Witness Name: Dr Tuhina Lloyd

Statement No: WITN0357001

Dated: 18 December 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DR TUHINA LLOYD

I, DR TUHINA LLOYD will say as follows: -

INTRODUCTION

1. This witness statement is made to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 Request dated 20 October 2025 (the "**Request**"). It was drafted on my behalf by Counsel and Solicitors acting for Nottinghamshire Healthcare NHS Foundation Trust ("**the Trust**"), with my oversight and input, and with assistance from the Medical Protection Society, following discussions in writing by email and by video conference.

2. I qualified as a doctor in July 1995 from the University of Nottingham and started my training in psychiatry in August 1996. My qualifications to date are;
   a. Bachelor of Medical Sciences (BMedSci) in July 1993.
   b. Bachelor of Medicine and Batchelor of Surgery (BMBS) in July 1995.
   c. Membership of the Royal College of Psychiatrists (MRCPsych) in June 1999.
   d. Master of Medical Sciences (MMedSci) in July 2000.

3. I undertook my pre-registration junior house officer (JHO) posts in Nottingham University Hospital (NUH) working in core medicine and general surgery between August 1995 and August 1996.

4. My core training in psychiatry was undertaken in the Nottinghamshire Rotational Training Scheme between August 1996 and August 1999. I spent 18 months working as a research fellow for the University of Nottingham in the Department of Psychiatry on a three-centre national research project called the AESOP (Aetiology and Ethnicity of Schizophrenia and other Psychoses) study. This was a research project investigating the incidence rates and putative causes of first episode psychosis in 3 UK cities.

5. I started my higher specialist training in psychiatry in February 2001 in the East Midlands North School of Psychiatry Rotational Training Scheme. In August 2001 I was successful in gaining a clinical lecturer post which enabled me to complete my higher specialist training in psychiatry whilst at the same time to continue in my research pursuits and teach undergraduate medical students.

6. I was appointed to the post of Consultant Psychiatrist in adult mental health (AMH) in June 2004, working with the Newark and Sherwood Early Intervention in Psychosis (EIP) team, Assertive Outreach team and LMHT looking after patients with complex psychosis from June 2004 to August 2018. This post was also part of the Nottinghamshire Healthcare NHS Foundation Trust.

7. I am currently a Consultant Psychiatrist working with the City South EIP Team within Nottinghamshire Healthcare NHS Foundation Trust ("NHFT"). I started working with the City South EIP Team in August 2018. From August 2018 to January 2025, I was allocated 3 direct clinical care sessions within my job plan to the EIP team (1.5 days) and a further 2 sessions working with patients that had complex psychosis within the City South Local Mental Health Team (LMHT). The three direct clinical care sessions allocated to the EIP team comprised one clinic with 6 half hour appointment slots, one home visit, a multidisciplinary team (MDT) meeting, emergency work and administration. The caseload for EIP from 2020 to 2022 ranged anywhere from 70 to 85 complex cases of first episodes of psychosis.

8. I was appointed to the role of Training Programme Director for higher specialist training in General Adult Psychiatry within the East Midlands North School of Psychiatry in 2009.

9. I was appointed to the post of the Head of Post Graduate Training in Psychiatry for the East Midlands which was a strategic role overseeing post graduate psychiatric training across 5 NHS Trusts across the East Midlands from 2015 to 2021.

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

10. The EIP team work in accordance with the EIP Service Operational Policy [**NHFT0004012**]. It receives referrals following the development of a first

episode of psychosis which is clinically significant and not better explained by another cause such as substance intoxication or an organic illness. The age criteria for adult mental health (AMH) EIP services is 18 to 65 years of age. There is also provision for 14 to 18 year old patients provided by Child and Adolescent Mental Health Services (CAMHS).

11. First episode psychosis refers to the very first time someone experiences psychotic symptoms, namely hallucinations, delusions, thought disorder and a loss of touch with reality. It is the first presentation of a psychotic disorder regardless of what the ultimate diagnosis turns out to be. First episode psychosis is a broad umbrella term which would include schizophrenia, schizo-affective disorder, bipolar disorder, either a severe, manic or depressive episode with psychotic features, and psychosis not otherwise specified.

12. Schizophrenia is a specific psychiatric disorder with characteristic symptoms and course. The International Classification of Diseases (ICD) and the Diagnostic and Statistical manual of mental disorder (DSM) are used to make clinical diagnoses in psychiatry. For a diagnosis of schizophrenia an individual must meet both the symptom criteria comprising specific characteristic symptoms and the duration criteria which is at least 1 month for ICD and greater than 6 months for DSM. DSM also requires an individual to have had a significant functional decline in social and occupational functioning.

13. EIP is founded on an extensive and compelling evidence base which has demonstrated that intervening early in the course of the psychotic disorder and reducing the duration of untreated psychosis (DUP) has a significant impact in

improving the long terms outcomes of that disorder for an individual. Effective early treatment is thought to reduce the probability of the emergence of longer term (treatment resistant) symptoms and also contribute to the avoidance of repeated relapses.

14. The NICE guidelines (NICE implementation guidance (2016) and RCP Centre for Quality Improvement referred to on p.6 of the EIP guidance) have made clear recommendations regarding evidence-based treatments that EIP teams should be offering to patients which are known to be effective in the management of psychotic disorders.

15. The EIP pathway is commissioned 3 years from the date of inception into services. The NICE guidelines recommend a number of evidence-based treatments including pharmacological treatment (antipsychotic medication) with informed choice made jointly with the person, cognitive and behavioural therapy for psychosis (CBTp), family interventions including behavioural family therapy (BFT) and carers support. In addition to this, services also provide social, occupational and educational support. Educational and employment support are frequently delivered by dedicated employment support workers ("ESW"); community support workers (CSW) deliver support with activities of daily living, social inclusion and occupational functioning. Carers' support is offered to all carers, both one-to-one and in the form of carers groups. The EIP services have a number of social groups run by peer support workers, such as a local pool and football group.

16. Physical health monitoring and promotion of healthy lifestyles is offered to all patients and includes a comprehensive physical health assessment (smoking status, BMI, blood pressure, glucose regulation, lipids and other lifestyle factors), either before or soon after a patient starts antipsychotic medication. Health checks and monitoring are then repeated annually with the consent of an individual. Interventions to encourage a healthy diet, exercise, smoking cessation and weight management are then offered as needed.

17. Different clinical professionals in the EIP team have different roles and responsibilities. The Community Consultant Psychiatrist (the post I held) has a key role in diagnosing an individual with a first episode of psychosis and also supporting diagnostic decisions made by junior members of the team. They provide expert input for complex and high-risk cases. They oversee medical management such as prescribing psychiatric medications. They also oversee the physical healthcare needs of patients which are directly related to their psychiatric condition and medications prescribed.

18. Junior trainee doctors undertake a similar role as the community consultant psychiatrist, but all of their work is carried out under the supervision and oversight of the community consultant psychiatrist. The level of supervision is determined by the experience and length of training of the junior doctor.

19. Team leaders oversee the day-to-day running of the multi-disciplinary team (MDT) and ensure the smooth coordination of care for patients. Their roles include allocating referrals and managing the distribution of caseloads, supervising care coordinators (CCOs) who are predominately community

psychiatric nurses (CPN) or on occasion occupational therapists or social workers. Team leaders lead and chair the MDT meetings, and they monitor risk and timely reviews of the patients. They will escalate any clinical or operational issues to the clinical lead or EIP service manager.

20. The clinical lead provides overall clinical leadership and governance to the team, ensuring that care is evidence based, safe and effective. Their main responsibilities include setting and maintaining clinical standards in assessment and treatment. They will often oversee and directly supervise the work of the care coordinators. The clinical lead often provides the 'clinical voice' at service management level.

21. Qualified nurses within the EIP service are the main care coordinators (CCO) who have a substantial role in care planning, supporting and monitoring the mental health of patients. They act as a liaison between the MDT members (psychiatrists, psychologists, other nurses, social workers, occupational therapists, employment specialists and both community support workers and peer support workers). They also have a lead role in liaison between inpatient services and the community team acting as a conduit between the two services. They also provide a link with external agencies such as GPs, housing, education, benefits and the voluntary sector.

22. Within the NHFT EIP services, a care coordinator undertakes a detailed initial assessment of a patient who has been referred to the services and, following discussion with the wider MDT, a decision is taken as to whether or not a patient meets the criteria for a period of more detailed assessment and treatment on

the EIP pathway. Once this is established, the care coordinator has a primary role and responsibility for monitoring a patient's mental health in the community setting, undertaking regular risk assessments and ensuring that the evidence-based treatments offered in a care plan are being delivered to a patient in a timely fashion. Full time CCOs within EIP services should have a capped caseload of 15 patients (Current standards for EIP implementation in the UK recommend a case load of 15 patients per full time CCO: Quality Standards for EIP services 3rd Edition. RCPsych, 2021) which allows them sufficient time to be able to carry out their wide-ranging and extensive duties.

23. Support workers within the EIP services provide a very important function in building trust with patients and families and engaging people early. They deliver practical and therapeutic interventions as part of the care plan. These include supporting patients with day-to-day activities of daily living such as prompting self-care, support with cooking, shopping, budgeting, using public transport etc. They are also involved in supporting and promoting social and occupational functioning. They support individuals to take their medication and help manage side effects. They often get involved in helping with heathy eating, exercise and attending physical health checks.

24. Psychologists within the EIP services deliver a broad range of psychological therapies, predominately CBTp but may offer other types of therapy (e.g. trauma focussed therapy), depending on individual patient needs. Psychologists also have an important role in helping the team think about psychological formulation, complex cases and difficult family dynamics which may be contributing to the continuation of symptoms.

25. EIP Managers / Service Managers are responsible for ensuring that the service runs efficiently and meets organisational and national standards. They are involved in workforce planning and recruitment, managing budgets and performance targets, ensuring compliance with policies and they may have a role in managing team leaders and overall resources within the service.

26. Social workers within EIP services predominantly take on more generic Care Coordinator responsibilities as described above under the role of qualified nurses. They bring their expertise and knowledge of the Mental Health Act 1983 and Mental Capacity Act 2005, safeguarding, financial and welfare rights issues and complex housing and benefits issues to the wider MDT. Social Workers with Approved Mental Health Professional (AMHP) training can assess patients for compulsory admission under the MHA.

27. The EIP team provides patients with NICE recommended treatments including pharmacological treatments (antipsychotic medication), psychological therapies, namely cognitive and behavioural therapy for psychosis (CBTp), and family interventions including behavioural family therapy (BFT). In addition to this, services also provide employment support from dedicated employment support workers and CSW who provide assistance with a number of activities as set out above.

28. Patients are normally monitored on a fortnightly basis in the community, predominantly by named care coordinators. Community support workers ("CSW") also play an important role in the monitoring of patients (under the supervision of a CCO) for patients who are allocated a CSW, combined with

clinic appointments with a medical member of the team as needed. Some patients were allocated a CSW based on need (support with ADLs, healthy lifestyle guidance, occupational and social functioning etc); CSWs can also provide a baseline level of monitoring of mental health; while they are not clinically qualified they have some knowledge and understanding of relapse indicators in same way that a family member might.

29. The level of monitoring is based on patient need and can be increased to weekly visits from a CCO during periods of concern about relapse. During periods of remission and stability the frequency of CCO visits may be reduced to every 3 weeks or monthly. In addition to this, patients can also be booked in to see members of the medical team and this is determined and is at the discretion of the care coordinator.

30. Medication concordance is monitored by care coordinators during their patient visits, through direct verbal questioning, checking the number of tablets remaining within a packet or dispenser pack and speaking to family members who often support patients with taking their medication. Particularly at the start of therapy, the services have an important role in delivering a patient's psychiatric medication to them and the frequency and amount of medication delivered is determined by the compliance levels of the patient. Patients who have demonstrated a low level of concordance or who have a tendency to forget to take their medication may get a weekly delivery of tablets and those who are concordant may have their frequency of delivery reduced to monthly. When concordance with medication becomes a significant issue, consideration is given to prescribing a long-acting depot preparation of antipsychotic medication

becomes important, but, in the absence of a CTO, for the most part this can only be administered with the consent of the patient.

31. The tools and practices available to our EIP team when faced with non-engaging patients include flexibility in the location of appointments and meeting patients where they are most comfortable (home, student accommodation, cafeteria, GP practice and more). Repeated gentle and non-confrontational outreach to build trust, limiting where possible changes of main clinicians to foster continuity of care, setting goals that are meaningful to the patient (move the focus away from illness to work, education or social goals) and shared decision-making.

32. There was limited guidance within the EIP Standard Operating Procedure (SOP) in respect of non-engaging patients during the period VC was under the care of the EIP team – see **[NHFT0004012, P.24]**. There was also the DNA policy **[NHFT0000417]** which offered some guidance on how to manage patients who did not attend an appointment.

33. I do not recall being given any formal training on non-engaging patients. I am aware that a Trust policy document existed during the period 2020-2022 in relation to the management of patients who do not attend appointments.

34. Tools and practices when faced with patients who were not concordant with medication include shared decision making with a patient which is a core principle of EIP and emphasized in the NICE guidelines. Clinicians discuss the treatment options and pros and cons of medication, and a decision is made jointly respecting patient preferences and values. CBTp is helpful where non-

concordance is driven by persecutory delusions or beliefs about voices through challenging these thoughts and perceptions. Psychoeducation can enable a clear understanding about a patient's condition and the benefits of their accepting treatment versus refusing it. Patients who forget to take medication due to cognitive decline can be prompted by alarms, automated calls, text messages or by family members. Simplified medication regimes can improve concordance such as once-daily dosing.

35. Over my 29 years of psychiatric experience, I have attended numerous conferences and CPD events where the topic of ensuring concordance with medication has been presented. I have not had any formal training such as CBTp or motivational interview training.

36. A depot would usually be prescribed to EIP patients when there are repeated concerns about a patient's concordance with medication or if a patient is struggling to remember to take their medication despite prompts being in place, something which can arise due to the development of cognitive decline in psychosis. On occasion, a patient may prefer and opt for a depot form of antipsychotic medication for reasons of convenience or if they struggle to swallow tablets, but this is not usual. The main indications determining the use of a depot form of antipsychotic medication include a history of repeated relapse due to stopping medication, limited insight into their condition and the benefits of medication, chaotic lifestyle and cognitive impairment.

37. A Community Treatment Order (CTO) would be used when a patient has been detained in hospital under Section 3 of the Mental Health Act 1983, has become

well enough to be discharged back to community care under the EIP team but where there is a significant risk of relapse in the event of non-engagement with treatment. Factors to be considered include repeated relapses due to stopping medication or disengagement from community services, severe lack of insight leading to treatment refusal despite clear benefit, a high risk of harm to self or others if treatment stops and difficulty maintaining engagement with an EIP team despite efforts at outreach.

38. Adult EIP services in Nottinghamshire are designed for individuals aged 18-65 with a first episode of psychosis. Individuals who do not meet these criteria will not be considered suitable to receive EIP treatment. Individuals with stable mental health and the mental capacity to make choices about their treatment who have made an informed decision not to receive continuing EIP treatment would also be considered for eventual discharge from EIP pathway.

39. The EIP team works with a range of other community health services including Crisis Resolution and Home Treatment Team (CHRT), Primary Care, LMHTs, Child and Adolescent Mental health Services and Substance misuse services:

    i. When a patient is starting to show clear signs of relapse and is considered to be at risk of harm to themself or to others, a referral is made by the CCO to the CRHT who take a short term lead in providing more intensive monitoring (more than weekly and out of hours/weekends) than can be provided by the EIP team and a package of home treatment. This more intensive monitoring continues whilst the patient remains admission vulnerable until there is an improvement in symptoms and a reduction in

risks. It will remain in effect until such time as the EIP team can resume their care and treatment in the community. In the event of no improvement or further deterioration of symptoms or an increase in risks which can no longer be safely managed in the community, then the CHRT act at gatekeepers for an informal admission to hospital or admission to hospital under the MHA as necessary.

ii. Joint management of a patient's physical health and shared care protocols for prescribing are undertaken with primary care. Once EIP involvement ends, any support for ongoing health needs is also provided by the GP and primary care services.

iii. Patients who have had ongoing complex long-term needs which cannot be met by primary care are transitioned to the LMHT and this transition takes place when a patient steps down from the EIP pathway after 3 years.

iv. Patients who are transitioning from CAMHS to adult EIP services do so over a 6 month period with joint working between child and adolescent and adult EIP services. This is to ensure smooth transfer between the two services.

v. Substance misuse services within the City of Nottingham is commissioned and provided by Nottingham Recovery Networks. Patients with substance misuse problems are sign posted and supported to access harm reduction and relapse prevention interventions from NRN.

40. When the EIP team received a referral from inpatient services a qualified member of the nursing staff (usually the allocated CCO) provides in reach to the ward to build an early relationship with the patient and start the process of initial assessment involving face to face meetings with the patient, liaison with medical

and nursing staff on the ward, gaining an understanding of the patient's clinical risks through reading the multi-disciplinary notes and risk assessments done by the inpatient staff and attendance at ward review meetings. The CCO is expected to attend the final discharge meeting to ensure a smooth transition into community care. All these sources of information were brought back to the weekly MDT meeting by the CCO and used by the team as part of the initial assessment process.

41. Outpatient appointments with psychiatrists serve a number of functions within EIP services. These include conducting a comprehensive assessment to establish or confirm the diagnosis of a first episode psychosis and consider differential diagnoses and rule out any physical causes of psychosis where indicated. The initiation and review of antipsychotic medication as per NICE guidelines monitoring response and side effects is another important function. Treatment is often adjusted in outpatient clinics based on clinical progress and any emerging side effects. Clinic appointments also allow for oversight of physical health checks, liaison with the GP for further tests and interventions and responses to crises and concerns raised by the patient, team members or family. Assessment of a patient's mental health, response to medication, side effects and general functioning/ recovery are all undertaken during these appointments.

42. Relevant information from a patient's history includes the pattern of previous relapses and the nature of previous risks; the nature of past psychotic symptoms such as command hallucinations which are strongly associated with

risk and poor insight can increase risk as the individual may not recognize the need for help.

43. The history and nature of risk to others during previous relapses is an important predictor of future risk, and the nature and target of aggression are important e,g: was violence directed towards a family member, authority figures or strangers? Was the violence pre-meditated and planned or was it reactive and impulsive? The access to and previous use of weapons, substance misuse and a past forensic history are also significant risk factors.

44. Likewise, the previous history of risk to self is a powerful predictor of future suicidal behaviour, especially if the attempts were psychotically driven. The presence of command hallucinations, symptoms of depressive disorder and hopelessness, pre-meditated previous acts of suicide such as getting one's affairs together, leaving a suicide note, organizing wills etc.

45. The consideration of protective factors which reduce risk may include good insight and treatment adherence, a supportive family, stable housing and employment, good coping skills and an understanding of early warning signs of relapse.

Insight and First Episode Psychosis

46. In the context of psychosis, insight refers to a person's awareness and understanding of their mental illness, particularly their ability to recognize that their experiences (such as hallucinations or delusions) are symptoms of a

psychiatric disorder and not reflections of reality. Insight exists on a spectrum and is often described by an individual's awareness of Illness, e.g. recognizing that one is mentally unwell or that one's experiences are due to an illness; an understanding that symptoms (e.g., hallucinations, delusions, disorganized thoughts) are part of the illness rather than caused by external factors, and the recognition that professional help or medication may be necessary to manage the illness.

47. On occasion, people with psychosis "mask" their symptoms. Masking is when a person with psychosis suppresses or hides their symptoms in order to appear well or to avoid treatment, stigma, judgement, or hospitalization.

48. Indications that demonstrate recovery from psychosis broadly include symptom reduction, functional recovery and both emotional and social restoration.

49. A reduction in hallucinations and delusions, less disorganised thought processes, improved reality testing, better insight and improved cognitive function (attention, concentration, memory and ability to plan and make decisions) are important indications of appropriate recovery. An individual's daily functioning, ability to return to work and education, manage independent living and engage with friends, hobbies and activities are also important markers of recovery. A stable mood, good self-esteem and coping mechanisms should also be taken into account when assessing recovery.

50. In contrast, relapse can be evidenced by a return or worsening of psychotic symptoms after a period of improvement or remission, with social and functional deterioration including changes in behaviour or withdrawal from family and friends, poor performance at work or college. Early signs and symptoms of relapse can be individual to each patient: work on early relapse indicators and early warning signs can determine what these are. Non-specific symptoms can include anxiety, dysphoria, insomnia, poor concentration and attenuated psychotic symptoms (Birchwood et al, 1989). Family and carers often notice these subtle changes first. Medication related indications may include non-concordance, poor insight and disengagement.

51. Important clinical indicators of acute psychosis include florid symptoms such as intense and frequent hallucinations, the return of delusional thinking, thought disorder as recognized by incoherent speech and a complete loss of insight. This is often associated with an increased risk of harm to self and/or others and can include self-neglect, increased levels of vulnerability and poor judgement leading to impulsive or risky behaviour. A significant deterioration in both occupational and social functioning as described previously with emotional and psychological signs of distress are other important indicators.

MDT Meetings

52. The MDT meeting took place every week and its main purpose was to bring together professionals from different backgrounds for information sharing, to coordinate care and to make joint decisions to reduce risk and prevent patient relapse. The structure of the meeting comprised discussion of new referrals,

the outcome of initial assessments carried out by CCOs and a broader caseload discussion where each CCO updated other members of the MDT on each patient's progress. The identification of any patients who might be relapsing and joint decision making on risks and management strategies formed a very important part of this meeting.

53. MDTs were attended by the community consultant, the EIP clinical team leader, CCOs and other CPNs, support workers, psychologists, non-medical prescribers, pharmacy colleagues, Behavioural Family Therapy workers, employment support workers and peer support workers.

54. It is my understanding that it was not usual practice for MDTs within the local mental health teams across the Trust including EIP to record the discussions which took place in MDTs.

55. I have been asked about weekly review meetings and risk assessment meetings. The only weekly meeting I was involved in was the EIP MDT: I am uncertain what the weekly review meeting was. Similarly my understanding of risk assessment meetings is that they involved CCOs taking complex cases with significant risk issues for discussion and formulation to an EIP psychologist. These meetings were held at a time when I was not able to attend. They were scheduled and took place on one of my non-working days when the psychologist leading the meeting had availability.

Community Consultant Psychiatrist

56. The community consultant psychiatrist was responsible for the direct medical management of all patients within their individual caseload but also had oversight of all patients within the EIP service. In my role as community consultant psychiatrist I provided clinical leadership and supervision to the EIP MDT and training and supervision to resident (junior) doctors.

57. As a community Consultant Psychiatrist I would consult the records of EIP patients often enough to maintain medical oversight; the frequency of review was otherwise determined by a patient's assessed level of risk and care coordinator feedback. The community consultant psychiatrist would typically review a patient's records with them before or during direct patient reviews, before more detailed case discussions in MDT meetings, CPA reviews or any reported risk events.

58. A Community Consultant Psychiatrist would also discuss EIP patients with clinical peers. The frequency of these discussions was responsive and depended on the level of risk and concern about a patient. This could vary from daily for acutely psychotic or high-risk cases to every few weeks for more stable cases. There have always been routine weekly multidisciplinary patient discussions and weekly, hour-long clinical supervision with resident (junior) doctors where cases can be brought for discussion.

59. In the event of clinical need and particularly in case of signs of relapse or risk, I would expect other members of the EIP team to raise issues with me.

Care Planning, Treatment and monitoring

60. The community consultant was fully involved in the care planning process of community patients who were receiving direct clinical care from them. This happened at the annual Care Programme Approach (CPA) reviews. The initial care plan was done by the named CCO in collaboration with the patient.

61. The community consultant was fully involved in the medical treatment of community patients for whom they were providing direct clinical care. They also had oversight of other treatments and recovery goals within the care plan which they were not responsible for delivering - e.g. CBTp family therapy, educational or employment support – as well as the oversight and supervision of medical treatments being delivered by junior doctors.

62. Whilst monitoring is usually carried out day-to-day by CCOs and other CPNs in the team, the consultant psychiatrist was also involved in decisions on the frequency of mental health monitoring, based on a patient's risk and stability.

63. Patients in an acute or unstable phase of their condition had weekly face-to - face monitoring from a CCO or qualified nurse. Once they were no longer in crisis or had progressed to early recovery, frequency of monitoring reduced to fortnightly by a CCO or qualified nurse. Patients within a stable phase of recovery had 4-6 weekly monitoring. This frequency would be adjusted by a patient's CCO, depending on emerging risks and rate of recovery.

64. The community consultant is responsible, in collaboration with the MDT, for determining whether a patient is ready for discharge from the EIP, albeit that discharge planning is and always has been a multidisciplinary process.

65. The community psychiatrist or another prescriber working with the EIP team reviewed medication approximately 3 monthly but more frequently following any changes in medication.

Contact with patients

66. The duration of contact for patients attending an outpatient clinic was determined by the Trust and job planning procedure [WITN0357002]. New patients were allocated one hour appointments and follow up cases allocated half an hour.

67. The duration of contact between CCOs and their patients varies, based on the nature of the meeting and the specific intervention being delivered. Contact for the purposes of medication drop off, for example, could be relatively short although even this would be flexible given that a medication drop-off or pick-up should not only be to ensure medication adherence, but also to monitor wellbeing, risk and engagement. If psychoeducation and relapse prevention work is being done, or a patient is receiving other psychological interventions from the CCO an hour or longer might be required.

68. Medication drops offs are usually short encounters between the patient and a member of the clinical team but they are often the most frequent point of contact

between a CCO and patient. As such, they present a valuable opportunity to build rapport, assess stability, and promote self-management. Every contact with an EIP patient carried out by a CCO should also provide an opportunity for the management or monitoring of medication concordance.

Aim and purpose of Care Plans

69. A care plan is a key document within the EIP, providing an outline of how a person experiencing psychosis will be supported in their recovery. It is developed collaboratively between the patient, their care coordinator, and (where appropriate) family or carer.

70. The aim is to provide a personalized, holistic, and recovery-focused approach to meeting the needs of someone experiencing psychosis, promoting stability, wellbeing, and social inclusion.

71. The purpose is to identify individual needs and goals for a patient addressing mental, physical, and social aspects of health. It should include the person's own recovery goals and what matters most to them. It has an important purpose in coordination if interventions so that all professionals (psychiatrists, psychologists, nurses, social workers, occupational therapists, etc.) work together coherently. It should clarify who is responsible for each aspect of care. The care plan should focus on building coping skills, resilience, and social functioning and support return to education, employment, or social activities. It should also include plans for managing potential risks such as relapse, self-

harm, or substance misuse, and provide detailed crisis and relapse prevention strategies.

72. The care plan is developed collaboratively between the patient, their care coordinator, and (where appropriate) the patient's family or carer. An initial care plan should be developed during the initial assessment phase of a patient's journey (within the first three months) and then reviewed at least annually at a patient's CPA review. If an individual's needs and goals change, then the review of the care plan could be brought forward.

73. Care planning is an individual process, tailored to each patient depending on their goals, aims and needs. A patient's diagnosis – whether first episode psychosis or established schizophrenia - did not determine specific differences in the care plan. All patients on the EIP pathway received care as defined by the NICE guidelines.

74. Where a patient was not engaging or not concordant with medication, proposals for depot antipsychotic medication and a Community Treatment Order (CTO) could be included in a care plan.

Discharge Planning

75. There should be an MDT meeting with prior planning for discharge in the lead up to discharge. Circumstances which were appropriate to consider discharge of an EIP patient were as follows.

i. The person has recovered from their psychotic episode and has remained symptom-free or stable for a sustained period (often 12+ months). They have good insight into their mental health and can recognise early warning signs of relapse. They are adhering to treatment (if still on medication) and engaging well with ongoing supports. No significant risks to self or others are currently identified. In this case, the person may be discharged back to primary care (GP) with a clear relapse prevention plan.

ii. Transition to Longer-Term Mental Health Services should be made at the end of the three year EIP pathway if the person develops a persistent or chronic psychotic disorder (e.g., schizophrenia, schizoaffective disorder, or ongoing complex needs). This option should be considered for patients who continue to experience residual symptoms or require long-term antipsychotic treatment and psychosocial support. In this situation, discharge would be to the Local Mental Health Team (LMHT) for ongoing care and monitoring.

iii. If the person disengages from EIP services for a prolonged period despite active attempts to re-engage (e.g., home visits, phone calls, letters); if there is no evidence of significant current risk, and the person is functioning independently, they may be discharged back to primary care with information on how to re-access services if needed. This should only occur with prior agreement of the carer and referrer.(see EIP SOP **[NHFT0004012, p.14]**.

iv. If a patient moves to another geographical area and care should transferred to a local EIP team covering the area that person is moving to. If a person no longer meets the EIP criteria (for instance, if reassessed and found to have an alternative non-psychotic diagnosis) they can be signposted to another service which best meets their needs.

76. At the point of discharge, the EIP should carry out an MDT review of mental health, medication, and the patient's social situation; create a relapse prevention plan (including early warning signs and who to contact); provide a written summary of progress and ongoing needs; share the care plan and relapse plan with the patient's GP, family, and (if appropriate) CMHT; and offer the patient information on how to re-access EIP or crisis services if symptoms return.

Non-attendance at appointments

77. In the event that a patient did not attend ("DNA") a scheduled meeting the EIP team had regard to the relevant policy: in this case **NHFT0004725** which was in place from September 2021 onwards and corresponded with VC missing several appointments with the team.

78. This policy provides that when it is clear that a patient has not agreed to a level of contact set by the clinician, the MDT should undertake an immediate assessment of the patient's level of risk. In an outpatient clinic setting the assessment of the patient's level of risk may be conducted by a member of the medical staff or another practitioner The requirement for either a full MDT risk

assessment or a full risk assessment undertaken by an individual staff member as a follow up to patients who DNA will depend on balancing the level of concern for the patient's well-being at that time with the rights of the patient to disengage or refuse contacts with adult mental health services. The level of response by the team must be proportionate to the assessed level of risk of the patient.

79. Depending on an assessment of risk of the patient who did not attend, the following actions may be considered (see NHFT0004725, p.7, para 7.2.3):

    i. If a patient is not contactable at their address or by telephone the care coordinator or other nominated team member should call all recorded contacts to ascertain the patient's whereabouts.

    ii. If the patient is not at their address, the care coordinator and service team should agree other agencies to be contacted for example GP, housing and family. They should include a discussion regarding contact with family members even if the patient has requested no contact with their family. This is to be judged on a case by case basis, determined by the level of risk.

    iii. If all contacts fail, the care coordinator should discuss their concerns with the MDT and agree the next steps to be taken, which could include involvement of the police. The police have the power of entry in the case of suspected concern regarding increased risk.

    iv. The care coordinator and responsible clinician should consider the use of a community treatment order for patients who have been detained

under the mental health act and are known to be non-concordant with treatment and follow up.

v. If the whereabouts of the patient are known and the level of risk is considered to be high, the care coordinator and team should consider the need for further assessment, including a mental health act assessment a mental capacity act assessment and adult safeguarding. The care coordinator should undertake an assessment of the patient's capacity if possible, and their appropriateness for discharge from services.

80. In accordance with the DNA policy **[NHFT0004725]**, all medical appointments were arranged and attended by a patient's CCO to ensure robust handover of information and joint decision making. If a patient did not attend their appointment, their multidisciplinary notes were reviewed in order to establish when they had last been seen and whether there were any concerns about their mental health or immediate risk of harm to themselves or to others. A discussion with the CCO took place to check if they were aware of any more recent concerns or risks and, based on this information, a decision was taken as to whether an urgent home visit was needed or if another routine appointment could be offered. The named CCO also followed up on the missed appointments with the patient with a phone call, usually on the same day or by the end of the week, depending upon the level of concern. After checking availability with the patient, the CCO would then reschedule the next medical appointment with the medical secretary. If a patient could not be contacted, attempts were made to speak to a relative or close friend to check whether they

had spoken to the patient recently and had any concerns about their mental health.

81. Missed appointments in outpatients' clinic for patients with psychotic disorders are common: the above practical approach to assess the "level of risk" was carried out before further steps were taken.

82. The community consultant in EIP (where all patients have a nominated CCO) was responsible for review a patient's case notes to assess their most recent presentation, their mental state and the presence of any risks for non-attending patients. This was followed by a discussion with the CCO to determine if they had any immediate concerns about the patient based on information from their last visit, or if they had had relevant contact from a patient's family or other agencies. Based on this information a "level of risk" was determined by the Consultant Community Psychiatrist and CCO. Whether or not a full MDT risk assessment or a full risk assessment was then undertaken by an individual staff member would then depend on the level of risk assessed.

83. While the community consultant can make a recommendation to the inpatient team for a patient to be placed on a CTO, the final decision on such matters is the patient's Responsible Clinician ("RC") under the Mental Health Act 1983. A CTO can only be put in place when a patient is in hospital under section 3 of the MHA. A CTO is suitable for patients who have been repeatedly non-concordant with treatment in the community and have previously disengaged from appointments. A CTO may also be used for patients who lack insight into

their condition or need for treatment or do not have the capacity to consent to treatment.

84. The decision on whether or not a patient should receive depot medication can take place in both the community and inpatient setting. In the community or inpatient setting where an individual is a voluntary patient depot medication can only be provided with the patient's informed consent and their understanding of the benefits versus risks of being on a depot. In an inpatient setting where an individual is under section 2 or 3 of the MHA a patient can be given depot medication without their consent provided that it is beneficial to their health and recovery. This would be a decision for the patient's RC under the MHA 1983.

Assessment of risk

85. Risk assessment within the EIP is a shared multidisciplinary responsibility. Certain roles take the lead responsibility: the CCO takes the lead responsibility for ongoing risk assessment and management and for maintaining and updating the written risk assessment form within a patient's electronic records as part of the care plan and the annual Care Programme Approach reviews.

86. The community consultant provides clinical oversight on risk assessments. The member of medical staff providing direct clinical care to a patient would lead on risk assessment during their initial assessment appointments with, when carrying out medication reviews or when seeing a patient in a crisis situation.

87. Risk was regularly discussed and reviewed at the MDT meeting and the perspectives and views from the team psychologists, other nursing staff and support workers were taken into account. Shared decision-making on risks helped ensure a comprehensive view of any risk factors.

88. The team manager/leader or clinical lead ensured that systems and policies for risk management were being followed. They were also responsible for reviewing any high risk cases and supporting staff in complex risk management situations. Risk assessment was therefore every team member's responsibility with the CCO taking a lead role, the community consultant and team leader having oversight and all the MDT having collective responsibility.

89. Risk assessments were carried out in accordance with the risk assessment form in a patient's electronic record. It was the responsibility of the CCO to keep this updated. Medical members of the team recorded risk as part of their entry in the patient records but it was not usual practice to use any formalised tools.

90. A risk assessment should be carried out at the point of an initial assessment and allocation to a CCO to inform the first care plan; at discharge or transfer of care to ensure handover and continuity, and at least annually at a patient's CPA review. In addition to this, each time there is a discernible change in risk e,g. if a patient is experiencing a crisis, relapse or safeguarding concern, the risk assessment should be updated.

91. The risk posed by mental health patients to others should be identified, assessed, and managed in accordance with NHS England, NICE guidelines, and standard CPA / risk management frameworks. Risk to others can be identified through direct assessment and collateral information and sources of information including:

    i. Direct patient interviews with exploration of thoughts of anger, fear, persecution, or thoughts about acting on delusional beliefs.
    ii. Family/carer reports: relatives may notice or experience verbal aggression, tension, or physical threats.
    iii. A review of the patient's records of past incidents (police involvement, forensic history, antisocial behaviour).
    iv. Observation during home visits or clinic appointments looking for agitation, hostility, poor impulse control, or substance use.
    v. Enquiring about environmental stressors such as housing instability, victimisation, or relationship conflict.

92. Significant warning signs of increased risk may include:

    i. Paranoid or persecutory delusions involving others.
    ii. Command hallucinations to harm someone.
    iii. High levels of anger or perceived threat.
    iv. Poor impulse control or intoxication.
    v. Non-compliance with medication or disengagement from care.

93. Within NHFT it was usual practice to use the local Trust risk assessment tool within the EPR system. Management included:

i. medication – to reduce psychotic or impulsive symptoms;

ii. psychological interventions: CBT for psychosis, anger management, relapse prevention;

iii. substance misuse work, including integrated support in the event of an increased risk in drug/alcohol use;

iv. crisis planning: early warning signs, agreed actions, and emergency contacts;

v. liaison with family or carers for monitoring and de-escalation support;

vi. safety planning for potential victims in the event that specific threats are made;

vii. safeguarding procedures or MAPPA referral (Multi-Agency Public Protection Arrangements) if the risk to public safety is considered serious.

94. During periods of acute crisis and identified increased risk, the MDT should review risk at least weekly with supervision and management oversight for high-risk cases. The MDT will work jointly working with police or forensic services if needed. A patient's record assessment, management plan, and communication with all relevant agencies should all be clearly documented.

95. As set out above, a patient's risk assessment should be updated whenever there is an identified change in risk. In the event that a patient experiences a crisis, relapse or safeguarding concern, the risk assessment should be updated.

96. The EIP teams works with people experiencing the most vulnerable and unpredictable stages of severe mental illness. This cohort of patients faces a broad spectrum of risks, both clinical (to self or others) and social (vulnerability, disengagement, safeguarding, etc.).

Risk of Self-Harm or Suicide

97. Many patients experience high rates of suicidal ideation during first episode of psychosis, especially in early recovery or after hospital discharge. Feelings of hopelessness, shame, or fear are often related to psychotic experiences. Risk Management Techniques include:

i. comprehensive suicide risk assessment (including intent, planning, means, protective factors);
ii. safety planning with the person and family (crisis numbers, coping strategies, early warning signs);
iii. close monitoring during high-risk periods — e.g. increased patient contact, crisis team support;
iv. pharmacological and psychological treatment for underlying psychosis and depression;
v. carer involvement to identify changes early;
vi. immediate escalation and possible hospital admission if active suicidal intent or means are identified.

Risk of Violence or Harm to Others

98. The risk of violence or harm to others can occur when a patient experiences paranoid or persecutory delusions, command hallucinations, or disinhibition (especially with substance use).

99. Risk Management Techniques include:

    i. discussion and formulation of risk at the monthly Risk Management meetings with a psychologist;
    ii. medication optimisation to reduce psychotic symptoms and agitation.
    iii. de-escalation and anger management techniques;
    iv. multi-agency working (police, forensic services, MAPPA if needed) where high risk to the public has been identified;
    v. environmental adjustments, avoiding triggers or unsafe contact;
    vi. carer support and safety advice in the event that family members are potential targets;
    vii. a crisis plan specifying actions if violence risk escalates.

Risk of Relapse or Deterioration

100. Psychosis is often episodic, and relapse risk is highest in the first few years. Risk Management Techniques include:

    i. relapse prevention planning to identify early warning signs and coping responses;
    ii. medication adherence support e.g. psychoeducation, side-effect management, shared decision-making;

iii. regular monitoring through frequent contact, home visits, or phone check-ins.

iv. family work to help relatives notice early changes;

v. rapid response from EIP or crisis team when relapse indicators appear.

Substance Misuse–Related Risk

101. Drug use generally but cannabis, amphetamines, Ketamine and alcohol in particular are significant contributors to onset and relapse of psychosis. Risk Management Techniques include:

i. referral, signposting and joint working with specialist drug/alcohol services such as Nottingham Recovery Networks;

ii. education about interaction between illicit substances and their impact on psychosis and the medication used to treat their disorder.

Relapse prevention and harm-reduction strategies

102. Neglect or self-neglect, disorganisation, reduced motivation, and cognitive deficits/negative symptoms of psychosis can all lead to poor nutrition, hygiene, or unsafe living conditions. Risk management techniques available to the EIP team include

i. practical support with daily living (Community support workers, housing liaison, benefits);

ii. regular home visits to monitor physical environment;

iii. physical health checks (weight, diet, medication side effects);

iv. The involvement of carers or community support if appropriate;

v. safeguarding referral if self-neglect is severe or life-threatening;

vi. referral for enablement, social care assessment or to the voluntary sector.

Adult Safeguarding / Vulnerability Risks

103. People with psychosis may be exploited, abused, or financially manipulated due to impaired judgement or social isolation. Risk Management Techniques include safeguarding assessments and referrals to the local authority if needed; education on personal safety, boundaries, and online risks; supportive networks (peer support, family, advocacy); joint working with social services, housing, and police; monitoring of financial and social vulnerability.

104. The risk of disengagement or loss to follow up arises where patients have poor insight, have experienced stigma, or feel ambivalent about treatment after a psychotic episode. Risk management includes:

i. assertive outreach — home visits, flexible appointments, text reminders;
ii. therapeutic engagement to build trust, motivational work, culturally sensitive care;
iii. family and carer collaboration to maintain contact;
iv. regular review of engagement risk at MDT;
v. use of CTO for patients who repeatedly disengage from treatment and follow up.

105. EIP patients also experience a number of physical health risks. These include the side effects of antipsychotic medication; the negative effects of poor

diet, smoking, and low activity levels. Risk Management Techniques provided by the team include baseline and annual physical health checks (BP, BMI, blood tests), lifestyle interventions such as encouraging exercise, assisting with diet, smoking cessation; GP collaboration for shared care of physical health complications.

106. I have been a psychiatrist for 29 years. During this time, I have attended numerous lectures at local CPD events and also Royal College conferences on the topic of risk assessment. The most recent Royal College of Psychiatrists ("RCP") training that I received on risk assessment was on Wednesday 28th June 2017 at the RCP International Congress in Edinburgh. This included face-to-face teaching/training on the assessment of Violence in Psychiatric Patients. I am familiar with the RCP publication, The Assessment and Management of Risk to Others (College Report 201) although I do not recall receiving specific training on it.

Mental Capacity

107. In accordance with the Mental Capacity Act 2005 ("MCA 2005") we would assume patients had capacity to make decisions about their treatment unless there was reason to think otherwise.

108. If a person's ability to make specific decisions is in doubt because of their mental state or their cognitive function, an assessment of their capacity is carried out. This can arise if psychotic symptoms interfere with treatment decisions, accepting a voluntary admission to hospital, consenting to sharing

information with family/carers, making decisions about living arrangements, financial/legal decisions and when there are safeguarding or vulnerability concerns and a patient is refusing interventions designed to protect them.

109. Training in the assessment of mental capacity is part of the Approved Clinicians Assessor training which I have undertaken every 5 years from 2004 onwards. This training is provided by the Maudsley Learning I last undertook this training on 1st March 2023. It involves the completion of ten online teaching modules which include modules on the Mental Capacity Act and patient scenarios involving capacity assessments. I also attended an afternoon of online lectures.

Raising concerns

110. The EIP processes and procedures for raising concerns about risk of harm are as follows. The first step after identification of a risk of harm would be immediate documentation by a member of the team. Any staff member who identifies a potential risk must document it promptly in the patient's record. The nature of the concern, evidence or observations, potential triggers, and protective factors should all be detailed. The concerns should be immediately shared with the multidisciplinary team (MDT) to ensure a coordinated response and escalated to both the team leader and community consultant if urgent.

111. If there is immediate risk of serious harm it is responsibility of the staff member to contact emergency services (999/111) or the duty psychiatrist immediately. The Team Leader or on-call manager should also be informed. Safeguarding procedures are initiated if a child or vulnerable adult is at risk.

The family or carers may be contacted (within confidentiality limits) to support safety. If the concern is not immediate or urgent it is discussed in the next MDT meeting. A risk management plan is developed, specifying the level of risk, any preventive measures (e.g. increased contact, medication review, safety planning), the named CCO responsible for monitoring and if involvement of crisis services were required.

112. If the level of risk was not high or immediate but could be managed at home and the need for monitoring was greater than the EIP team could provide then the patient would be referred to the CRHT. CHRT made an initial assessment on the telephone and if in their view the risks could not be safely managed by them a Mental Health Act assessment was called.

113. If the level of risk extends beyond the scope of the EIP team or CRHT or there is an imminent risk of violence or criminal activity and/or a safeguarding referral (e.g. to adult or children's social care), a police liaison will be asked to attend. A patient's risk was reviewed regularly or after any significant risk event until such time that those risks are no longer present. Any change in risk status triggered a review of the care plan and communication with relevant parties.

114. A patient under the care of the EIP team may show signs of relapse, disengagement or non-concordance with medication. All CCO and qualified nursing staff are trained to recognise early indicators of relapse which may include changes in sleep, mood, or functioning, emerging suspiciousness,

disorganisation, or withdrawal, missed appointments or refusal to engage and carer/family reports of deterioration.

115. The CCO will document these concerns and inform the wider EIP team. A clinical review is then triggered, either in an MDT meeting, or sooner, with the treating psychiatrist, if risk is elevated. An urgent assessment is arranged for the patient by the CCO to confirm whether a relapse or disengagement is occurring and to assess associated risks. Initially the CCO or duty worker will attempt direct contact with the patient via phone or text, followed by an urgent home visit. If contact fails, the team will attempt indirect engagement through the family, carers, or other trusted contacts (with consent). The CCO will update the risk assessment, focusing on risk to self or others, and vulnerability or safeguarding concerns, any medication adherence issues and side effects and social stressors (housing, finances, substance use, etc.)

116. Cases of potential relapse are reviewed at the MDT meeting (weekly) to determine the level of current and potential risk and any barriers to engagement (e.g. insight, medication side effects, mistrust, communication issues): an action plan will be put in place. The plan should be recorded in the patient's electronic records along with re-engagement strategies.

117. If the patient continues not to engage with the team or treatment the following steps should be taken.

i. Increase frequency/flexibility of contact e.g. outreach visits, short texts, meeting in neutral settings such at cafes/park.

ii. Offer practical or psychosocial support first in order to reduce pressure around medication.

iii. Involve family/carers to support engagement (with consent or in the patient's best interests as appropriate).

iv. Review whether care approach or staff assignment needs adjustment.

v. Use shared decision-making to address medication concerns and level of contact.

118. In the event that medication is being refused or missed the CCO will arrange an urgent review with the prescriber (psychiatrist or non-medical prescriber). The prescriber will then conduct a medication review to explore potential reasons for refusal (side effects, lack of insight, beliefs, practical barriers), to offer adjustments (e.g. lower dose, long-acting injection, alternative medication), and to provide psychoeducation about relapse prevention, side effects, and autonomy in treatment. If relapse risk is considered high or the patient is showing clear signs of relapse then a referral to CRHT will be made.

119. If disengagement or relapse lead to significant risks emerging, an urgent review with the treating psychiatrist will be booked and the team manager informed. Depending on the patient's presentation, level of risk, and willingness to engage with a treatment plan, a CRHT referral and Mental Health Act (MHA) assessment may be carried out. Where the patient is assessed as posing a serious risk of harm to themselves or others, a safeguarding referral or a police welfare check may be made: this would be only if all other engagement routes had failed and the patient's risk was deemed to be high.

120. In the event a patient is deemed unsuitable for EIP, a detailed discussion about their presentation, immediate risks and reported unsuitability of EIP will be discussed at the MDT. The patient would then signposted to the service which was likely to best meet their needs (e.g. LMHT, substance misuse services, IAPT etc) or, if their needs could not be met by secondary care services, they would be discharged back to their GP.

121. A forensic assessment would only be indicated in circumstances where a patient with psychosis poses an extremely high and significant risk of harm to themselves or others. Indications for a forensic assessment include a current or past history of serious violence, sexual or fire setting behaviour, serious threats to harm others or demonstration of escalating aggression; evidence of delusional beliefs or hallucinations linked to violence e.g. command hallucinations to harm others. A referral is generally made when usual community mental health risk procedures can no longer manage these escalating risks safely.

122. A forensic assessment is also usually requested when a patient is arrested or charged with an offence which has been driven by psychotic or other psychiatric symptoms and has a history of offending. This is to evaluate fitness to be interviewed or stand trial, to determine mental state at the time of the offence and to consider whether hospital treatment would be warranted instead of prison.

123. The EIP team may request a forensic assessment when there are complex risk factors e.g. co-existing substance misuse, a history of trauma, antisocial personality traits or there is a need for a structured professional judgement using forensic risk tools such as the HCR-20 **[WITN0133024]**. Whilst the HCR-20 is not limited to forensic psychiatry it was developed in forensic contexts and within our trust is predominantly used within the forensic directorate and staff must have focussed training before using it.

Information sharing

124. The EIP services followed strict national standards to ensure information sharing was lawful, necessary and proportionate. All information sharing at NHFT follows the principles set down in the Data Protection Act 2018 and UK GDPR which governs how personal and sensitive health information is processed, shared, and stored. Caldicott Principles, the NHS guidelines ensuring information sharing supports care but respects confidentiality are also adhered to, as is the Mental Health Act 1983 / 2007 which provides a basis for sharing information in the context of risk, detention, or compulsory treatment; safeguarding legislation which allows (and requires) sharing when there is risk of harm to a child or vulnerable adult and NHS Confidentiality Code of Practice which outlines how patient information must be handled across teams.

125. EIP staff share information on a "need-to-know" basis, ensuring the minimum necessary data is shared to support care or manage risk. The team use integrated electronic records, Rio, which allowed all professionals (psychiatrists, nurses, psychologists, support workers, pharmacists) to access

and update information in real time. Within Rio there were risk alerts, care plans, CPA (Care Programme Approach) reviews, and safeguarding notes. The CHRT and Acute inpatient wards also used the Rio electronic patient record system allowing continuity and note sharing during admission and discharge.

126. Another important source of information sharing was the weekly MDT meetings. These were attended by psychiatrists, psychologists, nurses, support workers, employment/vocational specialists, peer support workers, non-medical prescribers, and pharmacists and were chaired by the Team Leader. They served as a forum in which to share updates on patient progress, risk, and action plans.

127. Cross-Agency Meetings included CPA(Care Programme Approach) which included the service user, carers, and external professionals (e.g. housing support, re-enablement workers, third sector providers, social worker, substance misuse worker). They would also include MAPPA (Multi-Agency Public Protection Arrangements) meetings if there was an offending risk and MARAC (Multi-Agency Risk Assessment Conference) if a domestic abuse risk existed. Episodes of escalating risk or crisis information are always shared as appropriate with the CRHT, duty AMHP, GP or social services (if relevant) and safeguarding teams (if a child or vulnerable adult is at risk).

128. As far as the sharing of information is concerned, the main barrier was when a patient was admitted to hospital out of area. Communication became

challenging and often delayed and important information became inaccessible due to our team not having access to the inpatient electronic patient records.

Sharing Information with Family

129. A patient's named CCO took a lead role in family liaison but only with consent from the patient. All patients were strongly encouraged to consent and allow information to be shared with families. Family members were encouraged to attend patient reviews and to be involved in care planning whenever appropriate.

130. Where a patient withheld consent to share information or contact family members, confidentiality is maintained. The exception is if the patient poses a serious and imminent risk of harm to themselves or to others or where there are safeguarding concerns to a child or vulnerable adult or there were public protection concerns e.g. threats of violence, plans to commit a serious offence. In such cases only relevant information can be shared and only on a need-to-know basis.

131. If a patient has been assessed as lacking capacity to make an informed decision about sharing information, the team will share information with their family or carer only when it is considered to be in the patient's best interests to do so.

132. There can be situations where a patient's family has access to important information which is necessary to ensure safe and effective care e.g. a patient's

current address or whereabouts, concerns about deteriorating mental health etc: under these circumstances the team will contact the family to gain information from them without sharing any information we had on the patient.

133. Information was shared with third parties such as the police, local authorities, the GP, and independent healthcare organisations by telephone calls, emails, and letters. It was shared weekly with me mainly through face-to-face discussions with me either at our weekly EIP MDT, during joint clinic appointments or at any other time in between as needed in my office and through emails.

Related experience

134. I have not previously been involved in the care of any other mental health patient who, following discharge or when in the community killed or seriously injured a member of the public.

Chronology of events

135. It is my understanding that during the period that VC was under the care of the EIP team, it was not usual practice within the Adult Mental Health LMHTs in Nottinghamshire Healthcare NHS Trust to formally record discussions which took place at MDT meetings.

136. It was not usual practice within the Adult Mental Health LMHTs at NHFT to formally record discussions which took place at MDT meetings. This is my

understanding as to why records of MDT meetings in VC's records were not always made during the period that VC was under the care of the EIP team

Chronology of events

137. I was first scheduled to meet VC in clinic on 14th July 2020. VC had been admitted to hospital the previous day. He told inpatient staff that he had an appointment with me at Stonebridge centre at 10.00 hours and wondered if he could go **[NHFT0000168, p.57]**. He was advised that it was not possible because he was due to be assessed on the ward. He was calm and appeared to understand and staff offered to contact me. This took place on the same morning: staff contacted me and let VC know that I had confirmed I was aware of his admission.

138. Between the 30th June 2020 and 25th July 2021 I had consultant oversight of VC's care whilst he was under the EIP team in the community. I provided weekly clinical supervision to Dr Burri and advice as needed to Claudia Birtles, VC's CCO during that period. Advice and supervision to Dr Burri was provided predominantly at our weekly supervision sessions and to Claudia Birtles at the EIP MDT meeting and also individually when I was approached by her directly.

139. From 25th July 2021 to 23rd September 2022 I became more directly involved in VC's care after Dr Burri handed over the medical aspects of his care to me. VC was due to meet me for an outpatient follow up review on 9th August

2021 but failed to attend this appointment **[NHFT0000168, p.157]**. He was offered a further appointment with me on 10th August 2021 which he declined.

140. On the morning of 2 September 2021 I attended a MHA assessment on in the company of Jenny Shaw (AMHP) and Dr Jan, the second s.12 MHA 1983 approved doctor required for a MHA assessment. The assessment had been requested due to a perceived deterioration in VC's mental health. We attended VC's home address but he did not answer the door or respond to his mobile. VC was admitted to hospital following the execution of a s.135 MHA warrant to enter his property the following day **[NHFT0000168, p.164]** and was detained under section 2 MHA 1983.

141. Following VC's discharge from his third inpatient admission I was scheduled to see him for medical follow up in clinic on 15th November 2021. VC did not attend this appointment **[NHFT0000168, p.198]**.

142. VC subsequently failed to attend a further three scheduled appointments with me on 29th November 2021 **[NHFT0000168, p.199]**, 6th December 2021 (when I visited him at home **[NHFT0000168, p.199]**), and 17th January 2022 **[NHFT0000168, p.203]**. The appointment on 6th December 2021 was a joint home visit with his CCO, Claudia Birtles. We knocked on VC's front door several times and Claudia called his mobile but we got no response.

143. I met VC for the first time face to face on 14th March 2022 for a follow up clinic appointment after his fourth inpatient admission **[NHFT0000168, p.263]**.

He was well presented, articulate and engaged with the meeting. We spent a bit of time briefly re-capping on the events leading up to his recent hospital admission. In VC's view it was very much underpinned by an altercation he had with another resident in his accommodation. He told me that he had not missed any medication in the lead up to his admission and his mental health had been fine. He stated that he felt well and mentally stable. He denied any psychotic symptoms. I noted that VC was completing a masters degree and would hand in his dissertation in April. He was on track and coping well with it all. He had plans to find work after completion but has no concrete plans of whether or not he would remain in Nottingham. He told me that he was happy with his medication and had no appreciable side effects. He would collect his tablets from us fortnightly and meet his CPN for a review on these occasions. His wish was to keep his contact with us as low key as possible and we agreed to facilitate this as much as possible whilst monitoring his mental health. He was made aware of the options of CBTp and a support worker but VC did not feel this necessary. He refused a physical health check and baseline bloods. I recorded that VC appeared well with no overt evidence of psychosis. His mood was euthymic and he was functioning to a high level. I made no changes to his management or medication and planned to see him again in clinic in 3 months' time.

144. VC failed to attend two further clinic appointments with me on 13th June 2022 **[NHFT0000168, p.267-8]** and 1st August 2022 **[NHFT0000168, p.269]**.

145. VC was discharged from the EIP service on 23rd September 2022 following an MDT decision **[NHFT0000168, p.271]**. I was in attendance at that MDT meeting. It was not usual practice within the Adult Mental Health LMHTs at NHFT to formally record discussions which took place at MDT meetings. This is my understanding as to why records of MDT meetings in VC's records were not always made during the period that VC was under the care of the EIP team.

First knowledge of VC

146. In my Theemis interview, carried out on 12 June 2024, I confirmed that I first became aware of VC at the beginning of June 2020 and that I was fully aware of him by 14 July 2020 **[TCLT0000516**, p.8**]**. I first became aware of VC when a referral was made to the EIP team by the Crisis Resolution and Home Treatment Team (CRHT) who were undertaking the initial period of follow up following VCs first admission to hospital. The referral letter was discussed in our EIP MDT meeting which I attended. I am unable to recall the exact date of that particular MDT meeting.

147. The EIP team were provided with a referral letter from the CRHT [**WITN0196002**].

148. From my recollection, discussions I had in respect of VC were regarding the appropriateness of the referral to EIP services; these took place at the MDT meeting where it was agreed that Claudia Birtles, one of the EIP CPNs would conduct a joint visit with a member of the CHRT as part of the initial assessment

process and bring any relevant information back to the MDT meeting for further discussion. Following further discussion at our MDT meeting it was agreed that VC's presentation met the criteria for a first episode of psychosis and that he would be taken onto our EIP caseload.

149. I became fully aware of the details pertaining to VCs first arrest on 23 May 2020 prior to my initial clinic appointment with VC which was scheduled for Tuesday 14th July 2020. Prior to meeting a patient for the first time, it was my practice to spend time reading through the patient's multidisciplinary notes in detail. It is recorded in VC's records in an entry made at 9.54 am on 24 May 2020 that he had forced his way into a student flat in his residence in response to auditory hallucinations of a woman screaming. It is recorded that he was concerned that the woman might be his mother and his response to this was an attempt to try and help/save her **[NHFT0000168 p.1]**. VC is recorded as having presented with psychotic symptoms during his psychiatric assessment at the time including experiencing both second and third person auditory hallucinations; it is recorded that he had persecutory delusions, and his thoughts were disorganised and he was perplexed and confused.

150. I understand that VC was arrested for a second time on 24 May 2020 after he was sent home from the custody suite following an initial MHA assessment with follow up arranged with the CRHT (see **[NHFT0000168]**). It is recorded that he broke into the flat of the same student in response to hearing the voice of a woman screaming for a second time. On this occasion the student living in the flat jumped out of her window in fear, although the records of the

event do not suggest that VC had any intention of harming her or anyone else; rather it is recorded that he wished to assist the person inside whom he believed was in danger. Following his second arrest VC had a further mental health act assessment and was admitted to hospital under section 2 of the MHA.

151. With regard to VC's third arrest on 13 July 2020, I note from his records that the Police were contacted after he had forced his way into the flat of an individual who lived above him, and he verbally confronted some students whom he believed were talking about him and discussing him in a derogatory and persecutory manner. On this occasion it is recorded that he denied his actions were in in response to him experiencing third person auditory hallucinations. VC is recorded as having confirmed that he was taking his medication although it is also recorded that the nurse assessing him, Nigel Wade, considered he was attempting to conceal his symptoms **[NHFT0000168, p.56].**

152. I became fully aware of the details pertaining to VCs third arrest prior to my initial clinic appointment with VC which was scheduled for Tuesday 14th July 2020.

153. I also understood VC to have seriously assaulted two police officers during the execution of a section 135 warrant during a Mental Health Act assessment in September 2021 in the lead up to his third admission **[NHFT0000168 p.164]**. This was an extremely high threat situation where the police and individuals that were unknown to him (the MHA assessment team) had gained forced access into his property. VC was floridly psychotic at that time

and believed that there was conspiracy against him led by M15, the police and the government.

154. I have referred to the records of my appointment with VC on 14th March 2022 **[NHFT0000168, p 263]**. I note from these that we specifically discussed the events directly preceding his fourth admission when he got into an altercation with another resident in his shared lodging leading to VC punching this student. VC explained to me that in the period between his third and fourth admission he had been taking his medication and this had kept him well and free from any psychotic symptoms. VC acknowledged that he had been acutely psychotic during his first three admissions but not the fourth. VC gave an account of events leading up to the incident in his flat. He stated that the other students sharing the flat had been mocking him for weeks, calling him derogatory names behind his back in relation to his personal hygiene and mental health.

155. From my recollection of discussions on 14th March 2022 when VC and I talked about the events leading up to his 4th admission, he informed me that on the night in question, they accused him of leaving dark hairs in the shower and blocking up the drain. According to VC this led to an altercation between him and one student who used obscene language against him resulting in VC losing his temper. VC punched this student and locked the door to the room. Another resident called the police resulting in a further MHA assessment and admission to hospital. VC told me that he had locked the door so that students couldn't leave the room before the police arrived. VC insisted that the altercation was not

driven by him experiencing psychotic symptoms. In keeping with this, during the MHA leading to his fourth admission, the assessment team were not able to find any signs or symptoms of psychosis. Furthermore during his month on the ward the inpatient team were unable to identify any clear evidence of acute psychosis.

156. In light of the incidents leading to his arrests my view of VC's risk based on detailed reading of VCs multidisciplinary notes and conversations with his named CCO Claudia Birtles was as follows:

157. In the lead up to his first admission to hospital VC had forced his way into a student flat in his residence in response to auditory hallucinations of a woman screaming. He was concerned that the woman might be his mother and his response to this was an attempt to try and help/save her. It was very unfortunate that the student living in the flat jumped out of her window in fear, although VC had no intention to harm her or anyone else, only to assist the person whom he believed was in need of help. VC had a second admission within two weeks of his discharge from the first. On this occasion he verbally confronted some students in a neighbouring flat whom he believed were talking about him/discussing him in a derogatory way. There was no record of any physical violence on his part against these students.

158. VC seriously assaulted two police officers during the execution of a section 135 warrant during a Mental Health Act assessment in August 2021 in the lead up to his third admission. This was an extremely high threat situation where the police and individuals which were unknown to him (the MHA

assessment team) had gained forced access into his property. VC was floridly psychotic at that time and believed that there was conspiracy against him led by M15, the police and the government. It is the view of his care-coordinator and myself that his actions that day were a response to a high level of a threat and that he would come to harm in the hands of police, in keeping with his delusional belief system. It is very likely that VC acted in self-defence as he perceived himself to be under attack from the police and felt the need to fight for his life.

159. In my experience of having been involved in a number of similar MHAs with police involvement it is not unusual for an extremely charged situation such as this to spiral into violence. Once again there had been no prior planning or intention on the part of VC to harm the police officers, it was a situation that got out of control.

160. Having read through VCs multidisciplinary records pertaining to his fourth admission including an account provided by the student with whom he had the altercation **[NHFT0000168, p.228]** and also having heard VCs account of the incident, my opinion (given the lack of evidence that VC was suffering with psychosis during this fourth admission) was that this particular episode of violence was as VC had described, an altercation that had got out of hand which was not driven by psychosis. VC had been provoked and got into a fight as many young men without mental health difficulties might do.

161. During his time under the care of the EIP team, VC had never voiced any thoughts of wanting to harm others including members of the public. I am not

aware of any documentation in his case notes or risk assessments of VC experiencing command hallucinations telling him to harm others or delusions of control which may have caused potential risks to members of the public. In terms of other key risk factors which predict serious violence in psychosis, VC had no previous forensic or criminal history or a known history of substance misuse, both of which have been identified in systematic reviews as significant risk factors for violence in psychosis. It was my understanding that VC had good pre-morbid adjustment and was described by those who knew him as being a shy, intelligent and good-natured young man who focused on his studies. He had no anti-social personality traits that we were aware of, and appeared to come from a supportive family with a relatively stable upbringing. We were not aware of any previous history of trauma.

162. For the reasons described above, the team's risk assessment of VC was that during periods of acute psychosis there was a risk that when he found himself in a high threat situation he could react with hostility and the situation could spiral out of control into violence. We could not have predicted from his history, presentation and risk factors that at the time there was a serious risk of harm to the public.

163. After each of the above incidents of violence and aggression VC was admitted to hospital. It is my understanding that a risk assessment was undertaken by the inpatient team during each admission taking into account his previous acts of aggression and violence. The risk assessments should have identified the correlation between VC stopping or becoming non-concordant with

his medication and the subsequent deterioration in his psychotic disorder leading to the acts of aggression and violence.

164. My understanding, from the documents I have considered and discussions I had, was that VC's presentation was in keeping with recurrent episodes of psychosis defined by the presence of second and third person auditory hallucinations, persecutory delusions and thought disorder during acute episodes. He also had reasonably long periods of remission between acute episodes but continued to have some residual auditory hallucinations which fluctuated in frequency and intensity.

165. Diagnoses in psychiatry can be variable depending on the course and natural history of a patient's condition, the diagnostic tool/criteria being used and can very often vary from clinician to clinician. Both the International Classification of Diseases (ICD-10 and 11) and the Diagnostic Statistical Manual of Mental Disorder (DSM-4 and 5) are used to make clinical diagnoses in psychiatry, and for a diagnosis of schizophrenia to be made both the symptom criteria and duration of symptoms (at least one month for ICD-10 and 11) must be met.

166. VC was given a diagnosis of Paranoid Schizophrenia at the end of his second hospital admission as documented in his hospital discharge summary. Whilst VC would have met the symptom criteria for his first three hospital admissions (the presence of second and third person auditory hallucinations and persecutory delusions), his duration of symptoms during the first two admissions was less than a month. There was some uncertainty regarding the

length of symptom duration during his third admission. My EIP team and I had no access to clinical records from the private hospital or a discharge summary – this was a general problem between NHS and private providers. From the information we had available (as recorded by his care-coordinator in her liaison with the private hospital) it seemed unlikely that VCs symptoms lasted more than a month (admitted 3/9/21 and stepped down from the Cygnet unit on 1/10/21 having made a good recovery from psychosis).

167. The EIP could not be certain that VC would have met the duration diagnostic criteria for schizophrenia. During his fourth admission to hospital from January to February 2022 the inpatient team were unable to elicit any psychotic symptoms of diagnostic significance, and he was discharged from hospital within a month.

168. However, between his second and third admission VC eventually admitted that he had not made a complete recovery and had continued to experience persistent ongoing residual auditory hallucinations **[NHFT0000168, pp.137-8]**. ICD-10 was in use during 2021 and only required the presence of one characteristic symptom of paranoid schizophrenia for over a month which meant that time VC most probably did meet the threshold for paranoid schizophrenia at that time. Importantly, ICD –11 came into use in January 2022 which required at least 2 characteristic symptoms of schizophrenia to be present for over 1 month.

169. When I met VC for the first time in March 2022, he would no longer have met criteria for schizophrenia due the change in diagnostic criteria for

schizophrenia from ICD-10 to ICD-11. Based on ICD-11 his diagnosis would have been recurrent episodes of acute and transient psychotic disorder. The significance of distinguishing schizophrenia from recurrent episodes of acute and transient psychotic disorder lies in how they differ in course, prognosis, treatment planning, and long-term implications. Schizophrenia is a chronic psychiatric illness with symptoms persist over 1 month. It is a progressive condition with residual symptoms between episodes and functional decline is common over time. Acute and transient psychotic disorder has a sudden onset usually hours to days, a short duration (usually days to weeks, by definition less than 3 months) and either complete or near-complete recovery between episodes. Recurrent episodes may occur, but baseline functioning is often restored. The significance of distinguishing these two disorders is that acute and transient psychotic disorder suggests an episodic illness with recovery, while schizophrenia implies a long-term disorder. Many cases of acute and transient psychosis evolve into schizophrenia.

170. The NICE guidelines for EIP does not prescribe fundamentally different treatment pathways for schizophrenia versus acute and transient psychosis. The focus is on clinical presentation (first episode psychosis) rather than diagnosis. NICE recommended treatments apply broadly to anyone with a first episode of psychosis, whether or not that episode later results in a formal diagnosis of schizophrenia.

171. Furthermore, individuals with schizophrenia show a substantial impairment in overall cognitive performance which contributes to poor

independent living skills and levels of functioning. During periods of remission VC was able to maintain independent living skills, work part time and eventually complete a degree in mechanical engineering from a good university, which in my 29 years of experience as a Consultant Psychiatrist specialising in psychotic disorders, and according to the evidence base would be very unusual for an individual with schizophrenia.

172. Due to the reasons stated above I did not think that VCs presentation clearly met the threshold for a diagnosis of schizophrenia whilst under the care of our team but did meet threshold for an acute and transient psychotic disorder as classified in ICD11 and DSM5.

173. His likely treatment initially would be in line with the NICE recommended guidelines for patients with a first episode of psychosis which I have described previously, and he would be offered this treatment irrespective of his specific diagnosis. In the lead up to his third admission in September 2021 when the team recognized that VC had been non-concordant with his antipsychotic medication, it was our strong view that he should be commenced on depot antipsychotic medication and managed in the community on a CTO.

174. Following VC's first hospital admission, his care was provided initially by the CRHT. Although he met with his CCO from the EIP, Claudia Birtles, on 26 June 2020 **[NHFT0000168, p.53]** CRHT remained his lead care provider. He was only officially handed over to the EIP team by CRHT on 30 June 2020. This meant that I did I did not have the opportunity to assess VC prior to his second

admission (13 July 2020 – 31 July 2020). Claudia Birtles, who was VC's, named CCO started the process of his initial assessment and had appointments with him on 3 July 2020 and 9 July 2020. I was due to meet him for the first time in clinic on 14 July 2020 as scheduled by his CCO but unfortunately VC went back into hospital for a second time on 13 July 2020.

175. I did not have the opportunity to have any discussions with VC or his family prior to this second admission. VC's CCO brought his case to the EIP MDT for some feedback following her two initial appointments with him and I was present at that meeting and engaged in the dialogue. There was a discussion of VC's case at the time of his referral from the CRHT to our EIP team at the EIP MDT meeting.

176. I recall VC's CCO providing some feedback to the MDT regarding VC's presentation and background. I recall a general agreement by the team that he was suitable for treatment on the EIP pathway. I cannot recall any other specific discussions or advice that I gave or the specific date of this MDT meeting.

177. As detailed above, in between his first and second admission VC's care was provided by another team namely the CRHT and only officially handed over to our team on 30 June 2020. I did not have the opportunity to assess VC in this period due to the very short time window from the 30 June 2020 and the 13 July 2020 when he went back into hospital. There were no other doctors working with our EIP team at that time.

178. I became aware of VC's second admission on the morning of 14 July 2020 when his CCO, Claudia Birtles came to tell me that his outpatient appointment with me that morning would not be going ahead as he had been admitted to Highbury hospital the previous day.

179. During VC's second admission Claudia Birtles attended a number of VC's ward reviews and saw him face to face on the ward as part of her CCO inpatient in reach role. She brought feedback regarding his progress and treatment on the ward back to the EIP team at our weekly MDT meetings.

180. In terms of VC's condition, and insight I understood that VC had discontinued his antipsychotic treatment in the community in the period between his first and second admission due to concerns about side effects, namely sedation and the impact this might have on his abilities to study. His insight into his condition and need for medication was partial to begin with as he struggled to accept that he had suffered with a severe psychotic episode and believed he could stay well without ongoing treatment, but as the admission progressed his insight appeared to improve. I understood that he received some compliance therapy from a psychologist during this admission.

181. My understanding of his risk to others is as detailed at paragraph 93 above. In addition to this I felt there might be a risk of him discontinuing his treatment again in the future, but given he was in the very early stages of his condition, it was reasonable to give him the opportunity to work collaboratively with our team, build rapport, undertake some work on relapse prevention with

his CCO and allow him the chance to try another course of oral treatment in line with the EIP ethos of person-centred, recovery focused support taking the views and choice of the patient strongly into account.

182. At this point in time my knowledge and understanding of VC's case was predominately based on the multi-disciplinary notes and discussions that had taken place in our MDT meetings. I had not had the chance to directly interact with VC or form any firm opinions about his diagnosis or treatment. Claudia Birtles VC's CCO was acting as a conduit between inpatient services and our EIP team and had not raised any concerns or issues regarding his inpatient care. As such, I was happy to defer treatment decisions to the superior knowledge of the inpatient team who knew him better than I did. I did not discuss VC's case directly with Dr Seedat.

183. I considered VC's treatment needs to be re-establishment back onto his antipsychotic medication at an optimum dosage that effectively treated his symptoms and allowed him to gain sufficient insight so that he maintained concordance in the community. To undertake some psychological therapy/psychoeducation on psychotic disorders and concordance with treatment.

184. I can see that Rupert Ackroyd undertook a core assessment on 15 July 2020 **[NHFT0000187]**, but I did not make a contribution to this assessment. It would not be usual practice for a community consultant to contribute to an inpatient CORE assessment particularly where, as here, I had never met VC before and

had not been involved in the assessment leading to his admission. I did read VC's CORE assessment in the two hours prior to my first attempted clinic appointment with him on 14 July 2000, and my view as to the management of VC is as already stated above.

185. I am not listed as one of the ward review attendees not listed as an attendee **[NHFT0000168, pp.77-81]**. I did not attend VC's ward review on 21 July 2020 as inpatient liaison was not part of my job plan and there was not enough flexibility in my job plan to enable attendance at inpatient ward reviews. As previously mentioned, I had three direct care clinical sessions (one and a half days) allocated to EIP work which comprised a clinic session, a home visit session and MDT meeting time which took up the majority of my sessional allowance. Attendance at VC's inpatient discharge meeting would have meant cancelling scheduled clinic appointments which were a fixed commitment. Within the EIP services at NHFT, it was the role of the CCO to undertake ward liaison and act as a conduit between inpatient and community teams. Claudia Birtles therefore attended the ward review on 21.07.20 on behalf of the team.

186. I am unable to recall my specific views regarding VC's suitability for discharge as I had no direct involvement in his discharge planning. Dr Seedat and the inpatient team had very appropriately decided that VC would benefit from a period of CRHT follow-up given his rapid deterioration in mental health after his first admission and this seemed a very sensible and prudent decision. VC received weekly monitoring from his CCO upon handover to the EIP team in addition to medical appointments as determined by his CCO and the doctor

following him up. VC received treatment with Aripiprazole 10 mg daily, an oral antipsychotic tablet which again would be in keeping with usual clinical practice for a patient with first episode psychosis in recovery.

Following Second Admission (31 July 2020 – 3 September 2021)

187. I did not receive any information from the crisis team in respect of VC in the period following his discharge and I did not have the opportunity to read the notes made by the CRHT. I was not made aware of the entries made by Clive Chimbi on 1 August 2020 (at 3:35pm) and 3 August 2020 (at 11:49am) **[NHFT0000168, at pp.118-119 and 121- 122]**. Handover from the CRHT was undertaken by VC's CCO Claudia Birtles and she did not give feedback on any concerns raised by the CRHT to me or the EIP MDT.

188. It is possible that these entries may have caused me to question if VC was undertreated on the 10 mg of Aripiprazole which was the dose he was prescribed at the point of discharge from the hospital.

189. I was named in VC's "Summary & Care Plan" dated 1 September 2020 **[NHFT0000202]**, as being responsible for mental health actions, risk and safety actions, physical health, activities of daily living, medication, social and occupational needs and therapy. However, I had no involvement in the preparation of the care plan as this is primarily the role of the CCO in collaboration with the patient.

190. Due to a period of annual leave in August 2020 VC was booked in by Claudia Birtles for a medical follow up by my specialty trainee (ST5) Dr Bilal Burri. Dr Burri undertook VC's initial medical assessment and then, for the purposes of continuity of care, offered VC an ongoing follow up in outpatient's clinic. I provided oversight of VCs care through regular weekly supervision of Dr Burri as stipulated by the Royal College of Psychiatrists but was no longer directly involved in VC's care. I did not read the care plan, but my understanding was that Dr Burri did.

191. In my position as community consultant psychiatrist for the EIP team it was my responsibility to have an oversight of the actions and deliverables set out in the care plan. My responsibilities included ensuring that the care delivered was safe, appropriate and coordinated by the CCO, that decisions were based on sound clinical judgement, delegation of tasks to other professionals was appropriate and systems of oversight such as supervision were in place to ensure safe practice. This was achieved through one-to-one weekly supervision of my ST5 trainee Dr Burri and providing advice and psychiatric expertise to CCO Claudia Birtles during MDT meetings or at any other time that she approached me.

192. Consultant oversight does not mean personally checking or signing off every piece of documentation or care plan created by a CCO or personally delivering every action in a care plan. The steps I took in light of these responsibilities are as detailed in the above paragraphs.

193. I understood that VC had been offered CBTp, peer support and his CCO had undertaken work with him in January 2021 on relapse prevention, identifying early warning signs of psychosis and psychoeducation. VC's mother had also been offered carer's support. I understood that VC refused to take up the offer of CBTp and peer support.

194. CBTp would have offered VC a greater understanding of his condition, provided him with psychological skills to better manage and challenge residual auditory hallucinations and would have been helpful during times when his non-concordance was driven by persecutory delusions or beliefs about voices through challenging these thoughts and perceptions. A peer support worker could have provided the very important function in building trust with VC and supported the CCO with early engagement and providing him with an understanding of his experiences and a narrative from a service user's perspective. Initially VC had a very good relationship with his family who had always been supportive so behavioural family therapy would not have been indicated in the first year of the EIP pathway.

195. In my NHFT interview at **[NHFT0004710, at p.1]** I stated that: '*For the first year, it was my speciality trainee (Dr Burri) who followed him up*". The follow up of VC was undertaken by Dr Burri: VC's CCO Claudia Birtles booked VC in to see Dr Bilal Burri for an initial assessment in August 2020 to ensure that VC was seen by a member of the medical team in a timely manner. I had a period of annual leave booked during this time, so my clinic availability was limited.

196. I also stated that "Dr Burri had weekly 1 hour supervision with me and discussed news cases in particular but also ongoing patients". This is because ST4-6 trainees are doctors in advanced psychiatric training and would typically build up their own supervised caseload whilst in a training post.

197. Whilst I am unable to recall the details of any discussions that I had with Dr Burri in relation to VC I do remember that Dr Burri regularly brought his case to supervision sessions and the EIP MDT for discussion. I recall discussions about how Dr Burri should balance incremental increases in VC's antipsychotic medication with the emergence of side effects, namely sedation and slowing of cognitive processes which were especially pertinent to VC in relation to his academic studies.

198. Dr Burri was confident that VC had two consecutive episodes of a psychotic disorder. He did not make a specific diagnosis using the ICD-10 criteria for the following reasons; when EIP services were first set up in the early 2000s, there was a strong ethos around reducing stigma and instilling a sense of hope and recovery in this young patient group and their families. EIP services nationally were encouraged to work with diagnostic uncertainty and this has continued to be the case as referenced in the National Institute of Clinical Excellence (NICE) guidelines 2016. Patients are therefore often given a broad diagnosis of "first episode psychosis" during their time in services rather than a more specific diagnosis. This terminology is used both in the EIP literature, the Royal College of Psychiatrists Guidance and NICE guidelines.

199. It is also worth noting that the diagnostic stability of psychotic disorders can be low in the first 2-3 years of the course of illness and tends to increase as the illness trajectory becomes clearer which is another reason for using more broad diagnostic terminology like "First Episode Psychosis".

200. In November 2020, after VC disclosed to Dr Burri that he had continued to experience auditory hallucinations and they had been present throughout his last hospital admission and at the point of discharge it became clear that he had not made a full recovery from his psychosis. At this time, he also started to question if his voices were caused by a psychotic disorder or if there maybe another more sinister cause based on previous delusions that may be underpinning the voices. His insight into his condition was partial at best and he required further incremental increases in his antipsychotic medication. My understanding of his risks of harm to self and others based on discussions with Dr Burri and Claudia Birtles (CCO) was that these remained low.

201. I did not review the notes and correspondence in respect of Dr Burri's outpatient appointments with VC. A consultant supervisor would not be expected to review notes and every piece of correspondence written by an ST4-6 trainee provided the trainee is competent, which Dr Burri was (as demonstrated by his workplace-based assessments) and appropriately supervised. Dr Burri received an hour of face-to-face supervision every week as stipulated by the Royal College of Psychiatrists and also had the opportunity to bring cases for wider MDT discussion at weekly MDT meetings. Higher specialist trainees are expected to work with significant autonomy under indirect

supervision. The Royal College of Psychiatry guidance states that higher trainees should demonstrate the ability to manage cases independently with access to advice and support as required.

202. Dr Burri saw VC on 7 September 2020 **[NHFT0000168, at pp.132-133; CHCA0000025]**. I recall Dr Burri was very clear that VC had experienced a psychotic disorder with florid symptoms characteristic of psychosis. Based on my review of VC's case notes immediately following his first and second admission and discussions with his CCO in our weekly MDT meetings, I supported this view.

203. From my recollection the diagnosis of an affective psychosis was never raised or brought to clinical supervision by Dr Burri. Affective psychosis is an episode of psychosis that occurs in the context of a mood (affective) disorder such as depression or mania and comprise psychotic symptoms which are secondary to and occur during an episode of mood disorder (manic, depressive or mixed).

204. Dr Burri's view that VC's insight was superficial and that he was not very confident if VC had a deeper grasp of his illness in the long term. Based on NICE guidelines for NHS EIP standards, an individual with psychosis and partial insight should initially be offered oral antipsychotic medication in conjunction with psychological interventions such as psychoeducation/relapse prevention. Clinicians are advised to choose medication collaboratively even if insight is limited, titrating gradually and monitoring carefully for side effects. If adherence

becomes a significant issue and the individual lacks capacity, then a depot/long-acting injection should be considered.

205. Dr Burri made comments that he was "not very sure about his long-term commitment to take anti-psychotic medication" coupled with his "relatively superficial insight": he was worried by what he called "compliance issues on the horizon" **[NHFT0000168, p.133-4]**. When considering the risks of the combination of such lack of insight and commitment I would say the risks under these circumstances are that a patient may potentially default from taking their medication and relapse into an acute psychotic episode.

206. However, a significant number of patients on the EIP pathway are uncertain about a long-term commitment to take anti-psychotic medication and many choose to eventually trial a discontinuation of medication, usually after a 2-year period with careful titration and careful monitoring. Furthermore, partial insight is very common in psychosis, especially in the early or recovering phases of illness. There are a number of studies which support this and a meta-analysis by Minz et al (2003) shows that whilst insight improves as psychosis remits this is very often not complete. Neither of these features are therefore unusual in a first episode psychosis patient group.

207. In light of Dr Burri's concerns regarding the superficiality of VC's insight and his lack of confidence regarding VC's grasp of his illness, further psychoeducation and relapse prevention work should ideally have been undertaken earlier.

208. It was noted that the Care Co-ordinator would try to do some relapse prevention work with VC at the first opportunity. Relapse prevention refers to a structured and collaborative process aimed at helping a patient recognise early warning signs of relapse, maintain recovery and take timely action to prevent a further relapse. Relapse prevention should ideally have been undertaken as soon as possible after VC's discharge after his second hospital admission in August/September 2020 but there may have been good reason as to why it did not start immediately. It is my understanding that relapse prevention work was undertaken in January 2021. Depot medication can be discussed and becomes a consideration as part of relapse prevention if a patient has experienced recurrent relapses due to medication non-concordance, has difficulty remembering to take their medication, has superficial insight or there is clear concern from the team or family about concordance.

209. VC received weekly home visits from his CCO which was an appropriate level of support and monitoring for a newly discharged community patient with first episode psychosis. There are no fixed national intervals stipulating the frequency of appointments with a psychiatrist. The review frequency should be reflective of a patient's level of stability, phase of recovery and risk.

210. A psychiatrist should always remain clinically involved and available for review and advice as needed. Weekly contact by VC's CCO provided close monitoring and an opportunity to escalate concerns between medical reviews. Following his initial assessment of VC on 7th September 2020, Dr Burri and

Claudia Birtles felt that given VC's stable mental state as assessed at that time and the absence of any immediate risks of harm to self and others, VC's next medical review could take place in 3 months' time and be brought forward by his CCO as and when felt to be necessary.

211. I do not recall speaking to Dr Seedat about VC's contact with him but Dr Seedat did send an email to the EIP team including me urging the team to visit him face to face, assess his mental state and make sure he is okay late on Thursday 5th November 2020 **[NHFT0017766]** As I do not work on Fridays, I messaged Dr Seedat back on Monday 9th November which is the day that I opened the email after speaking to the team and getting some feedback. **[NHFT0018011]** I let Dr Seedat know that the team had been making a concerted effort to visit and follow up VC but more recently VC had not been at home for arranged visits. I stated that attempts had been made to see VC weekly, his mum had also been contacted to get further support and EIP CPN Gary Carter had managed to see VC on Friday 6th November. I asked Gary Carter to get VC booked in for an early review with Dr Burri in light of this event which resulted in the home visit on 10th November.

212. At the time of receiving the email from Dr Seedat it was not clear why VC had wanted to speak with him but I later came to understand that VC was concerned that he had not been entirely truthful with Dr Seedat at his final ward discharge meeting and wanted to confess that he had in fact continued to hear voices when he had stated at the review that the voices were no longer present. This may have been a sign that he was relapsing or could have been VC feeling

guilty and remorseful that he had not told the truth to Dr Seedat and had wanted to rectify this. I had some concerns that he had not felt able to discuss this with his own care team. Although this was not a definitive sign or indication that VC was relapsing, Dr Seedat's suggestion of an urgent review by the LMHT was a sensible one.

213. I felt Dr Seedat made a sensible suggestion regarding VC needing to be assessed urgently and earlier than scheduled by the LMHT to make sure that he was not showing signs of an early relapse. This took place the following day on 6th November 2020 by CPN Gary Carter. However, with regards Dr Seedat's comment about the LMHT needing to provide more close monitoring and regular visits, in the lead up to this incident VC's named CCO had visited him face to face on a weekly basis which in my opinion would constitute "close monitoring and regular visits". (Only one contact by the CCO was a telephone appointment on 3 September 2020 **[NHFT0000168, pp.131-2]**. VC also had an outpatient appointment scheduled with Dr Burri four days later on 7 September 2020 which his CCO, Claudia, also attended).

214. Given that Dr Burri had carried out the initial EIP psychiatric assessment on VC and taken him onto his caseload it was usual practice for the doctor who carried out the initial assessment to offer ongoing follow up for the purposes of continuity of care and building rapport and engagement. I did not feel that it was necessary for me to review VC at this stage and that Dr Burri was entirely capable of making a robust psychiatric assessment.

215. It is both appropriate and valuable for a higher specialist trainee to see psychotic patients who may be relapsing as managing relapse is a core competency in their psychiatric training. These situations often involve complex decision making about risk, medication concordance and engagement with services which are all important skills in training to become a consultant. Dr Burri was able to bring any questions, concerns and issues to his weekly clinical supervision session with me or to the weekly MDT meeting. As mentioned, in the first instance I felt it was appropriate for Dr Burri who had already met and assessed VC to undertake a joint review with the CCO and if he felt uncertain or in any way doubted his assessment VC's mental state or needed of a further opinion from me then I would have seen VC myself.

216. A discussion took place at our weekly MDT meeting regarding VC contacting Dr Seedat and the importance of Dr Burri offering VC an early home visit to assess his mental state and then according to his findings and any potential risks identified to make a suitable plan of action based on the assessment which would be fed back to the MDT. The home visit took place on 10th November 2020.

217. I discussed VC with Dr Burri following the visit and from my recollection the discussion took place as part of an MDT meeting. I am unable to recall exactly what was discussed but do remember that Dr Burri and Claudia Birtles fed back their assessment of VC and the plan they had put in place at our MDT meeting. The team were made aware that VC had disclosed that he had not been truthful about the resolution of his symptoms at his final ward discharge

meeting and that his auditory hallucinations had continued to persist. In light of this an increase in VC's medication was implemented which VC had consented to. The team were satisfied that the course of action was appropriate to the situation. No other risks had been identified.

218. When a patient intentionally or unconsciously conceals or minimizes psychotic symptoms this can delay early diagnosis and treatment. Hidden psychotic symptoms can pose significant risks such as self-harm or aggression if a clinician is unaware. Patients may also be untruthful about concordance with medication. All of these factors need to be taken into consideration in decision making processes around risk and treatment.

219. However, it is also worth noting that VC disclosing to clinicians that he had not been truthful but was now willing to talk more openly about his residual auditory hallucinations, work collaboratively with Dr Burri and Claudia Birtles and accept incremental increases in his antipsychotic medication was a sign that he was starting to trust the clinical team. VC was now prepared to be more open with the team about his ongoing voices and this meant that we were better able to monitor any emerging risks. The EIP standard operating procedure states that risk assessments should be carried out annually and any point where there is an increase in the risk of harm to self or others. Dr Burri had documented that he did not think there had been an escalation of risk to self or others in his clinic entry on 10th November 2020.

220. It is my recollection that Dr Burri and Claudia Birtles fed back their assessment of VC, the risks and the plan they had put in place at our MDT meeting. I am unable to recall the exact details of what was discussed but I recall that the team were satisfied that the course of action was appropriate to the situation.

221. I am aware that Dr Burri saw VC on 7 December 2020 **[NHFT0000168, at p.140]**. I cannot recall discussing this particular attendance with Dr Burri or reviewing the notes. It is very likely that the attendance would have been raised by Claudia Birtles who would have fed back the outcome of the appointment at our MDT meeting. It was usual practice for CCOs to give feedback on all patients on their caseload even if was to state that an individual was stable.

222. My understanding of VC's condition, insight risk and treatment needs at this time was that whilst VC was continuing to experience residual 2nd and 3rd person auditory hallucinations, they had quietened following the incremental increase in Aripiprazole meaning that he was less distressed by the content of the voices, he was able to function to a reasonable level and work part time in a warehouse. Dr Burri believed that VC was concordant with his medication and there were no immediate risks of harm to himself or others at that time. Dr Burri recorded that he felt VC was starting to gain better insight into his condition.

223. Whilst I am not absolutely certain what is meant by "hallucinations with suggestibility" I would hypothesise that Dr Burri was referring to the voices making comment that VC needed to prove his power in some way. These are

not the same as second person command hallucinations directly telling a patient to carry out a particular act/task.

224. Dr Burri saw VC again on 1 February 2021 **[NHFT0000168, at pp.145-146]**I am unable to recall if I discussed the details of this specific attendance with Dr Burri or during our MDT meeting but do remember Dr Burri talking about a plan to undertake a cognitive assessment on VC due some short term memory deficits he had been struggling with.

225. My understanding as to why VC's medication dose had been increased was that whilst VC's auditory hallucinations had decreased in frequency and "calmed down" allowing him to function in his warehouse job and manage his self-care and activities of daily living, their frequency remained unchanged. Also, VC was uncertain about the cause of his hallucinations and continued to question if they were caused by a psychotic disorder. The increase in medication dosage was a response by Dr Burri to better manage these ongoing residual symptoms.

226. VC's view that he was not suffering from psychosis indicated a lack of insight. This lack of insight may have impacted on his concordance with antipsychotic medication. If he did not think that he was suffering with a psychotic illness it is possible that he would not recognise the importance of taking medication to treat his symptoms of psychosis. If VC was not concordant with his antipsychotic medication, then his risk of deteriorating mental health would increase leading to a further relapse. However, the noticeable

improvement in VC's auditory hallucinations following the medication increases would suggest that he had in fact been taking an increased dosage in medication. In further support of this, when VC was seen by CPN Abigail Parsonage on the 22nd February 2021, he recorded as being bright in mood and states that the voices are much quieter, in the distance and he feels able to ignore them.

227. Dr Burri saw VC once again on 15 March 2021 **[NHFT0000168, at p.148]**. I recall discussing the details of this specific attendance with Dr Burri and the attendance was discussed at our MDT meeting. Dr Burri provided feedback on the cognitive assessment that he had undertaken on VC both in our weekly clinical supervision session and at the MDT meeting. VC scored well on the Addenbrooke's Cognitive Examination –REVISED (ACE-R) getting a maximum score on all domains except the memory subscale where he lost 3 points. This falls within a minor variation of a normal score as a loss of 1-3 points can be a result of fatigue, anxiety or age. He scored 18/18 on the attention and concentration sub scale. His Mini mental State score was 30/30 again indicating very good cognitive performance.

228. In the post-acute psychotic phase of an illness persistent cognitive impairment especially in memory, attention and concentration and executive functioning is an indicator that an underlying cognitive deficit associated with a psychotic disorder is present. This can be a significant predictor of long-term functional outcome, often more so than the severity of hallucinations or delusions. VC's cognitive assessment was not indicative of this.

229. I had frequent discussions with Claudia Birtles about VC during EIP MDT meetings and also at other times when she brought concerns directly to me. In VC's first year of treatment and follow up with the EIP team Claudia Birtles occasionally fed back on VC's progress at our weekly MDT meeting. From June 2021 to January 2022 Claudia Birtles frequently brought VC's case to the EIP MDT meeting. From June 2021 to September 2021 she brought concerns regarding emerging symptoms of relapse and from November 2021 to January 2022 she discussed the challenges that she was facing in engaging VC with appointments and home visits.

230. I had regular discussions with Claudia Birtles during his repeated missed outpatient appointment sessions with me between November 2021 and January 2022 which Claudia Birtles also attended. Discussions around VC's presentation, if she felt there had been any evidence of deteriorating mental health at her last home visit or any emerging risks and if any concerns had been raised about VC's mental health by family or the University were discussed. She then made arrangements to see him at her earliest opportunity and also reschedule his outpatient appointment with me.

231. The main issues raised by Claudia Birtles took place during our weekly MDT meetings: they were in relation to her difficulties in engaging VC in any meaningful discussion during her visits and his confrontational behaviour towards her. As a team we tried to problem solve and suggest strategies that she might use to regain his trust and develop a good relationship with him again.

Whilst VC was guarded and confrontational towards Claudia Birtles and often quite elusive (either not attending or trying to avoid follow up appointments with her), she as an experienced care co-coordinator did not find him to have reached a critical point in his presentation whereby he was actively hallucinating or expressing delusional thoughts. Discussions around when it might be appropriate to ask for a Mental Health Act assessment took place, but in the absence of any clear evidence of deteriorating mental health and no concerns being raised by his mother (who had always been very assertive in seeking help during times of crisis) or University staff raising concerns, we had very little grounds to call a Mental Health Act assessment.

232. I attended work two hours in advance of my outpatient clinic start time to familiarise myself with the background history of any patients that I would be meeting for the first time and update my knowledge on the progress of patients whom I was seeing for a repeat follow up appointment. I would therefore have read some (as much as time allowed) but not all of Claudia Birtles' multidisciplinary record entries prior to my scheduled appointment with VC on 9th August 2021 but would have concentrated on the medical staff entries. I also reviewed Claudia Birtles' entries prior to each scheduled clinic appointment and home visit with me thereafter to update my knowledge of his progress. My understanding of the treatment and monitoring provided by her was based on my reading of her entries in the multidisciplinary notes and the discussions that took place directly with her and during weekly MDT meetings.

233. I do not recall having individual discussions with other members of the nursing team during the first year that VC was under the care of the EIP team or in the period from August 2021 and January 2022. Discussions took place during our weekly MDT meetings involving other members of the nursing team.

234. I have been referred to the "Summary & Care Plan" dated 29 June 2021 **[NHFT0000201]** in which I was named as having responsibility for VC's mental health, risks and safety, physical health and activities of daily living, medication, social and occupational needs, therapy. I had not been directly involved in delivering care to VC in the period leading up to 29th June 2021, and as such, I was not involved in the preparation of the care plan. I read the care plan at the end of July 2021 when Dr Burri finished his ST5 training with the City South EIP team and handed VC's care to me for direct involvement and contact. This new care plan was put in place at a CPA review dates 29th June 2021 which was attended by Dr Burri who was delivering the medical component of VCs care. I was responsible for oversight of the case. Unless Dr Burri had concerns about the new care plan and had brought it to supervision for discussion I would not have read the care plan. I had read the previous care plan from September 2020 which corresponded with the majority of the time I was supervising Dr Burri.

235. In my position as community consultant psychiatrist for the EIP team it is my responsibility to have oversight of the actions and deliverables set out in the care plan. My responsibilities included ensuring that the care delivered was safe, appropriate and coordinated by the CCO, that decisions were based on sound clinical judgement, delegation of tasks to other professionals was

appropriate and that systems of oversight such as supervision were in place to ensure safe practice. In VC's case, this was achieved through one-to-one weekly supervision of my ST5 trainee Dr Burri and through providing advice and psychiatric expertise to CCO Claudia Birtles during MDT meetings or at any other time that she approached me. Consultant oversight does not mean personally checking or signing off every piece of documentation or care plan created by a CCO or personally delivering every action in a care plan.

236. Between his second and third admissions, VC's direct psychiatric care was delivered by Dr Burri (ST5) with supervision from me. This was until the end of July 2021 when Dr Burri left his post with the City South EIP team and handed over VC's direct care to me. It is entirely appropriate for a trainee in the higher training stage (ST4-6) to manage a defined caseload of patients under indirect supervision as long as the trainee's competence is appropriate to the level of complexity of the cases. VC's case was amongst one of the least complex on the EIP caseload during the time he was under the care of Dr Burri. As VC was on Dr Burri and Claudia Birtles' caseloads and I was not directly involved in his care I did not have any direct discussions with VC or his family during this period.

237. Dr Burri handed over VC's care to me at the end of July 2021 and VC was booked into my clinic on the 9th August 2021. When he did not attend, his CPN, CB, immediately followed up with a telephone call to see how he was and to ascertain why he missed his appointment **[NHFT0000168, p.158]**. He was offered an appointment with me the following day (10th August at 11.30 am).

VC told his CPN that he was very unlikely to attend this and would be busy. He stated that he would check his rota to determine when he could next come to clinic. His CPN then offered him a home visit with my higher trainee (ST6) who had the earliest availability for the following Thursday in order to make attendance easier for him. VC agreed to look at his rota and let his CPN know. He was seen by my ST6, Dr Sasitha Sasidharan the following day namely 11th August 2021 as she had earlier availability.

238. I was scheduled to undertake a mental health act assessment on VC on Thursday 2nd September after he showed clear signs of psychotic relapse and deteriorating mental health **[NHFT0000168, pp.163-4]**. Unfortunately, VC was not present at his home address when I attended the home visit with the AMHP and second doctor on that day. Arrangements were made for a further assessment to be conducted out of hours on the same evening in the hope that VC would have returned home by then. VC was admitted to hospital on Friday 3rd September 2021 under section 2 of the MHA. I was not in attendance as I do not work on Fridays.

239. Prior to taking VC onto my caseload in August 2021, I received a full handover from Dr Burri who had carried out VC's initial psychiatric assessment and follow up appointments during the first year of VC's case with the EIP team. In his handover at the end of July 2021 Dr Burri provided a comprehensive account of his condition, insight, risk history and treatment. As above, it was part of my usual practice to attend work two hours in advance of my outpatient clinic start time to familiarise myself with the full background history of any

patients that I would be meeting for the first time and update my knowledge on the progress of patients whom I was seeing for a repeat follow-up appointment by reading the multidisciplinary records. I would have read VC's previous medical staff entries in some detail as well as any previous care plans and risk assessments. I would also have read some (as much as time allowed) but not all of Claudia Birtles' and other nursing colleagues multidisciplinary records.

240. I understood from discussions during our weekly MDT meetings in June 2021 that VC's mum had expressed some concerns about VC's mental health, stating to Claudia Birtles in a phone call that *"he (VC) had sounded different"* **[NHFT0000168, p.155]**.

241. VC did not attend his routine clinic appointment with Dr Burri on 14th June 2021 and when questioned about this by Claudia Birtles during a home visit on 8th July 2021 he appeared unconcerned: he also minimised his mother's recent concerns about his mental health. In a further home visit with CPN Gary Carter on 6th August 2021 VC appeared abrupt and irritable. Whilst the nursing team or family had not been able to identify any clear psychotic symptoms or any of VC's early warning signs suggestive of relapse and there appeared to be no immediate risk of harm to himself or others, there did appear to be subtle change in his presentation and demeanour. In light of this it was important that he should have an early psychiatric assessment which was scheduled with me for 9 August 2021.

242. When VC did not attend his outpatient appointment with me, his CPN CB immediately followed up with a telephone call to see how he was and to ascertain why he missed his appointment **[NHFT0000168, pp.157-8]**. He was offered an appointment with me the following day (10th August at 11.30 am) as I had a cancellation. VC told his CPN that he was very unlikely to attend this and would be busy. He stated that he would check his rota to determine when he could next come to clinic. His CPN then offered him a home visit with my higher trainee (ST6) who had the earliest home visit availability for the following Thursday in order to make attendance easier for him. VC agreed to look at his rota and let his CPN know. He was seen by my ST6, Dr Sasidharan, on 11th August 2021.

243. ST6 trainees are senior specialty trainees in their final year before completing their training in psychiatry and applying for a consultant post. At this stage in their training they would be expected to be competent in the assessment and management of a complex psychiatric presentation including a psychotic relapse but remain under consultant oversight. It is both appropriate and valuable for an ST6 trainee to see psychotic patients who are potentially relapsing as managing relapse is a core competency in psychiatry and a crucial skill for a soon-to-be consultant.

244. I did not have capacity to carry out a home visit the following week. Dr Sasidharan had the earliest availability for a home visit and was, in my view, sufficiently senior to carry out the assessment. Sending her to carry out the assessment the following week was the best method of avoiding any further

significant delay and expediting VC's psychiatric review. A joint home visit with CPN, CB, who knew him well, was booked in.

245. On 10 August 2021 Dr Sasidharan visited VC at home **[NHFT0000168, at pp.158-160]**. In advance of this meeting, I met with Dr Sasidharan on the afternoon of 10th August 2021 for her weekly clinical supervision session (2-3 pm) and gave her a verbal handover of VC's background history and presentation and the current concerns that his mum and CB had raised regarding a potential relapse of his psychosis.

246. Dr Sasidharan presented her assessment of VC to the MDT at our weekly meeting at which I was present two days later. She also subsequently wrote a letter dated 15 October 2021 **[NHFT0000512]** setting out her recent impression of VC. At the MDT meeting we acknowledged as a team that whilst he had presented as being quite stable with very low grade symptoms when she and Claudia Birtles had seen him, he could be very skilled in masking underlying symptoms. We agreed that it would be important for the team to continue to monitor him as closely as possible until such time that he was no longer able to conceal his symptoms; this would give the team direct evidence of his deteriorating mental health so that a Mental Health Act assessment could be requested.

247. On 31 August 2021, at 3:09pm **[NHFT0000168, pp.161-162]** VC was visited by Claudia Birtles and Gary Carter. CB noted that VC was relapsing. As recorded in her Rio entry, CB fed back the details of the assessment and

discussed the case with me. Her meeting with VC provided clear evidence that he had started to relapse and was expressing complex delusional beliefs linking various support agencies. He was also refusing to engage with our team as he believed that EIP staff were part of the conspiracy and so he could no longer trust members of the team. We discussed next steps: as CRHT are the gatekeepers for inpatient admission in adult mental health, I suggested to CB that in the first instance she has a discussion with the CRHT so that they can make an assessment of the situation and decide whether or not VC could be supported with intensive home treatment or if he required an urgent MHA assessment.

248. In my view it was evident from the discussions with Claudia Birtles that VC had become acutely psychotic and most likely needed to be hospital in order to prevent further deterioration in his mental health and prevent risks of harm to himself or others developing. However, the first steps in trust processes would be a discussion with the CRHT who act as gatekeepers for admission into hospital.

249. It appeared that VC was no longer willing to engage with our EIP team or accept any further treatment. In light of his presentation it was very likely that he would also refuse to accept monitoring and treatment from the CRHT so a period of treatment in hospital under the MHA was the most realistic option with a switch to a depot form of medication and a CTO on discharge.

250. On 1 September 2021, at 10:33am **[NHFT0000168, at p.163]**: Gary Carter noted that the situation was not *"an absolute emergency"* but a MHA assessment was considered the way forward in the *"near future*". GC's entry in the Rio notes records a plan to discuss the situation at the next MDT with me.

251. In fact, the next MDT meeting was not scheduled until Thursday 3rd September. I did not agree with GC's assessment of the situation. In my view VC was experiencing acute and florid psychotic symptoms. My opinion at the time was that VC required a mental health assessment and treatment in a hospital setting urgently. This was the advice I gave to Gary Carter in a conversation with him on 1st September 2021 and I arranged to be in attendance at the MHA assessment which took place on the 2nd September 2021.

252. The Rio records record that an MHA assessment was arranged for 2 September 2021, at 9:35am **[NHFT0000168, p.163]**. At 1:02pm **[NHFT0000168, at p.164]** it was noted (by Rachael Masterson) that VC did not answer his door or respond on his mobile.

253. I had already engaged in a detailed conversation with Claudia Birtles on 31 August 2021 regarding VCs recent change in mental state, symptomology and potential risks and this discussion informed my understanding of his current presentation and risks. I already had relatively detailed knowledge of VC's psychiatric history and background from my handover with Dr Burri and from my scrutiny of VC's multidisciplinary records. On Wednesday 1st September

2021, I had a conversation with the AMHP who would be leading and arranging the MHA assessment and updated her on VC's background, past psychiatric history, previous risk assessment and current presentation and potential risks. Prior to the actual attempted MHA I was also able to update the second section 12 approved doctor on VC's psychiatric history and previous risks.

254. VC's Third Admission (under s.136 and then s.3 MHA) – Cygnet and Priory ("Third Admission") took place between 3 September 2021 and 22 October 2021. VC's Rio notes for 3 September 2021 **[NHFT0000168, p.164-167]** record that VC punched a police officer with significant force three times while police attempted to execute a s.135 warrant; that he assaulted other officers, headbutted an officer and wrestled handcuffs from an officer to use as a weapon.

255. I became aware of this incident at the EIP MDT on 9th September 2021 which I attended on my return from annual leave. CB informed the MDT that VC had seriously assaulted two police officers during the execution of a warrant during a Mental Health Act assessment. Following the MDT I had a more detailed discussion with CB around VC's risk assessment. My view was that VC found himself in an extremely high threat situation where the police and individuals unknown to him (the MHA assessment team) had gained forced access into his property. VC was floridly psychotic at that time and believed that there was conspiracy against him led by M15, the police and the government. CB and I both considered that VC's actions that day were a response to a high level of a threat and a belief that he would come to harm in the hands of police,

in keeping with his delusional belief system. It was very likely that VC acted in self-defence: he perceived himself to be under attack from the police and felt the need to fight for his life. In my experience, having been involved in a number of similar MHAs with police involvement, it is not unusual for an extremely charged situation such as this to spiral into violence. There had been no prior planning or intention on the part of VC to harm the police officers: VC's response was reactive to an intense and highly charged situation that got out of control.

256. I did not personally have any discussions with the clinicians at Cygnet or Priory in respect of VC's Third Admission. As mentioned in previous responses, it is the role of the CCO to undertake liaison with the inpatient team, attend ward reviews as necessary and in particular the final discharge meeting. VC's CCO, CB, fulfilled this role and acted as a conduit between the EIP team and the inpatient team in her role as CCO.

257. Given the knowledge that we now had with regard to the significant level of non- concordance with medication in the lead up to his 3rd admission, it was the opinion of the EIP team that VC should be started on a long-acting antipsychotic depot preparation. CB emailed the inpatient team **[NHFT0018143]** at the Cygnet hospital, sharing the views of the team. We also requested that should VC's section 2 of the MHA be converted to a section 3 with a view to a CTO being put in place at the point of discharge.

258. On the 17th September 2021 Claudia Birtles had a telephone discussion with VC whilst he was an inpatient at the PICU at Cygnet hospital **[NHFT0000168, p.191]**. They discussed the possibility of starting depot medication; VC was open to this as an option depending on the side effects, noting that it might be easier than taking medication every day. On the same day CB received an email from the ward that there were no plans to start a depot and told that this issue was best discussed when he stepped down from PICU **[NHFT0000168, p.190]**.

259. I did not attend ward reviews at the Cygnet or the Priory, either remotely or in person: inpatient liaison was not a part of my job plan. I had three direct care clinical sessions (one and a half days) allocated to EIP work which comprised a clinic session, a home visit session and MDT meeting time: this took up the majority of my sessional allowance. Attendance at inpatient reviews would have required the cancellation of another fixed commitment such as a clinic, home visit slot or MDT. It was the role of the CCO to undertake ward liaison and act as a conduit between inpatient and community teams. CB undertook this work.

260. VC's condition and treatment needs were discussed in the MDT. The main theme of discussions was around the severity of VC's psychotic symptoms during his third admission, concerns around his concordance with oral medication, the importance of VC being put on depot antipsychotic mediation and the need for a CTO. This form of discharge model would have provided better oversight of VC's medication concordance on discharge as well

as providing the powers of recall to hospital in the event of non-concordance with medication and/or disengagement from services.

261. The main challenges of a patient being admitted out of area include difficulties in communicating with the inpatient team, difficulties attending ward reviews in person and providing in reach to the patient. There are delayed updates on mental state, progress, incidents or changes in treatment. Incompatible electronic records can also mean that the community team cannot access the patient's multidisciplinary notes. All of these factors lead to a significant challenge in the continuity of care. There can be a feeling of isolation and disconnection for the patient being separated from their usual care team which can impact recovery. Families often feel excluded due to distance or lack of updates.

262. I have been directed to my Theemis interview **[TCLT0000516]** in which I made the following observations, with respect to VC's Third Admission:

i. *"…we really became quite concerned about his concordance because it became evident that he really hadn't been taking his medication reliably. At that particular Mental Health Act assessment, he'd been very violent towards the police officers."* **[TCLT0000516, p.13]**

ii. *"I remember [Claudia Birtles] bringing her views back to the MDT at that time, saying, "This is our opportunity to finally get VC onto a depot and possibly a CTO. We really need to push for this". And she even had a*

conversation with VC, and he seemed open at that point to thinking about a depot." **[TCLT0000516, p.16]**

iii. *"…a plea was made by [Claudia Birtles] because he'd gone in on a Section 2 of the MHA that had been converted to a section 3, to strongly consider a depot antipsychotic medication at that point…".* **[TCLT0000516, p.14]**

263. I myself commented in my NHFT interview **[NHFT0004710, at p.2]** that *"As a team, we really wanted VC on a depot, and we'd been pressing the inpatient team 3rd and 4th admissions to do that. We regularly discussed in the MDT wanting him on a depot. Claudia said his engagement was very superficial… felt we needed a depot, a CTO would also have been very helpful…"*

264. During the execution of a section 135 warrant at the Mental Health Act assessment in August 2021 in the lead up to his third admission, VC was placed in an extremely high threat situation where the police and individuals unknown to him (the MHA assessment team) had gained forced access into his property. VC was floridly psychotic at that time and believed that there was conspiracy against him led by M15, the police and the government. Both CB and I shared the view that VC's actions that day were a response to a high level of a threat and a fear that he would come to harm in the hands of police.

265. In VC's case his delusional beliefs were specifically about the police and this meant that his violence was particularly targeted at them. During his time

under the care of the EIP team, VC had never voiced any thoughts of wanting to harm others, including members of the public. There had been no documentation in his case notes or risk assessments of VC experiencing command hallucinations telling him to harm others or delusions of control which may have caused potential risks to members of the public. In terms of other key risk factors which predict serious violence in psychosis, VC had no previous forensic or criminal history and no known history of substance misuse, both of which have been identified in systematic reviews as significant risk factors for violence in psychosis. It was my understanding that VC had good pre-morbid adjustment and was described by those who knew him as being a shy, intelligent and good-natured young man. He had no anti-social personality traits, came from a supportive family with a relatively stable upbringing. We were not aware of any previous history of trauma.

266. In light of the above, my view of VCs risk of violence did change from a relatively low risk to a moderate risk in the context of a high threat situation. But I did not believe he was at risk of violence generally as in this case the violence was specifically targeted at the police whom he believed were out to get him.

267. Similarly, with regard to my view as to VC's risk of violence when non-concordant, I had been aware of VC as patient who had been referred to our team between his first and second admission, albeit that I had no direct involvement in his care. This was the first time that VC had been fully non-concordant with his medication so there was no change in my view.

268. It is my understanding that as per trust procedure an updated risk assessment would have been completed by the inpatient team at the point of admission to the Cassidy suite. It is my understanding that Dr Ben Lomas who was the lead psychiatrist at VC's MHA assessment completed a risk assessment in the multidisciplinary records on 3/9/21 and Busayo Ajewole (RMN at the Cassidy Suite) updated the formal risk assessment document on 4 September 2021.

269. CB had already raised the issue of depot medication with staff at Cygnet. On the 17th September 2021 she received an email from the ward that there were no plans to start a depot and she was told that this issue was best discussed when he stepped down from PICU **[NHFT0000168, p.190]**. She planned to have the same conversation with the Priory Hospital once VC had been stepped down. VC was stepped down to the Priory on 1st October 2021.

270. VC was discharged from the Priory on 22nd October 2021 **[NHFT0000168, p.194]**. The EIP was not made aware, nor was VC's mother. Both CB and I were on annual leave during this period but there was a plan that CPN Abigail Parsonage would attend the Priory ward reviews and communicate the team's views around VC's treatment to the ward staff. Unfortunately, the proposed plans of the EIP team for VC's discharge (for him to be placed on a CTO and started on an antipsychotic depot medication) were not communicated to the Priory staff.

271. My understanding as to the plan for VC's treatment and management following discharge was that he would be discharged on oral Aripiprazole at 20 mg daily with follow up as usual from the EIP team. The EIP team did not have the opportunity to contribute to this plan: there were no steps in place to reduce the risk of VC deteriorating. A pre-discharge risk assessment was required but without having access to the Priory inpatient electronic records, the EIP team and I could not be certain whether the inpatient team had undertaken this step prior to VC's discharge. Similarly, there was no MDT meeting involving the EIP ahead of VC's discharge: the EIP team were not invited to the discharge MDT meeting ahead of VC's discharge and we had no access to the Priory Hospital electronic record system so we did not know whether or not an MDT meeting had taken place.

Post Third Admission

272. VC was discharged on 22 October 2021 and CCO CB requested an outpatient appointment with me three days later on 25 October 2021 **[NHFT0000168, at p.195].** Due to a combination of annual leave and my clinics being at capacity, the next available appointment was not until 15 November 2021.

273. I note that VC failed to attend this appointment the plan was for his CPN to reschedule it **[NHFT0000168, at p.198]**. I did not have any significant concerns about VC failing to attend this appointment. I had read CB's entries leading up to the appointment earlier that morning. These reflected that VC had been seen for an assessment by her 10 days earlier on 5th November 2021

and that his mental state was stable and he denied any ongoing psychotic symptoms. Although she noted his limited insight and superficial engagement, CB also recorded an impression of some improvement in his mental state. She also recorded that he reported having mistakenly only taking half his prescribed dose of medication previously. CB did not feel that there were any significant concerns more than VC's usual baseline presentation. VC had also told his CCO at that appointment that it was likely that he wouldn't be attending his clinic appointment with me on 15th November 2021 due to a university deadline. There had also been text correspondence between VC and his CCO on 12th November 2021 which was not out of the ordinary and did not indicate any increase in risks.

274. After VC failed to attend the 15 November 2021 meeting, in accordance with NHFT 'Procedure: 01.08a - Merged Do Not Attends (DNA's)/Cancellations & Management of Patients Who Fail to Engage with Services or Seek to Disengage from Care in an Unplanned Way Procedure' ("DNA Policy") **[NHFT0004725**, at p.7] staff immediately carried out an assessment of VC's level of risk.

275. All medical appointments were arranged and attended by a patient's CCO to ensure robust handover of information and joint decision making. When a patient did not attend their appointment, a review of the patient's multidisciplinary notes to check when they were last seen and if there were any concerns about their mental health or immediate risk of harm to self/others at that appointment was elucidated. A discussion with the CCO took place to

check if they were aware of any more recent concerns or risks and based on this information a decision was taken as to whether an urgent home visit was needed or if another routine appointment could be offered. The named CCO also followed up on the missed appointments with the patient with a phone call usually on the same day or by the end of the week depending upon the level of concern and they rescheduled the next medical appointment with the medical secretary after checking availability with the patient. If a patient could not be contacted attempts were made to speak to a relative or close friend to check if they had spoken to the patient recently and had any concerns about their mental health.

276. Missed appointments in outpatients clinic for this particular patient group are common. In VC's case, the above practical approach to assess the " level of risk" was undertaken. On this occasion there were no immediate concerns and so the level of risk was not considered to be high. The next steps involving the need to undertake a full MDT risk assessment was therefore not considered to be required. Up to 50% of patients may fail to attend a single clinic so it is not usual practice to record the process due to time constraints.

277. VC did subsequently attend a meeting with his CCO at the Stonebridge Centre four days later on 21 November 2021 **[NHFT0000168, p.199]**. However, he failed to attend his next meeting scheduled with me on 29 November 2021 at 8:50am **[NHFT0000168, at p.199]** and a home visit was booked.

278. My concerns about VC's non-attendance started to increase at this point. When he had been seen by his CCO 10 days earlier on 19th November 2021 he had been more abrupt than usual and he had admitted missing a couple of doses of medication. I recognised that there was the possibility that VC may have started to become non-concordant with his medication again. The DNA policy was followed once again with a further assessment of the level risk.

279. CB and I again discussed VC's failure to attend. Whilst we could not be absolutely certain as to the reason why VC had missed this second appointment with me, he had not presented as overtly psychotic when last seen by his CCO nor had there been any immediate risk of harm to himself or to others. His main risk was one of potential deteriorating mental health due to VC becoming non-concordant with his medication and risk of disengagement from the team. In light of his abrupt behaviour, we agreed to take his case to the wider MDT meeting in two days' time - in accordance with **[NHFT0004725, at p.6, para 7.2.3.4]**. At the MDT meeting we acknowledged that as there had been no clear symptoms of psychosis elicited by VC's CCO or immediate risks of harm to himself or to others: the level of risk was not considered to be significant enough to require a formal risk assessment. We agreed that CB and I would attempt to see VC on a home visit and that CB would contact VC's mother and enlist her support with encouraging VC to attend his outpatient appointments.

280. CB spoke to VC's mother on the same day – 29 November 2021 **[NHFT0000168, p.199]**. Celeste Calocane ("CC") told Claudia that she had

spoken to VC over the weekend and re-iterated the importance of him attending his outpatient clinic appointments. VC had replied that he had some tight course work deadlines which had affected his ability to attend but he would re-arrange his appointment through Claudia. His mother did not express any concerns about his mental health in this call and I noted that in a previous call on 1 November 2021 she had confirmed that VC appeared to be focusing on his university work and appeared to be "okay" **[NHFT0000168, p.195]**.

281. VC was not at home for his 2.30pm appointment on 6 December 2021, at 8:56am **[NHFT0000168, at p.199]**: this was the third missed appointment with me. I planned to discuss next steps at the next MDT meeting. I was concerned that VC had been aware of this appointment but had not been present in the house. This suggested to me that he might be actively trying to avoid contact with the team and disengaging from services.

282. In light of VC's repeated missed appointments, we agreed to take his case to the wider MDT in accordance with the Merged Cancellation Policy 2021 **[NHFT0004725, at p.6, para 7.2.3.4]**. At the MDT meeting we acknowledged once again that, given there had been no clear symptoms of psychosis elicited by his CCO nor immediate risks of harm to self or others identified, the level of risk was not considered to be significant enough to require a formal risk assessment. We agreed that CB would contact VC's mother again to get her help and support with encouraging VC to attend his outpatient appointments.

283. I attended the weekly multi-disciplinary team meeting (MDT) in my role as VC's community consultant, the EIP clinical team leader, named CCO and other community psychiatric nurses (CPNs), support workers, psychologist, non-medical prescribers, pharmacy colleagues, behavioural family therapists, and employment support workers were also present. We had a detailed discussion about VC's presentation following his discharge from hospital after his third admission. From memory, CB stated that whilst VC had been guarded and at times quite confrontational towards her at home visits, she, as an experienced care coordinator, did not find him to have reached a critical point in his presentation whereby he was actively hallucinating or expressing delusional thoughts. There were also no concerns expressed to her or the team from VC's mother CC, who had always been very assertive in seeking help during times of crisis. CB was in email and telephone contact with Eleanor Turner the service lead from the University Mental Health Advisory Team who was acting as conduit between university staff (VC regularly met with his personal tutor) and our EIP services. The University Mental Health Advisory Service had not shared any concerns regarding VC with us at this time.

284. We acknowledged as a team that there was very little evidence or grounds to call a Mental Health Act assessment at that time. This would require clear evidence of a relapse of VC's psychosis and a risk of harm to himself and/or others. VC was a voluntary patient in the community with the rights pertaining to his voluntary status. In the absence of, for example, a CTO, we had no legal framework for recalling VC to hospital or enforcing antipsychotic treatment. We agreed at our MDT that CB would contact VC's mum once again

to try and enlist her help on how we might better engage him, knowing that VC often listened to his mum and had a good a relationship with her.

285. On 16 December 2021, at 5:00pm **[NHFT0000168, at p.200-201]** CB noted a telephone discussion with VC in which he was very confrontational and quite angry. He instructed CB never to speak to his mother again – albeit he did ultimately agree that CB could text CC to explain this **[NHFT0000168, at p.201]**. CB planned to discuss VC at the next MDT meeting and to contact his mother CC to inform her of VC's decision regarding on going contact. I note that VC did then attend the Stonebridge Centre to collect his medication the following day **[NHFT0000168, p.201]**.

286. I was on annual leave when the next MDT meeting took place on Thursday 23rd December 2021 so the matter was not discussed with me; it would have been discussed with other members of the MDT in my absence.

287. I had a further meeting arranged with VC in the new year for 10 January 2022. Once again he missed this appointment **[NHFT0000168, at p.202]**. This was the fourth appointment he had missed with me. As I recorded in his records, I was concerned that he had also disengaged from his Care Co- Ordinator, CB, and it was unknown if he was taking his medication. I recorded a plan to discuss his case once again "at MDT on Thursday" and with maybe to consider a *"final attempt at a home visit*" **[NHFT0000168, p.202]**.

288. I had ongoing concerns about his disengagement from our team and our inability at that time to monitor his mental health and medication. Repeated missed appointments can suggest a worsening of psychotic symptoms, a loss of insight or cognitive decline. Alternatively, it may signal a loss of trust in clinicians, concerns around stigma or a general ambivalence about the need for ongoing monitoring. The team's inability to continue to monitor VC's mental health, relapse of psychosis and any emerging risks to himself or others was an issue.

289. I was also concerned about his apparent disengagement from his CCO. CB was the clinician who knew him best and had the greatest knowledge and understanding of his condition; VC's disengagement from her visits left the team in a challenging position in relation to ongoing monitoring for signs of relapse or risk. A discussion regarding VC's level of risk would have been undertaken by me and his CCO in accordance with paragraph 7.2.3 of the policy at this juncture.

290. VC did come to the community base on 17th January 2022 to collect his medication. Nonetheless, there was concern that he may not be taking his medication as prescribed, and he therefore could potentially be at risk of relapse from a further psychotic breakdown.

291. On 17 January 2022, at 8:43am **[NHFT0000168, at p.203]** I noted that VC had once again failed to attend his outpatient appointment: his fifth missed appointment. I planned for the matter to be discussed *"at MDT on Thursday"*

where consideration would be given to discharging VC who had "*essentially disengaged and we have not been able to monitor him.*" I thought that we should consider speaking to his mother and university course tutors to see if there are any concerns before considering discharge.

292. Consideration was given as to whether VC's disengagement could indicate a worsening of psychotic symptoms and whether his abrupt and confrontational presentation could be in keeping with this. However, in the absence of any clear objective signs of acute psychosis with active hallucinatory behaviour and expression of delusional thoughts we could not be certain. It was also possible that VC may have lost trust and developed a sense of resentment with his treating clinicians especially after the team requested the last MHA assessment which led to his third hospital admission.

293. If the reason for his disengagement was deteriorating mental health then risks associated with this would subsequently increase. Historically these have been breaking into property in response to auditory hallucinations and an escalation of aggression and violence when placed in a high threat situation. However, with the information we had we could not be sure or assume at this time that there had in fact been a deterioration in his condition.

294. VC's insight into his condition had always been partial at best and generally worsened during periods of acute psychosis. However, with the information available to us at this time we could not be sure or assume that

there had in fact been a deterioration in his condition and that he was suffering from an acute psychosis.

295. While VC's disengagement may have been an indication of a lack of medication concordance and this was considered in our MDT meetings, again we did not have clear evidence of a lack of concordance and we could not be certain of this.

296. Disengagement may have been an indication that VC was relapsing, but it did not provide concrete evidence that VC's condition was deteriorating for the reasons described above. In the absence of psychotic symptoms or risk of harm to himself or to others, the options available to the team became limited. VC was not subject to a CTO enabling powers of recall back to hospital and we did not have access to a specialist Assertive Outreach service with the skill set and resourcing required to manage patients who do not engage with services. In any event, on the evidence we had, VC would not have met the threshold for referral to the CRHT or a MHA assessment. We were not made aware of any external concerns from his family or the university and we had no further ability to monitor him, nor were there any further interventions available to us to enable re-engagement.

297. In light of all of these factors, it was appropriate to consider discharge from the service with a view to re-engaging and working with VC if and when he re-presented to services.

298. On 18 January 2022, at "9:31am" **[NHFT0000168, at p.203]** Adele Pinder recorded that VC had assaulted a fellow student. She recorded a plan to discuss the matter with me and the CRHT. From memory, this discussion took place at the following MDT meeting, held on 20th January 2022.

299. An MHA assessment was undertaken on 19 January 2022 **[NHFT0000168, at p.205]**. It was decided not to detain VC but it was observed that VC was poorly engaging, relapsing, and in the absence of medication concordance and engagement, hospital admission would be the next step. The records note that VC denied symptoms of psychosis but that, in the view of those assessing him, his insight overall into his condition was "relatively low".

300. This was an assessment by experienced clinicians who had not been able to elicit any evidence of psychotic symptoms nor had they felt that he was at risk of harm to self or others. My view was that further assessment of his condition and risk was needed through initial intensive monitoring by the CRHT and if needed, a hospital admission under the MHA.

301. I have been referred to a note of 21 January 2022 at 11:00am **[NHFT0000168, at pp.206-207]** where it is recorded that when VC met a CPN for medication concordance. It is recorded that he appeared to take the medication he had just been given out of his mouth and put it in the bin as he walked away. I do not recall reading this note or being made aware of it at the time.

302. I have also been referred to a note dated 21 January 2022 at 4:22pm **[NHFT0000168, at p.207].** This is a record of a telephone conversation with Ellie Turner, part of the University of Nottingham mental health team. It is recorded that she was of the view that a mental health admission should be considered if there was another failure at medication concordance. I do not recall reading this note or being made aware of it at the time.

303. I have also been referred to entries on 22 January 2022 at 3:45pm **[NHFT0000168, at pp.207-208]** and 23 January 2022 at 11:22am **[NHFT0000168, at pp.208-209],** both occasions when VC was provided with medication, was noted to present with cracked lips and to refuse water. Again, I do not recall reading these entries or being made aware of them.

VC's Fourth Admission at Redwood in Highbury Hospital, NHFT (under s.135 and then s.2 of MHA) ("Fourth Admission"): 28 January 2022 – 24 February 2022

304. VC was detained under s.2 MHA 1983 on 28 January 2022 **[NHFT0000168, pp.214-5]**. This followed an attempted assault on a fellow student in a property on 18 January 2022 and a MHA assessment on 19 January 2022 **[NHFT0000168, p.205]** at which a decision was taken not to detain him.

305. In my appointment with VC on 14th March 2022 we specifically discussed the events directly preceding his fourth admission when he got into an altercation with another resident in his shared lodging. VC explained to me

that in the period between his third and fourth admission he had been taking his medication and this had kept him well and free from any psychotic symptoms. VC stated that he was angry about being detained in hospital for his fourth admission as he had not been psychotic. VC gave an account of events leading up to the incident in his flat. He stated that the other students sharing the flat had been mocking him for weeks, calling him derogatory names behind his back in relation to his personal hygiene and mental health. On the night in question, they accused him of leaving dark hairs in the shower and blocking up the drain. According to VC this led to an altercation between him and one student who used obscene language against him resulting in VC losing his temper. VC attempted to punch this student (who was able to block the punch) and locked the door to the room. Another resident called the police resulting in a further MHA assessment and admission to hospital. VC told me that he had locked to door so that students couldn't leave the room before the police arrived. VC insisted that the altercation was not driven by him experiencing psychotic symptoms. In keeping with this, during the first and subsequent MHA assessment leading to his fourth admission, neither assessment teams were able to elicit any signs or symptoms of psychosis. Furthermore, during VC's month on the ward, the inpatient team were unable to identify any clear evidence of acute psychosis despite VC being in a setting where he was being closely observed and under a great deal of scrutiny.

306. During a telephone conversation between VC's mother and Dr Gibson on 2 February 2022, his mother expressed the view that he had appeared "normal" to his parents. She told Dr Gibson that she had not detected any ways

in which he was unwell in the lead up to his fourth admission. She expressed the view that he felt scared and "persecuted" by mental health services.

307. I have been asked, in the context of VC's fourth admission, for my reflections on the appropriateness of my previous proposal that consideration be given to VC's discharge. Given the lack of evidence that VC was suffering with psychosis in the view of two experienced MHA assessment teams and over a four week assessment period during this fourth admission, and in light of the view of his mother who knew him well, I consider that it is possible that VC's disengagement with our team on this occasion was not entirely due to an acute psychotic relapse, and that it may have been, as his mother suggested, due to him feeling "persecuted" by the team. Similarly, it is possible that this particular episode of aggression was as VC had described, an altercation that had got out of hand, rather than one which was driven by psychosis. VC had been provoked and got into a fight as many young men without mental health difficulties might do.

308. In terms of my involvement with VC's inpatient care during this admission, on 3rd February 2022 I contacted VC's inpatient consultant, Dr Thangavelu by email with concerns that VC was becoming a "revolving door" patient [**WITN0206011**]. I suggested that he be started on depot medication whilst detained under the MHA and placed on a CTO: this would have enabled the community team to recall him to hospital in the event of a future disengagement and discontinuation of treatment.

309. In my email I stated that Claudia Birtles' view was that VC continued to lack insight and that we needed a robust discharge plan for when he was back in the community under our care to prevent a further relapse. Dr Thangavelu and I discussed the case subsequently. Dr Thangavelu explained that VC had not displayed any active symptoms of psychosis during his inpatient stay; he stated that the inpatient team had found him to be *"really quite well"* and as such, converting his detention under the MHA from section 2 (admission for assessment) to section 3 (admission for treatment - which is required for a CTO) could not be justified. Dr Thangavelu did agree to have a conversation with VC about depot medication although that conversation had already taken place and VC had not been keen. It was my understanding that four separate conversations did take place between VC and the inpatient staff but VC refused to accept a depot – see **[NHFT0000168, p.220, MDT note 31 January 2022; p.225, discussion with Dr Gibson on 3 February 2022; p.239, Dr Thangavelu discussion 10 February 2022; p.251 ward round, 17 February 2022]**.

310. I did not attend ward or discharge meetings at Highbury Hospital: this was not part of my role. VC's CCO CB fed back details regarding back VC's progress and decisions that had been taken by the inpatient team to the EIP MDT, in particular, her regret that VC had not been moved onto depot medication or placed under a CTO (see **[NHFT0000168, p.238]**).

311. It recall discussing, within the EIP, how disappointed we were with the inpatient's team decision not to start VC on depot medication as this would have

given our team oversight of his concordance with medication. The EIP team expressed concern that we would be back in the same position that we were in following VC's discharge from his third admission: we risked VC gradually disengaging from his appointments and treatment and would have no means of ensuring that he was taking his medication and no power to recall him to hospital in the event of non-concordance or failure to attend appointments.

312. I have been referred to my NHFT interview **[NHFT0004710, at p.2]** in which I refer twice to the fact that, *"as a team, we really wanted VC on a depot, and we'd been pressing the inpatient team 3rd and 4th admissions to do that."* That *"with the final admission, we again advised that a depot would be helpful, and either the consultant or his ST6 trainee addressed this at least fours time with VC on the ward. However, he was not willing. I recall having a conversation with VCs consultant Dr Thangavelu who told me that the severity of his symptoms had not been significant during this inpatient episode."*

313. I am unable to recall the exact date of my conversation with Dr Thangavelu but it was shortly after my email of 3 February 2022 requesting that VC be put on a depot and CTO. In my conversation with Dr Thangavelu I explained the challenges that the EIP team had faced following VC's discharge from his third admission. I told Dr Thangavelu that VC had failed to attend five scheduled appointments with me and that I had not been able to meet and assess him. I explained that VC's contact with CB had been superficial, with little meaningful discussion about his mental health and treatment. I also

explained that VC had been confrontational and abrupt with his CCO and eventually stopped attending appointments with her.

314. I asked Dr Thangavelu to consider putting VC onto depot antipsychotic and a CTO at the point of discharge as this would allow the team to have oversight of VC's treatment and the CTO would make it possible for him to be recalled to hospital in the event of non-concordance with his depot or missed scheduled appointments. I explained that without a depot and CTO the EIP would find it difficult to ensure that VC received the treatment and monitoring which he needed.

315. Dr Thangavelu stated that he understood the challenging position that the community team had faced, but that VC had not displayed any active symptoms of psychosis during this particular admission which would justify a move to a section 3 of the MHA. He did agree to have further conversations with VC regarding starting a depot antipsychotic whilst on the ward. It is my understanding that four separate conversations took place.

316. VC's CCO CB attended his discharge meeting. I understood from her that ultimately, the inpatient team reached the conclusion that it was not appropriate to administer depot under restraint at this time. Their reasoning was that VC was strongly against receiving depot injections. VC had assured Dr Thangavelu and his colleagues that he was willing to work with the community team. VC had not displayed active symptoms of psychosis and so a move to Section 3 of the MHA could not be justified. I had not made a contribution to this plan. It was my understanding that VC would be discharged from the ward

as voluntary patient on oral antipsychotic medication, namely Aripiprazole 20 mg daily with regular follow up from his CCO and medical appointments as needed.

317. In terms of risk reduction, the only steps in place were VC's assurance that he would take his medication and meet regularly with the community team and that he would be provided with oral antipsychotic medication, namely Aripiprazole 20 mg daily with regular follow up from his CCO and medical appointments as needed.

318. A risk assessment was required ahead of VC's discharge **[NHFT0000045]**. There was also an MDT discharge planning meeting in advance of VC's fourth discharge: this was held on 24th February 2022 and attended by VC's CCO, CB.

Post Fourth Admission 24 January 2022 onwards

319. VC's risk and safety assessment was updated on 28 January 2022 **[NHFT0000190]**. This was drafted by VC's CCO within the EIP team to update the written risk assessment and safety plan. I was not involved in drafting this plan.

320. In April 2022 it was agreed that VC's care should transfer over to a new CCO, Gary Carter ("GC"). It was my understanding that a detailed and comprehensive hand over of care took place between CB and GC following handover. VC was known to GC from previous joint home visits conducted with

CB; he had also been present and involved in previous MDT meetings and discussions regarding VC. Our discussions regarding VC predominantly took place when GC brought VC to the MDT as a subject of discussion.

321. Between my assessment of VC on 14th March 2022 and my next scheduled appointment with VC in June 2022, I do not recall GC bringing VC for any detailed discussion at the MDT meeting beyond telling the team that VC was fine and collecting his medication fortnightly as per his care plan.

322. On the morning of my appointment with VC in June 2022, I read through GC's notes and became aware of the monitoring being provided by him. It became apparent that VC's engagement with his CCO was superficial at best. Shortly after this appointment I had a period of sick leave followed by annual leave.

323. On 4th July 2022 VC advised the team that he was outside the UK **[NHFT0000168, p.269]**. From that date onwards, GC regularly raised issues at the MDT regarding the challenges he had been facing in engaging VC. As a team we had numerous discussions about how GC might attempt to re-engage VC: methods included repeated texts, phone calls, a letter urging VC to come to the team base to collect his medication, phone conversations with VC's mother to find out his whereabouts, asking Celeste Calocane to write to VC and attempted home visits.

324. With respect to my meeting with VC on 14 March 2022, **[NHFT0000168, at p.263],** and in my letter to his GP on 22 April 2022 **[NHFT0000266]**), I described VC as being well presented, articulate and engaged with the meeting.

I noted that VC had reported to me that he had not missed any medication in the lead up to his admission and that his mental health had been fine. I also noted that he wished to keep his contact with mental health services as lowkey as possible and that I *"agreed to facilitate this as much as possible whilst monitoring his mental health".*

325. As referred to in that letter, I planned to meet VC again in three months' time – ie in or around June 2022. I can confirm that this was in fact the only opportunity I had to see VC due to numerous missed appointments with me.

326. My appointment with VC on 14th March 2022 was a half an hour follow up slot. It is usual practice within EIP services in Nottingham City to be given a follow up appointment rather than another full initial assessment appointment (1 hour) when a patient is already known to the team, has already undergone a full initial assessment and in the case of VC, has had four prior hospital admissions with a diagnosis assigned after each admission.

327. As I was already familiar with VC's past psychiatric history, the time was spent recapping the events leading up to his fourth admission and his current presentation. VC was well and symptom free at that time having recently been discharged from hospital following a period of treatment. During the appointment VC was calm, articulate and able to engage in a plausible and rational discussion about his mental health, treatment and university goals.

328. VC denied any hallucinations or persecutory delusions and did not display any evidence of psychosis during this meeting. He told me that he recognised that he had experienced psychotic symptoms during his first, second and third admissions but denied having experienced them during the fourth admission. Nevertheless he said that he understood the requirement for him to take antipsychotic medication and gave me his assurance of future concordance. His level of insight appeared to be good. At that time given the stability in his mental health there was no obvious risk of harm to himself or others. He refused a physical health check and bloods but this was common amongst our patients particularly those, like VC, who were needle-phobic.

329. In retrospect, having reflected on VC's presentation between his third and fourth admissions, it is very possible that VC's assertions that he had not missed any medication prior to his fourth admission may not have been true. It is also possible that he was masking symptoms and his insight into his condition was not as good as he presented it to be. However, there was an absence of any psychotic symptoms at his two mental health act assessments prior to his fourth hospital admission, and during the four-week admission itself, the inpatient team had seen no evidence of psychosis – see by way of example the entry on 22 February 2022 which refers to *"no overt signs of psychosis"* **[NHFT0000168, p.257]**. In my experience, I believe it is unusual to be able to mask symptoms for such a considerable length of time under the levels of observation a patient is subject to in an inpatient setting. VC's relative stability and the absence of psychotic symptoms would suggest that he was taking some of his medication during the period between his third and fourth admission.

330. At his appointment with me on 14th March 2022, VC was very clear that he wished to have minimal contact with our team as he had an important deadline for his dissertation which needed to be his focus over the next few months. He agreed to attend our mental health base fortnightly to collect his medication and to meet with his named care-coordinator for monitoring and any support he might need but otherwise wanted to be left to get on with his university work. VC was only prepared to engage on his own terms and he was angry about his fourth admission which he believed had been unnecessary.

331. Whilst it was not my preference for VC to have "low key" contact with our team, he was a voluntary patient in the community with the rights and choices pertaining to his voluntary status. Engagement with services and treatment is by consent and entirely voluntary in the community. VC appeared well, mentally stable and free from psychotic symptoms. In my view he had capacity to make decisions regarding his care and treatment and I had no reason to question his mental capacity in any domain. We had no CTO in place with conditions specifying his level of contact with team members or powers of recall should he break these conditions. I was also aware that in his final ward review the month previously, VC had told the inpatient responsible consultant that his reason for not attending any of my appointments between October 2021 and January 2022 was because he had felt persecuted by our services. As such, it was my view that fortnightly contact with his care coordinator (who could bring any concerns to our weekly MDT meeting) and a meeting with me in three months' time once

his dissertation work had been handed in was a reasonable and appropriate compromise.

332. I expressed my view that VC retained the requisite capacity to make decisions about his care in my NHFT interview **[NHFT0004710, at p.2]**. This view was informed by my assessment that on discharge from his fourth admission VC was stable, free from psychotic symptoms and able to engage in an articulate and rational discussion about his condition and treatment. In my opinion he was able to understand the discussions we had, use and weigh the relevant information and communicate his views regarding treatment and follow up. There was no basis for concluding that he lacked capacity to make these decisions.

333. VC had previously discussed with his CCO, CB, that, given the geographical distance and the DVLA regulations post-discharge which meant that he could not drive for a 3 month period, he would not be able to attend appointments on a weekly basis: he was, however, prepared to attend fortnightly. This is documented in CB multidisciplinary records dated 11th March, 2022 **[NHFT0000168, p.263]**. He re-iterated and was very clear at the clinic appointment with me on 14th March 2022 **[NHFT0000168, p.263]** that fortnightly attendance to collect his medication and see his CCO was what he was prepared to do. He said his priority at the time was completing his dissertation.

334. 14th March 2022 was my first meeting with VC and I was acutely aware that he had not attended any of his previous outpatient appointments with me.

I was also aware that in his final ward review the month previously, VC had told the inpatient responsible consultant that his reason for not attending any of my appointments between October 2021 and January 2022 was because he had felt persecuted by our services. I did not want to alienate him and risk early disengagement once again; I did not want VC to feel that the team was being authoritarian in its approach or was failing to take his views into consideration. It was also my view that fortnightly contact with his care coordinator (who could bring any concerns to our weekly MDT meeting) and then seeing me in three months' time once his dissertation work had been handed in was a reasonable and appropriate compromise that we needed to make to keep VC attending for appointments and still allowing some oversight of his mental health.

335. Between March and June 2022, VC attended the team base to pick up his medication on a fortnightly basis and to see his CCO for monitoring of his mental health. Originally, as a team we had identified that weekly attendance would have been the preferred option to allow better oversight of his concordance with medication and closer monitoring of his mental health. However, fortnightly appointments with a CCO is generally the usual level of contact that the majority of EIP patients receive, so it was not "low key" in general terms; rather, it was less frequent than we had originally planned.

336. On 13 June 2022, at 8:41am **[NHFT0000168, at pp.267-268]**, VC did not attend his 10:00am appointment: his CPN was to reschedule. On 01 August 2022, at 8:43 **[NHFT0000168, at p.269]**, VC did not attend his 11:00am appointment and another would be arranged by his CPN. In respect of these

missed appointments, I was concerned that VC had disengaged from follow-up with the EIP team and was no longer collecting his medication. I had concerns about potential future relapse of his condition and the risks pertaining to this.

337. When a patient did not attend their appointment, a review of the patient's multidisciplinary notes to check when they were last seen and if there were any concerns about their mental health or immediate risk of harm to self/others at that appointment was elucidated. A discussion with the CCO took place to check if they were aware of any more recent concerns or risks and based on this information a decision was taken as to whether an urgent home visit was needed or if another routine appointment could be offered. The named CCO also followed up on the missed appointments with the patient with a phone call usually on the same day or by the end of the week depending upon the level of concern and they rescheduled the next medical appointment with the medical secretary after checking availability with the patient. If a patient could not be contacted attempts were made to speak to a relative or close friend to check if they had spoken to the patient recently and had any concerns about their mental health.

338. An immediate assessment of VC's level of risk was undertaken in accordance with paragraph 7.2.1 of the DNA Policy **[NHFT0004725, at p.7]** through a review of multidisciplinary notes to check if any concerns or risks to self or others had been highlighted since he was last seen and I had a discussion with CCO with any immediate concerns that he may have regarding VC's mental health and current presentation. No immediate risk of harm to self

or others had been identified or brought to the attention of the team by family or the University when he did not attend his appointment on 13th June 2022 and up to that point VC had been attending the team base and collecting his medication so the level of risk was not deemed high.

339. VC came to the team base for what turned out to be the last time to collect his medication on 4th July 2022. He was next due to attend for medication on 18th July 2022. A staff member texted him on 18th July 2022 to see what time he was going to attend, upon which VC responded by saying he was out of the country until October **[NHFT0000168, pp.268-9]**. The team suspected that this might not be the case as VC had provided us with false addresses with a view to evading contact from services in the past.

340. On 27th July, VC's CCO made telephone contact with VC's mother, CC **[NHFT0000168, p.269]**. She confirmed that VC was in Nottingham, not abroad; in a subsequent conversation on 3 August 2022, CC confirmed that VC had been in recent telephone contact with his sister.

341. According to VC's CCO at the time, GC, VC's mother had not seemed particularly concerned about VC's mental health or disengagement with services. On 29 July 2022, GC attempted to contact VC by telephone **[NHFT0000168, p.269]**; he was unable to leave a message. VC subsequently failed to attend an outpatient appointment with me on 1st August.

342. When VC missed his CPA review on 4th August 2022 Gary Carter and I acknowledged that VC had not collected his medication since 18th July 2022 and was therefore at risk of relapse from his psychosis. VC had told another

member of the nursing team that he would be out of the country until October 2022 which we subsequently found to be untrue after his CCO had a conversation with VC's mother who confirmed that he was still living in Nottingham.

343. Following this a decision was made that Gary Carter would attempt a home visit to see VC on the same day (4th August 2022) in an attempt to assess his mental health **[NHFT0000168, p.270]**. We also agreed to take VC's case to MDT and form a plan of how we trying to re-engage him with the team. Gary Carter attempted a joint home visit with support worker Paul Williams to see VC at his property on 4th July 2022. Another resident answered the door and told Mr Carter that nobody with that name (VC) lived in the property.

344. GC noted he would take the situation back to me and "Emma" (meaning Emma Robinson, Team Leader) on Monday and noted *"To consider – discharge to GP? Report as a missing person?"* **[NHFT0000168, p.270]**. I have been asked but cannot now recall GC discussing the matter with me at this time.

345. We discussed how to re-engage VC with the team and persuade him to collect his medication at MDT meetings. The team decided initially to make contact with VC via telephone calls and text messages and, when this became unfruitful, planned home visits to see VC and contact with his mother to gain her help was the next steps. VC had completed his degree and graduated from University at this point so we assumed that he would not have had recent contact with his tutor. During his two years under the EIP team he had little if

any contact with his GP so his family were our only real port of call. I note that Gary Carter made contact with CC on 31 August 2022 **[NHFT0000168, p.270]** at which time she stated that she had not seen VC for many months, but that she had spoken to him recently. I note that VC's mother did not at that time have an address for him but that this was given to her by GC who noted an intention to *"go out and see VC to determine his mental state and general wellbeing".* The Rio records do not reflect whether or not such a visit took place. My understanding at the time was that the visit went ahead but VC was not at home.

346. On 23 September 2022, at 1:17pm **[NHFT0000168, at pp.270-271]**: Sharon Heath entered a note on Rio recording that VC had been discussed at an MDT meeting on 22 September 2022 where it was decided to discharge him back to his GP due to non engagement, with a view for the GP to refer back to services in future if needed. Sharon Heath's letter to the GP **[CHCA0000013]** states: "If [VC] chooses to engage with services, or his mental health deteriorates, please re-refer back to our team in the future."

347. I was present at this MDT, from memory, Emma Robinson (team leader), Gary Carter (CCO), Abigail Parsonage (CPN), Adele Pinder (CPN) Frances Doughty (CPN) and Paul Williams (PW) were all in attendance. There were other team members in attendance as well but I am unable to recall exactly who they were.

348. It was decided to discharge VC from the service as a non-engaging patient. Despite a nine-month period of trying to engage him in the community

from October 2021 to September 2022 we reached a point where it became very clear that VC was actively and intentionally disengaging with services and his medication. He was trying to avoid the team; he had misled us and told us in July 2022 that he had moved abroad and would not be returning to the UK until October 2022. He had stopped collecting his medication in July 2022 and for a three-month period his CCO had been unable to locate him and was therefore no longer in a position to monitor him. Several attempts to contact VC by phone had been made; text messages were unsuccessful; we had attempted to visit him at home but found that he was not present at the address we had on record.

349. There was no further intervention that we could offer as a team. VC was not on a CTO: there was no community-based MHA power which could be used to require him to accept treatment or to attend appointments; nor was there a power to recall him to hospital should he break these conditions. He was a voluntary patient and so attendance to see his CCO and treating psychiatrist and take his treatment could not be enforced.

350. At the point of VC's discharge from the EIP, neither his family, the University, or the Police had contacted us to raise any concerns about his mental health during this period of active disengagement (which had previously given the team grounds for requesting a MHA assessment). We therefore had no evidence that he was relapsing or acutely psychotic or that risk of harm to self or others was present at the time.

351. The possibility of referring VC to the crisis team or requesting a MHA assessment was rejected as an option during the final months of VC's care. This was on the basis that the EIP team had no evidence that he was in crisis or psychotic and therefore he was not 'admission vulnerable'. Without direct evidence of deteriorating mental health or concerns raised regarding escalating risks, the team would have struggled to justify the need for either option.

352. The possibility of referral to the Local Mental Health Team (LMHT) for longer term case management was also rejected as an option on the basis that the LMHT was less resourced than EIP and *'unlikely to have offered anything more specialist in terms of engagement strategies and outreach'* **[NHFT0004783]**. The de-commissioning/disbanding of the Assertive Outreach services 10 years ago has left clinicians with limited options for managing patients who are not subject to a CTO and are therefore "revolving door" patients and difficult to engage.

353. We could not have reported VC as a missing person given VC had proactively contacted the Trust to request his medical notes and the team were aware that he had had telephone contact with a sibling.

354. The possibility of a welfare check was raised, but it was thought unlikely that the police would respond to a request to check on VC's safety and welfare. Previous requests to the police earlier that year had been met with refusal on the grounds that the police had neither the resources nor the expertise to carry out these checks on patients with mental health difficulties. They would only become involved in the event of imminent risk to life or limb. It was my

understanding that GC had already attempted two home visits - the second one being to the new address - but failed to see VC. In fact I now understand that the second attempted visit did not take place.

355. As a service we had no other mechanism or interventions available to us to re-engage VC. We did not have the team structure or resources of the previous assertive outreach services which had a structure and skill set specifically designed to enable the engagement and management of patients who did not wish to engage with services and had become revolving door patients such as VC. The Nottingham assertive outreach services were disbanded in around 2015 so there was no longer an option to refer VC to this type of specialist service. It was my understanding at the time, that VC's care coordinator was struggling with a caseload that was over the numbers that would be expected nationally for an EIP care coordinator (15) and had several other high risk patients on his caseload. [NHFT0000451].

356. Whilst the team accepted that it was likely VC's mental state would potentially deteriorate again at future date without medication and that he would most likely re-present to services, in the lead up to his discharge from our team we had no evidence that he was psychotic or in crisis. There had been no concerns expressed to our services about his mental health or that he posed a risk to himself or to others by his family, the university or the police.

357. It is not uncommon for patients who have disengaged or discharged from services to re-present back into services. There are a number of routes back into services including the GP, family, the Crisis team, Street Triage and the

Police. As a service we were fully aware that VC's lack of engagement could well be an indication that his mental health was deteriorating. We anticipated that VC might be referred back into services through one of these routes.

358. The time for relapse can vary for each individual from weeks to months. As a service we were no longer able actively to monitor or engage VC, and had we decided to keep him on the books but without any active intervention, we would not have changed his behaviour or its consequences. Our previous team discussions and risk assessments of VC had clearly identified that his previous acts of violence had been reactive rather than planned or intentional and as such we did not perceive him to be a serious risk of harm to the general public.

359. Ideally we would have seen VC face to face to make an assessment of his current mental state before discharge. However, in light of his active disengagement and avoidance of the team this became extremely challenging.

VC's Discharge

360. The team had not been able to locate and visit VC in-person in the three months leading up to September 2022. There was therefore no plan formulated to inform VC of the decision to discharge him in person. While the EIP team were, supplied with a new address for VC, it appears that no visit to this address was ever carried out. I was unaware of this until after the tragic events of June 2023.

361. It was usual practice within the EIP teams for the CCO to write a detailed individualized discharge letter to a patient's GP, outlining a patient's history,

background, treatments received whilst under the care of the EIP team, medication, an up-to-date risk assessment, the requirements for follow up and a crisis plan. I am uncertain why this did not happen in this instance and why the EIP team leader Sharon Heath rather than CCO GC wrote the discharge letter.

362. Historically patient GPs had been invited to attend discharge meetings or MDTs to discuss discharge planning. Due to time constraints and busy schedules, however, they had frequently been unable to attend. It is my understanding that in light of this, they were no longer invited to these meetings.

363. As I commented above and in my NHFT interview, if an assertive outreach team had existed, VC would have been referred to them **[NHFT0004710, at p.4]**.

364. Assertive Outreach services are a specialist community mental health team designed for people with severe and enduring mental illness who have become "revolving door" patients and struggle to engage with mainstream services. They were set up as part of the National Service Frameworks for Mental health in 1999 but disbanded and absorbed back into Community Mental health Teams across the country between 2010 and 2016. The teams were set up with the level of resourcing and skill set required to provide an assertive outreach approach.

365. The level of resourcing available in Assertive Outreach services enabled staff to pursue contact with patients assertively, seeing them at home, in

hostels, in cafes and even on the street if needed. Their structure included a large proportion of support workers who could actively and intensively attempt to engage patients in the community. Assertive Outreach teams had small caseloads of 10-12 patients per CCO and could offer frequent contact, sometimes several times a week. The whole team took responsibility for the patient rather than a single CCO which gave multiple chances to build a connection and meant that if the CCO was not available or on leave the patient was well known to other team members and trusted them. This structure also reduced the chance of disengagement if a trusted care coordinator left. The focus was not just on mental health and medication, but also on housing, benefits, education, and employment. The Active Outreach staff also adopted a flexible and collaborative approach to care. Given VC's persistent and active attempts to disengage from services, in my view his needs would have been better met with care and treatment from a specialist Assertive Outreach team – had one existed.

366. Primary care could not provide assertive outreach of the type VC required. Similarly, if the EIP had retained VC on our caseload I do not believe that we were in a position to provide the monitoring or mitigate a relapse in his mental health for the reasons already described.

367. The requirements of the Nottinghamshire Healthcare Trust Crisis Resolution and Home Treatment Team ("CRHT") were that a patient must be showing clear signs of being in an acute crisis with evidence of risk to themselves or others before they could be referred to the CRHT.

368. At that time of his discharge, we had no evidence that VC was in crisis or psychotic and therefore he was not 'admission vulnerable'. Without direct evidence of deteriorating mental health or concerns raised regarding escalating risks our team struggled to justify the need for CRHT. A further requisite for a CRHT referral is that a patient should be willing to engage and work with their team. This would have been highly unlikely in VC's case.

369. The DNA Policy **[NHFT0004725, at pp.6-7]** requires an assessment of a patient's risk and consideration of their appropriateness for discharge.

370. VC's risks were well known to members of the EIP team and had been discussed at EIP MDTs on many occasion and clearly documented over the two years that he was under the care of mental health services, each time there was an escalation or evidence of a change in risk of harm to self or others. At the point of discharge we were not aware of any immediate risks or an appreciable change in risk of harm to himself or others. The team had MDT discussions about the risk of discharge during the final month in the lead up to his discharge. The main risk identified at that time was a risk of deteriorating mental health. In these discussions we acknowledged that historically when VC's mental health deteriorated and he became acutely psychotic there had been one episode of violence against two police officers whom he believed were a significant threat to his immediate safety and he reacted to this high threat situation by assaulting the police officers. This was reactive to a high threat situation. VC had never seriously injured or attacked a member of the

public in a planned or pre-meditated way as a direct result of his delusions. During his periods of remission, he essentially kept a very low profile and concentrated on his course work and exams.

371. Paragraph 7.2.3.2 of the DNA Policy **[NHFT0004725]** provided that a letter should be sent to a person's home detailing actions to be taken with timescales if contact is not made. I am uncertain as to why this did not happen in VC's case and this question would be better answered by VC's CCO at the time, GC.

372. In accordance with 7.2.3.3. of the DNA policy, in the weeks leading up to VC's discharge, his mother was contacted by his CCO on two occasions, initially to ascertain his whereabouts after a failed home visit on 4th August 2022 followed by a second phone after the team acquired a new address for VC. GC noted that VC's mother suggested she might write to VC and attempt to reach him **[NHFT0000168, p.270]**. We considered contacting the university but as VC had completed his degree and graduated we thought it unlikely he would have had recent contact with his tutor. During his two years under the EIP team, VC had little if any contact with his GP so this was not considered to be useful. We did not know who VC's housing provider was so contact was not made with them.

373. We considered involving the police to report VC as a missing person. However, following MDT discussion in the final weeks leading up to his discharge, this was no longer considered to be relevant as VC had contacted

the Trust and requested to see his medical notes and the team were aware that he had recently made telephone contact with a sibling. Following VC's request for his medical notes we were provided with VC's correct address.

374. As above, a welfare check was posited but it was thought unlikely that the police would respond to a request to check on VC's safety and welfare given there were no grounds to suggest he was at imminent risk.

375. In the weeks leading up to VC's discharge his mother was contacted by his CCO on two occasions, initially to ascertain his whereabouts after a failed home visit on 4th August 2022 followed by a second phone after the team acquired a new address for VC. VC had given the team explicit instructions to not involve his family in any decisions about his care so in line with procedures for maintaining confidentiality we did not involve the family in decisions pertaining to discharge. Information governance did, however, allow the team to contact the family to collect information from them rather than divulge information about VC. As above, VC's mother suggested she would write and contact him.

376. I have been asked what consideration was given to a Mental Health Act assessment prior to VC's discharge. In the weeks leading up to VC's discharge I recall that consideration. The Mental Health Act 1983 has a set of core principles that establish the circumstances in which a person with a mental disorder may be detained without their consent. It has built in safeguards to ensure any actions taken to detain a patient are necessary, appropriate and respect the individual's rights.

377. The Mental Health Act Code of Practice sets out the importance of the principle of least restriction. As set out in paragraph 1.2: "where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained."

378. Detention or even assessment (as a step to detention) under the MHA must be a last resort. All less restrictive alternatives (engagement, community support, voluntary admission, etc.) should be considered and attempted first. So if a mental health team has not seen the person and has no evidence of deterioration to self or risk to others, calling an MHA assessment cannot be justified.

379. Before carrying out an assessment under the MHA with a view to detention, there must be reasonable cause to believe a person has a mental disorder of a nature or degree that warrants detention. If the team has not seen the patient or has no recent or reliable information showing risk or deterioration, there is no basis upon which an assessment can be carried out.

380. The Act should not be used solely because a person is behaving in a way that others find difficult or because they have refused services. A refusal to engage, missed appointments, or non-compliance alone are not enough to warrant assessment for detention: the team must have objective evidence of mental disorder and risk. Taking all the above information into consideration we could not justify calling for an MHA assessment in VC's case.

381. As a team we frequently requested MHA assessments, undertook mental capacity assessments and requested advice from the adult safeguarding team when it was appropriate and required. As such we were well versed in the thresholds required for requesting a MHA assessment and, as above, we did not have the required evidence that VC's mental health was deteriorating or that he was at risk of harm to himself or others such as to warrant an MHA assessment.

382. The MCA 2005 only applies if a person lacks capacity in the relevant domain.

383. As we had no evidence as a team that VC lacked capacity to make decisions about his treatment and care the MCA was not considered.

384. In the lead up to his discharge we were not aware of any adults that VC was in contact with who specifically required safeguarding. As such, adult safeguarding procedures were not relevant to his case.

385. In the lead up to VC's discharge, referral to the Local Mental Health Team (LMHT) for longer term case management was discussed as an option. This option was rejected on the basis that the LMHT was less resourced than EIP and 'unlikely to have offered anything more specialist in terms of engagement strategies and outreach'. The de-commissioning/disbanding of the Assertive Outreach services 10 years ago has left clinicians with limited options for managing patients who are revolving door and difficult to engage (excepting for those subject to a CTO).

386. Referral to the crisis team was also considered and rejected on the basis that the EIP team had no evidence that VC was in acute crisis 'admission vulnerable'. Without direct evidence of deteriorating mental health or concerns raised regarding escalating risks the team the CRHT would not have accepted a referral to their service and the EIP team would have struggled to justify this option.

387. VC's CCO made a concerted effort but failed to see him face to face in the last 3 months under the care of the EIP team. He was therefore unable to make an assessment of VC's mental health or mental capacity.

388. On discharge, the plan was that VC would get his medication from the GP. This plan should have been communicated to the GP in the discharge letter which is usual practice for the EIP team. VC was not considered to be a high-risk patient on our EIP caseload. During his time under the care of the EIP team, VC had never voiced any thoughts of wanting to harm others. There had been no documentation in his case notes or risk assessments of VC experiencing command hallucinations telling him to harm others or delusions of control which may have caused potential risks to members of the public. In terms of other key risk factors which predict serious violence in psychosis, VC had no previous forensic or criminal history or a known history of substance misuse, both of which have been identified in systematic reviews as significant risk factors for violence in psychosis. It was my understanding that VC had good pre-morbid adjustment and was described by those who knew him as being a shy,

intelligent, good-natured and focused on his studies. He had no anti-social personality traits, came from a supportive family with a relatively stable upbringing. We were not aware of any previous history of trauma.

389. For the reasons described above our risk assessment of VC was that during periods of acute psychosis there was a moderate risk that when he found himself in a high threat situation he could react with hostility. There were several patients on our caseload who were considered high risk with a significant number of the risk factors described above.

390. I was not aware of the bench warrant without bail issued by Nottingham Magistrates Court on 22 September 2022 in relation to VC's failure to attend court until after the tragic events took place in June 2023. Had I been aware of the warrant it is likely that, as a team we would have made direct contact with police to request/undertake joint working.

My contributions to other investigations into VC

391. I exhibit the following documents:

i. The note of my interview by NHFT on 8 January (year unspecified) **[NHFT0004710].**

ii. The transcript of your interview with Theemis [**TCLT0000516**].

iii. The questions directed at me from the letter of concern from the victims' families **[NHFT0004803].**

iv. My responses to those questions [**NHFT0004783**] confirming who drafted them (the black and red text).

392. I agree to the accuracy of the transcripts/note.

393. I have been subject to a Maintaining High Professional Standards (MHPS) interview and Exhibit a copy of my response to the interview questions and transcript [**WITN0357003**].

Reflections

394. The VC attacks have had a devastating impact on the victims and families of victims and everyone involved. I am both saddened and sorry about this tragic event and its aftermath.

395. During the last two years I have spent a considerable amount of time looking back and reflecting on what could have been done differently given our level of resourcing, VC's voluntary status in the community and both the legal and ethical constraints we found ourselves in as a team. Throughout the time that VC was under the care of the EIP team there was a constant tension between his rights as a voluntary patient and the potential risks which became apparent when he disengaged from the team and discontinued medication.

396. When a voluntary patient disengages from services and treatment in the community, the only powers that the team had was to call a MHA assessment. This was dependent on being able to assess an individual's mental state and provide evidence that they had reached a critical point in their condition with a clear deterioration in mental health and risk to themselves or others. In the absence of this evidence, the team found themselves with limited interventions

for voluntary patients who actively and deliberately disengaged. Based on the MHA principles of least restriction and in my experience of having worked in the trust for 29 years, VC's having simply disengaged from services and treatment did not meet the threshold for instigating a Mental Health Act assessment.

397. Historically we were able to refer this group of patients to Assertive Outreach services which had the specialist skills, team structure and resources to manage patients who struggled to engage with services. This was no longer an option after Assertive Outreach teams were disbanded and absorbed into the LMHTs around 2015.

398. Our EIP team were working under significant resource restraints at the time VC was under our care. As a community consultant I had one and a half days of direct clinical time allocated to the EIP service which, in my opinion and that of other EIP consultant colleagues within the trust, often fell short of the time needed to provide the necessary oversight for a caseload of 80 complex patients with psychosis. Likewise, some CCOs had caseloads above the recommended EIP implementation standards of 15 patients. The extra time and resources needed to track down and locate disengaged patients was not available and proved highly challenging for the team.

399. In VC's case, concerted efforts to re-engage him with the resources available to us were unsuccessful. We were not able to determine if his final disengagement from our service in July 2022 was due to a relapse of his persecutory delusions or merely a loss of trust with his treating clinicians and

an unwillingness to continue taking his medication as had most likely been the case in the lead up to his fourth admission.

400. As a team were aware that VC had felt persecuted by the team and during his fourth admission his mother had been unhappy about his detention and treatment under the MHA deeming it to have been unnecessary on that occasion. During those final three months when VC was lost to follow up, we had no information about his current mental state, risk or capacity because we had not been able to see him. Any risk assessment undertaken at that time was purely based on historical risks and conjecture about his current presentation and risk. VC had very recently completed a dissertation and gained a degree in mechanical engineering, which would have been almost impossible if he had started to relapse and had been experiencing acute psychotic symptoms.

401. If VC had been discharged from inpatient care on a depot and a CTO this would have given the EIP team the necessary oversight of his medication and the powers of recall to hospital in the event of him not attending appointments with his CCO and doctor. There was a real opportunity for him to have been put on depot medication and placed on a CTO during his third admission when VC was being treated under section 3 of the MHA at the Cygnet hospital and stepped down to the Priory hospital.

402. VC's CCO had made a concerted effort to recommend this to the inpatient teams and had even spoken to VC who was willing to consider a depot antipsychotic at that time, but unfortunately due to a communication breakdown between our trust and the private hospitals this did not happen.

403. VC's fourth admission was under section 2 of the MHA, but as a patient with a relapse in a diagnosed condition, VC really ought to have been admitted for treatment under section 3 MHA. Had this happened VC could have been subject to a CTO and depot medication which would have empowered our team to administer injectable antipsychotic medication and allowed recall to hospital in the event of non-compliance. It would have also enabled police involvement in the event of disengagement and locating VC through the execution of a warrant.

404. Better interprofessional working between mental health services and the police was another area where joint working across professions may have enabled VC to be located and re-engaged with treatment. The experience of the team at that time was that in the absence of a CTO it had become increasingly difficult to gain the help and support from the police with voluntary psychiatric patients who had become lost to follow up. Previous requests to the police earlier that year had been met with refusal on the grounds that the police were neither resourced nor did they have the expertise to carry out these welfare checks on patients with mental health difficulties. Only if there was "imminent risk to life or limb would they be prepared to be involved." The following year after VC was discharged (2023) the UK police forces implemented the "Right Care, Right Person national policy (RCRP). Under RCRP the police will no longer attend welfare checks unless there is a "clear threat to life or safety, or a criminal offence had been committed" for which police powers were required. Welfare visits due to non-contact, disengagement

or general concern are deemed health or social care responsibilities, not policing.

405. In my own individual practice and collectively as a team we have learnt lessons and accepted the recommendations made by all the enquiries to date there have been considerable changes in practice as described below.

406. My deepest condolences go out to the victims and families of victims.

Changes in Practice

407. Following the tragic incident, both the EIP team and I have made considerable changes to our practice based on the recommendations put forward by the Themis Homicide Investigation, the CQC report and our own internal investigation findings.

408. The EIP consultants within the Trust have been meeting on a monthly basis for peer supervision to discuss challenging cases and lessons learnt from serious incidents. Within these meeting we have been benchmarking against each others' practice and national policies and guidelines for first episode psychosis. I have personally started meeting with one of my EIP consultant colleagues bi-monthly for supervision and mentorship. The Trust have put administration support in place for all the EIP MDTs, and CCOs have a responsibility to record all MDT discussions in the electronic records so that the rich and detailed discussions which take place at these meetings is fully captured. These entries are audited at the end of the week. The EIP services

now have a discharge checklist which clinicians follow in the lead up to patients being discharged from our services or transferred to other teams. The EIP services have introduced an action log to ensure that important actions from the previous MDT identified and not missed. A named clinician from the team is identified to complete a particular action and this checked the following week.

409. In terms of discharge planning for complex patients, we have started to invite GPs to discharge meetings and have held our meetings at GP practices when they have not been able to attend our team base.

410. The Trust have updated their policy on management of patients who are difficult to engage or who fail to engage with services to ensure that there are clear and detailed guidelines and a consistent approach to managing this challenging group of individuals. A flowchart is now available for patients who do not engage with services. The Trust have also been developing more robust care pathways for patients who do not engage with mainstream services (cluster 16 and 17) with a recognition that current services do not adequately meet the needs for this "revolving door", difficult to engage patient group. This is ongoing work in progress.

411. I have reflected on whether the EIP team placed too much emphasis on complying with VC's educational priorities. Whilst there has always been a strong ethos within EIP services *"to value each person as an individual, respect their aspirations and commitments in life and seek to understand their priorities, needs, abilities and limits"* in line with the NHS constitution, we have always

tried to balance the needs and rights of an individual with the need to protect themselves or others.

412. When EIP services were first set up in the early 2000s, there was also a strong ethos around reducing stigma and instilling a sense of hope and recovery in this young patient group and their families. EIP services nationally were encouraged to work with diagnostic uncertainty and this has continued to be the case as referenced in the National Institute of Clinical Excellence (NICE) guidelines. Patients are therefore often given a broad diagnosis of "first episode psychosis" during their time in services rather than a more specific diagnosis such as schizophrenia. This broader terminology is used both in the EIP literature, the Royal College of Psychiatrists and NICE guidelines. It is also worth noting that the diagnostic stability of psychotic disorders can be low in the first 2-3 years of the course of illness and tends to increase as the illness trajectory becomes clearer which is another reason for using more broad diagnostic terminology like "First Episode Psychosis". The reluctance to use diagnostic labels was driven by the fact that early diagnoses of psychotic disorders are often unstable and likely to change in the first two years and not due to prioritizing educational needs.

413. I was aware of concerns about the disproportionate overuse of MHA restrictive measures with black African and black Caribbean patients publicised in the context of Mental Health Act Reform. I was aware of the Mental Health Act Reform White Paper published in August 2021. On page 12 of the paper there is a section titled "We will give everyone a voice and the power to express

their views about the care and treatment they want to have". This section highlighted the need to "giving someone a greater say in their care stating that this can lead to greater engagement in treatment and potentially longer-term therapeutic benefits". Working collaboratively with patients and taking their views into full consideration to promote positive engagement was already enshrined into the EIP ethos and reading this paper perhaps gave these existing values more strength.

414. However, as a team we did not avoid the use of restrictive practices such as requesting a mental health assessment when it was clearly needed and a patient had reached a critical threshold: I was aware of the concerns about disproportionate overuse of restrictive measures with black African or black Caribbean patients but they did not prevent me from carrying out a thorough and appropriate assessment of patients' needs, whatever their ethnic backgrounds. .

Recommendations

415. Standardised risk assessment tools cannot accurately predict or forecast future risk events and generally have low predictive validity. They are, however, useful as a support to structured clinical judgement and formulation (NICE 2021/2015).

416. In my opinion the current trust risk assessment document serves as a tick box exercise and does not encourage dynamic risk assessment or

formulation. A more high-quality standardised risk assessment tool should be used which facilitates formulation-based thinking rather than checklist scoring.

417. Information-sharing and multi-agency working should be improved with the creation of a joint risk forum with multi-agency panels to review and monitor individuals with complex risk profiles.

418. Greater decision-making powers should be given to community teams (who generally have a better understanding of a patient's natural history and course of illness) in respect of putting patients on a CTO.

419. Parliament should assess whether current mental health laws e.g. thresholds and criteria for detention or CTOs adequately protect the public and patients and review the current principles of “least restrictive practice”.

420. There must be sufficient investment in community mental health and crisis care.

421. All mental health trusts must have specialist teams designed for patients with severe and enduring metal illness who struggle to engage with mainstream care.

422. Locally, interagency protocols should be formalised to ensure clear information-sharing agreements between mental health teams, primary care, the police, housing and probation.

423. Fast-track alerts between agencies should be introduced for when risk indicators arise.

424. Information-sharing and multi-agency should be improved with the creation of a joint risk forum with multi-agency panels to review and monitor individuals with complex risk profiles.

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: 18th December, 2025

Index to First Witness Statement of Dr Tuhina Lloyd

No.	URN	Document Description
1	NHFT0004012	EIP Service Operational Policy
2	NHFT0000417	Policy Document, Re: Cancellations and Management
3	WITN0357002	Trust and job planning procedure
4	NHFT0004725	Procedure: 01.08a - Merged Do Not Attends (DNA's)/Cancellations & Management of Patients Who Fail to Engage with Services or Seek to Disengage from Care in an Unplanned Way Procedure'
5	WITN0133024	HCR -20 Rating Sheet
6	NHFT0000168	VC Rio Records
7	NHFT0017766	Email from Dr Seedat re VC call, dated 5.11.2020
8	NHFT0018011	Email from Dr Lloyd to Dr Seedat re VC call, dated 9.11.2020
9	NHFT0000512	Letter from Dr Sasidharan
10	NHFT0018143	Email from CB to Dr Lloyd re VC tribunal, dated 17.09.21
11	TCLT0000516	Theemis interview of Dr Lloyd
12	NHFT0004710	NHFT interview of Dr Lloyd
13	WITN0206011	Email from Dr Lloyd to Dr Thangavelu dated 3.2.22
14	NHFT0000045	NHFT Transfer and Discharge policy
15	NHFT0000451	NHFT Level 2 investigation report
16	NHFT0004803	Questions to NHFT from victims' families
17	NHFT0004783	Responses from Dr Lloyd to questions from victims' families
18	**WITN0357003**	Dr Lloyd MHPS interview transcript
19	NHFT0000187	Core Assessment dated 15 July 2020
20	NHFT0000202	Summary and Care Plan dated 1 September 2020

21	CHCA0000025	Letter from Dr Bilal Burri to Cripps Health Centre dated 23 September 2020
22	NHFT0000201	Summary and care plan dated 29 June 2021
23	NHFT0000190	Risk and Safety Assessment updated 28 January 2022
24	NHFT0000266	Letter from Dr Tuhina Lloyd to Cripps Health Centre dated 14 March 2022
25	CHCA0000013	Letter from Sharon Heath to Cripps Health Centre dated 23 September 2022
26	**WITN0196002**	**EIP Referral Letter**