Witness Name: Adele Pinder

Statement No: WITN0396001

Dated: 11th February 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF ADELE PINDER

I, Adele Louise Pinder, will say as follows:

Introduction

1. I am Community Psychiatric Nurse (CPN) in the Early Intervention in Psychosis team at Nottinghamshire Healthcare NHS Foundation Trust (NHFT).

2. I make this statement in response to a request made under Rule 9 of the Inquiry Rules 2006, dated 17 December 2025. In this statement, I discuss my career and role, my training and system of work, and my interactions with Valdo Calocane (VC).

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

Career and Role

4. I qualified as a Registered Mental Health Nurse (RMN) in 2016.

5. After qualifying, I began working as an RMN (Band 5) at Thorneywood Adolescent Unit (CAMHS inpatients), which is part of NHFT. In June 2018, we relocated to Hopewood Adolescent Unit, and In March 2018, I was promoted to Team Leader (Band 6) but did not substantively begin this role until the team relocated to Hopewood Adolescent Unit, and I began working on Phoenix ward. I worked on Phoenix Ward until December 2020.

6. As a Team Leader, my roles and responsibilities included providing senior cover to the Hopewood site, including supporting the wards to manage and co-ordinate incidents, checking safe staffing levels and putting out appropriate cover for shifts, regularly reviewing incoming referrals and making decisions about these, completing handovers with other senior nurses, providing supervision to junior members of the team, escalating concerns to bronze on call, completing the rota, and providing senior support to the mother and baby unit.

7. I would also work on the ward directly as Nurse in Charge which involved running the shift, administering medication, engaging directly with patients, families and other services where required, completing handovers to the multidisciplinary team (MDT), completing diary jobs including safeguarding referrals, updating core documents including risk assessments and writing in progress notes.

8. In January 2021, I began my current role in the Early Intervention in Psychosis (EIP) Team as a Community Psychiatric Nurse (CPN) (Band 6). I am still

working in this role but was on sick leave between 21st July 2025 to 8th January 2026. I am now back at work in the team.

9. Within the EIP, I act as a CPN Care Co-ordinator (CCO). This involves holding my own caseload of patients, for whom I assess, plan, implement and review care, and generally support in their recovery from a first episode of psychosis. This includes delivering cognitive behavioural therapy informed interventions, relapse planning and recovery-based work. I am also responsible for delivering and monitoring the effectiveness of medication, supporting patients during periods of crisis, offering support and input to families and carers, and liaising with other agencies where appropriate. I am responsible for escalating any concerns within the MDT, with the management team and the Consultant Psychiatrist.

10. I am registered with the Royal College of Nursing.

Early Intervention in Psychosis Service and Role of the CPN

11. The EIP Team provides an early intervention service to young people and adults between ages 18-65, who are experiencing their first episode of psychosis. The aims of the service are to reduce distress, build and maintain independence, prevent relapse and promote recovery, as well as promote social inclusion, and reduce the risk of longer-term treatment resistant symptoms. The EIP Service is also set out in the EIP Operational Policy [NHFT0004012].

12. The EIP service offers two pathways: the First Episode Psychosis (FEP) pathway and the At Risk Mental State (ARMS) pathway. It is important to note

that the South EIP teams do not have an ARMS pathway and if it is felt a patient meets criteria for ARMs, we must flag this as an unmet need and refer to the Local Mental Health Team (LMHT). When being referred to EIP, every individual will have a comprehensive assessment to determine the most appropriate pathway and treatment plan. For some patients, a longer period of assessment is required, to further establish the cause of the symptoms and ensure a comprehensive plan of care can be made within the correct service.

13. The EIP team has inclusion and exclusion criteria. In order to be eligible for treatment from the EIP, a patient must meet the inclusion criteria [NHFT0004012, pg.4]. The inclusion criteria are:
    a. People experiencing a first episode or first presentation of psychosis, with a maximum of 3 years duration of untreated psychosis.
    b. People between the ages of 14 – 65 (with the Nottingham head-to-head team taking individuals from the ages 14-17).
    c. People who have not received treatment for psychosis with anti-psychotic medication that commenced over 12 months ago.
    d. People registered with GP practices covered by the seven Clinical Commission Groups within Nottinghamshire.

14. Once it is established an individual meets the criteria for either the FEP or ARMS pathway, they will be allocated a CCO. The CCO holds responsibility for coordinating the patient's care and, together with the patient, will develop a person-centred care plan that will provide the foundations of the treatment

pathway. The EIP team recognizes the importance of involving patients, carers and families in patient care and always seeks to obtain their views and opinions.

15. There are various treatments available to EIP service users. These include: pharmacological approaches such as anti-psychotic medication, anti-depressant medication and benzodiazepines, as well as providing short term prescriptions for poor sleep should this be required. Medication may also be provided via a depot injection, for example, if there are issues with concordance, or remembering to take medication. Medication is also used in combination with psychological therapies, which in EIP is provided via CBT and CBTp (CBT for psychosis).

16. Behavioural Family Therapy (BFT) is also available via EIP, and this provides support for the whole family. In addition, EIP offers Individual Placement Support (IPS), which focuses on support around employment and vocational opportunities. Social inclusion is offered through a variety of channels including support from the CCO, established groups within EIP, and with support workers and peer support workers in the team.

17. All service users open on an EIP pathway will also be offered yearly physical healthcare assessments and more frequently as required. CCOs and support workers also work with delivering CBT-informed interventions including, but not limited to, stabilization, relapse prevention work, sleep and worry interventions. Service users on the FEP pathway are offered outpatient appointments with a Consultant Psychiatrist on a 3-month basis.

18. Allocated CCOs hold some responsibility in monitoring and managing the mental health of those on their caseload, including looking out for any signs of relapse or deterioration. Other members of the team may go out on visits with the CCo, depending on the patient's care plan or risk level. CCOs will also work closely with other members of the MDT involved in their patients' care, in addition to liaising with external agencies/services, including the patients' General Practitioner (GP). The team would also liaise with family members where appropriate to ascertain their views and opinions.

19. Medication was sometimes given to patients directly from the EIP service, for example, if the patient had recently been started on medication, and this had yet to stabilise, or it was possible that changes would need to be made. Other situations where EIP may provide medication would be if a patient was unwell or experiencing a relapse, had a recent discharge from hospital or a risk of non-concordance.

20. CCOs would regularly visit their patients in line with the agreed care plan and would ask about medication on each visit. At each visit, the CCO would regularly be asking if the patient is still taking their medication, how they are finding it, and if they are experiencing any side effects or unwanted symptoms. In addition, the CCO would ask the patient if they felt the medication was helping or making a difference to their symptoms. The CCO would also ask about medication in any interim contact they had with the patient, such as during a phone call in between appointments.

21. Patients would also see the Consultant Psychiatrist or doctor every three months for a review of their mental health, care and treatment plans, medication, and any changes to risk. This would be completed in collaboration with the CCO where possible, and emphasis would be placed on trying to ensure the patient saw the same doctor on each occasion for consistency of care. Medication would be reviewed during the outpatients' appointments but could be reviewed sooner if the patient or CCO identified a need for this. Appointments with the Nursing Medical Prescriber (NMP) could also be utilized if a review was required prior to this.

22. Families and carers were consulted about medication if the patient was happy for this to be discussed with them. They would be also consulted where there were concerns a patient was unwell and lacked capacity and insight to make decisions about medication themselves.

23. Any patients who had already been prescribed two anti-psychotic medications would be offered Clozapine, as per the EIP guidance and standards [NHFT0004012, pg.18]. If this was accepted, further discussions would have to take place with the Consultant Psychiatrist and the MDT, regarding the suitability for Clozapine and ensuring the patient and family would be aware of both the risks and benefits of the medication.

24. Other options for supporting and monitoring medication concordance were looking at a flexi pack/dosette box as an aid, asking if families were able to

support and encourage taking medication, utilising the Crisis Team for medication concordance and increasing visits and the amount of support offered.

Tools or practices available to the EIP team for non-engaging patients

25. Should a patient begin to disengage from the service, their CCO would raise this within the MDT meeting. Discussions would be had about the patients' current symptoms, and a note made of risk including both historical and current risks and any exacerbating factors. The MDT would also discuss the patients' capacity and insight into their condition if this was known.

26. In the first instance CCO would try to make further contact with the patient. This would be via a variety of means, including telephone call, text messages, emails if we had one on file.

27. Depending on the circumstances an urgent home visit or cold call would be conducted, sometimes with two members of the team if concerns had been raised about risk posed by the patient in the event of non-concordance. If the patient was not in, did not answer or did not engage this would be brought back again to the team and escalated to management, the Consultant, and within the MDT as to what further steps may be needed. Other forms of communication may be attempted such as sending out a letter, speaking to the patients' GP, or family and carers. Attempts would be made to ascertain whether any family had seen the patient, and whether they had any concerns. The GP may be asked if they have any alternative contact details for the patient or their family, when

they last saw them, and if they could contact the patient to let them know EIP were trying to get hold of them.

28. The CCO would be considering offering alternative options for the patient to meet with us, in order to help promote engagement. We may offer to meet somewhere less formal than an outpatients' appointment, such as in a public place, at their home, the GP or university campus. We also offer flexibility around dates for appointments and try to ascertain where the patient would feel most comfortable meeting. We may also be offering shorter appointment times so as not to overwhelm them in the first instance, and ease into engagement that way. Other options to try different members of staff would be considered, for example if the working relationship had broken down.

29. When a patient stopped or was not engaging, their core documents would be updated. This would include updating the core assessment form, risk assessment, adding a note on the progress notes, and updating the alert section on RiO. If my concerns were urgent, I would raise this with the MDT and/or Consultant Psychiatrist at the earliest opportunity. If my concerns were not urgent, I would also raise the issue in my monthly supervision meeting, where my supervisor might be able to give me advice on how to handle the situation, and work with me to try and formulate a plan for engaging the patient. If I knew the patient and they had a crisis plan in place, I would go back to that on RiO and review if there was anything on there that would help me to engage them. I would also look at previous notes to help guide my practice to see if anything has helped to engage them in the past.

30. If necessary, I would be liaising with the Crisis team to look at home treatment options. This may include completing a joint visit with the Crisis team, a gatekeeping assessment, or if required to organize a Mental Health Act Assessment (MHAA). This process may also involve contacting the Police if we are concerned about a patient's welfare, if we believe they are missing or need support carrying out the MHAA.

31. The EIP team had the Service Operational Policy and the Trust Did Not Attend (DNA) policy in place for clinicians to follow.

32. I do not recall any formal training during this time on how to manage patients that were not engaging.

Tools and Practices available to the EIP team when faced with patients who were not concordant with medication

33. If a patient told me they had had stopped taking their medication, I would ask them about this, to listen to their views and to find out why they had stopped taking their medications, and if so, how long since they had stopped. I would be looking for any early warning signs or signs of relapse and take appropriate steps in this scenario on balance of risk.

34. After learning that a patient was non-concordant, I first raise this within our MDT meeting, to order to make management and the Consultant Psychiatrist aware. We would consider whether the patient had the capacity to make the decision

not to take their medication and what insight they had into their mental health condition. However, if my concerns about the patient could not wait, I would raise these with the appropriate individuals as soon as possible.

35. I would organize a face-to-face outpatients review with the Consultant or doctor to review the patient's medication and other potential options they may consider. The CCO would be discussing the risks posed to the patient should they not take medication and how this could lead to further deterioration in their health.

36. If a patient had stopped taking their medications, I would be suggesting we review the care plan and look at increasing the frequency of our visits to offer additional support and monitor for any further signs of deterioration.

37. The CCO would also be able to speak to and refer to the Crisis Team for support with medication concordance if we felt there were further risks posed and deterioration in mental state from not taking their medications. An option to ask for a MHAA would also be considered if home treatment was not suitable.

38. We would also consider speaking to family members and carers about the patient's non-concordance and taking on board their views and concerns.

39. I do not recall having any specific training in this area other than the medicines management e- learning course online.

Circumstances in which a patient might be considered unsuitable to receive EIP treatment (or continue receiving EIP treatment)

40. The EIP service has exclusion criteria [NHFT0004012, pg.5], which are:

    a. Outside of the age range 14-65.

    b. Individuals with severe learning disability and severe communication difficulties where they would be unable to benefit from the service.

    c. Individuals experiencing psychotic symptoms with a confirmed organic cause.

    d. Individuals with an extensive forensic or offending history and are at high risk of re- offending may be more suitable for community forensic services.

    e. Individuals whose psychotic symptoms only occur in the context of acute intoxication with a clear link observed between the remission of symptoms and cessation of drug and alcohol use within 7 days.

    f. Individuals that have already received 3 years under an EIP service and have been discharged.

    g. Individuals that have been experiencing symptoms over 3 years and is not deemed to be a first episode of psychosis.

    h. Individuals that have been on anti-psychotic medication for another condition for over 12 months the referral will not usually be accepted.

    i. Individuals who have been assessed as experiencing psychotic symptoms for the first time because of preexisting and long standing chronic mental health problems.

41. There are times when symptoms are not clear and require a period of extended assessment. This will be decided in the MDT meeting and fed back to the patient at the earliest opportunity. We may also complete a joint assessment with the Local Mental Health Team (LMHT) to identify the most appropriate pathway for their needs.

How the EIP team worked with other community health services

42. The EIP team regularly works alongside other community health services. Patients are consulted during the initial phase of care planning to ensure that they understand what services we may be working alongside.

43. The EIP team works closely with service users' GP, which usually begins during the referral process. The GP will be updated regularly throughout the individual's care, particularly if there are changes to medication, changes to risks, and any safeguarding concerns. Physical health results are also shared with the patient's GP to ensure that any follow up actions or referrals are completed. We may also need to liaise with any specific services the patient is open to or receiving treatment from.

44. The EIP team has weekly MDT meetings to discuss new referrals, discharges, any escalations in risks, patients in crisis, non-concordance and non-engagement. There may be discussions about referring patients to the Crisis Team, which would happen promptly if required. This would involve discussions with the patient first and then to the Crisis Team to give an overview of why we believe they need additional support from them, what their current symptoms

are and an overview of risk. If a patient is accepted by the Crisis Team, we remain involved, complete some joint visits and handover regularly. Joint visits with the Crisis Team would happen if, for example, the CCO knows the patient well already, and therefore the Crisis Team thought it would be beneficial for the CCO to join the visit. Similarly, if the CCO sees a patient individually, without the Crisis Team (such as to take the patient to an appointment), the CCO will then report back to the Crisis Team thereafter.

45. The EIP may also offer and refer a patient to Haven House (24hr crisis house) if needed, but we discuss and agree this with the Crisis Team first. Similarly, if we need to refer a patient for a MHAA, this goes through a gatekeeping process in the Crisis Team first. A referral for an assessment is then completed by the EIP, who also will liaise with Adult Social Care about the process.

46. The EIP team also liaise with social care where there are possible safeguarding concerns, or in the event an individual needs support with housing, or other additional support to meet their basic needs. We may request a social care needs assessment to start the process of a care package if needed. Individuals may have allocated social workers in place, in which case regular liaison would take place between the two teams.

47. We would engage with the LMHT approximately 6-9 months prior to the EIP pathway ending if we felt an individual required ongoing support from secondary mental health services. This would involve us putting in a referral to the team, detailing the initial reason for referral into our team, what our interventions had

been, list of medications, include risk assessment, core documents and explain what we felt the patient needed from the LMHT for their ongoing care and treatment.

48. We would also engage with the LMHT to complete a joint assessment if needed and to provide a handover of care in the circumstance a patient would be transferring over to the LMHT pathway. We would also hand over referrals submitted to EIP that were deemed more suitable for the LMHT to review in their referral meetings.

How the EIP team worked with inpatient services

49. If an individual was admitted to one of the inpatients wards, the CCO would contact the ward to introduce themselves and to explain they were part of the CCO team. team. We would give an overview of to our concerns regarding the patient, what we had trialled already in the community, and if there were any safeguarding concerns. We would request an invitation to the first ward review meeting for the patient, and subsequent ward reviews to remain involved and provide consistency in care. It would be up to the CCO if they felt it appropriate to visit the patient in hospital, although this is something I would always seek to do myself (providing the patient was happy for me to attend).

50. The EIP team are not automatically notified when one of their patients is admitted to the ward. However, if the CCO had organised a MHAA for a patient, the CCO would look at the patient's notes to see if this had taken place, and in doing so, the CCO might see that the MHAA resulted in the patient being

admitted. The patient's family might also inform the EIP team that the patient had been admitted.

51. During ward reviews, the CCOs would put our views forward in terms of the patient's journey to date, and how we felt things might progress thereafter. We would discuss how long the patient had been open to the EIP for, what interventions had already been tried, what risks and/or safeguarding concerns we had, and what the long-term goals were for the patient. We would also discuss and whether we felt any changes needed to be made to medication, and/or whether depot medication needed to be considered. This also included whether we felt they may need to be placed on a Community Treatment Order (CTO) for discharge to be successful. However, the EIP were not responsible for making the ultimate decision of whether a CTO should be made; this was the decision of the ward's Registered Consultant (RC).

My Caseload

52. Between 2021-2023 my caseload was frequently more than 15, and I sometimes had up to 20 patients. While I cannot say for certain what the caseload of my colleagues was, it is my understanding that my colleagues also had a caseload of more than 15 at this time.

Meetings within EIP

53. MDT meetings were held every week on a Thursday morning at 10.30. There was an expectation that wherever possible all members of the immediate team

attended unless other clinical needs arose. The immediate MDT would include the Consultant Psychiatrist, any other doctors, members of the management team, CPNs, Support Workers (SWs) and peer support workers (PSWs), CBT therapists, and IPS workers. Other individuals might attend the MDT if needed, for example, if a member of the Employment Support team wanted to discuss a patient.

54. We did not have weekly review meetings or risk assessment meetings during this period, only the weekly MDT meeting each week on a Thursday. I have been away from work since July 2025, however I understand that daily risk meetings now take place, as well as team morning meetings.

55. My supervision meetings were monthly, and I was supervised by Emma Robinson, who was the team manager until January 2023; after this, my supervision was taken over by Eleanor Rawson (Clinical Lead).

56. In supervision we would discuss my health and wellbeing, any issues within the team, training needs, any incidents, safeguarding issues or concerns to raise. We would also discuss my own clinical cases and decide who to bring to the meeting. This would usually depend on who, if any of my patients I needed further supervision around, any complex issues that needed discussion, or concerns I had related to their mental health or risk.

57. In supervision, we would also discuss any cover in the team, allocation of patients, and new referrals/patient discharges.

The Role of the Community Psychiatric Nurse

58. CPNs in the EIP service manage a caseload of service users who are experiencing their first episode of psychosis and use a range of evidence-based principles to provide timely and effective care. This includes working in collaboration with service users and their families to identify personal goals and maximize recovery and engagement.

59. CPNs work collaboratively with their patients during the early stages of engagement, to develop a care plan that felt appropriate to their needs. To do so, CPNs consider what the patient feels they need, what the service provides, and what the CPN considers the patient requires. CPNs explain that the frequency of appointments could change and could be reviewed regularly in line with the patient's wishes, and any change or deterioration in their health.

60. CPNs assess, monitor and act upon risk, including escalating to the team, Consultant and other services (i.e. GP, other services involved in the patients' care). CPNs also coordinate care, which involves close liaison with other professionals.

61. CPNs would monitor their patients by communicating with and arranging appointments with them frequently. This would be for the purpose of assessing and reviewing their mental state, providing evidence-based interventions and support in areas identified.

62. I would usually see my patients either once a week or once a fortnight, depending on the patients' individual circumstances, presentation and risk. The support that an individual EIP team member could offer could increase to two visits a week before further additional support from the Crisis Team or another worker in the EIP team would be required.

63. Typically, I would spend between an hour and an hour and a half with each patient, though this would vary depending on what we were doing in the appointment, what the patient could tolerate and whether the patient was engaging.

64. The frequency and length of appointments with patients would also be discussed within the MDT meetings, so that the rest of the team were aware of the frequency of contact and could raise whether this should be reviewed again. If I had concerns that a patient was becoming unwell, I would attempt increase the amount of contact I had with them, even if they were not initially in agreement with this. For example, if the patient was not engaging with face-to-face appointments, I might try and speak with them on the phone instead. If the patient stopped engaging completely, I would then start conducting cold calls.

65. I do not recall any training or guidance on the frequency or length of contact we had with patients.

66. CPNs hold some responsibility in managing/monitoring medication concordance for the patients on their caseload. CPNs were able to ask patients

at each appointment if they were taking their medication, how they were finding it (for example, whether they were experiencing any benefits or unwanted side effects), and if they had stopped taking their medication, when they stopped and the reasons why; as explained above, CPNs could also ask these questions if they speak to patients outside of their appointments, such as over the phone.

67. If a patient was not concordant with their medication, the CPN might raise this at the MDT, to ask the Consultant Psychiatrist whether they are able to suggest any alternatives. Alternatively, the CPN might provide the patient with a leaflet setting out the different types of medication available, together with the common side effects; if the patient felt that an alternative medication might be better for them, the CPN could then ask the Consultant Psychiatrist if this would be suitable. Either way, if the patient was experiencing side effects from their medication, their CCO would also seek to organize a medication review straightaway, albeit the availability of appointments might mean this appointment could not happen as quickly as hoped.

68. Depot injections are another option that can help with concordance, but this cannot be enforced in the community; depot injections can only be enforced where the patient is detained under the MHA, or if the patient was discharged from hospital on a CTO, by recalling them to hospital.

69. Should a patient forget or become confused about their medication, we could offer the option of a flexi or blister pack. The patient's CPN could also ask the

patients family/carers about the patient's concordance and if they would accept any support from the family to take their medication

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70. The CPN would also bring the case to the MDT meeting to discuss further and develop a plan to support medication concordance. This may involve making a referral to the Crisis Team to support medication concordance until stabilized or to look at hospital admission should home treatment not be considered suitable.

Care Plans

71. I created my care plans on the RiO system. I would seek to develop a collaborative care plan with the patient at the earliest opportunity after acceptance into our service. The Care Plan would be focused on the patient's goals and needs, and what the EIP service was to meet these needs. Ideally, the EIP would also have input from other teams such as social care, employment support, and the patient's GP on the care plan, although this may not be possible right at the outset. In general, my care plans would usually cover (as a minimum): mental health needs, physical health needs, social and occupational needs, medication, therapy, and family/carer interventions. I would seek to update the care plan every 3-6 months or sooner if something has changed, which is in line with the guidance I was given on care planning and the frequency with which it should be undertaken. I would offer my patients a copy of their care plan and give them regular opportunities to review it.

72. The type of changes that would prompt me to update a patient's care plan includes changes to the patient's: medication, risk, appointment frequency,

engagement, diagnoses, physical health, family or carer needs, social or occupational needs, or therapy.

73. There were some differences in care planning for an EIP patient compared with a patient with an established diagnosis of schizophrenia, particularly regarding medication. For example, those with an established diagnosis of Schizophrenia could be offered the option of Clozapine if the patient had already tried two anti-psychotics without good effect. The medication that those with an established diagnosis of schizophrenia might take might also necessitate more frequent physical health checks, although all types of patients will need some level of physical health checks. We would also consider offering a depot/long-acting injectable anti- psychotic to patients with Schizophrenia where there may be issues with non-concordance.

74. However, some aspects of care planning would be the same for both patients within the EIP team and those with an established diagnosis of Schizophrenia. For example, both types of patients would be able to access offering psychological-based interventions such as CBTp and family interventions in conjunction with pharmacological methods. Employment-based Programmes (IPS) and social inclusion services would also be offered, as well as support services to carers and families (including the option of BFT and carer support groups).

75. Additionally, both types of patients are encouraged to complete work on identifying the patients early warning signs and triggers which may include

writing a relapse prevention plan, crisis planning and completing an advance statement.

76. Furthermore, both those under the care of the EIP and those with an established diagnosis of schizophrenia can use the support of the Crisis Team during an acute episode or relapse. Moreover, care planning for both types of patients needs to be person centered and involve the patient with Schizophrenia wherever possible when making decisions.

77. For patients who were not engaging in treatment or non-concordant with medication, I would include the following details in their care plan:

    a. When the patient stopped engaging or stopped taking their medication, if they gave a reason for this
    b. What the plans were to continue to try to engage the patient. This might include: completing cold calls, phone call or text attempts, emails, letters to be sent out, raising in MDT meetings, management and the Consultant Psychiatrist, contact to be made to family or carers, contact to be made to the GP, review with medic, meet with someone in the team they trust, considering flexible approaches. I would also consider whether there was anything else that had worked in the past that we could try again.
    c. Were these plans working? What were the next steps?
    d. Whether they had capacity and insight and did we need to try reassess capacity and who would be doing this

e. Whether there was a plan to refer to the Crisis Team or for a MHAA and when this would be.

78. Once a care plan had been developed in collaboration with the patient, it would be for the CCO to organize implementation. This may include taking steps such as offering psychological interventions to the patient and initiating referrals. Other ways of implementing CCOs could include booking in the patient for a review with the Consultant Psychiatrist (or, if they were not available, a specialist doctor who would have regular supervisions with the consultant) organizing for physical health checks to be carried out and starting to focus on the patients' goals. There would usually be a section in the care plan describing the patient's mental health needs, physical health needs, social and occupational needs, medication, family and carer needs, substance misuse (where appropriate) and therapy or CBT informed interventions.

79. During every visit with a patient, I would be thinking about whether the current care plan is working and meeting their needs. I would be asking the patient about their own views on the current care plan, and if I had any concerns and/or felt their care plan could be added to or changed in any way, I would seek to discuss my concerns with the patient, as well as with the MDT. We would also seek to discuss the care and treatment plan in the outpatients' appointments with the Consultant Psychiatrist.

80. Discharging patients from EIP requires planning to promote successful discharge from the service or smooth transition to another team where required.

81. At least six months before a patient's three years on the FEP pathway is due to finish, the MDT (led by the CCO) would start considering what the next steps would be for the patient. These next steps may include making a referral to the LMHT, another service or discharging the patient back to primary care. Discharge planning may also involve signposting, looking at support from charities or input from social care.

82. Discussions around discharge would be had with the patient and their families/carers where appropriate. We would also discuss in the patient's outpatients appointment and with other teams or professionals involved in the patient's care. Discharge would be discussed in MDT meetings to gather the views of the entire team and forward plan.

83. Discharge planning can be difficult if the patient chooses to disengage from the team. All attempts to actively engage the patient must be made and regular discussions within the MDT and management team should take place.

84. All members of the MDT would regularly contribute to the MDT meetings, with clinicians discussing their caseloads and updating the team about their patients, including any concerns. We would also discuss any upcoming discharges or patients that were disengaging.

85. Before the incident which is the subject of this Inquiry, and when I first joined the EIP team in 2021, the team did not routinely document the discussions and

decisions reached at MDT meetings. I do however recall writing some MDT notes for my patients once I had discussed them, as I was used to doing this when working on the ward as a Clinical Team Lead. When I did write notes for patients, I would add these to their progress notes on RiO.

86. Now, MDT discussions and decisions are documented within 24 hours of the MDT meeting, in line with a specific structure which covers medication, risk, patient and carer feedback and formulating plans of action.

87. I would discuss patients with the Consultant Psychiatrist during the weekly MDT meetings, and on an ad hoc basis as required otherwise, where I wanted to share changes in risk, medication changes, or if I wanted some advice or support with the current care plan. I would usually have these conversations face to face, but if I was unable to find the Consultant Psychiatrist, I would contact them via email or phone instead.

88. There were policies in place for when a patient did not attend an appointment. Policy 01.08 for "Do Not Attends (DNA'S) / Was Not Brought / Cancellations & Management of Patients Who Fail to Engage with Services or Seek to Disengage from Care, in an Unplanned Way" [NHFT0000417] was issued in November 2018.

89. Policy 01.08a for "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" [NHFT0004725] was

issued in September 2021. Policy 01.08a replaced policy 01.08 in September 2021, meaning they were each in place at different times during VC's care.

90. When a patient missed or did not attend an appointment, the MDT assessed the patient's risk. The level of response by the team and the CCO should be proportionate to the level of risk of the patient. Initially the CCO should attempt to contact the patient on the day of the missed appointment to enquire about the patient's wellbeing, what the reason was for missing the appointment and whether this can be re- arranged.

91. Where there are concerns about the patients' risk and they are not contactable by phone, text, email or other methods of communication the CCO should try to contact the patients recorded contacts to ascertain the patients' whereabouts, whether they have had any contact or have concerns. A letter should also be sent to the patient's known address.

92. Where there are further concerns and no contact had the CCO or identified team member should attempt a cold call at the patients' address to check on their wellbeing. If they are not in this should be bought back to the MDT and a further plan of action identified. This may include contacting other agencies, including letting the patients' GP know or contacting the Police to report as a missing person or to complete a welfare check. Other options proportionate to the risk identified would be to consider the need for a MHAA.

93. The CPN/CCO could contribute to decision making about discharge, though patients could not be discharged without agreement of the Consultant and the MDT. The CPN/CCO could ask the Consultant about medication options and ask about possible alternatives, dose increases or decreases, but the final decision and prescription would come from the Consultant.

94. I believe the views of CCOs/CPNs in the EIP team were listened to when decisions were made about patients, and the CCO/CPN was always consulted when making decisions about patients unless they were not at work. CCO/CPN'S would usually be the clinicians seeing their patients the most and so usually had extensive input into their care and decision making within the EIP team.

95. I consider that the views in respect of my patients were fully considered when it came to decision making when it came to decision-making by the Responsible Clinician in the EIP.

Assessment of Risk

96. As a CPN, my role in assessing risk was to see my patients and re-assess risks on each visit/appointment. This would involve sharing any new information with the MDT, and discussing within the MDT, within supervision or within the Consultant and management team. My role was to think about risks in relation to risk to self, risk to others and risk from others. Other risk factors to consider were safeguarding or social concerns. I would be developing a care plan and

risk formulation to carefully consider those risks and what actions needed to be taken to minimize or mitigate risk.

97. I would also be responsible for adding alerts to the RiO system in relation to risk and updating other professionals involved in the patients' care, including external services where appropriate. I would have to consider whether the actions our service could take would address the current risks or whether further actions would be needed to maintain safety. This may include seeking input from the Crisis Team or arranging a MHAA.

98. In terms of the tools that were available to me from the NHFT in respect of risk assessments, I used the RiO risk assessment document to complete risk assessments and formulation for our patients. I do not recall ever having any training in completing this document, but rather learning on the job; I only felt confident in completing the risk assessment document because of the training I received during my nursing degree. It is only since the incident which is subject to this Inquiry that we receive training on formulating risk.

99. CCOs were able to create our own safety and crisis plans with patients, which would help with identifying risks and how collaboratively we were able to help them manage these. This would involve looking at what they could do to help themselves, what services could do to help them, and what their carers/families could do to help them. It would also draw upon what may have been useful for the patient in the past. At the time, there was no specific NHFT template for these safety and crisis plans on RiO; instead, we would look at other documents

that already existed, such as template documents that were available on the Samaritans website. However, I understand that there is now a template crisis plan available on RiO.

100. We were able to use the Comprehensive Assessment of At-Risk Mental States (CAARMS) risk assessment tool [NHFT0003689] which was introduced to our team in 2021 and training provided on the same.

101. We did not have access to a Historical Clinical Risk 20 (HCR-20) risk assessment tool as this is used in forensic services, however, I am now aware that we can ask for a consultation with the community forensic team if required. I am unsure, however, if these consultations were available to us at the time of my interactions with VC, as they were not suggested as an option to us. We would report incidents via the Ulysees incidents and risk system.

102. In terms of how I would assess risk, before meeting a patient for the first time, I would review the referral documentation and risk details (if available). I may contact the patient's GP or referrer for more information initially and specifically ask about details on risk. During the initial call with the patient following the referral, I would use the EIP screening tool on RiO to ask questions about the patient's symptoms and behaviours. I would also ask the patient direct questions about risk, such as whether they were experiencing any thoughts of hurting themselves or others. I may also ask to speak to the patient's family or carers to gather their opinion and whether they are concerned about anything specific that they would want us as a service to know. I would

also consider speaking to other services which were involved or had previously been involved in the patients' care to gather a more thorough picture of the risks identified; for example, if the patient had been referred to EIP, I might follow up with the team who had made the referral if I thought it necessary to do so.

103. If the patient has been known to secondary mental health services before, I would review their core documents on RiO and any uploaded documents attached. I would also look at previous risk assessment details, including any alerts on RiO, any previous hospital admissions or input from the Crisis Team. If the patient had been referred from out of area, I would contact the secondary mental health providers for further details where needed. I would review the patient's progress notes, looking at first contact with services and, where possible, access the health and social care portal (HSCP) to review any additional relevant information the GP holds. There was a link to the HSCP on each patient's progress notes, however the HSCP itself was not very easily accessible. Even when I could access the HSCP portal, this would contain limited information, such as the fact that a patient had had a GP appointment, but not what the appointment was about. If I needed further information which I could not get on the HSCP, I would call the patient's GP to follow up.

104. When assessing risk, I would consider the patients' baseline presentation and if I, other clinicians or the patients' family, had noticed any changes in their patterns of behaviors. I would be thinking about any early warning signs or relapse indicators and specifically any early warning signs to indicate a relapse in psychosis. I would consider any recent events or triggers

for the patient, as well as any changes in the patients' circumstances as these may contribute to a change in risk.

105. The risks posed by mental health patients to others would be identified by reviewing the referral documentation, progress notes, initial assessment notes, CAARMS and risk assessment documents, self-reported risks, and information from family and carers. Other factors that would be used to identify risk included observation and monitoring of the patients' behaviors, information from other services involved in the patient’s care, discharge records, health and social care portal, and alerts on RiO.

106. The risks posed by mental health patients to others would be assessed through routine interactions and appointments with the patient, through communications with the patients' carers and family, liaison with other agencies or services involved in the patients’ care, through noted changes in patterns of behavior, direct questioning about risk and thoughts, observations, and monitoring of medication concordance.

107. The specific risks posed by the patient to others would inform the strategies that would be implemented to manage that risk. The appropriate steps would be discussed in the MDT, and if I had a supervision coming up, I would also discuss my concerns there. The choice of risk management strategy would also depend on the patient's capacity to make decisions about their mental health and treatment. If the risk could not be managed within the EIP team, for example, if the risk was escalating or the patient was not engaging

and/or concordant despite the EIP's best attempts to do so, the EIP would then consider contacting the Crisis Team for support, including with instigating a MHAA.

108. I would update a risk assessment if there was a change in risk, whether this was a change in risk to self, to others, or from others. This might be prompted by safeguarding or safety concerns, concerns raised by family or carers, self-reported risks by the patient (including any risks associated with self-harm, suicidality or thoughts and/or plans to harm others). I would also update a risk assessment with any information from other services such as the Police or Social Care, or previous interactions with therapy services.

109. I would also update the risk assessment prior to referring a patient to the Crisis Team or another service such as the LMHT. In addition, I would update the assessment again after the patient was discharged from the inpatient wards or the crisis team. Risk assessments would also be updated prior to being discharged from the EIP service and sent to the relevant services.

110. I would also update a risk assessment if I was acting as the covering CCO for a patient (for example, because the patient's assigned CCO was on leave, and one of the events described above occurred.

111. Some of the typical risks encountered in the EIP team were:

a. Risks to self: Self harm, suicidality, self-neglect, social isolation, and poor dietary intake, disengagement, alcohol and substance misuse, vulnerability due to untreated psychosis.
b. Risks to others: Command hallucinations, thoughts to harm others, weapon carrying, delusional beliefs about others, thought disorder or ideas of reference affecting someone's ability to think and behave rationally, abuse or coercive control, and alcohol and substance misuse.
c. Risks from others: Abuse and controlling relationships, risk of retaliation from others due to psychotic symptoms, other safeguarding concerns, and trauma.

112. The risk management techniques used for the typical risks encountered in the EIP team vary depending on the risk identified, the patient's presentation, capacity, and their insight. All, however, would be discussed in the MDT meeting, escalated to the management team and Consultant, and a plan of action made. The risk management technique chosen may involve referring to other services, increasing the frequency of visits or appointments, arranging a MHAA, referring to social care and safeguarding, liaising and referring to drug and alcohol services, arranging urgent medical appointments to discuss medication, liaising with family and carers, liaising with other agencies such as the police, PREVENT etc.

113. I do not recall being given any formal or face-to-face training on risk prior to the incident which is the subject of this Inquiry. However, I had completed risk training on the e-learning modules online, and I do recall covering risk

management during my nursing training prior to qualifying in 2016. I have also had safeguarding and prevent training.

114. Since the incident, I have been given two face-to-face training sessions on risk. The first session took place on 02 September 2024 and was delivered by Dr Lomas from the Crisis Team. The second took place on 30 April 2025 and was delivered by Monica Bajawa and John Stocks, who are both Trainee Advanced Clinical Practitioners (ACP). This training covered how to identify and formulate risk.

115. I was not familiar with the Royal College of Psychiatrist's publication on the assessment and management of risk to others (College Report 2021), and I have not received any training on this.

Capacity

116. The role of a CPN in assessing capacity is to recognize that capacity can fluctuate and is related to specific decisions. My role when carrying out specific interventions is to assume capacity unless there is a reason to doubt this. I would then need to consider the Mental Capacity Act and the five principles of this, possibly conducting a capacity assessment around that specific need, related to their care and treatment within mental health services.

117. However, if the decision was specifically related to another area, such as a physical health need, I would be asking the patient's GP or primary care team to consider their capacity in this area. Often our patients may be

presenting with psychosis, which can alter their perception of reality and lead to a disturbance or impairment in their executive functioning. This may also affect their insight and capacity to make decisions around their medications or engagement with the service and may need further capacity assessments by a medic or within a MHAA.

118. I do not recall being given any formal training on assessing capacity. However, I have regularly completed my mental capacity act training on e-learning.

Raising concerns

119. The processes and procedures for raising concerns about the risk of harm posed by a mental health patient to members of the public were as follows:

a. Contact the police immediately via 999 if there is an urgent or imminent risk or threat to the public. The EIP team member making the call could communicate clearly our concerns about the patient's risk, the patient's whereabouts (if known), next of kin details, and mental health history.
b. Contact 101 to update the police regarding an existing incident if it is not imminent.
c. Communicating with Street Triage.
d. Communicating with Liaison and Diversion in the courts if a patient has been arrested and will be seen by them. Communicating our existing concerns and sharing risk assessment details.

e. Referring to the Crisis Team urgently if gatekeeping was required or immediately asking to arrange a MHAA if necessary.

f. Contacting safeguarding and completing Multi-Agency Safeguarding Hub (MASH) referrals and Multi-Agency Risk Assessment Conference (MARAC) referrals where appropriate. Updating existing social workers.

g. Making a PREVENT referral where appropriate.

h. Ensuring all professionals involved are aware of escalation in risk and plans to mitigate risk.

i. Consider if it is safe to see the patient, if so where to see the patient. This would likely be at base rather than in their own home.

j. Liaison and updates given to other providers if needed for the safety of others, such GPs, schools, employment.

k. Updating the MDT, including the management team and Consultant Psychiatrist.

120. The processes and procedures if I considered that a patient was relapsing were:

a. Discuss in MDT.

b. Maintain regular contact with the patient.

c. Discuss my concerns with the patient and carers/families where appropriate.

d. Consider increasing frequency of contact and adjusting care plan accordingly. This may involve joint working with an additional CCO, support worker or peer support worker as needed; for example, an extra CCO might attend if a more thorough assessment of the patient was

needed, or the patient's peer support worker might attend if the patient had a good pre-existing relationship with them. Adjusting the care plan may also involve identifying a need for social care.

e. Asking the patient about their symptoms and whether they thought there was anything that might help in order to gather as much information as possible.
f. Booking in an urgent medic review where possible to review medication options and current treatment plan.
g. Assessing whether the patient would be able to engage with home treatment with the Crisis Team or whether an urgent admission may be needed.

121. The processes and procedures where I considered a patient was not engaging were to:

a. Discuss in MDT and assess the patient's risk, and their capacity to make the decision not to engage. Discussions in MDT would be continued throughout the period of non-engagement.
b. Continue making frequent attempts to contact the patient. Using different methods of communication and preferable to the patient; phone calls, text messages, emails, letters.
c. Consider whether the patient may agree to engage in a different way. For example, with another clinician, at another venue or base, on a different day or time.

d. Attempt to contact all recorded contacts for the patient to ascertain the patients' whereabouts and or any concerns they have about their mental health and wellbeing.
e. Complete a cold call to the patients address if no contact has been made and there are concerns regarding their mental health and risk. Further cold calls would be made as appropriate, trying different dates and times.
f. Liaise and update other professionals involved in the patient's care including their GP at the earliest opportunity. Ask if they are engaging with the GP, have they seen them or have any other contact details or addresses for them.
g. Contact the Police to do a welfare check or report as a missing person if required, and no contact has been made ensuring communication about the patients risks and mental health condition.
h. Refer for a MHAA if required and / or support from the Crisis Team.
i. Discuss with safeguarding if appropriate.

122. The policies and procedures I would consider where a patient was not taking their medication were:

a. Discussing in MDT.
b. Maintaining regular contact with the patient.
c. Discussing my concerns with the patient and carers/families where appropriate.
d. Consider increasing frequency of contact and adjusting care plan accordingly. May involve adding in additional support such as joint

working (two CCO's if indicated), support worker or peer support worker. May also identify a need for social care.

e. Continuous assessment of the patient's mental state and risks
f. Finding out the reason for stopping their medication, and how this might be resolved.
g. Assessing the patient's capacity for not taking medication, and whether a referral to the Crisis Team for medication concordance might be needed, or consideration for a MHAA.
h. Offering other alternatives if possible after discussing with the medic, consider other anti-psychotic medication and offer information on other choices.

123. Suitability for EIP treatment would usually be determined at the initial assessment and would depend on whether the patient met the exclusion criteria for the EIP service.

124. The policies and procedures where I considered the patient to be unsuitable for EIP treatment after assessment were to discuss this in the MDT meeting and determine a plan of action. This might include referring the patient to another service, signposting, offering advice for the GP, and looking at psychological therapies. This would be discussed with the patient clearly prior to discharge, and a letter sent out to the patient and GP.

125. The circumstances in which I would request a forensic assessment of a patient are:

a. If there is a direct link between a patient's criminal activity/ offending and their mental health.
b. If there are increasing concerns around a patient's risk to others in the context of their mental health.
c. If the patient is a repeat offender.

Information sharing

126. In terms of the systems that were in place for sharing relevant information, Policy no 08.01 on Information Sharing Between Professionals, Service Users and Carers was issued in August 2018 and therefore was in place during the EIP's contact with VC. I exhibit the August 2018 version of Policy no 08.01 to this statement as WITN0396002. The review date of Policy 08.01 was July 2021 although I do not believe it was updated until 2023, after VC was discharged [NHFT0012786].

127. Patients open to the EIP team were entitled to their confidentiality and could ask us not to share information with their family or carers. We would not be able to give any new information to families or carers unless the patient agreed to this. Although, there would be situations where we could break this confidentiality, for example, if there was a serious risk to the patient themselves or others (including the public), or if the patient lacked capacity at the time to consent to the disclosure of information and we considered it to be in the patient's interests to share information with their family or carers.

128. Occasionally there would be difficulties engaging patients open to the EIP team and so building a trusting therapeutic relationship with the patient would be key. Should the patient request that no information be shared with families or carers, breaking this confidentiality could lead to quick disengagement by the patient, disabling the team from being able to effectively monitor and assess risk. This risk would be weighed against the factors in favour of disclosing information when deciding whether there is a need to break confidentiality.

129. Unfortunately, as a team we often faced barriers when trying to communicate with the Police and ascertain information about incidents that had taken place involving our patients. Manage risk effectively was very difficult without having all the details to formulate a plan.

130. Another barrier to information sharing was not using a shared system with other agencies. For example, this meant we could not view information from Police where required, did not have easy or thorough access to GP records or appointments, and had no access to information from local social care.

131. When it came to sharing information with a patient's family, I would first ask the patient whether they consented to this. However, I would also explain during the first meetings with a patient that there would be circumstances where we may need to break confidentiality and explain what that may include.

132. Following a patient's referral, providing the patient had given their consent for information to be shared with their family members, the EIP would contact the patient's family to provide general information on the service, interventions we provide, information about psychosis and recovery, who to contact in an emergency, and what support is out there for families and carers. We would also answer any questions that the patient's family might have about their involvement with EIP.

133. In order to share information, I would usually speak to a patient's family on the phone, or in person should they be present at an appointment. I would also explain to the family member the circumstances in which we may not be able to disclose information and when we would, and in addition explain that this did not stop them from disclosing any concerns to us.

134. If a patient withdrew consent to information being shared with their family, I believe that consideration was given to the patients' capacity at the time they made that decision, and consideration would then be given as to what would be in the patient's best interests.

135. Information would not be shared with family members if it was sensitive, personal information, such as sexuality, religion, care plans, diagnosis, health issues, unless it was deemed necessary to do so. Each topic would be considered separately and reviewed regularly on the balance of risk.

136. We also would not share disclosures of abuse made by the patient with family members (unless the patient has agreed for this to be shared). If the patient has disclosed abuse from a family member, then it may also not be appropriate to share information with them.

137. Information would be shared notwithstanding any objection from the patient where the information related to any significant risks to self, to others or from others, and where the person did not appear to have capacity to decide whether to consent to the disclosure. We would consider sharing information about non-concordance with medication if the likelihood of this increased the level of risk. The same goes for disengagement from the service.

138. This decision would still need to consider the patients' views and wishes and may require further discussions with senior management or the Trust's Mental Capacity Act lead.

139. Information was shared with third parties involved in the patients' care. With the patient's GP, this was usually done by phone call, letters, or sending an email to the surgery to make them aware of changes within the patients' care or treatment plan.

140. Information shared with the Police was done via a phone call, although sometimes sent to a secure email address as if they requested to check who we were. With social care or safeguarding, information sharing would usually

be via a phone call or online referral form, depending what process was in place to follow.

141. We did not always receive updates from other agencies, such as the Police, relating to our patients. It was sometimes very difficult to call up and find information from them relating to incidents we were aware of but had little details on.

142. In general, GPs shared information with us on a routine basis.

Related experience

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

Chronology of events

144. Below, I set out a chronology of my interactions with VC. I confirm that I do not recall having any interactions with VC beyond those which have already been identified by the Inquiry.

145. In terms of the circumstances in which I would be involved in a patient's care whilst not being that patient's CCO, I may be asked to cover the caseload of another CCO is if they were off sick or on annual leave. I may also be asked by another CCO to attend a joint visit if a specific patient had to be seen in pairs.

I may also answer phone calls in the office from other agencies if that a patient's designated CCO was not available.

146. Prior to my first involvement with VC, he was regularly brought for discussion at MDT by his CCOs. I recall discussing concerns raised about VC's relapse, particularly during the period whereby there was an incident in his University accommodation and he had tried to take students hostage. We discussed this in the MDT (unclear of which one or the date) and with the management team agreed to escalate this to a Mental Health Act Assessment.

147. I also recall having regular discussions about how to engage VC and whether there were any other alternative options his CPN or the team could try to do this.

148. Myself and other members of the team had discussed VC with his CCO, Claudia Birtles. I do not recall specific details about these discussions, however, do recall that CCO Claudia Birtles regularly brought VC to be discussed at those MDT meetings due to concerns about his mental state and disengagement.

149. At the time of my involvement with VC, I was of the understanding that he had a diagnosis of Schizophrenia, and that this had been diagnosed during one of his inpatient admissions. In terms of VC's condition, my understanding was that VC suffered with auditory hallucinations and persecutory delusions about others as symptoms of his Schizophrenia. VC also presented with paranoid thoughts. VC was guarded during his contact with EIP, appearing to

only engage on a superficial basis at times, particularly when he began to disengage from the team.

150. In terms of my understanding of VC's insight at the time of my involvement with him, I understood that VC had limited insight into his diagnosis and condition, initially appearing to agree with experiencing some mental health difficulties and then denying he had ever experienced any, despite being open to secondary mental health services (EIP).

151. In relation to VC's medication concordance, it is very difficult to say whether VC was ever fully concordant with his medication as we do not watch people taking their medications; it is not our role to so, nor would we be able to enforce concordance. VC often admitted to still taking his medication when the team and his CCO enquired about this, though at times VC remained guarded and did not appear to want to have in-depth conversations about his mental health or medication. I was aware of at least one occasion whereby we had referred VC to the Crisis Team for medication concordance, and he was observed spitting out his medication in the bin.

152. In terms of my understanding of VC's risk, I was aware that VC presented a risk to others, and knew about this from the referral into our service following his first admission into hospital. It was apparent that VC had been responding to unseen stimuli and had beliefs that others were trying to cause harm to him, or to others close to him. This had resulted in him breaking into a neighbour's flat causing the girl living inside to jump out of her window. The next admission

had similar circumstances whereby he barged into other neighbours' flat demanding to know why he had been speaking about him. Preceding his third admission, we had concerns about his disengagement and there were incidents raised by the university relating to other students in the accommodation.

153. In summary, there was an increased risk to others in the context of VC becoming unwell and having a relapse in his Schizophrenia. This was exacerbated by concerns he was not fully concordant with his medication and when unwell experienced persecutory delusions, paranoid thoughts and auditory hallucinations that were derogatory in nature.

154. I was not aware of any risks to himself or from others. Other risks I was aware of was his poor engagement and suspected non-concordance with medication.

155. In terms of how my understanding of VC developed over the course of time and my interactions with him, I was aware of VC's presentation and condition due to regular discussions within MDT meetings. VC's CCO would regularly update the team in relation to any concerns regarding VC, changes to risk or if any cover was required for her caseload during periods of leave. I was aware of VC's background and the reason for his initial referral into our service.

156. 155. I recall reading "Risk and Safety Assessment 6 of 9 [NHFT0000192, pp.1-5], Risk and Safety Assessment 7 of 9 [NHFT0000191, pp.1-5] and Risk and Safety Assessment 8 of 9 [NHFT0000190, pp.1-5]. It is

possible I read the others during the period open to EIP although I cannot recall doing so.

(a) 02 June 2021, 10:02am

157. The Patient Summary Record includes an entry by CPN Abi Parsonage on 02 June 2021 at 10:02am [NHFT0000168, pg.154]. I visited VC with Abi Parsonage on this occasion.

158. Prior to this appointment, VC's Mum had rang the Crisis Team and expressed some concerns about VC's mental state. This was my first time meeting VC, although I was aware of his background.

159. I did not believe VC to be presenting with any acute psychotic symptoms at this appointment. He was honest about still experiencing residual voices; however, this had been consistent in his previous discussions with his CCO and CPN Abi Parsonage. VC did not report any increase in frequency or distress in the voices and was not observed to be responding to unseen stimuli. Nor did he appear perplexed and was able to able to answer the questions asked. He did not appear to be guarded during this appointment and welcomed us pleasantly. There was no evidence of thought disorder, ideas of reference or delusional beliefs expressed.

160. When discussing medication, VC explained that he was still taking his medication and we did not have any reason to doubt him. There was no

evidence during the appointment that he was unwell or behaving outside of his baseline and subsequently asking to inspect or check his medication would not have been appropriate. On balance, this may have led to further suspicions about services and fed into his prior delusional beliefs about others. This could also have led to early disengagement.

161. The home visit was conducted by two CPNs due to the risk VC had previously posed to others when unwell. VC's mum had contacted the Crisis Team a few days prior with concerns about his mental health, and therefore, it was not felt safe for one member of staff to complete a visit alone.

(b) 19 August 2021, 03:18pm

162. The Patient Summary Record includes an entry by CPN Abi Parsonage on 19 August 2021 at 03:18pm [NHFT0000168, pp.160-161].

163. I recall being at this home visit with Abigail Parsonage. I recall turning up and VC being very guarded, not wanting to speak to us and subsequently not letting us into the property. I recall VC trying to end the conversation quickly and therefore we were unable to probe further into his current mental state and risk of relapse. Abigail and I did, however, have a discussion following the visit and agreed that it appeared he may be exhibiting signs of relapse considering he was more unkempt than the last time Abi saw him, how guarded he was and unwilling to engage. VC did not present this way during my first visit to see him

with Abigail Parsonage on 02 June 2021 so this was somewhat concerning due to a change in his presentation.

164. On the back of this appointment, the plan was to discuss with VC's CCO on her return from leave. However, due concerns that VC may be relapsing we agreed to offer him a further appointment on 23 August 2021. VC did not reply so we attended his home address on the 24 August 2021. When we attended, VC did not appear to be in. At this point we rang VC and he answered the phone. VC did not appear to want to talk, said he was not in and not free to talk. VC told us to send him another text for a new appointment. We could not probe further on the phone as it was clear he did not wish to speak. The plan following this was to discuss in MDT.

165. I cannot recall whether I attended any MDTs on or after this date where VC was discussed, as unfortunately we did not regularly document the MDT discussions in the notes during this time frame. I can see from the progress notes that VC's CCO Claudia Birtles was aware there were concerns VC was relapsing, so I can only assume we had relayed these concerns either directly to CCO Claudia Birtles or within an MDT meeting that week. Subsequently, the decision was then made to arrange a MHAA after a visit from the CCO and further concerns about relapse.

(c) 18 January 2022, 09:44am

166. In January 2022, I was a CPN in the EIP team. I was not VC's CCO as some of the entries state. My only involvement with VC at this time was when I answered a call in the office from Ellie Turner.

167. The Patient Summary Record includes an entry on 18 January 2022 at 09:44am, which states that I spoke with Ellie Turner from Nottingham University's Mental Health services [NHFT0000168, pg.203]. Ellie Turner shared with me an email she had received from VC's flatmate. I exhibit this email to my statement as WITN0396003.

168. I had answered the phone in the office to Ellie Turner from Nottingham University's Mental Health Services and took the information as VC's CCO was not in. I cannot recall whether VCs CCO was off sick during this time, on annual leave or on other visits. However, due to the concerns raised and previous incidents I felt it needed to be followed up immediately with a call to the Crisis Team for gatekeeping (to consider a MHAA). I believe I contacted the Crisis Team for a gatekeeping discussion and due to risks posed to others agreed it would be appropriate to call for a MHAA straight away with the Police in attendance.

169. My colleague Abigail Parsonage then rang social care to arrange for a MHAA to be conducted. The MHAA took place, albeit not on the same day that it was requested. Following the MHAA, VC was not detained and deemed appropriate for Crisis intensive home treatment. Following this VC was not engaging effectively with Crisis for home treatment, and another MHAA was

called by the Crisis Team. I was not involved in this or any further plans for VC's care.

170. On the date I received this email from Ellie Turner, I contacted the Police via 101 to request information about the incident at the University [NHFT0000168, pg.204]. Unfortunately, the officer stated they could not disclose this information and would ask their sergeant to contact me later. I do not recall being contacted back or given any further information.

171. In terms of my understanding of the risks associated with VC's condition in January 2022, the last time I saw VC was in August 2021 although I was aware of concerns that he had been beginning to disengage with the team around December 2021, and that he had missed a few outpatients' appointments with his CCO and Dr Lloyd.

172. When the call came from Ellie Turner on 18 January 2022, I was concerned due to the risks historically posed to others by VC when VC was unwell. I suspected at this point that VC may be relapsing, hence speaking to the Crisis Team and agreeing to call for a MHAA. I do not remember if I had updated any of VC's core documents, however from reviewing risk assessment 6 of 9 [NHFT0000192, pg.5] it looks like I may have updated this as the headings January 2022 is how I update my risk assessments. However, I cannot be certain that this was me.

173. I cannot recall which MDT's I was in or specifics of what was discussed, and there is limited documentation from the MDTs in general during this time frame. However, I do recall speaking about VC regularly in MDT's, about his disengagement and other flexible ways to try to engage him.

(d) 22 September 2022

174. The Patient Summary Record includes an entry made on 23 September 2022 by Sharon Heath. This entry discusses an MDT discussion that took place in respect of VC, and reads:

> "*Discussion within MDT on 22.09.22, as no contact has been made with Valdo for a period of time despite attempts to make contact and having done cold calls, decision made within the team to discharge back to GP due to non-engagement with view for GP to refer back to services in the future if needed.*"
>
> [NHFT0000168, pg.270]

175. I did not attend this meeting and therefore cannot comment on what was discussed in relation to VC's discharge.

176. I was not aware of the bench warrant without bail that was issued by Nottingham Magistrates Court on 22 September 2022 in relation to VC's failure to attend court.

177. If I had been aware of this warrant, I would have liaised with the police regarding this, explaining that we did not know VC's whereabouts, and that he

had disengaged from the team. I would also have raised the warrant in the MDT and with the management team; I may also have let VC's GP know.

Reflections

178. This has been a very tragic case and understandably has had a profound detrimental impact on the deceased's families and the survivors of the attacks.

179. I also believe this has had a very negative impact on other service users experiencing psychosis or Schizophrenia, and stigma around these diagnoses has only increased. I believe some of the negative misinformation that has been circulated in the media has been unhelpful for these individuals and may have affected their openness about symptoms and confidence to seek help.

180. My practice has changed because of these events. As a service, changes have been made to the way in which we work, in particular, how we manage risk. I feel this has been positive, as we now have daily risk meetings allowing us to raise concerns directly with the management team, which then allows for swift escalation to senior management if required. The way in which we document information has also changed, for example how we document MDT decisions, which I also feel is a positive step in the right direction.

181. Unfortunately, the stress of the case and additional workload has had a negative influence on my own wellbeing. I am extremely anxious about the notes I write due to the scrutiny and judgement we have been under.

Documentation is important however I believe the work we are now expected to do can take away vital time with our patients.

182. I am much less confident now in my own practice and decision making. I believe this has also had a strong influence on the team where this has affected the team's ability to take positive risks and feel confident when discharging patients. This has also had an influence on high caseload numbers which are still regularly over 15.

183. I do not believe there was a reluctance to use diagnostic labels/restrictive practices in VC's case as a direct result of complying with his priorities for education. I know that he had a diagnosis of Paranoid Schizophrenia, but I do not believe this was kept private from university because of a potential adverse impact on his long-term prospects.

184. However, it is important to note that the ethos of EIP is based on hope and recovery, with a strong focus on reducing and minimizing stigma. In my opinion, too much focus on a patient's diagnoses can lead to disengagement and can impact the patient and clinicians' relationship.

185. I was aware of the concerns regarding the disproportionate use of MHA restrictive measures with black African and black Caribbean patients, but I do not believe those concerns or publicity impacted mine or the team's decision making in respect of VC. I do not believe we avoided the use of restrictive practices or approaches due to these concerns or publicity. Our role was to

respond to the concerns in front of us and I believe that MHAAs were called appropriately in response to VC's presentation and presenting risks at various points throughout his time open to EIP.

186. I confirm I have not given any interviews or otherwise made any public comments about the actions of VC or matters under investigation by the Inquiry.

Recommendations

187. In terms of the recommendations, I think the Chair of this Inquiry should make to ensure lessons are learned and to prevent similar attacks in the future, I consider that there should be a review of the training material provided for student mental health nurses during training. A greater focus on managing risk and how to formulate risk assessments may be useful.

188. I also think that there should be a review the policies within the Police Force in relation to sharing information with community services where risks are identified. In my experience we can often hit barriers when requesting information from the Police in relation to incidents involving our patients. However, I believe this information is crucial to our risk formulation and care planning.

189. I also consider that increased staffing in EIP teams should be recommended, so that staff are adequately able to meet the intensive needs of the patient group. There is no waiting list for EIP services, which I do agree with, however this can often mean clinicians are working above their remit with high caseloads.

190. In terms of improvements that could be made locally and nationally to multi-agency working to increase effectiveness in preventing similar outcomes in the future, I believe healthcare professions and public services could benefit from a national shared system where basic information can be viewed. An example could be an extension of the NHS app that professionals can log into to access healthcare records, police records, and social care records. This is important because, at the moment, we are unable to see information provided by services in other localities outside of Nottingham. For example, if a patient has been picked up by Police in London, we would not be informed of this nor be able to view this on our patient records. This can lead to a gap in information sharing which may be relevant to overall risk picture and care of a patient.

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: 11.02.2026

Index to First Witness Statement of Adele Pinder

No.	URN	Document Description
1.	NHFT0004012	EIP Operational Policy
2.	NHFT0004725	Procedure 01.08a – Merged Do Not Attends/Cancellations
3.	NHFT0003689	Comprehensive Assessment of At-Risk Mental States (CAARMS) risk assessment tool
4.	NHFT0000417	Procedure 01.08 – Do Not Attends
5.	WITN0396002	Policy 08.01 on Information Sharing between Professionals, Service Users and Carers (August 2018)
6.	NHFT0012786	Policy 08.01 on Information Sharing between Professionals, Service Users and Carers (2023)
7.	NHFT0000192	VC Risk Assessment 6 of 9
8.	NHFT0000191	VC Risk Assessment 7 of 9
9.	NHFT0000190	VC Risk Assessment 8 of 9
10.	NHFT0000168	Medical Records of VC from 24/05/2020 to 14/06/2023, Various NHFT Staff/Teams, re: Patient Record Summary
11.	WITN0396003	Email from Eleanor Turner to Adele Pinder dated 18 January 2022