of past psychotic symptoms such as

persecutory delusions or command hallucinations can help predict future risk behaviours.

68. Based on Cygnet's 'Transfer and Discharge' Policy (CYGN0000112), the formulation of a transition plan for a patient being transferred from PICU to an acute mental health unit is a structured, multidisciplinary process designed to ensure safety, continuity of care, and patient involvement. The transition plan is formulated during a CPA or CTP review meeting. This meeting is the central forum for discussing the transfer and involves a range of clinical professionals and stakeholders. Specifically, the following professionals are expected to be involved; the RC, who retains clinical responsibility for the patient until transfer is complete; the named nurse or designated nominee, who coordinates the patient's care and supports communication; the MDT, which may include psychiatrists, psychologists, occupational therapists, and social workers. The care coordinator, who ensures continuity of care across services. External agencies, such as the funding authority, community mental health professionals, and staff from the receiving acute unit. Advocates, family members, and carers, where appropriate and with consent from the patient may also form part of this meeting. During the CPA/CTP meeting, the team exchanges information, agrees on the transfer process, and identifies the level of support the patient will require during and after the transition. The plan includes arrangements for visits to the new location, medication handover, risk assessments, and contingency planning in case of relapse or deterioration.

69. In the case of VC, the health service responsible for ensuring that the transition plan was followed was Cygnet, specifically the Registered/Unit Manager of the discharging location. They are accountable for implementing the policy fully and ensuring that all procedures are followed. Additionally, the care coordinator and the receiving RC share responsibility for ensuring that the plan is enacted and that the patient's needs are met in the new setting.

Community Treatment Orders ('CTOs')

70. Based on Cygnet's 'Transfer and Discharge' Policy [CYGN0000112], a patient diagnosed with paranoid schizophrenia or experiencing psychosis may not be safely discharged from inpatient care without a depot medication and CTO when there are significant risks that require structured oversight and legal authority to ensure continued treatment in the community.

71. A CTO should be considered necessary for patients detained on section 3 of the MHA when there is a high likelihood that the patient may disengage from services, refuse medication, or relapse into a state that poses a risk to themselves or others. The RC must be satisfied, based on a current and thorough risk assessment, that discharge is safe. If this cannot be assured, a CTO provides a legal framework to enforce treatment and monitoring outside the hospital setting. This would obviously need to be balanced against any known history of use of CTO and its impact on compliance, risks and chances of readmission back to hospital.

72. Risks to self in this context include self-neglect, suicide, or self-harm, particularly if the patient has a history of such behaviours or lacks insight into their condition. Risks to others may involve aggression, violence, or unpredictable behaviour linked to psychotic symptoms. These risks are especially concerning when the patient has previously required emergency interventions such as seclusion, restraint, or police involvement.

73. Specific criteria that may justify the use of a CTO and/or depot medication include the following:
    - History of aggression in the community and inpatient settings: Patients with repeated episodes of aggression may pose a continuing risk to others. A CTO ensures they remain under supervision and receive treatment, reducing the likelihood of further incidents.
    - Risk of becoming violent in the absence of treatment: If clinicians assess that the patient is likely to become violent without medication or structured support, a CTO allows for conditions to be set around treatment adherence and monitoring

- History of violence: A documented history of violence, especially if linked to psychotic episodes, is a strong indicator for CTO consideration. The order helps manage risk and prevent recurrence in the community.
- History of non-concordance with medication: Patients who have previously refused or discontinued medication may relapse quickly. A CTO allows for legal conditions to be placed on medication adherence, with recourse if the patient disengages.
- History of social isolation: Social isolation can exacerbate psychotic symptoms and reduce the likelihood of voluntary engagement with services. A CTO ensures that the patient remains connected to care and support networks.
- History of disengagement from treatment: If the patient has previously withdrawn from services or refused follow-up, a CTO provides a structured framework to maintain engagement and prevent deterioration.
- History of masking psychotic symptoms: Patients who conceal symptoms may appear stable but remain at risk. A CTO allows for ongoing monitoring and intervention, even when symptoms are not overtly disclosed.

74. In all cases, the decision to discharge without a CTO must be supported by a robust care plan, a detailed assessment of health and social needs, and confirmation that appropriate community support is in place. Where these conditions are not met and the risks are significant, a CTO is a necessary safeguard to protect both the individual and the public.

<u>VC's treatment</u>

75. The only occasion that I was involved in VC's care during his admission to Victoria House was when I attended his ward round on 28 September 2021 providing cover for Dr Tania Engel [CYGN0000033 and **CYGN0000050**]. I saw VC in that ward round as part of the MDT. I had no other direct involvement with VC aside from regular morning meetings where we discussed patients' presentations, risks, daily tasks that pertain to care and treatment for all patients. Given I was not a part of the team who were directly overseeing VC's care, my involvement was limited.

76. I have no recollection of the ward round on 28 September 2021. I am unable to retrospectively confirm that the risk assessment [CYGN0000001, p72]; care plan [CYGN0000041] and patient review [CYGN0000033] were all conducted at the ward round on 28 September 2021. However, the specialty doctor was usually tasked with ensuring the patient review form [CYGN0000033] was completed, in which case it is most likely that I would have completed it on that day. As far as I am aware, all of the information obtained at the MDT was captured on the patient review form [CYGN0000033]. The mental state examination would have been summarised by Dr Shoilekova as the RC, who would have had a broader, more detailed and longitudinal view of VC's presentation and recovery journey. I do not recall any signs of aggression or violence; if there had been any such signs I would expect it to have been noted and acted upon, and this may be buttressed by the fact that he was allocated more section 17 leave into the local area later that day.

77. In relation to the risk assessment at the MDT on 28 September 2021 [CYGN0000001, p72], the risk rating was a collective opinion of the MDT and usually takes account of his presentation from admission up until the date of review, so would have indicated a downward trend for his aggression (rated "moderate" on that day) which would have been rated as "high" prior to admission requiring PICU. In contrast, it would appear his insight into the need for medication had not improved when comparing with the previous week's ward round dated 21 September 2021 [CYGN0000061] hence the risk of non-compliance remained moderate which meant that although he was accepting the treatment in hospital, the MDT would not be surprised if he refused it in the community due to his lack of insight, albeit he was accepting all his prescribed medications as evidenced in the nursing feedback section of the patient review forms and Risk assessment tool [CYGN0000001, p72].

78. The conclusions under 'Signature risk signs' of the risk assessment [CYGN0000001, p72] are usually identified in the formulation meeting or at the first consultant review using historical notes, referral information and the patients' mental state examination. I was not involved in reaching these conclusions, hence cannot comment on how they were reached.

79. I note that under the heading ‘Risk Reduction Plan’ of the risk assessment, there is a comment “See DRA” [CYGN0000001, p.76]. This refers to the Daily Risk Assessment which was completed every 24 hours to monitor immediate risks and its dynamic nature being a true reflection of current risks, which would be handed over daily during staff change over times and daily MDT.

80. I can confirm that I was not directly responsible for completing the risk assessment or care plan documents on 28 September 2021, and my involvement in VC’s care was limited, accordingly I am unable to explain any differences or lack thereof in relation to the risk assessment/care plan documents from 21 September 2021. However, if his risk ratings were still considered to be the same by the MDT in the ward round of 28 September 2021, the risk detail section would usually reflect this in both risk assessment documents (See p 181 of CYGN0000001 and CYGN0000041).

81. The risk assessment on 28 September 2021 identifies VC as experiencing a third relapse of psychosis, with paranoid and persecutory delusions, auditory hallucinations, and a lack of insight. It notes a history of non-concordance with medication, verbal and physical aggression, and high-risk behaviours, including assaulting police officers and requiring CS gas and Taser deployment during detention. The assessment also documents compliance with medication since admission and no further aggression or AWOL attempts during the review period on PICU.

82. In terms of alignment with the Royal College of Psychiatrists’ guidance, the risk assessment of 28 September 2021 reflects several core principles. It uses the PARA tool, which is a structured judgement tool considering both current and historical risks. It includes MDT input and documents risk formulation and risk reduction plans, including medication compliance and behavioural observations. It also identifies specific risk domains such as violence to others, AWOL, non-compliance, and psychotic symptoms.

83. With respect to Cygnet’s internal policy on individual risk assessment and management, the assessment meets many of the stated criteria. It is updated following a significant incident, uses the PARA tool to rate current risks, informs

care planning, and includes a risk reduction plan. It also notes improvements in behaviour and compliance.

84. In my opinion and for the above reasons identified above, the 28 September 2021 risk assessment appropriately identifies and manages key risks in line with Cygnet's internal policy [CYGN0000114] and broadly reflects the principles of the Royal College of Psychiatrists' guidance.

85. The MDT were involved in updating the care plan as part of the ward round on 28 September 2021 as is the usual practice and requirement. Whilst I was not directly responsible in the ward round for updating the care plan, it is usually reflective of the MDT views and is often updated with the patient's views as the ward round progresses. To the best of my knowledge, the information relating to background section would have been part of the referral information received prior to admission, hence I am unable to provide any further information given my limited involvement.

86. I was not part of the ward round on 14 September 2021, hence am unable to offer any further information regarding the comment under "Views" as follows: 14.09.21- when asked about assaulting police: "I think that was a loss of judgement. I am regretful now".

87. The strategy of offering regular one-to-one time to VC, as outlined in his care plan, serves several important therapeutic and clinical purposes. One-to-one sessions are a core component of person-centred mental health care. Their primary purpose is to provide a safe, structured space for the patient to express thoughts, emotions, concerns, or frustrations. For individuals experiencing psychosis or schizophrenia, such sessions can help build trust with staff, reduce feelings of isolation, and allow early identification of changes in mental state or behaviour. In VC's case, where there is a history of aggression, non-concordance with medication, and psychotic symptoms, regular one-to-one time enables staff to monitor his mood and presentation, intervene early if agitation arises, and reinforce therapeutic engagement. These sessions also support de-escalation strategies and contribute to risk management by providing opportunities for the patient to feel heard and supported.

88. When a patient does not engage in one-to-one sessions, several steps can be taken to encourage participation and maintain therapeutic rapport. Staff may need to modify how sessions are offered—using less formal language, adjusting timing, or choosing a more comfortable setting for the patient. Engagement may improve over time as the patient becomes more familiar with staff and the environment, so consistency and patience are key. If direct one-to-one sessions are declined, staff can engage the patient through informal interactions during daily routines or group activities. Non-engagement should be documented, and the patient's mental state monitored through other means, such as observation and collateral information.

89. The MDT can review the care plan and consider alternative strategies, including psychological input or advocacy support. While engagement is encouraged, it is important to respect the patient's right to decline. Staff should continue to offer opportunities without coercion. Staff should also explore whether symptoms such as paranoia, low mood, or cognitive difficulties are contributing to non-engagement and address these clinically. Where engagement may fluctuate due to psychotic symptoms or mistrust of services, these steps help maintain a therapeutic alliance and ensure that care remains responsive to his needs.

90. I am unable to comment on the section entitled 'Views' made in the 14 September 2021 care plan as I was not part of that review, but this was likely VC's expressed view. I can confirm that the view expressed in the care plan on 28 September 2021 that, "I would rather not have my medication in depot form. I would rather continue with tablets" would have been made by VC in ward round as this can also be found in the patient feedback section of the patient review form [CYGN0000033]. Patient's views are usually captured in care plans as patient centred care, the care plans are usually offered to the patients during ward rounds with the aim of improving their insight. Patients' views are added to their care plans to ensure that the care provided is person-centred, collaborative, and respectful of the individual's preferences, experiences, and values. This approach is fundamental to modern mental health care and aligns with legal, ethical, and clinical standards. Including the patient's perspective helps to promote engagement and trust between the patient and the care team. When patients feel heard and involved in decisions about their treatment, they are more likely to participate actively in their care,

adhere to treatment plans, and communicate openly about their needs or concerns. This is particularly important in cases involving psychosis or schizophrenia, where insight may fluctuate and therapeutic relationships can be fragile.

91. From a clinical standpoint, understanding how a patient perceives their condition, treatment, and environment can inform risk assessments, guide interventions, and help tailor support strategies. For example, in VC's care plan, his views on medication, his understanding of his legal status under the Mental Health Act, and his preferences regarding treatment modalities are documented. These insights allow the multidisciplinary team to adjust their approach, offer appropriate advocacy, and monitor changes in engagement or mental state over time. [CYGN0000041].

92. Moreover, incorporating patient views supports legal principles under the Mental Capacity Act and the Mental Health Act, which emphasise the importance of involving individuals in decisions about their care wherever possible. It also aligns with national standards for care planning, such as those set out by NICE and the Care Quality Commission, which advocate for shared decision-making and recovery-oriented practice.

93. In summary, adding patients' views to care plans enhances the quality, safety, and effectiveness of care by ensuring it is tailored to the individual, promotes autonomy, and fosters therapeutic engagement.

94. In terms of whether VC's care plan differed significantly on 28 September 2021 from the last review on 21 September 2021, several significant aspects stand out. VC is described as settled and stable in his manner on the ward, which is a positive indicator of his overall mental state. However, he occasionally presented as thought disordered and perplexed during interactions with staff, suggesting ongoing psychotic symptoms. His engagement remained limited, as he spent long periods in his bedroom and interacts minimally, although there was a noted increase in his interactions with staff and participation in regular one-to-one sessions and escorted Section 17 leave. Importantly, there were no concerns regarding his personal hygiene, and he appears to be showering more regularly and maintaining a well-kempt appearance. He was attending meals, accepting a

good level of diet and fluids, and was concordant with prescribed medications, physical observations, and weekly COVID swabs. His sleep pattern was also reported to be good. A key event noted is his tribunal on 23 September 2021, which resulted in continued detention, followed by formal detention under Section 3 of the Mental Health Act on 24 September. Since then, his presentation appeared increasingly flat, which may reflect a change in his emotional state or response to the legal decision.

95. Despite my limited contact with VC, several aspects of the feedback were reassuring. VC's lack of agitation, aggression, or violence, would suggests he was not posing a risk to himself or others and was maintaining behavioural stability. His concordance with medication and physical health monitoring indicates a cooperative attitude towards treatment and supports the likelihood of clinical stability. The improvement in personal hygiene and regular attendance at meals further suggest that he was functioning well in terms of basic self-care. Additionally, his increased engagement with staff and participation in escorted leave are positive signs of therapeutic involvement and potential progress in his recovery.

96. Despite these reassuring elements, there are also some concerning aspects. The presence of thought disorder and perplexity during interactions points to persistent symptoms of psychosis or cognitive disturbance, which may require further assessment or adjustment in treatment. His tendency to remain in his room with minimal engagement, although improving, could reflect negative symptoms of schizophrenia, depression, or a lack of motivation.

97. The feedback recorded on 28 September 2021 is identical to that recorded on 21 September 2021 in the patient review form [CYGN0000033]. That section of the review is provided by nursing or support staff.

98. Other aspects were meant to be pre-populated by the designated professionals/team member e.g. Psychologist or occupational therapist, prior to ward round, but it appears this did not happen. I am unable to provide a clear rationale as to why.

99. However, if my memory serves me right, the patient review form was not a live document so could only be updated by one professional at a time. My role during the ward round on 28 September 2021 was to update the patient feedback during the ward round and the "Key checks by doctor" sections ensuring there was compliance with an identifiable treatment certificate as well as the action points as informed by the RC.

100. As I was not directly involved in VC's care barring the cover arrangement on 28 September 2021, I am unable to comment further on the extent of VC's engagement, family contact and diagnosis, treatment, medication and transfer to Priory Hospital Arnold given my limited involvement.

101. I had no further involvement in VC's care. Dr Tania Engel completed the rest of the transfer documents following her return to work.

REFLECTIONS

102. Based on my review of the contemporaneous records, I consider that VC received appropriate assessment, treatment, and monitoring during his admission to Cygnet Victoria House between 11 September 2021 and 1 October 2021. During his stay he accepted oral Haloperidol and showed improvement in psychotic symptoms. He displayed no aggression, maintained good personal hygiene, engaged with staff, and participated in escorted community leave without incident. His observations were gradually reduced as he remained settled throughout admission.

103. The contemporaneous documentation shows that the clinical team recognised VC's limited insight and the potential benefit of depot antipsychotic medication. Dr Shoilekova recorded in her tribunal report that he would most probably benefit from a depot formulation in the longer term. He refused this option, and his Section 2 detention was regraded to Section 3 shortly before his transfer. Given the brief interval before his repatriation to his local hospital and the complexities involved in switching from oral Haloperidol to depot formulation, it is unlikely that such treatment could have been safely initiated prior to transfer. I consider that the

decision to transfer him to a local hospital rather than discharge directly to the community was clinically appropriate.

104. The records I reviewed indicate that the admitting clinicians were aware of VC's previous sectioning events and psychotic history, as set out in the RC, Dr Shoilekova's report, the AMHP assessment, and the joint medical recommendation. These materials demonstrate that relevant background information was available to the treating team, and I have seen no evidence of any deficiency in information sharing at that stage.

105. From the material reviewed, I am unable to comment in detail on the broader operation of multi-agency or national information-sharing systems. However, the documentation available to me suggests that inter-agency information was shared appropriately within the framework of the Mental Health Act and referral processes between hospitals when Cygnet were involved in VC's care.

106. This case highlights the importance of continuity of care, adherence to prescribed treatment, and close community follow-up for patients with a history of non-compliance and limited insight. Early consideration of long-acting injectable medication, robust risk assessment, and coordinated communication between community and inpatient teams remain essential to the effective management of such patients.

107. In summary, the records support that VC's care at Cygnet Victoria House was safe and appropriate within the period of admission. I endorse the lessons arising from this case, particularly the need for clear communication and timely information transfer between inpatient units, community mental-health teams, and other agencies, together with structured review processes for patients who disengage from services or decline depot medication.

RECOMMENDATIONS

108. I have no additional recommendations to make beyond those recorded by Dr Shoilekova at the time, who advised that VC would most probably benefit from depot antipsychotic medication in the longer term.

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

Dr Austin Nwawueze

Dated: 03/12/2025

Index to First Witness Statement of Dr Austin Nwawueze

No	Inquiry URN	Document Description
1	NHSE0000515	NHS England Guidance, Acute inpatient mental health care for adults and older adults
2	NHSE0000539	NICE Clinical Guideline, CG178, Psychosis and schizophrenia in adults: prevention and management
3	NHSE0002308	Royal College of Psychiatrists CCQI, Standards for Inpatient Mental Health Services, Fourth Edition
4	NHSE0002386	NICE Clinical Guideline, CG136, Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services
5	CYGN0000112	Cygnet Health Care: Transfer and Discharge Policy (All Services) – Issued March 2021
6	CYGN0000114	Cygnet Health Care: Individual Risk Assessment and Management Policy – Issued June 2021
7	CYGN0000015	Cygnet Health Care – Notification of Discharge/Transfer dated 04/10/2021
8	CYGN0000117	Cygnet Health Care: Family and Carer Involvement Policy – Issued August 2020
9	CYGN0000033	Cygnet Health Care patient review form for review on 28 September 2021
10	**CYGN0000050**	Medical records of Valdo Calocane from 11/09/2021 – 01/10/2021, Cygnet Victoria Albert Ward, Re: Pink Notes for Valdo Calocane
11	CYGN0000001	Report dated 12/09/2021, compiled by Cygnet Health Care re: Section 17 Leave form of Valdo Calocane
12	CYGN0000041	Cygnet Health Care – Care Plans for Valdo Calocane 11/09/2021 – 01/10/2021
13	CYGN0000061	Cygnet Health Care patient review form for review on 21 September 2021