

IN THE MATTER OF THE INQUIRIES ACT 2005

AND IN THE MATTER OF THE INQUIRY RULES 2006

THE NOTTINGHAM INQUIRY

**CLOSING STATEMENT OF
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST**

A. INTRODUCTION

1. The Inquiry has heard evidence about the devastating impact VC's crimes continues to have, and the impact other cases involving homicide or attempted homicide by mental health patients, has on the victims of such attacks, their families and friends, and the wider community.¹ Tragedies involving such brutal acts of violence rightly shock the public.
2. As the Ritchie Report into the care and treatment of Christopher Clunis in 1994 did, this Inquiry represents an important moment to identify learnings and changes that could be made; and to reinvigorate a shared commitment by health care, policing and others to implement meaningful improvements.
3. Severe and enduring mental illnesses, such as schizophrenia, require a long term commitment to care. Similarly, sustainable and enduring change will require recommendations that strike the right balance between timely improvements and long-term, lasting change. The Trust's thoughts on potential recommendations are set out in part E of these Closing Submissions.
4. Nottinghamshire Healthcare NHS Foundation Trust ("the Trust") has heard the evidence from the Survivors and the Bereaved Families, as well as evidence from those who lived or worked with VC. It recognises the anger, frustration and grief that is still experienced

¹ NHFT0024124

by those impacted by VC's crimes and the response of public bodies in the aftermath, including those of the Trust. The Trust recognises that repeated apologies can appear empty, if they are not accompanied by meaningful action. In these Closing Submissions the Trust has therefore sought, where appropriate, to set out the steps it has taken in light of these events and the evidence it has heard through the Inquiry to make improvements and support the Inquiry to carry out its Terms of Reference. Importantly, this includes supporting the process through which organisations and individuals are held to account.

5. The Trust cared for VC for a period of nearly 2.5 years. His first presentation coincided with the early stages of the Covid-19 pandemic, a time during which the Trust, in common with the rest of the health and care sector, found itself having to rapidly adjust its operation. Routine governance was suspended as nationally and regionally-mandated "derogations" were implemented by the Trust; its staff were redeployed to the "front-line" and social-distancing impacted on patient/staff/family interactions.² These arrangements continued, with some variation, up until July 2021 when NHS England confirmed that the transition to recovery had begun.
6. VC first presented in May 2020 as a mature student, with no known prior history of mental ill health or criminal justice interactions. His clinical indication was first episode psychosis, likely brought on by study-related stress and lack of sleep. He was one of 700 patients treated annually by the Trust for first episode of psychosis.³
7. The Trust's episodic analysis of VC's care is set out in Part B of these Closing Submissions.
8. The Trust has engaged openly and candidly with the Inquiry. It has supported 171 staff – current, former and agency - to give evidence, both written and oral; no restrictions have been sought by the Trust in terms of it or its staff's evidence. Members of the Trust's leadership team have attended the majority of the oral hearings. The Board has followed closely all evidence heard by the Inquiry. Having done so, the Trust wishes to make the following overarching observations:

² Dr John Brewin, 15 January 2026, Paragraph 28, Page 9, WITN0380001

³ Dr Susan Elcock, 3 June 2026, paragraph 5, page 2, WITN0356098

- (a) The evidence largely underscored the findings of the health-led investigations and reviews carried out prior to the Inquiry. The Trust has publicly stated its full acceptance of these findings and it reiterates that here. It has worked conscientiously to implement the agreed action plans, under the oversight and support of the ICB, NHS England, and the CQC. The Trust recognises that more work remains to be done to improve its regulatory position and provide assurance around patient safety and quality.
- (b) The Inquiry has heard evidence about the complexity in striking the right balance between patient autonomy and public protection. However, it would be wrong to suggest that this indicates a lack of any awareness of public safety risk. Many of those who gave oral evidence clearly articulated how central this is to their practice.⁴
- (c) The Trust agrees that the weight of evidence shows that overall assessment of risk throughout VC's care was insufficiently longitudinal and poorly documented. The Inquiry has heard evidence from a range of witnesses about the assessment of risk in non-forensic settings; the nationally set risk tools routinely used in forensic settings⁵; the lack of such tools for the community setting and the consequential local variation in adoption; the risk presented specifically by patients with schizophrenia⁶; the incidence rate of mental health homicide⁷; the policy prioritisation of suicide awareness; and the disinvestment in national mental health homicide research and monitoring⁸.
- (d) Information held by the Police but not shared with the Trust presented further collateral context that could have been used to inform assessment of risk; attempts at engagement and/or clinical decision-making as to management of VC's condition. In particular, the Trust only now knows of:
 - i. the fact of and impact of VC's stalking of Sebastian⁹ in the period July 2021-July 2022.

⁴ Dr Jonathan Gibson, 12 May 2026, Page 44, Lines 9-18, INQT0000082

⁵ Dr Ruth Tully, 23 October 2025, paragraph 2.2.4 - 2.2.23, page 14, WITN0358001

⁶ Professor Seena Fazel, 22 February 2026, Pages 4-13, WITN0401001

⁷ Professor Louis Appleby, 24 October 2025, Paragraph 15, Page 5, WITN0069001; Julian Hendy, 21 November 2025, paragraph 26, WITN0258001

⁸ Professor Louis Appleby, 24 October 2025, Paragraph 13, Page 4, WITN0069001; Julian Hendy, 2 November 2025, Paragraph 103, Page 20, WITN0258001

⁹ Sebastian, 10 November 2025, paragraphs 49-53, WITN0151001

- ii. the fact and details of VC's visit to MI5 in May 2021 and the briefing provided by the Met Police.
 - iii. speeding offences in August 2021 and February 2022
 - iv. the bench warrant for his arrest, and
 - v. the assault investigated by Leicestershire Police in May 2023.¹⁰
- (e) While there remain uncertainties about VC's time prior to his first presentation to the Trust's care in May 2020, the evidence that the Inquiry has heard does not appear to establish any diagnosed earlier mental illness.
- (f) The importance of real partnership working between public bodies like the Trust and the Police has been powerfully illustrated. While the Police have rightly reminded the Inquiry what their core role is, their own evidence also illustrates the practical impossibility of not engaging with individuals who are mentally unwell and underscores the importance of effective partnership working¹¹. Integrated working, such as that of the Street Triage team and the support provided on the two instances where powers under section 136 and/or section 135 of the Mental Health Act 1983 ("MHA") were utilised are positive illustrations of effective close working. It is clear to the Trust, however, that it could do more to help train and support Police colleagues more widely with tools to assist their interactions with mentally unwell individuals and that information sharing arrangements between the two remain an area for improvement.
- (g) Meaningful attempts were made to work with the University but practical and legal limitations regarding VC's accommodation restricted the ability of both the Trust and the University to achieve what were often shared objectives (such as encouraging VC to return to Wales on his discharge from his first inpatient admission in June 2020). Nonetheless, given that Nottingham is a university city and the frequency of student access to mental health services the Trust

¹⁰ NGPF0007824

¹¹ PC Jamie Severn, Nottinghamshire Police, 3 March 2026, Page 33, Line 23 to Page 35 Line 17, INQT0000010

recognises that clearer partnership working arrangements are needed, particularly in relation to safeguarding.

- (h) The Trust also recognises that it did not always get the balance right between patient confidentiality and providing information to other individuals about VC's care and treatment. Whilst there were some good periods when the triangle of care was implemented, the Trust has recognised that there were other occasions when it failed to properly update VC's mother and involve her in her son's care.¹² Work has been done by the Trust in this area, with Carer awareness and Triangle of Care being included in the mandatory training package for staff for inpatient settings.¹³
- (i) Similarly, the Trust should have done more following the events to contact the bereaved families and survivors of the attacks and to involve them in the Trust's process of investigating the events of 13 June, including by challenging the police in relation to their request not to discuss the incidents or take any actions internally to investigate what went wrong.¹⁴ The Trust has apologised to the families for the approach taken and for the way that this added to their suffering during this period. The Trust recognises that these early interactions contributed to an enduring lack of trust in the Trust's candour, willingness to learn, and openness to admitting when things had gone wrong and why.
- (j) The Trust's Board and the Executive Team have taken decisive action to strengthen mental health services, addressing many of the issues that have arisen to date in relation to VC's care. Key improvements made are described in part D of these Closing Submissions.¹⁵

B. Episodic review of the care and treatment provided to VC

- 9. This section seeks to address paragraph 2 of the Inquiry's Terms of Reference. It is recognised, however, that the matters reflected in this section also have relevance to paragraphs 4, 5 and 6 of the Terms of Reference.

¹² Dr Susan Elcock, 20 May 2026, Page 115, Line 6 - 9, INQT0000091

¹³ Diane Hull, 5 December 2025, Paragraph 382, page 132, WITN0133001

¹⁴ Diane Hull, 21 May 2026, Page 31, Line 14 - 18, INQT0000093

¹⁵ Witness statement of Ifti Majid, paragraph 142, page 36-38 WITN0263001

10. The weight of psychiatric evidence heard by the Inquiry is that VC had a complex mental illness, and he was sophisticated at masking his symptoms which made him difficult to assess and treat.¹⁶ The consensus of the clinicians who assessed VC at relevant points throughout the period 2020-2023 seems to be that his episodes of violence and aggression and other criminal behaviours (stalking, damage to property) were the result of his psychosis.
11. The Trust has followed the evidence of those involved in caring for VC, the majority of which were the Trust's staff (whether permanent, agency or bank), closely. In this section, the Trust has sought to set out its analysis of this evidence, recognising concessions and reflections made by those giving evidence. It would emphasise the open and candid way staff engaged with the Inquiry, providing detailed and reflective written and oral evidence, in the spirit of assisting the Inquiry in its work and contributing to improvements in clinical practice. The Trust reiterates its confidence in the candour of its staff.

Episode 1: 24 May 2020: first MHA assessment

12. The issues that arise in connection with this event include:
 - a. Whether relevant legislation and guidance were followed in respect of the assessment.
 - b. Whether the decision not to admit VC to hospital and detain him under the MHA was reasonable.
 - c. Whether race played any role in the decision not to admit and detain VC.
13. Additional aspects arising in connection with these key issues are:
 - a. The purpose and reasonableness of the "gatekeeper" role of the Crisis Resolution and Home Treatment team ("Crisis Team").

¹⁶ Professor Blackwood, AM transcript, pages 15, 51, 77, 84, 85; PM page 3, INQT0000044

- b. Whether Crisis services were sufficiently staffed/there was otherwise a delay in seeing VC.
- c. Interactions with VC's family.
- d. Community care planning and risk assessment.

Legislation and guidance

14. The MHA and its statutory Code of Practice ("CoP") provide materially that:

- a. The appropriate statutory provision when considering admitting a person with no prior mental health history to hospital is s.2, as the full extent of the nature and degree of their condition is unclear and no treatment plan has been formulated (sections 14.27 and 14.28 of the CoP).¹⁷
- b. Section 2 of the MHA is only available if the person is suffering from a mental disorder of a nature or degree which warrants their detention in hospital for assessment or assessment followed by treatment, and in the interests of their own health or safety or with a view to the protection of others.
- c. CoP at para 14.7 provides: *"Before it is decided that admission to hospital is necessary, consideration must be given to whether there are alternative means of providing the care and treatment which the patient requires. This includes consideration of whether there might be other effective forms of care or treatment which the patient would be willing to accept..."*¹⁸
- d. Consideration must be given to a range of matters including the patient's wishes, (CoP 14.8), risk to the patient if they do not receive treatment (14.9), risk to others and whether there are other methods of managing this risk (14.10), and alternative options including management in the community by a crisis team (14.11).¹⁹
- e. CoP provides at 14.13: *"Professionals must consider available alternatives, having regard to all the relevant circumstances, to identify the least restrictive way of best achieving the proposed assessment or treatment."*²⁰

¹⁷ NHSE0000312_0118-0119

¹⁸ NHSE0000312_0114

¹⁹ NHSE0000312_0114-0115

²⁰ NHSE0000312_0115

- f. The ultimate decision whether to make an application for admission to hospital is made by the AMHP (CoP 14.49-52).²¹
15. There is no assumption in the statutory frameworks of the Mental Capacity Act 2005 ("MCA") or MHA or associated guidance that a person who lacks capacity to make decisions about their mental health treatment should be detained, or should be subject to constant supervision. If a patient lacks capacity to consent to the medical treatment which doctors consider is appropriate, but is nevertheless willing to accept the treatment, the MCA enables that treatment to be given in the patient's best interests without any surrounding legal framework such as MHA detention²².
16. The assessment was carried out by Dr Gandhi (Locum Special Register),²³ Dr Malik (Section 12 Approved Doctor)²⁴ and Ben Williams (Approved Mental Health Practitioner ("AMHP"))²⁵. Annette Palmer (Crisis) was also in attendance but not in a formal decision-making capacity.²⁶
17. The professionals were all in agreement²⁷ that VC was experiencing first episode psychosis, likely brought on by sleep deprivation and university exam stress. VC's mother confirmed there was no previous mental health history. VC understood that he was unwell and consented to home treatment provided by the Crisis Team. Ms Palmer felt comfortable that the Crisis Team could manage his needs in the community and that this was consistent with the MHA and CoP, as summarised above.²⁸

²¹ NHSE0000312_0114; NHSE0000312_0121-0122

²² Alex Ruck Keene, 19 November 2025, Paragraph 60, Page 32, WITN0288001

²³ Dr Rahul Sushil Gandhi, 1 December 2025, WITN0302001; Dr Rahul Sushil Gandhi, 21 April 2026, INQT0000057 and INQT0000058

²⁴ Khuram Fraz Malik, 11 December 2025, WITN0355001; Khuram Fraz Malik 21 April 2026, INQT0000057

²⁵ Benjamin John Williams, 7 November 2025, WITN0115001; Benjamin John Williams, 21 April 2026 INQT0000058; NOCC0000044

²⁶ Annette Palmer, 21 November 2025, Paragraph 22, Page 7, WITN0299001; and Annette Palmer, 21 April 2026, Page 80, Line 8 – 9, INQT0000058

²⁷ Dr Rahul Gandhi, 1 December 2025, Paragraph 75, Page 17, WITN0302001; Dr Khuram Malik, 11 December 2025, Paragraph 72 – 73, Page 18, WITN0355001; and Benjamin Williams, 7 November 2025, Paragraph 52, Page 17, WITN0115001

²⁸ Annette Palmer, 21 April 2026, Page 96, Line 1 – 20, INQT0000058

18. VC was prescribed olanzapine and zopiclone.²⁹ The Crisis Team were to visit VC that evening to observe him taking his medication, and thereafter to visit him twice a day³⁰. All appropriate professionals were involved in the assessment, consultation took place with the Crisis Team and VC's mother, and relevant guidance was followed.

Decision not to admit to hospital

19. The decision whether to admit to hospital under Section 2 MHA was for the local authority's AMHP to make. It could only be made if the two psychiatrists, Dr Malik and Dr Ghandi had recommended admission. Their clinical judgement based on the information known to them at the time, including an in-person assessment of VC, and applying the relevant guidance in the MHA CoP, was that the criteria for detention were not met. The AMHP and the Crisis Team representative agreed. The consensus view was that although VC had a mental disorder which required treatment in the form of oral medication for psychosis and sleeping pills, that treatment did not need to take place in hospital. It could be given in the community under the supervision of the Crisis Team with twice daily visits. The decision was based on a range of factors³¹ including the following:
- a. VC appeared to be presenting with psychotic symptoms including delusional and paranoid beliefs, evidence of which had been documented in the RIO record and observed during the assessment.
 - b. Although VC had been arrested for kicking a door, he was not aggressive during the assessment, which took place around 14 to 15 hours later.
 - c. VC did not report any thoughts of harm to himself or others during the assessment.
 - d. VC had no known prior mental health history and his mother confirmed he had no history of violence or aggression. He had been unwell for a week and the contributing factors to his presentation were assessed to be temporary ones, namely sleep deprivation and exam stress. People with that presentation could improve within a matter of days.³²

²⁹ Dr Rahul Gandhi, 1 December 2025, Paragraph 104, Page 22, WITN0302001; Dr Khuram Malik, 21 April 2026, Page 32, Line 23 – 25 - Page 33, Line 1, INQT0000057; and Dr Rahul Gandhi, 21 April 2026, Page 126, Line 23 – 25 & Page 127, Line 1 – 12, INQT0000057

³⁰ Dr Rahul Gandhi, 1 December 2025, Paragraph 91 and 93, Page 20, WITN0302001

³¹ Dr Rahul Gandhi, 1 December 2025, Paragraph 99, Page 21, WITN0302001

³² Dr Khuram Malik, 21 April 2026, Page 71, Line 8 – 14, INQT0000057

- e. VC was able to talk about his mental health difficulties despite being guarded and suspicious and showed some insight. He was willing to accept oral medication and the supervision of the Crisis Team.
 - f. Oral medication for psychosis and to help VC sleep, under the regular and frequent supervision of the Crisis Team, was less restrictive than compulsory admission and appeared likely to be able to manage the identified risks to VC and to other people (confirmed by Dr Ghandi in his oral evidence)³³.
20. The team involved were not made aware of other pieces of relevant information, including the degree of force with which VC had kicked the door and the resulting damage; that VC was trying to push his way into the flat and had tried to access other flats too; that VC had had to be restrained with handcuffs by police officers; and that the other residents were concerned VC would try and gain entry to the flat again.³⁴ Dr Gandhi explained that, in the context of an assessment being conducted following the involvement of the police, his usual practice was (with the rest of the team) to obtain information about the circumstances of the incident which led to the involvement of the police from the Custody Sergeant.³⁵ Dr Malik gave evidence to the same effect,³⁶ noting that the conversation starts with an open question to the Custody Sergeant about the circumstances of the alleged criminality.³⁷ The report of the AMHP, Benjamin Williams,³⁸ which records that *'We spoke with the Sgt in charge of the case who explained that there was no violence from Valdo when he broke in the home'* tends to suggest that this is what happened here – a collective approach to the Custody Sergeant to seek relevant information.
21. The published CQC report states in respect of the decision not to detain on 24 May 2020 that: *"VC's referral to the CRHT team can be seen to have been appropriate and following MHA 1983 Code of Practice guidelines to provide person-centred care that offers the least restrictive intervention. However, the fact that he was re-arrested so*

³³ Dr Rahul Gandhi, 21 April 2026, page 131 INQT0000057

³⁴ Dr Khuram Malik, 21 April 2026, Page 30, Line 10 – 18 & Page 72, Line 4 – 20, INQT0000057; Dr Rahul Gandhi, 21 April 2026, Page 118, Line 1 – 25, INQT0000057; Dr Rahul Gandhi, 21 April 2026, Page 12, Line 15-22, INQT0000058

³⁵ Dr Rahul Gandhi, 21 April 2026, Page 117, Line 5 – 25, INQT0000057

³⁶ Dr Khuram Malik, 21 April 2026, Page 31, Line 6 – 10 & Page 77, Line 5 – 24, INQT0000057

³⁷ Dr Khuram Malik, 21 April 2026, Page 94, Line 13 – 23, INQT0000057

³⁸ NOCC0000044, page 3; Benjamin Williams, 7 November 2025, Page 0003, WITN0115001

*quickly after leaving custody from his first arrest raises questions about the quality of the initial mental health assessment and the assessment of risk that took place".*³⁹

22. To the extent that CQC reviewer witnesses suggested they would have made a different decision about admission, they were careful to point out that they were not present at the time and did not conduct a clinical assessment of VC, with their views being given with the benefit of hindsight and only on the basis of written documentation, for example Dr Sarah Dracass.⁴⁰ The other CQC reviewer, Dr Mona Ahmed, said in oral evidence that *'I think it's important to bear in mind that this was his first presentation and you want to avoid those more restrictive interventions....it could have been possible for that decision to have been a bit more risk informed.'*⁴¹ The AMHP who assessed VC the following day, Eleanor Cullen, did not agree that the outcome of the first assessment should have been detention in hospital even if the risk to others had been assessed as High rather than Medium by her colleague Benjamin Williams.⁴²
23. The Theemis Review⁴³ noted that the prescribed medication was not administered before VC was released from Police Custody. Mr Williams explained his view for why this did not occur, noting that he while is not medically qualified, any anti-psychotic medication may have taken some time to have effect, the prescribed sleeping medication would have an immediate effect⁴⁴. He also reflected⁴⁵ that *"Olanzapine is often the first medication that I see prescribed in respect of psychosis. As such I was not concerned that Dr Ghandi was proposing to prescribe anything inappropriate"*.
24. VC's mother told the AMPH she would travel to Nottingham,⁴⁶ with the intention of bringing VC home to Wales with her, but, as acknowledged in the Theemis Review, the Police had no authority to continue to detain VC and he was discharged from custody before his mother arrived.⁴⁷

³⁹ CQCM0016518_0020

⁴⁰ Dr Sarah Dracass, 16 April 2026, Page 22, Line 8 – 25, Page 64, Lines 1 – 25 and Page 65, Line 1 – 19, INQT0000054

⁴¹ Dr Mona Ahmed, 16 April 2026, Page 81, Line 15 – 17 & Line 25, Page 82, Line 1, INQT0000054

⁴² Eleanor Cullen, 22 April 2026, Page 29, Line 12 – 25, Page 34, Lines 7 – 17 and Page 46, Line 1 – 25, INQT0000060

⁴³ Theemis Review ("Independent investigation into the care and treatment provided to VC" dated January 2025), Paragraph 5.1.2, Page 39 – 40, NHNB0018966_0080

⁴⁴ Benjamin Williams, 21 April 2026, Page 48, Line 4 – 8, INQT0000058

⁴⁵ Benjamin Williams, 7 November 2025, Paragraph 68, Page 22, WITN0115001

⁴⁶ Benjamin Williams, 7 November 2025, Paragraph 65, Page 22, WITN0115001

⁴⁷ NHNB0018966_0081

The purpose and reasonableness of the "gatekeeper" role of the Crisis team

25. The Crisis service at the Trust operates in accordance with national policy and guidance and Trust developed policies and procedures.⁴⁸ Dr Michael Skelton, a consultant psychiatrist in the Crisis team at the Trust describes the purpose and operation of the Crisis Team in his witness evidence⁴⁹. In that evidence, he references the NHS England framework "The Community Mental Health Framework for Adults and Older Adults", published in September 2019, ("Community MHF"),⁵⁰ in which the history and role of Crisis is set out.
26. Dr Skelton specifically notes the description in the Community MHF of *"a wide range of potential interventions, including: assessment, advice, and consultation for mental health problems, advocacy services, co-ordination and delivery of care, support for co-occurring drug and alcohol use disorders, employment, education, volunteering and training services, psychological and pharmacological treatment, help and advice around finances..."*.⁵¹
27. More recent guidance has been published in 2023 by the Royal College of Psychiatrists is also referred to by Dr Skelton at paragraph 18 of his witness statement: "Practice Guidelines for Crisis Line Response and Crisis Resolution and Home Treatment teams" (2022)⁵². In describing the purpose of CRHT teams, this guidance sets out that *"CRHTs provide intensive support at home for individuals experiencing an acute mental health crisis as an alternative to hospital admission. CRHTs gatekeep ALL requests for acute in-patient beds"* (emphasis as in the original document).
28. The Trust's policy in place at the time governing the admissions procedure for adult mental health inpatients and the role of Crisis appropriately reflects this purpose and provides for a "gatekeeping" function⁵³.
29. Ms Palmer's attendance at VC's first MHA assessment was entirely consistent, therefore, with this core role. She described the "gatekeeping" role she understood she provided at MHA assessments, as per the Trust's policy, and this is precisely the role

⁴⁸ The service specification for CRHT for the period 1 April 2019 — 31 March 2020" [WITN0207009] and "Crisis Resolution and Home treatment (CRHT) Teams: Standard Operating Procedure (AMH Greater Notts, Mid-Notts & Bassetlaw. December 2021) [NHFT0006966]

⁴⁹ Dr Michael Skelton, 23 November 2025, Paragraph 18, Pages 9-10, WITN0207001

⁵⁰ NHNB0004953

⁵¹ Dr Michael Skelton, 23 November 2025, Paragraph 20, Page 11, WITN0207001

⁵² Exhibit NHNB0003187; WITN0207001, page 9-10, para 18

⁵³ NHFT0000072

she performed at VC's first assessment.⁵⁴ It is of note that the Trust's policy includes in the Risk section both risks to the patient and risk of harming others that "*cannot be managed through home treatment or Haven Crisis House*". Ms Palmer is clear that she did not have the ability to refuse or stop a MHA assessment conclusion that admission or detention was warranted.⁵⁵

Whether race played any role

30. Dr Gandhi did not have any independent recollection of the discussions that took place as part of the MHA assessment, but five years later in 2025 while reflecting on events, had wondered whether his own cognitive biases, based on research evidence about over-representation of young Black males in psychiatric detention, had played a part⁵⁶.
31. Dr Malik confirmed in oral evidence he had no recollection of the question of race being discussed and that the professionals would have been focused on clinical risk.⁵⁷
32. Likewise, Mr Williams confirmed that a factor such as race did not come into his thinking and that the assessment was carried out on "the person that's in front of us".⁵⁸
33. There is no mention of considerations about race in the contemporaneous documentation.

Whether Crisis services were sufficiently staffed/there was otherwise a delay in seeing VC

34. The documented plan, entered onto VC's records at 4.32pm by Ms Palmer and following the conclusion of VC's assessment was that there would be an "*Evening visit with medication today with 2 [Crisis] staff members*".⁵⁹
35. It was clearly envisaged, therefore, that any medication visit would be an evening one and that, depending on how promptly VC was processed by the Police, there could be a period of time between release from Police custody and this visit occurring. VC's records state that Police release occurred at 6.21pm. Ms Palmer describes in her witness statement visiting his address at around 9.50pm. She explained in oral evidence

⁵⁴ Annette Palmer, 21 November 2025, Paragraph 14, Page 4, WITN0299001; and Annette Palmer, 21 April 2026, Page 84, Line 6 – 25 & Page 85, Lines 1 – 16, INQT0000058

⁵⁵ Annette Palmer, 21 April 2026, Page 85, Lines 17 – 20, INQT0000058

⁵⁶ Dr Rahul Gandhi, 21 April 2026, Page 16, Lines 17 – 25, Page 17, Line 1 – 11, Page 22, Line 12 – 25, Page 23, Line 1 – 25, Page 50, Line 8 – 25, Page 51, Line 1 – 4, INQT0000058

⁵⁷ Dr Khuram Malik, 21 April 2026, page 13/lines 13-25 and page 14/lines 1- 14, INQT0000057

⁵⁸ Benjamin Williams, 21 April 2026, page 70/lines 1-18; INQT0000058

⁵⁹ NHFT0000168 p 1

why it took the time that it did for a member of the Crisis Team (which ultimately ended up being her) to attempt to visit VC and deliver his medication⁶⁰.

Episode 2: 25 May 2020: second MHA assessment

36. The issues that arise in connection with this assessment include:
- a. What was understood about the incident involving Feven, who lived in a neighbouring flat to VC and was seriously injured on 25 May 2020, and how was this documented and used to inform subsequent risk assessment.
 - b. Should the occurrence of that incident (happening as it did shortly after the decision had been made not to admit VC to hospital under the MHA) have caused an incident report to have been raised pursuant to the Trust's policies and procedures at the time and, if so, why did this not happen.
 - c. Why no incident report was raised in relation to this incident after 13th June 2023 (and when the chronology of VC's care became known).
37. The assessing doctors, Dr Malik and Dr Sadraei did not have any information about the severity of the injuries sustained by the neighbour, but were aware that she had jumped from her flat in fear as VC was trying to smash her door down and that she had been taken to hospital in an ambulance complaining of lower back pain⁶¹. No information is contained in the contemporaneous records as to the severity of the injuries sustained.
38. In oral evidence, Dr Malik explained that he was not aware at the time of the assessment (some 20 hours after the incident) that the incident had happened within an hour of release. He felt that VC had degenerated significantly compared to his presentation at his first assessment⁶².
39. The overall clinical impression remained of first episode psychosis due to sleep deprivation and stress. Community treatment was not considered viable having already failed very shortly after discharge, and a violent, potentially criminal offence been

⁶⁰ Annette Palmer, 21 April 2026, pages 112-116, INQT0000058

⁶¹ Dr Malik, 21 April 2026, page 53, INQT0000057; page 3, NHFT0000168

⁶² Dr Malik, 21 April 2026, pages 55-56, INQT0000057

committed.⁶³ VC was not considered to have capacity to consent to informal admission, and was therefore detained under Section 2 MHA,⁶⁴ and admitted just after midnight to the Rowan 1 Ward.

40. The Trust accepts that no incident report was raised in relation to the events on the evening of 24 May 2020, and that the policy in place at the time supported a report being raised in such circumstances. The 'gateway' policy was "15.01 Reporting of Accidents, Incidents and Near Miss Situations."⁶⁵ Any member of staff can raise an incident, using the Ulysses system in operation at the Trust. While multiple reports relating to the same incident are not encouraged, this is also occasionally the case where various members of staff become aware separately of a reportable incident.
41. Having reflected on the evidence obtained by the Inquiry, the Trust agrees with the oral evidence of Dr Ahmed⁶⁶ that an incident report should have been raised. This is the case both at the time, and in the aftermath of the events on 13 June 2023 when the Trust reviewed the care it had provided to VC. No clear rationale has been provided to date by those involved in this incident as to why an incident report was not raised. Dr Malik and Dr Gandhi⁶⁷ both accepted that an incident report should have been raised and that neither of them had done so. Ms Palmer also agreed an incident should have been logged and that she had not done so. She suggested that the person best placed to raise such a report was the person who had received the most direct briefing as to the events in question, which appears to have been the Street Triage team. The Trust continues to explore these issues through its ongoing professional practice reviews and will keep the Inquiry updated as relevant over the coming period.

Episode 3: 25 May – 17 June 2020: first inpatient admission and discharge

42. The issues that arise in connection with this event are:
 - a. Whether appropriate records were kept.

⁶³ NHFT0000004

⁶⁴ NHFT0000004

⁶⁵ CQCM0005588,

⁶⁶ Dr Mona Ahmed, 16 April, Page 125, page 126, line 1-2 INQT0000054

⁶⁷ Dr Ghandhi, 21 April 2026, Pages 15-16, INQT0000058

- b. Whether the purpose of a core assessment was sufficiently clear and understood and, when carried out, the reasonableness of such assessments.
- c. Clinical decision-making, specifically in relation to medicines management; risk formulation and assessment; clarity of diagnosis; psychological interventions/psycho-education for VC and understanding of his insight.
- d. Engagement with VC's family.
- e. Multi-agency working, particularly with the Police and the University.

Record keeping

- 43. The Trust uses RiO and other electronic records systems, which are designed to capture key information in readily identifiable parts of the record. The RiO system includes various tools and functionality features, such as risk assessment pages and the ability to add 'flags' to highlight additional specific risks relevant to the patient.⁶⁸
- 44. All professionally regulated clinical staff are expected, under the terms of their registration,⁶⁹ to maintain appropriate clinical records and to use them in their practice.
- 45. Targeted, topic-specific guidance is also provided by the Trust. For instance, guidance was available to support the completion of core assessments,⁷⁰ risk assessments,⁷¹ and discharge planning and documentation,⁷² amongst others. This guidance was supplemented by training,⁷³ available primarily as eLearning during the relevant period (as a result of the Covid-19 pandemic arrangements).
- 46. Clinical leaders (whether nursing, medical or other speciality) are expected to model best practice, support training for junior staff and raise concerns where identified. That may result in an audit or other process being undertaken. Dr Seedat, as VC's Responsible Clinician and the supervising consultant, has accepted that he did not appropriately check the records being made by those under his supervision.⁷⁴

⁶⁸ NHFT0014976

⁶⁹ WITN0299002; RLIT0000029

⁷⁰ NHFT0000046

⁷¹ NHFT0005369

⁷² NHFT0000045

⁷³ NHFT0015073

⁷⁴ Dr Faizal Seedat, 23 April 2026, pages 67-70, INQT0000062

47. In its section 48 review, the CQC concluded that poor record keeping and the lack of a holistic approach to care planning led to decisions that did not meet VC's needs and did not take into account the potential risk that he presented to others."⁷⁵
48. Staff involved in caring for VC during his first admission have accepted aspects of their record keeping that could have been more detailed,⁷⁶ as well as instances where incomplete or inaccurate information was carried through to later updates⁷⁷. This had an impact on the clarity and articulation of risk assessments. In particular, the Trust accepts that:
 - a. Entries such as "...there have been no incidents of violence yet but this would be a potential concern if acutely unwell"⁷⁸ could have been articulated more precisely.
 - b. the background to VC's admission and the incident involving Feven (as the Trust understood it at the time) was not clearly recorded.
49. Dr Seedat also accepted that he could have uploaded a copy of the journal shared with him by VC's family⁷⁹ and other clinicians who gave oral evidence agreed that seeing this underlying source material might have been helpful,⁸⁰ although they also noted that the age of the material (i.e. dating from the time of first admission) would have been a factor in the weight it was given, particularly in the later stages of VC's care by the Trust.⁸¹ Dr Lomas explained that he "*would definitely want to talk to the patient in detail about it, but I would put this in the context of how very many patients we see that have thoughts of violence, in the context of psychosis and other disorders*".⁸²
50. The journal ought to have been uploaded to RiO by Dr Seedat (or he ought to have caused it to be uploaded): it was a primary source of information; other clinicians may

⁷⁵ WITN0155033_023

⁷⁶ Amanda Frost, 22 April 2026, pages 97-98, 108,114-118, INQT0000060; Dr Faizal Seedat, 23 April 2026, pages 67-70, INQT0000062

⁷⁷ Dr Anna Ludvigsen, 22 April 2026, pages 40-46, INQT0000059

⁷⁸ NHFT0000168_0017

⁷⁹ Dr Seedat, 23 April 2026, pages 39-42, INQT0000062

⁸⁰ For example Dr Manzar, 27 April 2026, pages 22-24 and 81-85, INQT0000064 accepts they were "quite significant" (p. 22), that "red rum" would suggest "a significant violent intent" (p. 23), and that they "absolutely" should have been shared with other doctors assessing VC's risk (p. 24). See also Dr Lomas, 28 April 2026, pages 55-57, INQT0000065

⁸¹ Dr Lomas, 28 April 2026, pages 55-57 and 73-74, INQT0000065

⁸² Dr Lomas, 28 April 2026, page 57, INQT0000065

have read and understood that information in different ways from Dr Seedat; and the relevance and significance of information in the journal may have altered over time as events unfolded.

51. Dr Seedat did, however, make an entry in VC's records summarising what he took from the information received and included the following pertinent information:
 - a. VC's experience of psychotic symptoms (including auditory hallucinations in the third person); emotional instability and religious pre-occupation;
 - b. VC's sense of being mocked;
 - c. His paranoia about being monitored and the use of technology in this context, as well as his belief that those monitoring him had rented neighbouring flats; and
 - d. Reference to VC wanting to "hurt these people he was hearing."
52. Dr Seedat concluded his summary entry with his clinical analysis of this information, as follows:

"In summary –

*Clearly shows Psychotic symptoms starting and developing over time with associated behaviours around increased religious pre-occupation, crying etc. Clear evidence of auditory hallucinations 3rd person, passivity and persecutory delusional beliefs. This suggest more of a functional illness rather than it being precipitated by stress or isolation."*⁸³

53. Dr Seedat did explore with VC the risk of harm being caused to a third party when he was unwell and the fact that this could result in someone being killed.⁸⁴ In his evidence, Dr Seedat confirmed he had a "clear recollection" of this discussion "...but the documentation lacks the context in which it was said...which was to impress on VC about the potential risk of his behaviours, including unintended consequences". Dr Seedat saw this as psychoeducation but his words did not amount to an "opinion nor...conclusion that VC would kill someone".⁸⁵

⁸³ NHFT0000168, p21

⁸⁴ Dr Seedat, 23 April 2026, pages 6-8 and 118-120, INQT0000062

⁸⁵ Dr Seedat, 3 February 2026, Paragraphs 375-378, page 141-143, WITN0163001_0141

54. Dr Seedat was not the only person to have not understood the meaning of the phrase “red rum” (or, if they did understand the meaning, given it prominence in their review of the journal):
- a. Elias Calocane supplied a copy of the journal to Nottinghamshire Police on 15th June 2023, within 2 days of the murders.⁸⁶
 - b. The journal was amongst the material submitted to Professor Blackwood (and the other expert psychiatrists) for the purposes of the criminal proceedings.⁸⁷ None of them placed any weight on the phrase “red rum”.
 - c. DC Neil Beddoe examined very closely material relating to VC’s mental capacity and set it out in his detailed report of 30 November 2023.⁸⁸ It is clear that he read the journal for the purpose of preparing his report, as he quotes from the journal and refers to Exhibit EAMC/2: see page 3 of the report. DC Beddoe did not pick up on the significance of the phrase “red rum”.
 - d. The journal was disclosed to the CPS and Prosecuting Counsel. None of them placed any significance of the phrase “red rum”.
 - e. The journal was disclosed to the Inquiry by Nottinghamshire Police⁸⁹ (on an unknown date, but disclosed to all Core Participants on 17th November 2025).
 - f. No Core Participant made reference to the phrase “red rum”, having seemingly not picked up the significance of it, in their Opening Written and Oral Statements (nor did Counsel to the Inquiry).
 - g. The first witness to be asked questions about the journal was Dr Ludvigsen on day 31 of the Inquiry,⁹⁰ after all relevant police witness had given evidence, after the psychiatrists who had provided reports to the criminal proceedings had given evidence, and the CPS and Prosecuting Counsel had given evidence, and after the Inquiry’s expert witnesses had given evidence - it seems like everyone had missed the potential significance of the phrase “red rum” until then.

⁸⁶ NGPF0003390, item D206

⁸⁷ Professor Blackwood, 30 March 2026, page 1, Lines 21-25 , INQT0000044

⁸⁸ NGPF0000474

⁸⁹ NGPF0002527

⁹⁰ Dr Anna Ludvigsem, 22nd April 2026, Page 58, Line 20, INQT0000059

55. In any event, Dr Seedat openly accepted⁹¹ that he did not know the meaning of this phrase when he first considered the journal but his summary entry did accurately reflect that VC's experience of his psychosis included feelings about wanting to cause harm to those who he felt were targeting him.

Core Assessment

56. Core assessments are completed as part of the "clerking-in" process for inpatients, described more fully in the Trust's Service Guidance for Adult Mental Health Acute Inpatient Wards.⁹²
57. They are intended as a comprehensive initial assessment of both physical and mental health presentation.⁹³ Dr Ludvigsen has accepted that the purpose of this assessment was not entirely clear to her at the time, in part likely as a result of her recent re-deployment to an inpatient mental health setting as a result of the emergency measures put in place to respond to the Covid-19 pandemic. Dr Ludvigsen has further accepted that she relied on the existing entries made onto VC's Rio records when completing the assessment; that these were incomplete (see para 4 above) and that this impacted on the quality of her record keeping within the core assessment.
58. Many clinicians (such as Dr Ludvigsen, who had been working in a predominantly non-patient facing role) were suddenly deployed with minimal notice to work in unfamiliar clinical settings in response to the Covid-19 pandemic. The consequence of redeploying clinicians as a response to the pandemic emergency response was that the usual induction and training process was not always able to be provided. This was compounded by the unusual circumstances of the pandemic and the fear held by many staff, which Dr Ludvigsen described well in her oral evidence: *"...during the pandemic, the usual challenges present in a place like an acute ward were there. So generally high acuity of unwell patients, but in addition to that, obviously we were in the very early stages of the pandemic before really we knew what the clear picture was going to be of that, when we were seeing images from the hospitals in Italy and other places coming in, way before vaccines were considered."*⁹⁴

⁹¹ Dr Seedat, 23 April 2026, pages 53-54, INQT0000062

⁹² NHFT0000130; See also Dr Rupert Ackroyd, 22 April 2026, pages 2-3, INQT0000059 and Crib sheet he refers to at pages 19-20, NHFT0007543

⁹³ Dr Anna Ludvigsen, 13 November 2025, Paragraph 70, Page 36, WITN0166001

⁹⁴ Dr Anna Ludvigsen, 22 April 2026, pages 31-32, INQT0000059

Clinical decision-making

59. The Inquiry has heard evidence on a range of matters relating to clinical decision-making during this episode including the following specific aspects:

- a. Medicines management: different views have been expressed about the medication that VC was commenced on (Aripiprazole) and the dosage (5mg). This remained the dosage at the point of discharge. The Inquiry heard evidence about whether this was a "sub-therapeutic" dose or not, although the Trust notes that no direct expert evidence has been obtained on this specific point.⁹⁵ Dr Seedat⁹⁶ remained of the view that precise dosage was a matter of clinical judgement, taking into effect the strength of anti-psychotic medications; potential side effects and observation around improvement on the dosage. MHA CoP recognises that views and preferences about care and treatment includes matters relating to medication.⁹⁷ Similarly, the NICE guidelines "*Psychosis and schizophrenia in adults: prevention and management*" dated 12 February 2015⁹⁸ set out a range of factors that should inform the choice of antipsychotic medication; a choice that "should be made by the service user and healthcare professional together". At the start of treatment, the NICE guidelines⁹⁹ state that "*At the start of treatment give a dose at the lower end of the licensed range and slowly titrate upwards within the dose range given in the British national formulary (BNF) or SPC*". In VC's case, Dr Seedat¹⁰⁰ felt that he did evidence improvement and that his view was that this dose was therefore therapeutic. The Trust accepts that clearer record keeping on this issue would have assisted with understanding the clinical decision-making at this stage.
- b. Risk formulation and assessment: the Trust agrees that the documentation of risk formulation and assessment was poor. This included some entries incorporating "cut and paste" elements from previous assessments, without apparent active consideration about building a longitudinal understanding.
- c. Discharge planning: VC was discharged into the care of the Crisis Team, pending him deciding where he would live, after which care would "pass on" to the relevant

⁹⁵ Dr Mona Ahmed, 12 March 2026, Paragraphs 81-83, Pages 19-20, WITN0425001

⁹⁶ Dr Faizal Seedat, 23 April 2026, Page 98, Line 2 – 10, INQT0000062

⁹⁷ Paragraph 9.14, Page 76, NHSE0000312

⁹⁸ Paragraph 1.3.5.1, NICE0000015

⁹⁹ Paragraph 1.3.6.3, NICE0000015

¹⁰⁰ Dr Faizal Seedat, 23 April 2026, Page 98, Line 11 – 18, INQT0000062

Early Intervention in Psychosis ("EIP") team. 3-day follow-up was planned as part of discharge and booked to take place the day after discharge (18 June).¹⁰¹ The records¹⁰² reflect appropriate discussion with VC, his family and the University about his living arrangement options. Ultimately, however, once he was assessed as being fit for discharge, there were limited options available to either the Trust, his family or the University to compel any particular option. While the CQC noted deficiencies in the discharge planning for later admissions, it did not comment critically on this first discharge and the Trust considers that the involvement of the Crisis Team and close liaison with VC's family and the University illustrate good discharge planning, grounded in awareness of the risks that might arise in the community but with appropriate plans in place to seek to manage these.

- d. Diagnosis: Dr Seedat was clear in his recorded discussions as part of discharge planning that VC's presentation was "not isolated, appears to be going towards an illness" and that VC's "family have not taken the news very well".¹⁰³ It is less clearly documented what exactly was discussed with VC and his mother on 17 June, although the entry records that Dr Seedat answered questions about VC's presentation, diagnosis of first episode psychosis "and why no specific label used and how this was not useful at this time".

Psychology/psychoeducation

60. The Trust has accepted the CQC's findings that *"no psychological assessment or interventions related to psychoeducation and relapse were offered despite the new diagnosis and VC and his mother expressing his difficulties in coming to terms with it"* and that this represented a *"missed opportunity in VC's care and goes against NICE guidelines on first-episode psychosis"*.¹⁰⁴ However, this broad finding does need to be understood in the context of what was offered and provided to VC, as well clinical judgement as to the most effective point at which such interventions can be offered.
61. The Trust has described in its evidence the challenges of recruiting psychologists.¹⁰⁵ These challenges are not unique to the Trust and reflect national skill shortages, compounded at this time with the impact of the Covid-19 pandemic. Dr Seedat felt¹⁰⁶

¹⁰¹ NHFT0000168_0049

¹⁰² NHFT0000168_0049

¹⁰³ NHFT0000168_0045

¹⁰⁴ WITN0155033_0021

¹⁰⁵ Dr Faizal Seedat, 23 April 2026, Page 82, Line 3 – 10, INQT0000062

¹⁰⁶ Dr Faizal Seedat, 23 April 2026, Page 11, Lines 1 – 17, INQT0000062

that attempts were made to have discussions with VC and his family that were intended to support psychoeducation. He did not agree that this was a completely missed opportunity, but he did agree that there is benefit to these interactions taking place in a psychological space, while reflecting that an inpatient setting is not always the most conducive environment for these interventions to be effectively delivered.¹⁰⁷

62. VC was offered occupational therapy, with the records¹⁰⁸ reflecting a narrow range of interest by VC (gym) and a lack of engagement with other support offered (sleep hygiene). The clinical impression was of "occupational imbalance." Ongoing attempts were made to engage VC with activities and to encourage him to exercise in hospital grounds (the gym being unavailable as a result of social-distancing arrangements in place at the time).¹⁰⁹

Engagement with VC's family

63. The Trust accepts that good care requires a partnership between healthcare professionals, the patient, and their family. This promotes safety, supports recovery and sustains wellbeing. The Trust has promoted a Triangle of Care guide for its staff since 2010.¹¹⁰
64. Good engagement was demonstrated through this episode, with regular contact between Dr Seedat and others caring for VC and his mother, notwithstanding the Covid-19 pandemic restrictions in place around visiting. This extended to discharge planning, with discharge scheduled for a day when VC's mother could be present in Nottingham to support him.¹¹¹
65. The records also reflect that Dr Seedat did attempt to explain the potential longer-term implications of VC's illness and to begin the process of providing psychoeducation to both VC and his family.¹¹²

¹⁰⁷ Dr Faizal Seedat, 23 April 2026, Page 11, Lines 18 – 25 and Page 12, Line 1 – 8, INQT0000062

¹⁰⁸ NHFT0000168_0019-0020

¹⁰⁹ NHFT0000168_0027

¹¹⁰ Diane Hull, 21 May 2026, Page 83, Lines 15 – 20, INQT0000093

¹¹¹ NHFT0000168_0039

¹¹² NHFT0000168_0049

Multi-agency working

66. Early steps were taken to liaise with the University¹¹³ and there was ongoing contact throughout this episode. The University were clear that their preference was for VC to return "home" to Wales.¹¹⁴ Trust staff were also supportive of this but VC expressed (and maintained) a clear preference to remain living independently (either in Birmingham or Nottingham). VC was a capacitious adult, residing in a privately-leased flat and ultimately neither the University (Eleanor Cullen), the Trust (Dr Seedat) or VC's mother were able to persuade him to return to Wales.
67. On 31 May 2020, PC Marsden emailed Dr Seedat to seek his view on whether or not VC might have had capacity on 25 May 2020 during the incident when Feven was injured.¹¹⁵ Dr Seedat read this email in the context of him usually being contacted by the police when they wanted to know whether someone was fit to be interviewed. In such cases, he usually completes a form.¹¹⁶ For this reason, he replied to PC Marsden to ask whether he was being asked to complete such a form, to which PC Marson replied "[a]n email will suffice".¹¹⁷
68. Dr Seedat responded to PC Marsden on 2 June 2022. He indicated that VC had presented with clear symptoms suggesting an acute psychotic illness and had no memory of the events in question. Dr Seedat indicated it was his view that VC "did not have the capacity to be responsible for his actions as this was not done in a clear conscious state".¹¹⁸
69. Dr Seedat's evidence was that he never intended or understood that this response would be used to decide whether VC was going to be charged or not charged by the police.¹¹⁹ However, Dr Seedat also accepted that he shouldn't have responded in the terms he did.¹²⁰ The Trust agrees that this response was open to misinterpretation and Dr Seedat should have sought clarity from the Police as to the purpose of the request.

¹¹³ NHFT0000168_0016-0018. Dr Seedat attempted to contact the University, but his email bounced back

¹¹⁴ NHFT0000168_0022

¹¹⁵ WITN0163012

¹¹⁶ Dr Faizal Seedat, 23 April 2026, Page 32, Line 14 – 21, INQT0000061

¹¹⁷ WITN0163012

¹¹⁸ WITN0163014

¹¹⁹ Dr Faizal Seedat, 23 April 2026, Page 33, Line 9 – 16, INQT0000061

¹²⁰ Dr Faizal Seedat, 23 April 2026, Page 35, Line 11 – 15, INQT0000061

Episode 4: 18 June – 13 July 2020: first period of community care

70. The issues that arise in connection with this event include:
- a. Whether the Crisis Team provided appropriate post-discharge care and whether their assessment of VC's risk was reasonable.
 - b. Identification and management of VC's medication concordance.
 - c. Interface between Crisis and EIP.
 - d. Engagement with VC's family.

Crisis care following discharge

71. The documented discharge plan¹²¹ was that the Crisis Team would care for VC in the period immediately following his discharge from inpatient care. Crisis staff were involved in the discharge planning process and were present at the ward review on 15 June¹²² reflecting their active role in discharge planning.¹²³ The Crisis Team utilizes a RAG (Red, Amber, Green) clinical risk rating system and clinical decision tool related to care planning. Patients on a "Green" rating are considered to be towards the end of their treatment with the service and should have a discharge plan/date in place.¹²⁴
72. The first post-discharge visit was scheduled for the day after VC's discharge, following which an Amber RAG rate was maintained. This took place by phone-call (with Covid-19 pandemic restrictions being suggested as the reason for this), as did a further check-in on 20 June. On 22 June, Dr Seedat raised his concerns about these visits having taken place via telephone with Dr Lomas, "as he [VC] is likely to down play any symptoms/problems".¹²⁵

¹²¹ NHFT0000168_0049

¹²² NHFT0000168_0045

¹²³ NHFT0000981; NHFT0007069

¹²⁴ Josephine Baker, 2 December 2025, Paragraph 21, Page 6, WITN0147001

¹²⁵ NHFT0000168_0051

73. An in-person visit was arranged as a result of this intervention.¹²⁶ The Trust agrees that this immediate follow-up care should have been provided in-person, notwithstanding the Covid-19 pandemic restrictions.
74. An in-person assessment visit, known as the "three-day review", did take place on 23 June. Ms Baker, an experienced Crisis team nurse, gave evidence about what information she would have reviewed before doing so, namely "*the running records [also referred to as 'progress notes'], his core assessment, his risk assessment, his care plan, any previous MDT entries from the inpatient ward*" and his discharge summary.¹²⁷ Ms Baker confirmed she was aware of VC's interactions with the police prior to his first admission, although not the full extent.¹²⁸ Ms Baker's impression of VC's mental state was different to that formed by the Crisis nurse who conducted the telephone review on 18 June, with Ms Baker reflecting on how "very difficult" it can be to assess a patient's mental state via telephone.¹²⁹ Ms Baker recorded a clear assessment of risk in VC's notes, reflecting three key points:
- a. His ability to mask psychotic symptoms
 - b. A history of violence and aggression when his mental health deteriorates, and
 - c. Further risk of deterioration in mental health state if non concordant with medication.
75. The team assessing VC reduced his Crisis RAG rating to "Green", meaning he was ready to be discharged from the service. This decision was reached on the basis that the Crisis team accepted VC's assertions that he was compliant with his medication and they did not consider any further support from Crisis was required at the time.¹³⁰ His view was endorsed in the Crisis Multi Disciplinary Team ("MDT") meeting that took place on 26 June, apparently reflecting the view that VC did not require "*intensive home treatment*".¹³¹ The MDT agreed that VC's care should be transferred to EIP.¹³²

¹²⁶ NHFT0000168_0051

¹²⁷ INQT0000075, page 89, lines 23-25

¹²⁸ Josephine Baker, 7 May 2026, pages 89-91, INQT0000075

¹²⁹ Josephine Baker, 7 May 2026, page 92, lines 22-24, INQT0000075

¹³⁰ Josephine Baker, 2 December 2025, paragraph 22, pages 6-7, WITN0147001

¹³¹ NHFT0000168_0053

¹³² NHFT0000168_0053

76. The plan recorded by Ms Baker indicated that there should be a telephone check-in with VC on 26 June. This call was made by Daisy Coleman, who recorded VC as indicating that the voices he was hearing were "dying down". Ms Coleman told VC of the plan to handover his care to EIP.¹³³

Interface Crisis/EIP

77. The process of handing over care from Crisis to EIP began on 26 June, with Claudia Birtles, VC's appointed Care Coordinator ("CCO") introducing herself (by telephone) that same day, and concluded with a joint in-person visit by Crisis and EIP on 30 June.¹³⁴ Ms Birtles' record of her first in-person meeting with VC includes information relevant to risk and medication concordance.¹³⁵

Identification and management of VC's medication concordance

78. Warning signs around concordance begin to emerge when VC's lack of clarity around what quantity of medication he had remaining or how he obtained more were recorded in his notes.¹³⁶ However, although a replacement supply was arranged, no other active steps seem to have been taken at this stage to investigate warning signs around medication concordance and explore more closely whether he was taking his medication as prescribed.
79. When clear concerns were raised by VC's mother on 11 July, no steps were taken beyond seeking to return her call. The Trust agrees that this is a missed opportunity to intervene prior to the events of 14 July when VC again came into contact with the Police.

Engagement with VC's family

80. While there was a clear handover from the Crisis Team to EIP in terms of what was communicated within the Trust and to VC, there is no corresponding record of any update being provided to VC's family at this stage to confirm his CCO and provide a point of contact. Instead, it was left to VC's mother to make contact with the Trust, when she rang on 11 July with concerns about his mental state.¹³⁷ The Trust agrees that this was not consistent with its expectations around family involvement.

¹³³ NHFT0000168_0053

¹³⁴ Claudia Birtles, 29 January 2026, paragraph 140, pages 48-49, WITN0348001

¹³⁵ NHFT0000168_0054

¹³⁶ Claudia Birtles, 29 January 2026, paragraph 151, page 52, WITN0348001

¹³⁷ Claudia Birtles, 29 January 2026, paragraph 156, pages 53-54, WITN0348001

81. VC's mother raised clear concerns in a telephone call to the Crisis Team about VC's medication concordance and mental state on Saturday 11 July. Ms Birtles, having seen the note of the call sought to return her call on 13 July, her first working day after Mrs Calocane's call.¹³⁸ There is no record of any contact or visit being made to VC in light of the concerns raised by his mother.

Episode 5: 14 July 2020: police detention and third MHA assessment

82. The issues that arise in connection with this event include:
- a. The role and involvement of the Street Triage Team.
 - b. Whether relevant guidance and protocols were followed in respect of the third MHA assessment.
 - c. The rationale for the admission being under section 3 of the MHA.

Street Triage role and involvement

83. This event, beginning with a third instance of violence and aggression by VC towards neighbours, was attended by the Street Triage Team after Police colleagues requested their support.¹³⁹
84. On the basis of their impression of VC's mental state, he was detained under section 136 of the MHA and taken to the Cassidy Suite.
85. The Trust considers this to be a positive illustration of inter-agency working and appropriate use of the powers under section 136 of the MHA.

Whether relevant guidance and protocols were followed in respect of the assessment

86. VC's third MHA assessment was carried out by Dr Seedat, Dr Manzar and Mr Culpin (AMHP). It was carried out in a timely manner, following VC's detention under section 136, consistent with the MHA and CoP.

¹³⁸ WITN0348001, page 54, para 157

¹³⁹ Dr Faizal Seedat, 3 February 2026, paragraph 259, pages 134-135, WITN0163001

87. Dr Seedat and Mr Culpin saw VC together.¹⁴⁰ Dr Manzar saw him separately, prior to Dr Seedat and Mr Culpin assessing him.¹⁴¹ Dr Manzar's notes of his assessment were available to Dr Seedat and Mr Culpin.¹⁴²
88. Mr Culpin's evidence was that, while not routine, this was not an entirely unusual occurrence and on this occasion, he did not feel it detrimentally affected the assessment, noting that he "spoke with Dr Manzar before" he and Dr Seedat met with VC and so was "aware of the nature of his assessment" and had had the opportunity to "talk though" the details.¹⁴³ The MHA CoP simply provides¹⁴⁴ that "Where possible, the assessment should be undertaken jointly by the doctor and the AMHP".
89. All those assessing felt that it was clear that VC required inpatient care, pursuant to section 3 of the MHA.¹⁴⁵ Mr Culpin found it helpful that Dr Seedat was able to draw on details of VC's first inpatient stay.¹⁴⁶
90. VC's mother was appropriately informed about the assessment, although her involvement came after the assessment had been concluded and did not inform the outcome of the assessment. In any event, her views about VC's mental state and medication concordance appeared supportive of the assessment outcome.¹⁴⁷

Episode 6: 14 July – 31 July 2020: second inpatient admission and discharge

91. The issues that arise in connection with this event include:
- a. Clinical decision-making, specifically in relation to medicines management; risk formulation and assessment; and understanding of VC's insight.
 - b. Inpatient/community collaborative care.
 - c. Discharge planning and adequacy of discharge summary.

¹⁴⁰ Geoffrey Culpin, 10 November 2025, paragraph 54, page 18, WITN0189001

¹⁴¹ Geoffrey Culpin, 10 November 2025, paragraph 49, page 16, WITN0189001

¹⁴² Geoffrey Culpin, 10 November 2025, paragraph 44, page 14, WITN0189001

¹⁴³ Geoff Culpin, 27 April 2026, Page 6, lines 4-7, INQT0000063

¹⁴⁴ Paragraph 16.47, NHSE0000312_0148

¹⁴⁵ Geoffrey Culpin, 10 November 2025, paragraph 77, page 27, WITN0189001

¹⁴⁶ Geoff Culpin, 27 April 2026, page 7, lines 4-7, INQT0000063

¹⁴⁷ Geoffrey Culpin, 10 November 2025, paragraph 68-70, pages 23-24, WITN0189001

- d. Engagement with VC's family.
- e. Multi-agency working, particularly with the University.

Clinical decision-making

92. A range of issues arise under this overall topic.

Transfer, core assessment and initial decision-making

93. Following VC's third MHA assessment on 14 July 2020, a bed was identified for him on Rowan 1, the same ward that he had been admitted to during his first inpatient stay. Transfer to Rowan 1 from the Cassidy Suite was recorded as being "delayed", "*due to Rowan 1 receiving a difficult transfer earlier*".¹⁴⁸ VC's mother appears to have been kept appropriately informed about him remaining on Cassidy, as well as what the plan was in terms of transfer and arrangements for securing his flat (which she had sought assurance on).¹⁴⁹ VC's mother asked to be informed when transfer had taken place.¹⁵⁰
94. Ms Ajewole's entry in his records states that VC was transferred at 23.20pm on 14th July, with three staff members accompanying him but "without issues".¹⁵¹
95. Dr Ackroyd commenced his medical clerking-in by completing the core assessment, with his clinical impression of VC being "*relapse of psychosis shortly after discharge with FEP [first episode psychosis]*".¹⁵² The documented plan was for his treatment to be re-established (starting on 10mg Aripiprazole, an "increased" dose); an update provided to his family in "social hours" (noting Dr Ackroyd's entry was made at 2.55am) and "*some psychoeducation re treatment when able*".¹⁵³ Dr Ackroyd gave detailed written and oral evidence about his core assessment, reflecting on the purpose of this assessment (which he felt was not clear across teams) and how it was carried out. He explained that before conducting this, he would "certainly look at existing core assessments because they can be really helpful, summary documents, ...a recent discharge summary,...at progress notes for just giving me recent events that had precipitated the admission

¹⁴⁸ NHFT0000168_0059

¹⁴⁹ NHFT0000168_0059

¹⁵⁰ NHFT0000168_0059

¹⁵¹ NHFT0000168_0059

¹⁵² NHFT0000168_0059

¹⁵³ NHFT0000168_0059

itself." He accepted that some of the information included in his Core Assessment was "pulled through" from the previous Core Assessment.¹⁵⁴

96. Reflecting on the Core Assessment process, Dr Ackroyd also felt that differentiating timely clerking-in of patients from a more considered process to conduct an assessment intended to provide a *"succinct and clear history with a good summary of the patient's care journey through the care services"* would be beneficial and that ideally this would be carried out by the regular treating team, not least as an *"incentivised task that really forces you to know your patient well"*.¹⁵⁵
97. He also explained the Core Assessment Crib Sheet¹⁵⁶, the reliance he would have placed on this during his *"first few weeks as a core trainee"* but how this diminished as he gained a *"pretty good understanding"* of how to carry out an assessment of this nature, including obtaining and documenting psychiatric history.¹⁵⁷
98. The records do not state who updated VC's mother or when, but Ms Rivers' entry made at 5.53am on 15th July states that "[VC's] mum...is aware of his transfer to Rowan 1".¹⁵⁸
99. VC was informed of his section 3 rights and informed staff that he wanted to appeal his section. Nurse Helena Samila's entry in his records states that he was provided with the relevant paper work and a list of solicitors to support him in taking this forward "as he wishes to go through this himself" (rather than use an advocate).¹⁵⁹

Diagnosis

100. Dr Ludvigsen's record of VC's 72-hour review states his diagnosis as "schizophrenia *like illness*". Her record goes on to describe Dr Seedat exploring *"Valdo's insight into his mental state and possible serious mental illness. Very frank discussion. Valdo does not accept that he may have an ensuring mental illness. Dr Seedat reflected that it seemed strange he had not chosen to read up on psychosis and possible causes. In his opinion it appears increasingly likely that Valdo has schizophrenia. Valdo does not fully accept this – he is hoping it will go away 'that I can use my will to power through it'".*¹⁶⁰

¹⁵⁴ Dr Ackroyd, 22 April 2026, page 4, lines 1-6, 10-11, 15, INQT0000059

¹⁵⁵ Dr Ackroyd, 22 April 2026, page 23, lines 8-25, INQT0000059

¹⁵⁶ NHFT0007543

¹⁵⁷ Dr Ackroyd, 22 April 2026, page 20, lines 12-16, INQT0000059

¹⁵⁸ NHFT0000168_0059

¹⁵⁹ NHFT0000168_0061

¹⁶⁰ NHFT0000168_0064

101. At the time of his discharge, Dr Seedat continued to stress the likely long-term nature of his illness, with treatment likely "*for at least 2 years*".¹⁶¹

Psychoeducation

102. Psychoeducation and support for VC to address his apparent poor insight and understanding of the likely trajectory of his illness was identified as necessary at his 72-hour review.¹⁶²
103. Occupational Therapy ("OT") and psychology staff¹⁶³ attended at MDT meetings and met with VC in 1:1 sessions.¹⁶⁴ These sessions explored medication (its purpose, the importance of concordance and not changing without clinical support).
104. The records reflect sustained attempts to engage VC in OT opportunities,¹⁶⁵ with a variety of different activities offered and encouraged.

Risk formulation and assessment

105. The first formal entries relating to risk are made in nursing entries into VC's progress notes. These vary in content and detail but more often than not these entries do not explicitly reference the harm caused to Feven and the risk more generally of violence and aggression when unwell.¹⁶⁶
106. Standalone risk assessments were carried out on admission¹⁶⁷ and prior to discharge¹⁶⁸. This accorded with the Trust's policy in place for inpatient units.¹⁶⁹
107. Dr Ludvigsen accepted that her entry in VC's 72-hour review stating that "there have been no incidents of violence yet but this would be a potential concern if acutely unwell"

¹⁶¹ NHFT0000168_0106

¹⁶² NHFT0000168_0066

¹⁶³ Angela Pudue, 19 November 2025, WITN0297001; Dr Gareth Foote, 23 February 2026, WITN0413001

¹⁶⁴ NHFT0000168_0074

¹⁶⁵ NHFT0000168_0076; NHFT0000168_0089; NHFT0000168_0104

¹⁶⁶ NHFT0000168_0067, NHFT0000168_0075

¹⁶⁷ NHFT0000196

¹⁶⁸ NHFT0000222

¹⁶⁹ NHFT0001243; NHFT0000045

was inaccurate.¹⁷⁰ Dr Seedat also accepted that he did not review and approve records made by junior members of clinical staff operating under his clinical supervision.¹⁷¹

108. It was during this 72-hour review that Dr Seedat's frank discussion with VC about the risk he presented when unwell, and the consequential importance of maintaining his medication, occurred. At this early stage post admission, VC's insight and remorse were recorded as being limited, with Dr Ludvigsen recording that he *"appeared non-plussed when confronted with the effects of his behaviour with the neighbour during this incident and also the previous admission"*.¹⁷² Dr Seedat made clear the potential implications for VC if he failed to work on his insight and accept treatment, spelling out to him that *"the danger is that this will happen again and perhaps Valdo will end up killing someone"*. At this stage, VC appeared to remain under the impression he can control this himself, saying *"it will not happen again"*.
109. In terms of other opportunities for the formulation and assessment of risk, Dr Ackroyd explained that the purpose of a Core Assessment was not to formulate a detailed assessment of risk, although there was content included within it that *"might relate to"* risk¹⁷³. He agreed that the Crib Sheet did not prompt any entry relating to risks to others and only explicitly addressed risks to self. However, he did not feel that *"the absence of that question...wouldn't mean it wouldn't be discussed"*.¹⁷⁴ He explained that in collating contextual information, such as family history, this was contributing to an understanding of the patient's risk factors: *"... it's compiling the history in combination with the pre-disposal and risk factors. When you consider the formulation, this would certainly be a predisposing risk factor if he had a relative with schizophrenia, and I outlined in the evidence that the largest study around inheritability, and I think a grandparent would be sort of 5% risk versus 1% of the general population risk. So five times the risk, ultimately, than the general population if you had grandparent with schizophrenia."* He agreed that this was relevant when considering potential diagnosis.¹⁷⁵

¹⁷⁰ Dr Anna Ludvigsen, 22 April 2026, Pages 53-54, lines 17-25, 1-23, INQT0000059

¹⁷¹ Dr Faizal Seedat, 23 April 2026, pages 6-7, lines 22-25, 1-15, INQT0000061

¹⁷² NHFT0000168, page 64

¹⁷³ Dr Rupert Ackroyd, 22 April 2026, Pages 21-22, lines 22-25, 1-3, INQT0000059

¹⁷⁴ Dr Rupert Ackroyd, 22 April 2026, page 22, lines 9-15, INQT0000059

¹⁷⁵ Dr Rupert Ackroyd, 22 April 2026, page 11, line 5-14, INQT0000059

Medicines management

110. Dr Ackroyd enacted Dr Seedat's prescription¹⁷⁶ for an increased dose of Aripiprazole and gave his view as to the dose that he had initially been commenced in, namely that 5mg was *"not an effective dose"*, noting that *"the evidence suggests for a first episode psychosis 10 milligrams is the minimum effective dose. For multiple episodes, 15 milligrams would be the effective dose and the reference for that would be the Maudsley Prescribing Guidelines"*.¹⁷⁷ However, he did caution that this did not *"negate 5 milligrams being a reasonable starting point because it's often a poorly tolerated medication... So there is evidence and suggestion that we should start it lower and build up the dose gradually and I think the plan from the previous admission had been to start at 5 milligrams and presumably would have been to titrate that dose up with CRHT, the Crisis Resolution Team. So yes, it's not the minimum effective dose for treating a psychotic episode, but there is logic for starting at that dose before one would increase."*¹⁷⁸
111. The possibility of depot medication was raised during VC's 72-hour review. At that stage, VC is not recorded as entirely dismissive of the option and it is left that staff would provide him with further information about this option.¹⁷⁹ The detail of precisely what "pros and cons" Dr Seedat explained to him during this review is not recorded in Dr Luvigsen's entry.¹⁸⁰

VC's capacity

112. Capacity was kept under review at key stages throughout VC's admission. It is correct to reflect, as the Theemis Review did¹⁸¹ that in the ward review documenting the most detailed discussion of medication concordance and depot (21 July 2020) VC was assessed as not having capacity to make decisions about admission and/or treatment. However, (a) his views were still appropriately taken into account, as part of a broadly composed MDT, at which his mother was also present; and (b) that was not the final decision-making point on the issue of medication management on discharge. The record of that meeting notes that *"Valdo was informed by Dr Seedat that he has time to think about whether he wants to take a depot on discharge or would prefer to stay on oral tablets (ensuring his concordance)"*;¹⁸² this was in the context of Dr Seedat suggesting

¹⁷⁶ Dr Rupert Ackroyd, 22 April 2026, page 27, lines 11-20, INQT0000059

¹⁷⁷ Dr Ackroyd, 22 April 2026, page 28, lines 13-18, INQT0000059

¹⁷⁸ Dr Rupert Ackroyd, 22 April 2026, pages 28-29, lines 19-25, 1-7, INQT0000059

¹⁷⁹ NHFT0000168_0064

¹⁸⁰ NHFT0000168_0064

¹⁸¹ NHNB0018966-0185

¹⁸² NHFT0000168_0079

discharge would be towards the end of the month and later entries in the records reflect ongoing awareness of VC's capacity, in the context of multi-disciplinary discharge and care planning discussions, many of which involved his mother.

Inpatient/community collaborative care

113. Claudia Birtles was kept updated throughout this period, both by email and by being invited to attend ward rounds (via Teams).¹⁸³ She and Dr Lloyd are recorded appropriately on relevant documentation.¹⁸⁴
114. Ms Birtles shows active engagement with the inpatient team, attending meetings and ensuring Dr Seedat was aware of cover arrangements in absence.¹⁸⁵
115. Similarly close collaborative working is demonstrated in terms of the Crisis Team's involvement pre-discharge.

Discharge planning

116. From early on in this admission, the following issues were identified as central to effective discharge planning¹⁸⁶:
- a. Medication concordance
 - b. Accommodation,¹⁸⁷ and
 - c. Psychoeducation.
117. The records reflect a number of discussions with VC and his mother about his accommodation, including the use of section 17 MHA leave to enable VC to go and view potential flats.¹⁸⁸ In the end, it was agreed that he would return to his flat, where he held a tenancy up to September 2020.¹⁸⁹ Dr Seedat documented, on 21 July, a plan for him to be accompanied on escorted leave to the flat to "*see if Valdo will be okay going there to live for the short time to do his exams*" (in August).¹⁹⁰ Dr Seedat's record goes on to

¹⁸³ NHFT0000168_0073

¹⁸⁴ NHFT0000168_0064

¹⁸⁵ NHFT0000168_0091

¹⁸⁶ NHFT0000168_074

¹⁸⁷ NHFT0000168_074

¹⁸⁸ NHFT0000168_0078

¹⁸⁹ NHFT0000168_0082

¹⁹⁰ NHFT0000168_0082

state that it was "*suggested that he will benefit from going to stay with his parents after the exam*".¹⁹¹

118. This escorted visit took place on 22 July and the record suggests it was an uneventful visit, although VC did tell them that one reason he wanted to go to the flat was to apologise to his house mates "*face to face*".¹⁹²
119. A further detailed ward review took place on 28 July, with VC's mother present, along with Merima Jordan from the Crisis Team. While discharge moved ahead as anticipated, it appears from the record of this review that the clinical team had some hesitation about how he would fare on discharge, with Dr Seedat explaining to VC's mother that "*Valdo may need more support when he is discharged*" and that the Crisis Team would be best placed to provide this (rather than EIP alone).¹⁹³
120. The discharge summary,¹⁹⁴ prepared by a junior doctor, includes a primary diagnosis of paranoid schizophrenia; reference to the fact that this was the second admission, following a previous admission "*under similar circumstances*" and that the impression was that he posed "*an increasing risk to himself and others*".¹⁹⁵ In the section dealing with risk factors, the harm suffered by Feven as a result of the events of 24-25 May 2020 is referenced. Previous medicines non-concordance is noted. Discharge was approved Dr Matthews in Dr Seedat's absence as planned. Dr Matthews' recorded in VC's records¹⁹⁶ that he was "*satisfied that his [VC's] notes indicate he is to be discharged from the ward and that his section can be removed. He has made significant progress and has a treatment plan in place.*" In oral evidence, Dr Seedat accepted in oral evidence that the discharge documentation could have been better and more detailed, particularly in terms of risk information and reflecting the wide audience for this document (including, for instance, primary care). It is unclear whether either Dr Seedat or Dr Matthews' saw the discharge summary before it was issued.

¹⁹¹ NHFT0000168_0082

¹⁹² NHFT0000168_0086

¹⁹³ NHFT0000168_0104-0108

¹⁹⁴ NHFT0000222

¹⁹⁵ NHFT0000222, page 2

¹⁹⁶ NHFT0000168_0117

Engagement with VC's family

121. VC's consent was appropriately sought and obtained to enable staff to share information about him and his care with his family.¹⁹⁷ His mother was the most frequent point of contact during this episode, as with earlier ones. The recorded contact from her suggests she was able to openly ask questions, share concerns and speak with a range of staff, including with Dr Seedat¹⁹⁸.
122. The records reflect that VC's mother in particular was periodically updated¹⁹⁹, involved in MDT meetings²⁰⁰ and ward reviews²⁰¹. Steps were taken to ensure that key reviews could take place on days when VC's mother was available; her work commitments were known to those caring for VC.²⁰²
123. Ms Birtles made VC's family aware of arrangements in her absence and ensured they knew who to contact while she was away.²⁰³
124. Evidence has been heard about steps taken to involve VC's family in his care, including through telephone updates; in-person visits by members of his family²⁰⁴; involvement in ward reviews²⁰⁵ and discharge planning. VC's mother met with key staff involved in VC's care both in an inpatient context, as well as Ms Birtles and Crisis Team staff.
125. Discharge was planned for a day when Mrs Calocane could be in Nottingham to support VC.²⁰⁶

Multi-agency working, particularly with the University

126. There is little documented evidence of collaborative working with the University during this admission, despite VC's frequent references to his studies; the clear importance he placed on this; and his stated intention of resuming his studies in September.
127. Although plans were made for an escorted visit to his flat, it appears that the University were not informed about this and nor were their views sought about a potential return.

¹⁹⁷ NHFT0000168_0006-0007; NHFT0000168-0024

¹⁹⁸ NHFT0000168_0081-0082

¹⁹⁹ NHFT0000168-014; NHFT0000168-0018

²⁰⁰ NHFT0000168-0010-0012

²⁰¹ NHFT0000168_0077 – 0078; NHFT0000168-0104-0105

²⁰² NHFT0000168_0069-0070

²⁰³ NHFT0000168_0090-0091

²⁰⁴ NHFT0000168_0071-0072

²⁰⁵ NHFT0000168_0069-0070

²⁰⁶ NHFT0000168_0039

This represents a missed opportunity, both in terms of supporting VC but also in terms of considering what support might be needed for his flatmates, if he did return as planned.

128. The first documented liaison takes place on 30 July 2020, one day before planned discharge, when Amanda Frost informed the University of this. The University's concerns were recorded in the records but with no clarity as to next steps and no apparent review of the planned discharge in light of the concerns expressed.²⁰⁷
129. On the same day, Eleanor Turner emailed Mr Culpin,²⁰⁸ expressing her (a) surprise about the planned discharge of VC to his previous address and (b) her concerns for both VC and the other residents. She also made Mr Culpin aware that there was no need for him to remain in Nottingham, as all University work was now online (as a result of the Covid-19 pandemic restrictions).
130. Mr Culpin forwarded that email on to Dr Seedat and there followed an exchange between the two about VC's current mental state, with Dr Seedat expressing his clinical view that VC was *"well...taking his meds, he will have close follow up"*. Mr Culpin queried whether he was on depot or oral meds and what follow-up was planned. Dr Seedat confirmed that *"He is on meds, oral meds, he has demonstrated good insight"* and that he would be followed up by both the Crisis team and also his *"LMHT...he has CCO Claudia Birtles"*.²⁰⁹ In oral evidence Dr Seedat reiterated his view that VC's insight had improved by the end of that admission²¹⁰ and that by then he did understand *"that he had an illness...the link between his symptoms and his behaviour, and...the importance of taking medication which controlled his symptoms, which would then control his behaviour. VC was able to link his readmission to hospital at this point in time, in terms of stopping his medication and his symptoms reappearing"*.²¹¹ The contemporaneous notes suggest Dr Seedat was explicit with VC on these points and reflect VC acknowledging what Dr Seedat is saying.²¹²

²⁰⁷ NHFT0000168_0112

²⁰⁸ WITN0163008_0003

²⁰⁹ WITN0163008_0001

²¹⁰ Dr Faizal Seedat, 23 April 2026, Page 35, Lines 14 – 22, INQT0000062

²¹¹ Dr Faizal Seedat, 23 April 2026, Page 35, Lines 14 – 22, INQT0000062; NHFT0000168_0077-0081

²¹² NHFT0000168_0063 – 0066; NHFT0000168_0077-0081

131. In oral evidence, Dr Seedat did not accept that VC had shown no remorse, pointing to his stated desire to apologise to his flatmates when he was escorted to visit his flat.²¹³
132. Dr Seedat also expressed his views regarding the limited options available to the Trust in terms of where VC was discharged, noting he was an adult; held a tenancy that he had paid for; had no income and was unlikely to have his paid tenancy reimbursed if he broke his tenancy. Dr Seedat's view was that the University needed to "*work with landlords and see how they support their students in such situations*". He also noted that in both incidents had returned in VC's "*other flat and not in the one he is returning to*".²¹⁴
133. In oral evidence, Dr Seedat agreed his tone in response to Mr Culpin was frustrated but he felt that "*if she [Ms Turner] had directly communicated with me, I would have discussed with her about the risk management and the things that we had done, the things we had put in place*".²¹⁵ This appears to place an onus on such joint working and coordination entirely on the University, rather than seeing this as a mutual relationship, where there was benefit to testing discharge plans so as to ensure risks had been appropriately identified and mitigated. Safeguarding considerations should also have expressly been considered and reflected in the records.

Episode 7: 31 July – 1 September 2021: second period of community care

134. The issues that arise in connection with this event include:
- a. Understanding and assessment of risk following discharge.
 - b. Management of disengagement and uncertainty over medicines concordance.
 - c. Engagement with VC's family and response to concerns shared.
 - d. Multi-agency working.
135. Going into the Inquiry, this appeared to be VC's longest and most incident-free period of care in the community. The Trust now knows that there were events during this period that it was not aware of that give a different impression about his mental state and, had

²¹³ Dr Faizal Seedat, 23 April 2026, Page 35, Line 23 – 25 and Page 36, Line 1 – 11, INQT0000062

²¹⁴ Dr Faizal Seedat, 23 April 2026, Page 32, Line 16 – 20, INQT0000062

²¹⁵ Dr Faizal Seedat, 23 April 2026, Page 34, Line 17 – 20, INQT0000062

these been known, might have led to more assertive measures being considered for his treatment, prior to the events of 3 September 2021.

Understanding and assessment of risk following discharge

136. VC was discharged as planned on 31 July 2020, with initial post discharge care being provided by the Crisis Team.
137. The Trust notes the questions raised about this by the CQC in their section 48 review and why, despite him already being within the EIP's caseload, the Crisis Team assumed responsibility.²¹⁶ The clinical rationale appears to have been that the very intensive care he was felt to require following discharge was best able to be provided by the Crisis Team.
138. In any event, although there was good involvement by both Crisis and EIP in planning for VC's discharge, Clive Chimbi accepted in oral evidence that no summary care plan was prepared by the Crisis Team in relation to VC, as should have been the case.²¹⁷ Mr Chimbi also accepted that from the very first post-discharge interactions with VC, there was evidence that VC was resistant to taking his medication, and that in light of this, it may have been premature to reduce his RAG rating from red to green.²¹⁸
139. Related to risk formulation was a lack of documented clarity around VC's diagnosis. Ms Birtles accepted that the summary care plan dated 1 September 2020²¹⁹ did not refer to paranoid schizophrenia as the working diagnosis. She was unable to say why it did not and agreed that there was no record of her discussing this likely diagnosis with either VC or his mother.²²⁰
140. Dr Burri and Dr Lloyd, who were the psychiatrists caring for VC during this period, both gave evidence as to their understanding of his diagnosis and risk. Dr Burri was a Specialty Trainee (an ST6, working towards qualifying as a consultant),²²¹ supervised by Dr Lloyd. In oral evidence, Dr Burri confirmed he did not disagree with the diagnosis of schizophrenia but explained that when he saw VC for the first time on 7 September he

²¹⁶ WITN0155033_0037

²¹⁷ Mr Clive Chimbi, 5 May 2026, Page 20, Line 13 – 25 & Page 21, Line 1 – 9, INQT0000072

²¹⁸ Mr Clive Chimbi, 5 May 2026, Page 32, Line 7 – 19, INQT0000072

²¹⁹ NHFT0000202

²²⁰ Claudia Birtles, 29 April 2026, Page 68, Line 8, INQT0000067

²²¹ Dr Burri, 28 April 2026, page 4, lines 10-18, INQT0000066

added a question mark next to this diagnosis to indicate that this was still being fully explored and understood.²²²

141. Dr Lloyd confirmed in oral evidence that, regardless of the precise diagnosis (schizophrenia/two consecutive episodes of psychosis/psychotic disorder), the treatment would have been the same in terms of antipsychotic medication in conjunction with psychological therapies.²²³ She went on, however, to caveat the extent of her involvement in VC's care, stating that she *"wasn't directly involved in VC's care at this time...Dr Burri was the doctor that was working with him directly, and so my involvement was more indirect in terms of supervising him and providing expertise to the MDT"*.²²⁴ She was unable, therefore, to comment on why risk assessment management plans or relapse prevention plans had not been developed, with input from VC's CCO and the medical team caring for him.²²⁵

Management of disengagement and uncertainty over medicines concordance

Crisis post-discharge care

142. Mr Chimbi's record of the Crisis Team's visit to VC at home on 1 August 2020 at 3.35pm, the day after discharge, records that VC (a) had not taken his medication; and (b) could not find it while staff were there. Risk is recorded on this record as *"Deterioration in mental state of [sic] non compliant with medications"*.²²⁶ VC subsequently rang the team, as requested, to confirm he had now found his medication. The following day's visit records no concerns about concordance.
143. Mr Chimbi's next visit, on 3 August 2020, record further worrying signs regarding VC's engagement and uncertainties as a result as to concordance.²²⁷
144. VC was discussed in an MDT meeting that same day, with Dr Skelton recording *"If Valdo is unhappy with CRHT concordance, it is best for a joint discussion with him and LMHT around recent relapses/potential for lack of insight/risks etc. and achieve some agreement"*.²²⁸ This is consistent with planned handover in due course from Crisis to EIP

²²² Dr Burri, 28 April 2026, pages 47-48, lines 12-25, 1-11, INQT0000066

²²³ Dr Lloyd, 6 May 2026, Page 2, lines 16-24, INQT0000074

²²⁴ Dr Tuhina Lloyd, 6 May 2026, page 5-6, lines 25, 1-8, INQT0000074.

²²⁵ Dr Tuhina Lloyd, 6 May 2026, pages 5-6, lines 21-25, 1-8, INQT0000074

²²⁶ NHFT0000168_0119

²²⁷ NHFT0000168-0122

²²⁸ NHFT0000168_0122

Local Mental Health Team ("LMHT")) and with seeking to involve VC in his care. A red RAG rating was maintained at his next MDT review on 4 August 2020.

145. Crisis visited him at home again on 4 August 2020 and, as at the last home visit, he said that he had already taken his medication. He is recorded as agreeing to "*wait for CRHT staff to arrive before taking medication as of tomorrow*." He is further recorded as stating that "*he will be a lot happier when the crisis team stop coming*".²²⁹
146. At MDT on 5 August 2020, Dr Lomas recorded that the red RAG rating is to be retained "*for concordance*". That same day, VC is reported by Ms Barber as having taking his medication in front of her.²³⁰
147. A more positive assessment was made by Mr Chimbi on 6 August 2020 following a joint Crisis/LMHT visit and following this, VC's RAG rating was reduced to green. He was not assessed as meeting the Crisis admission criteria or being admission vulnerable and handover was confirmed from Crisis to LMHT, with this formally taking place on 15 August 2020.²³¹ Apparent concordance seems reflected by VC requesting a further supply of medication, which was delivered in a home visit by Ms Birtles on 14 August.²³² Mr Chimbi's discharge record notes a risk of relapse if he becomes non-compliant.²³³

Handover to LMHT

148. LMHT's first solo visit was carried out by Ms Parsonage in Ms Birtles' absence on 21 August 2020. Ms Parsonage reports VC was difficult to engage and assess in light of "*monosyllabic answers*". Ms Birtles reports a more positive interaction on 27 August, with his usual tendency to be "*fairly introverted*" noted.
149. A relatively stable pattern of contact, including Dr Burri's first outpatient appointment with VC, continues through August and into September.

October 2020-May 2021

150. In the period from early October 2020 however, VC's family begin to report concerns about him stopping contact with them. This prompted an increasingly assertive approach to VC's care and treatment, with regular visits to VC; telephone and text message

²²⁹ NHFT0000168_0123

²³⁰ NHFT0000168_0124

²³¹ NHFT0000168_0130

²³² NHFT0000168_128-129

²³³ NHFT0000168_125-126

contact and medical review, following which VC's medication was reviewed and increased:

- a. An attempted home-visit by Ms Parsonage and a colleague on 9 October 2020. Ms Parsonage's record reflects an awareness of the potential risk VC presented when unwell and she visited with a colleague for this reason. VC was not home but they were assured by a flatmate reporting he seemed okay.²³⁴
- b. A home visit on 26 October 2020 by Mr Carter, the record for which is short and reflects a seemingly perfunctory conversation in which VC simply stated he will call his parents.²³⁵
- c. A phone call from VC direct to Dr Seedat on 5 November, during which Dr Seedat attempted to direct VC in the right direction by emphasising that LMHT were now responsible for his care.²³⁶
- d. Mr Carter and Ms Parsonage visited VC on 6 November 2020, following Dr Seedat requesting they do so. VC's concordance was questionable on the basis of Mr Carter's entry, where he noted a resupply of medication was taken as "*due (overdue indeed)*" but VC reported he had "*about 10 left*". Despite this, Mr Carter concluded his entry stating "*No issues or concern at this time...*".²³⁷
- e. Mr Carter did arrange an outpatient appointment with Dr Burri and Ms Birtles, in light of the concordance concerns identified and that was scheduled for Thursday 12th November 2020.²³⁸
- f. Before that could take place, VC texted Ms Birtles on 10 November 2020 requesting an urgent appointment. He was unwilling, when she called him, to say anything about why he wanted it, other than that he "*had something very important to discuss*". Ms Birtles and Dr Burri managed to arrange for Dr Burri to see him that day.²³⁹

²³⁴ NHFT0000168_0135

²³⁵ NHFT0000168_0135

²³⁶ NHFT0000168_0136

²³⁷ NHFT0000168_0136

²³⁸ NHFT0000168_0136

²³⁹ NHFT0000168_0137

- g. In that visit, VC told Dr Burri a number of important things:²⁴⁰
- i. He had not told Dr Seedat the truth prior to discharge from inpatient care on 31 July and had in fact still been hearing voices. He said he was "*tired for [sic] being in the hospital*".
 - ii. The hallucinations he was experiencing were auditory and visual and involved themes of punishment; commands to VC to 'prove his power' and monitoring of VC (with MI6 and the Police mentioned).
 - iii. He denied having stopped medication, although admitted he had missed a "*couple of odd days when he forgot*". He agreed to an increased dose of Aripiprazole (15 mgs) and short-term prescription of benzo diazepam.
 - iv. He had suspended his university studies.
 - v. He had no thoughts of harm to himself or others.
 - vi. He had a willingness to trust and work with Ms Birtles.
- h. Dr Burri documented the plan following this visit as including close monitoring in the community by his CCO, with potential involvement of the Crisis Team if "*risks escalate or compliance an issue*". He scheduled a further appoint for 6 weeks time.²⁴¹ There is no record of him seeking consultant psychiatric input into the plan.
151. Ms Birtles delivered the increased medication that day and followed-up by telephone on 12 November 2020. Short-course medication supplies of around 7-days enabled frequent visits to/from VC and he attended the Stonebridge Centre on 17 November 2020 as planned, to collect another batch of medication. Ms Birtles explored with him the possibility of Cognitive Behavioural Therapy for psychosis ("CBTp") and he confirms he would consider this. She also provided information about psychosis.²⁴²
152. He did not attend his next planned appointment on 24 November 2020 but Ms Birtles visits him at home that day to provide a further 7-days of medication. She raised with him his apparent lack of contact with his mother and he reported ongoing hallucinations. He made Ms Birtles aware that he was exploring employment possibilities.²⁴³
153. This pattern of engagement continued into early 2021, with VC reporting to Ms Birtles in late December 2020 that his symptoms continued largely unchanged despite the

²⁴⁰ NHFT0000168_0138

²⁴¹ NHFT0000168_0138

²⁴² NHFT0000168_0139

²⁴³ NHFT0000168_0139

increase in Aripiprazole. Ms Birtles tested concordance at this December home visit, with VC taking medication "with water" in her presence. He had what appeared to be a small (four tablets) surplus remaining and Ms Birtles records that she "Reiterated the importance of concordance". By this point he was working night shifts and his apparent ability to maintain employment and every-day functionality was felt to provide assurance as to his mental state.²⁴⁴

154. On 1 February 2021 Dr Burri saw VC for a further planned outpatient appointment and prescribed a further increase in his medication, from 15mg to 20mg. The clinical rationale for this is not explicit in Dr Burri's record of this appointment; no "*acute risk of self harm, suicide or harm to others*" was noted, but Dr Burri concluded that "*There is scope for increase of dose of Aripiprazole*" and VC consented to this. VC did raise concerns about his memory and difficulties he was experiencing with short term memory. Dr Burri arranged for him to have a formal memory assessment at his next appointment. VC's long-standing refusal to engage with psychological interventions offered was maintained, with Dr Burri noting "*He is not keen for Psychotherapy*".²⁴⁵
155. Two attempted phone contacts in March by members of the EIP team were unsuccessful²⁴⁶ but in the same time period VC did attend a further outpatient appointment with Dr Burri, at which his memory test results are discussed, as well as routine²⁴⁷ blood results, with some physical health follow-up identified as required as a result.
156. VC then appeared to be in a relatively stable pattern up until 29 May 2021, when concerns were raised with the Crisis Team by his mother. In that phone call, VC's mother reported that VC has disclosed to his brother that he had not been taking his medication for 2-3 weeks and her telephone conversations with him did not make sense; she felt he was deteriorating. Mrs Lopez's record of her telephone discussion with VC's mother clearly records her concerns about the potential implications if VC is unwell and non-concordant: "*Last time when he became unwell, he was hearing voices telling him his family is in danger and he was having thoughts to attack his neighbour and went to neighbours house with intent. This is Mum's main concern, he will be suspicious of there [sic] and act on his paranoia*".²⁴⁸

²⁴⁴ NHFT0000168_0143

²⁴⁵ NHFT0000168_0146

²⁴⁶ NHFT0000168_0147

²⁴⁷ NHFT0000168_0148

²⁴⁸ NHFT0000168_0154

157. Although the Crisis Team did carry out a home visit, they did not identify any immediate risks, concluding "*No obvious signs of deteriorating and also I have not nursed Valdo before to note if he is masking his symptoms*". It was left for LMHT to follow-up with him. VC's brother's apparent agreement to this plan is recorded in the records.²⁴⁹

June-September 2021

158. Ms Birtles was on leave so Ms Parsonage and Ms Pinder visited VC at home on 2 June 2021. He was assessed as being well and not as having relapsed. He appeared unsure as to what his mother's concerns were and "stated he wanted to tell her not to ring the crisis team". No change to his care plan was assessed as being needed.²⁵⁰

159. VC's mother informed Ms Birtles that she felt assured both by the visits from the Crisis Team and by her more recent conversations with VC; she felt he was "okay".²⁵¹

160. By late June, there was further suggestion of disengagement, with VC not attending planned appointments (on 28 June), not answering his phone (2 July) and appearing "*surprised*" when Ms Birtles visited him on 8 July 2021.²⁵² Mr Carter found him "*irritated*" by his arrival on 6 August 2021, "*eager to close our interaction down*".²⁵³ He did not attend his outpatient appointment with Dr Lloyd on 9 August 2021 and Dr Lloyd recorded Ms Birtles' concerns that "*he might be relapsing*".²⁵⁴ A medical home visit was booked for 10 August 2021. The day before this took place, Ms Birtles rang VC and found him "fairly abrupt" and she concluded that "*Although there were no obvious signs of relapse during the telephone call I would say that Valdo's responses were a little more abrupt/stilted than previously*".²⁵⁵

161. Dr Sasidharan saw him as planned at home on 10 August 2021, but concluded that his mental health was stable and no change in medication was advised. This appeared to be a more positive assessment than the views formed by those who knew him well.²⁵⁶

²⁴⁹ NHFT0000168_0153

²⁵⁰ NHFT000168_154

²⁵¹ NHFT0000168_0154

²⁵² NHFT0000168_155; NHFT0000168_0156

²⁵³ NHFT0000168_0157

²⁵⁴ NHFT0000168_0157

²⁵⁵ NHFT0000168_0158

²⁵⁶ NHFT0000168_0159

162. Six days later, on 16 August 2021, VC visited Rowan, wanting to speak with Dr Seedat. Ms Amanda Frost's record of his visit stated that he wanted to know whether staff heard voices on the ward *"and whether they communicate with Artificial Intelligence...Valdo went on to say that the police had information about services"*.²⁵⁷
163. Ms Parsonage telephoned VC that same day and he confirmed he was willing to share his concerns with her "in person". She visited him on 19 August 2021 with Ms Pinder and found him *"guarded...more unkempt...Less friendly and warm than he usually is"*. The impression she formed was that he was *"Likely relapsing"* and that although *"No risks noted today"* he had been *"difficult to assess due to guarded presentation"*.²⁵⁸ No further contact was managed (despite attempts by text, phone and a home visit being booked) until Ms Birtles returned on 31 August.²⁵⁹
164. Ms Birtles' and Mr Carter visited VC on 31 August 2021. Ms Birtle's documented assessment is clear. She concluded he was *"currently relapsing"*, that he appeared *"paranoid/suspicious and...not trusting of services"* with *"Complex delusion beliefs"* and *"No insight"*. He refused to engage and would not accept any further visits. There was a clear sense of concern for Ms Birtles and Mr Carter's safety underpinning her note and the visit was brought to an end, with VC showing them out of the flat and *"abruptly"* closing the door behind them. Ms Birtles recorded that she discussed VC with Dr Lloyd. She recorded that he *"May require MHA due to lack of insight, refusal to engage and a risk of further decline in mental state."*
165. That same day, VC was placed on the bed list *"awaiting a MHAa"*.²⁶⁰ On 1 September 2021 VC was still waiting MHA assessment. Mr Carter describes his case as not *"an absolute emergency"*. He documents that he plans to discuss VC in MDT with Dr Lloyd and the following day, 2 September 2021, Dr Lloyd documented that a MHA assessment had been arranged for that day at home. She attended with the duty AMHP (Jen Shaw) and Dr Jan (second doctor). VC did not answer his door or mobile. Further attempts are made later that day and in the evening. Dr Lomas, Dr Manzar and Jen Shaw conclude following the third failed attempt, discussion with his mother, and visual (external) inspection of the flat that he *"may have left the property in anticipation of being assessed"*.²⁶¹

²⁵⁷ NHFT0000168_0160

²⁵⁸ NHFT0000168_0161

²⁵⁹ NHFT0000168_0162

²⁶⁰ NHFT0000168_0163

²⁶¹ NHFT0000168_0164

166. A warrant under section 135 was sought and execution attempted on 3 September 2021. The events of that evening ended VC's second period of community care.

Engagement with VC's family and response to concerns shared

167. Contact with VC's family during this period was less frequent than while he was an inpatient but the records reflect ongoing and ready communication between VC's mother in particular and those involved in VC's care, particularly Ms Birtles.

168. When concerns are raised, these were taken seriously and promptly responded to:

- a. In May 2021, the Crisis Team visited VC at home the same day that VC's mother rang with concerns. An update was provided to Elias Calocane as to the plan for VC's care and the assessment reached regarding his mental state.²⁶²
- b. In mid-June 2021, Ms Birtles proactively reached out to VC's mother on her return from leave and on becoming aware of the concerns raised in her absence.²⁶³

169. Ms Birtles recognised the value of VC's mother's views, recording on 9 August 2021 her plan to seek them after her "stilted" telephone call to VC.²⁶⁴ VC's mother was also actively involved in the events in the period between 31 August and 3 September 2021, speaking with VC and relaying her impression to Ms Birtles when she rang on 3 September 2021 during a break at work²⁶⁵.

Multi-agency working

170. Effective multi-agency working was demonstrated through the interactions between Liaison & Diversion, Police Officer Gail Collins, Dr Burri and Ms Birtles in the period from 22 March 2021-15 April 2021 and then again in the period 29 July-30 July 2021 on the issue of VC potentially paying compensation for the damage caused to his neighbour's door and a potential conditional caution.²⁶⁶ These interactions demonstrate a willingness and confidence by the Police in sharing information, in seeking involvement from those providing mental health treatment to VC, in communicating options to VC and supporting him through the criminal justice process.

²⁶² NHFT0000168_0153

²⁶³ NHFT0000168_0154

²⁶⁴ NHFT0000168_0158

²⁶⁵ NHFT0000168_0164

²⁶⁶ NHFT0000168_015; NHFT0000168_0156; NHFT0000168_0157

171. However, as has become clear through the course of the Inquiry, this was in fact only a partial picture of the Police's involvement and knowledge of VC. Key information not shared by the Police with the Trust during this period is summarised in Part A of these Closing Submissions.

Episode 8: 2 September-24 October 2021: Third admission

172. The issues that arise in connection with this event include:

- a. The fourth MHA assessment, and the initial decision to detain under section 2 and subsequent conversion to section 3 following the fifth MHA assessment.
- b. Out of area placements, including oversight, information sharing and access, and discharge planning.

173. Additional aspects arising in connection with these key issues are:

- a. Inter-agency working.
- b. Involvement of VC's family.

Fourth MHA assessment

174. On 2 September 2021, Jen Shaw (AMHP), Dr Lloyd, Dr Jan and Rachael Masterson attended VC's residence to carry out an MHA Assessment. There was no answer and VC did not answer his phone. Telephone calls were made to VC's mother, sister and brother, who did not know his whereabouts but raised concerns about his mental health.²⁶⁷

175. A second attempt to carry out an MHA Assessment was made later that day by Dr Lomas, Dr Manzar and Jen Shaw (AMHP), which was also unsuccessful. It was decided to obtain a section 135 warrant, which was granted the following day.²⁶⁸

²⁶⁷ NHFT0000168_0164

²⁶⁸ NHFT0000168_0164

176. On 3 September 2021, Dr Lomas, Dr Manzar and Amie Staples (AMHP) attended VC's residence. They were congregating around the corner from his flat when they were approached by VC. At this time, VC was polite and calm, and invited them into his property. However, when they were in the hall, he stopped and asked them to leave and come back when the police were here. The Inquiry has seen bodycam video footage from the police which records the events that followed, including VC assaulting PC Pritchard.²⁶⁹
177. Dr Lomas was subsequently asked by the police in December to provide a witness statement in relation to this incident,²⁷⁰ which he did on 27 January 2022. Mr Lomas understanding was that he was giving a statement as a witness to a crime, not as a professional witness or an expert witness, and it would therefore not have been appropriate to make judgements about VC's capacity or fitness to plead or any of the aspects of the legal process.²⁷¹ He was not contacted again by the police in relation to this statement or any further evidence they required regarding VC's medical history or mental state at the time of the incident.
178. VC was initially taken to A&E given he had been tasered. He was then transported to Cassidy Suite, with the police indicating that they may lay charges at a later date.²⁷² Louise Symcox (who attended with the police as part of the Liaison & Diversion team) added an alert to VC's RiO record under Violence and Aggression, indicating that a serious assault had occurred.²⁷³
179. An MHA assessment was undertaken by Dr Lomas, Dr Manzar and Amie Staples at the Cassidy Suite on 3 September 2021.²⁷⁴ As VC was unwilling to answer direct questions, Dr Lomas and Dr Manzar could not elicit the detailed psychopathology that would clearly demonstrate to them the full extent of the nature and degree of his illness. As the essential elements of a treatment plan for VC were not clear beyond the immediate management of his violence and aggression, it was considered appropriate to detain VC under section 2 of the MHA. Whilst section 3 was discussed, this was considered to go against the least restrictive principle in the absence of any specific treatment plan.²⁷⁵ Dr

²⁶⁹ NHFT0000168_0165

²⁷⁰ NGPF0000030

²⁷¹ Dr Benjamin Lomas, 28 April 2026, page 69, lines 10-15, INQT0000065

²⁷² NHFT0000168_0165

²⁷³ NHFT0000168_0165

²⁷⁴ NHFT0000168_0167, NHFT0000168_0168

²⁷⁵ WITN0316001_0040

Lomas remains of the view that the correct decision was reached.²⁷⁶ Dr Manzar believes the correct decision was made at the time, although in light of the tragic events that followed a section 3 admission may have been appropriate at this time.²⁷⁷ This was undoubtedly a finely balanced clinical decision, but in any event VC was converted to a section 3 detention 3 weeks later the decision had no material impact on his treatment.

180. VC's risk and safety assessment and summary care plan were updated by Busayo Ajewole on 4 September 2021.²⁷⁸ Ms Ajewole accepted in her evidence to the Inquiry that these entries were wrong and contained "significant" errors, which were later incorporated into the letter sent to VC's GP on 9 September 2021.²⁷⁹ Ms Ajewole has subsequently made changes to her practice in relation to record keeping.²⁸⁰

Out of area bed management and placement at Cygnet

181. Dave Waldron has explained in his evidence to the Inquiry that a patient will be considered for out of area treatment if there is not a local adult mental health bed for them to be admitted into, or if the available bed is not suitable (for example, if the patient requires a psychiatric intensive care unit ("PICU") bed, and only a lower-level bed is available). Admission out of area or to an independent provider is always considered to be a last resort, unless there are good clinical reasons for the placement (such as safeguarding).²⁸¹
182. Subcontracted bed providers had read only access to the Rio patient records²⁸² and were covered at the time by the Trust's policy "Continuity of Care Principles Standard Operating Procedure".²⁸³ This policy was designed to provide quality oversight. The provider was expected to provide regular updates to the Patient's care coordinator at the Trust and/or the Trust's Bed Manager, one of which would then update Rio and upload any relevant paperwork²⁸⁴.
183. The position was different for Spot purchased beds, which did not have access to RiO. These providers were covered by the Trust policy "Admitting Patients to Spot Purchased

²⁷⁶ WITN0316001_0040

²⁷⁷ WITN0350001_0045

²⁷⁸ NHFT0000168_0174

²⁷⁹ Busayo Ajewole, 27 April 2026, Page 68, lines 19-25; Page 69, lines 1-25; Page 70, Lines 1-25, Page 71, lines 1-21, INQT0000063

²⁸⁰ Busayo Ajewole, 27 April 2026, page 81, lines 3-7, INQT0000063

²⁸¹ Dave Waldron, 2 February 2026, paragraphs 11-12, pages 3-4, WITN0389001

²⁸² Dave Waldron, 2 February 2026, paragraph 18, pages 5-6, WITN0389001

²⁸³ NHFT0000425

²⁸⁴ Dave Waldron, 2 February 2026, Paragraph 18, pages 5-6, WITN0389001

Beds".²⁸⁵ This policy included expectations for the Bed Management team to share the relevant information with the provider of the spot purchased bed to support safe and best transitions upon admission and discharge, as well as effective information sharing.

184. Dr Lomas was firmly of the view that a PICU bed was required for VC because of the additional security this would provide for staff compared to a general psychiatric ward.²⁸⁶ Between the 4 and 11 September 2021, the Trust's Out of Area Bed Coordinator made repeated attempts to locate a PICU bed for VC, as the Trust had no available beds. During this time, there were no available PICU beds outside the area that could meet VC's needs²⁸⁷.
185. On 11 September 2021, VC was admitted to Cygnet Victoria House. Mr Waldron accepted in his oral evidence that the referral form he completed did not contain sufficient information re previous incidents of violence etc. and that erroneous information was carried through to discharge by Priory.²⁸⁸
186. Claudia Birtles updated VC's mother on 7 September 2021²⁸⁹ and then again on 13 September 2021.²⁹⁰
187. On 17 September 2021, Claudia Birtles completed a social circumstances report for VC in advance of the upcoming Tribunal hearing on 23 September 2021. Ms Birtles recorded in this report that he had "*no prior history of violence and aggression towards others*".²⁹¹ Whilst she did also include in this report details about the assault on 3 September 2021, she accepted in her witness statement to the Inquiry that this was an error and should have documented differently.²⁹² Ms Birtles also attended a remote ward discussion about VC with the Cygnet on 21 September 2021 to discuss his care²⁹³.

²⁸⁵ WITN0389002

²⁸⁶ Dr Benjamin Lomas, 2 December 2025, Paragraph 90 – 92, Page 42 – 44, WITN0316001

²⁸⁷ David Waldron, 2 February 2026, Paragraph 35, Page 10, WITN0389001

²⁸⁸ David Waldron, 8 May 2026, Page 13, Line 15 – 25, Page 14, Line 1 – 25, Page 15, Line 1 – 25, Page 16, Line 1 – 25 & Page 17, Line 1 – 14, INQT0000078

²⁸⁹ NHFT0000168_0181

²⁹⁰ NHFT0000168_0190

²⁹¹ Cygnet – Social Circumstances Report for Tribunal by Claudia Birtles dated 17 September 2021, Page 0005, NHFT0000275

²⁹² Claudia Birtles, 29 January 2026, Paragraph 351, Page 116, WITN0348001

²⁹³ NHFT0000168_0191

188. On 23 September 2021, the Tribunal decided that VC's detention should continue.²⁹⁴ Claudia Birtles updated VC's mother later that day.²⁹⁵

189. On 24 September 2021, VC had a fifth MHA assessment and was detained by Cygnet under section 3 of the MHA. The Trust was informed by Cygnet that it had assessed VC as being ready to be "stepped-down" to a regular acute bed. The Trust arranged for him to be admitted to Bestwood Ward at Priory Arnold Nottingham, and he was transferred there on 1 October 2021 and detained under section 3 of the MHA.

190. The Trust was fully aware that the Priory Arnold Nottingham was under special measures.²⁹⁶ These are arrangements that the CQC considers are sufficient to allow care to be provided safely. The transfer of VC was consistent with these measures and the Trust was satisfied that the Priory Arnold Nottingham would provide him appropriate care.²⁹⁷ The Trust also had in place appropriate clinical and contractual oversight measures.²⁹⁸

Treatment by the Priory

191. VC was discussed at the Weekly Bed Management meeting with the Priory Group on a number of occasions²⁹⁹, and the Priory Group Bed Huddle on the 20 October 2021³⁰⁰.

192. On 14 October 2021, Claudia Birtles was informed that the Priory were planning to discharge VC.³⁰¹ No further updates were provided to the Trust until it was informed on 22 October 2021 that VC had been discharged.³⁰² It has subsequently become apparent that VC's section was rescinded on 18 October 2021 and that the final part of his stay at the Priory was therefore as an informal patient.³⁰³

193. The Trust's Out of Area Bed Manager updated VC's RiO record on 3 November 2021 with the discharge summary received from the Priory Arnold³⁰⁴. The CQC found in its section 48 report that there were differences between the Trust's RiO records and the

²⁹⁴ NHFT0000168_0191

²⁹⁵ NHFT0000168_0191-0192

²⁹⁶ Julie Attfield, 20 May 2026, Page 41, Line 12 – 25, Page 68, Line 4 – 13, INQT0000092

²⁹⁷ Julie Attfield, 20 May 2026, Page 69, Line 2 – 24, INQT0000092

²⁹⁸ Diane Hull, 5 December 2025, Paragraph 394 – 410, Page 135 – 139, WITN0133001

²⁹⁹ WITN0389017_0005-0006; WITN0389018; WITN0389019

³⁰⁰ WITN0389022_0005

³⁰¹ NHFT0000168_0192-0193

³⁰² NHFT0000168_0193-0194

³⁰³ CHCA0000014_0003

³⁰⁴ NHFT0000168_0195-197

Priory in relation to the discharge³⁰⁵. Mr Waldron accepted in his oral evidence that he could have sought further details from the Priory about the discharge, and why VC brought a hammer back to the hospital on his return from section 17 leave.³⁰⁶

Episode 9: 24 October 2021-17 January 2022: third period of community care

194. The issues that arise in connection with this event include:

- a. Medication concordance.
- b. Record keeping/ Updating of RiO.
- c. The involvement of VC's family.

195. Following VC's third discharge, Claudia Birtles planned to see and speak with him weekly. This was intended to monitor medication concordance more frequently than had occurred previously given her concerns about his engagement. Whilst Ms Birtles accepted that this plan should have been expressly documented in VC's care plan,³⁰⁷ the evidence shows that she adhered to the plan and escalated matters to EIP Consultant (Dr LLoyd) when she became concerned about VC's non-engagement and lack of insight.

196. Ms Birtles spoke with VC on 25 October 2021. VC did not answer his phone when Ms Birtles called on 29 October. He also failed to attend a face-to-face visit on 1 November.³⁰⁸ VC then sent a text to Ms Birtles on 4 November 2021 after another missed call to say he had "*plenty of tablets left*". Ms Birtles was consequently concerned about non-compliance and relapse so she booked a further outpatient appointment for him.³⁰⁹

197. VC attended the appointment at the Stonebridge Centre on 5 November 2021. Ms Birtles was left with the impression that their relationship had broken down and that VC was not demonstrating any insight into his condition. Further, although he was not demonstrating

³⁰⁵ NHFT0000568_0037

³⁰⁶ David Waldron, 8 May 2026, Page 41, Line 5 – 21, INQT0000078

³⁰⁷ Claudia Birtles, 29 January 2026, Paragraph 369, Page 121 – 122, WITN0348001

³⁰⁸ NHFT0000168_0195

³⁰⁹ NHFT0000168_0197

any symptoms, she was concerned that he was only taking 10mg rather than the 20mg he had been prescribed.³¹⁰

198. VC contacted on 12 November 2021 to collect his medication but he failed to attend that day. He missed another appointment on 15 November 2021.³¹¹
199. VC next attended the Stonebridge Centre on 19 November 2021 to collect his medication. He remained very guarded and would not engage in conversation, making it difficult for Ms Birtles to assess his level of risk. However, he did indicate to her that he would start taking the higher dose of medication that had been prescribed. Ms Birtles remained concerned about the risk of relapse and therefore booked an outpatient appointment with Dr Lloyd for 6 December 2021.³¹² He failed to attend this appointment and his case was discussed at the next weekly EIP MDT meeting on 9 December 2021.³¹³
200. During this period, Ms Birtles maintained appropriate contact with VC's mother,³¹⁴ including discussions by telephone with her on 1 November, 29 November and 14 December 2021.³¹⁵ However, when Ms Birtles spoke with VC on 16 December he became confrontational and angry after Ms Birtles indicated that she had contacted his mother. VC told Ms Birtles that she was not to speak with her again.³¹⁶ Ms Birtles discussed this exchange with her line manager and was told to respect his confidentiality on this occasion. Ms Birtles was aware that this confidentiality could be overridden in appropriate circumstances.³¹⁷
201. VC attended the Stonebridge Centre the following day on 17 December 2021 to collect his medication.³¹⁸

³¹⁰ NHFT0000168_0198; Claudia Birtles, 29 January 2026, Paragraph 373 – 377, Page 123 – 125, WITN0348001

³¹¹ NHFT0000168_0198

³¹² NHFT0000168_0199

³¹³ NHFT0000168_0199

³¹⁴ Claudia Birtles, 29 January 2026, Paragraph 369, Page 121 – 122, WITN0348001

³¹⁵ NHFT0000168_0195; NHFT0000168_0199-0200

³¹⁶ NHFT0000168_200-201

³¹⁷ Claudia Birtles, 29 January 2026, paragraph 390, WITN0348001_0128-0129

³¹⁸ NHFT0000168_201-202

202. Ms Birtles attempted to contact VC on 31 December 2021 on her return from annual leave, but he did not answer.³¹⁹ His case was also discussed at the weekly EIP MDT meeting.³²⁰
203. VC did not answer his phone when Ms Birtles called on 6 and 7 January 2022.³²¹
204. Ms Birtles arranged another outpatient appointment with a clinician for 10 January but again VC failed to attend. After Ms Birtles sent him a follow-up text message he simply replied on 11 January: "Got exams".³²²
205. On 15 January 2022 the incident took place at VC's student accommodation, which resulted in the police attending. The seriousness of this incident was not fully understood at the time by Trust clinicians. This was because no action was taken by the police and VC was allowed to remain in the property³²³ and video footage of the incident was not shared with the Trust.³²⁴
206. VC missed a fifth outpatient appointment with Dr Lloyd on 17 January. Dr Lloyd recorded in RiO her view that she was considering discharging VC due to his failure to engage:
- "...[VC] has essentially disengaged and we have not been able to monitor him. Perhaps a conversation with his mum and course tutors to see if there are any concerns currently before considering discharge".³²⁵*
207. The Trust's position is that it would have been wrong to have discharged VC at this stage simply because he was not engaging.
208. Ms Birtles tried to call VC on 17 January 2022 but again there was no answer.³²⁶ Ms Birtles planned to discuss his disengagement at the next planned team meeting on 20 January.

³¹⁹ NHFT0000168_202

³²⁰ Claudia Birtles, 29 January 2026, paragraph 399, WITN0348001_0131

³²¹ NHFT0000168_202

³²² NHFT0000168_202-203

³²³ Dr Benjamin Lomas, 2 December 2025, paragraph 113, WITN0316001_0054

³²⁴ Dr Benjamin Lomas, 28 April 2026, Page 90, Lines 18-24, INQT0000065

³²⁵ NHFT000168_203

³²⁶ NHFT0000168_203

209. The following day, the Trust was contacted by Ellie Turner at the University. Ms Turner told the Trust about the incident that had occurred at VC's flat on 15 January.³²⁷ Claudia Birtles updated the Risk & Safety assessment for VC on RiO as a result of this incident.³²⁸

Episode 10: 19-27 January 2022: seventh MHA assessment

210. The issues that arise in connection with this event include:

- a. Whether relevant guidance and protocols were followed in respect of the assessment.
- b. Whether the decision not to admit VC to hospital under the MHA on 19 January 2022 was reasonable.

211. Additional aspects arising in connection with these key issues are:

- a. Interactions with the police, university and VC's flatmates.
- b. Discharge planning and risk assessment.

212. On 18 January 2022, Dr Lomas and Dr Skelton had a detailed discussion about VC's case, given that one of them would likely be attending an imminent MHA assessment regarding him and given the past risks, particularly the extreme violence that took place on 3 September 2021 during the previous MHA assessment. Dr Lomas was keen to share his first-hand knowledge of VC, in case he should not be on duty when the MHA would occur.³²⁹

213. The seventh MHA assessment was undertaken the following day, on 19 January 2022, after a section 135 warrant was obtained. VC was compliant in getting into the ambulance, escorted by police, in contrast to the previous assessment that took place on 3 September 2021.³³⁰ The assessment was conducted at the Cassidy Suite by Dr

³²⁷ NHFT0000168_203

³²⁸ NHFT0000168_203

³²⁹ Dr Michael Skelton, 23 November 2025, paragraph 160, WITN0207001_0098

³³⁰ Dr Michael Skelton, 23 November 2025, paragraph 151, WITN0207001_0091

Skelton and Dr Omar Manzar³³¹. VC engaged during this assessment and was cooperative. There was a detailed conversation about VC's previous non-concordance, higher degree of risk and instability. In addition, the incident which led to the assessment and that police attended (but did not arrest him) was considered to be part of the picture showing relapse.³³²

214. However, VC's presentation appeared more stable than was initially anticipated, and his engagement with them was reassuring and did not suggest the same level of risk.³³³ Dr Skelton concluded that VC did not pose any imminent risk to himself or others.³³⁴ VC had also demonstrated more insight than during the previous assessment and he was willing to resume taking his medication.³³⁵ These factors favoured a trial of intensive daily CRHT medication concordance.
215. Consideration was given to the possibility that VC was misleading them, regarding his concordance with medication and willingness to engage with community treatment. As a result, Dr Skelton considered it appropriate to look at admission "if it becomes clear he is not engaging or further risks become apparent."³³⁶
216. On balance, whilst admission was carefully considered as an option, Dr Manzar and Dr Skelton felt that, having regard to the MHA Code of Practice, the criteria for admission were not met and instead a community-based treatment plan, supported by intensive input from the Crisis Team,³³⁷ would be appropriate. This was in the context of VC being in the middle of university examinations at the time and would be consistent with the least restrictive principle under the Mental Health Act.³³⁸
217. In urgent mental health assessment situations, it can be very difficult to obtain collateral information.³³⁹ Dr Manzar³⁴⁰ and Dr Skelton have both accepted in hindsight that more detailed information could have been collected at this time. This was particularly the case in terms of understanding the details of altercation with VC's flatmates.³⁴¹ The Trust

³³¹ NHFT0000070_0007-11

³³² Dr Michael Skelton, 23 November 2025, paragraph 154, WITN0207001_0095

³³³ Dr Mohammad Omar Manzar, 17 December 2025, paragraph 216, WITN0350001_0048

³³⁴ Dr Michael Skelton, 23 November 2025, paragraph 158, WITN0207001_0097

³³⁵ Dr Michael Skelton, 23 November 2025, paragraph 154, WITN0207001_0095

³³⁶ Dr Michael Skelton, 23 November 2025, paragraph 154, WITN0207001_0095

³³⁷ NHFT0000208

³³⁸ Mohammad Omar Manzar, 17 December 2025, paragraph 211-15, WITN0350001_0050-51

³³⁹ Mohammad Omar Manzar, 17 December 2025, paragraph 225, WITN0350001_0053

³⁴⁰ Mohammad Omar Manzar, 17 December 2025, paragraph 228, WITN0350001_0054

³⁴¹ Dr Mike Skelton, 7 May 2026, Pages 13-17, INQT0000075

also considers that too much emphasise may have been placed on VC's autonomy, especially in relation to his desire that any treatment plan not impact his studies.

218. Between 21 and 25 January 2022 VC was seen daily by the Crisis Team. On 27 January 2022, Dr Skelton determined that another MHA assessment was required³⁴². There were several factors contributing to this decision, including non-engagement with Crisis, medication non-concordance, VC being untruthful about his accommodation and the University's concerns about the safety of other students.³⁴³

Episode 11: 28 January- 24 February 2022: fourth admission

219. The issues that arise in connection with this event include:

- a. Why admission was under s2 and not s3 of the MHA.
- b. RiO records, care plans, treatment and risk assessments.
- c. Inter-agency working.
- d. Discharge planning.

Seventh MHA assessment

220. On 28 January 2022 a further section 135 warrant was obtained to gain access to VC at his home. VC was again compliant and travelled willingly to the Cassidy Suite for assessment. The sixth MHA assessment was undertaken that day by Dr Ben Lomas and Dr Omar Manzar³⁴⁴.

221. During the assessment, Dr Lomas did not detect signs of psychosis that could be observed in VC's behaviour or general demeanour as there had been at the previous assessment.³⁴⁵ The lack of clear psychopathology was relevant because of the degree or current manifestation of his disorder. Dr Lomas considered the possibility that VC was still symptomatic and was simply able to deny his experiences and control his responses.

³⁴⁶

³⁴² NHFT0000168_212-213

³⁴³ Dr Michael Skelton, 23 November 2025, paragraph 164, WITN0207001_0100

³⁴⁴ NHFT0000070_0007-11

³⁴⁵ Dr Michael Skelton, 23 November 2025, Paragraph 130, Page 79 – 80, WITN0207001

³⁴⁶ Dr Michael Skelton, 23 November 2025, Paragraph 132, Page 81, WITN0207001

222. Dr Lomas discussed the issue of depot medication with VC but he refused.³⁴⁷ The MHA Code of Practice is clear that people with mental health conditions should be able to express their views and preferences about their care and treatment, including decisions about their medicine.
223. VC was considered to require 24-hour nursing observation and care in a hospital setting because the attempts by Crisis to support and monitor VC in the community were not eliciting sufficient detail or assurance about his mental state or concordance with treatment. Further assessment of his current mental state was required in hospital including the provision of 24-hour oversight that is provided by a patient being in a hospital setting.³⁴⁸
224. VC was also considered to pose a significant risk to others because, in his previous presentation, he had acted on his delusional beliefs. A short-term inpatient detention under section 2 was therefore necessary to mitigate any immediate risks, with further measures to be considered to reduce long-term risks.³⁴⁹
225. Detailed consideration was given to the possibility of an admission under section 3. However, on balance it was felt that further assessment was required given the lack of clear psychopathology currently.³⁵⁰ This would allow the clinical picture to become clearer and, consequently, a more definitive treatment plan could be formed. Given this diagnostic uncertainty at the time, detention under Section 2 was agreed, with the intention that further observation and assessment would allow his mental state to settle and enable him to articulate any psychotic symptoms more clearly, should these be present.
226. A section 2 detention was therefore considered to be in accordance with MHA CoP, ensuring adequate containment of the risks identified in VC's case at that point.

³⁴⁷NHFT0000168_0214-0216

³⁴⁸Dr Benjamin Lomas, 2 December 2025, Paragraph 128, WITN0316001_0061; Dr Mohammad Omar Manzar, 17 December 2025, Paragraph 271, Page 64 & Paragraph 307, Page 72, WITN0350001

³⁴⁹ Benjamin Lomas, 2 December 2025, paragraph 131, WITN0316001_0062

³⁵⁰Dr Benjamin Lomas, 2 December 2025, Paragraph 192, WITN0316001_0061; Dr Mohammad Omar Manzar, 17 December 2025, Paragraph 281, Page 66, Paragraph 284, Page 67 & Paragraph 298, Page 70, WITN0350001

227. The CQC section 48 inspection considered this admission to be a missed opportunity³⁵¹. Dr Manzar's evidence was that, in retrospect, section 3 may have been a more appropriate framework as it would have provided a more robust legal and clinical basis for treatment, particularly given the chronicity of his psychotic illness and the need for sustained intervention³⁵².
228. However, the use of section 2 did not preclude VC being detained under section 3 if necessary, if the outcome of the inpatient assessment was that depot medication, administered against VC's wishes for the foreseeable future, was necessary and proportionate to the nature of his illness.³⁵³

Subsequent consideration of Depot medication/CTO

229. Dr Gibson and Dr Thangavelu discussed the option of a depot with VC during their Ward rounds on 31 January,³⁵⁴ 3 February,³⁵⁵ 10 February³⁵⁶ and 17 February 2022.³⁵⁷ VC expressed his view that he did not want depot medication
230. Whether admission under section 3, which would have enabled the treating team to consider the option of a Community Treatment Order ("CTO"), was appropriate at this stage is an area of clinical judgement where different professionals may reach different conclusions.³⁵⁸
231. The CQC section 48 report found that despite multiple hospital admissions and evidence that VC was still symptomatic on the treatment prescribed, there was no real change to his care and treatment. In addition, due to the challenges of providing consistent treatment for his illness, VC's lack of engagement and poor compliance with medicine, there was evidence to support changing his treatment from oral medicine to a depot injection. The decision not to enforce to depot took too little account of VC's significant risk history when psychotic and placed too much emphasis on his personal assurances

³⁵¹ WITN0155033_0003

³⁵² Dr Mohammad Omar Manzar, 17 December 2025, Paragraph 312, Page 73, WITN0350001 & Dr Mohammad Omar Manzar, 27 April 2026, Page 43, Line 15 – 21, INQT0000064

³⁵³ Dr Benjamin Lomas, 2 December 2025, Paragraph 137, Page 64, WITN0316001; Dr Mohammad Omar Manzar, 17 December 2025, Paragraph 285, Page 67, WITN0350001

³⁵⁴ NHFT0000168_0220

³⁵⁵ NHFT0000168_0224-0225

³⁵⁶ NHFT0000168_0237-0238

³⁵⁷ NHFT0000168_0249-0250

³⁵⁸ NHFT0000451_0018

to them on the ward.³⁵⁹ The Trust's own Level 2 investigation reached a similar conclusion.³⁶⁰

232. Both Claudia Birtles and Dr Lloyd were encouraging the treating clinicians to consider depot medication. Dr Gibson's evidence was that these views, along with all other relevant factors, were carefully considered but that ultimately a different view was reached by him and Dr Thangavelu³⁶¹.
233. Whether admission under section 3 (which would have enabled the treating team to consider the option of a CTO), was appropriate at this stage is an area of clinical judgement where different professionals may reach different conclusions.³⁶²
234. Dr Gibson accepted on reflection that it could have been argued that the nature of VC's condition meant that it was appropriate to convert to Section 3 for the purposes of depot and CTO. Dr Gibson concluded, in oral evidence, that "all the factors were taken into account...the wrong decision was made" as too much weight was given to pursuing the least restrictive option.³⁶³
235. Dr Thangavelu agreed with Dr Gibson that there was a case based on nature for section 3, but remained of the view that a forced injection could not be justified.³⁶⁴ He accepts, however, that it would have been good practice to have documented the fact-specific factors on Section 2, Section 3, CTO and depot medication that he had considered for VC.³⁶⁵
236. The Trust considers that this was particularly important in this instance given VC's clinical history and the need for a longitudinal assessment of risk. Each previous investigation has found that this admission was a missed opportunity. The clinical decision not to convert VC's admission to a section 3 should have not only considered VC's presentation at the time but the nature and degree of VC's mental disorder having regard to his previous response to treatment in hospital and the community, as required by paragraph 14.6 of the MHA COP. Specifically in this case:

³⁵⁹ WITN0155033_0039

³⁶⁰ NHFT0000451_0018

³⁶¹ Dr Jonathan Gibson, 12 May 2026, Page 38, Line 4 – 25 & Page 39, Line 1 – 6, INQT0000082

³⁶² NHFT0000451_0014, paragraph 42

³⁶³ Dr Jonathan Gibson, 12 May 2026, Page 42, Line 17 – 25 & Page 43, Line 1 – 14, INQT0000082 & Dr Jonathan Gibson, 17 November 2025, Paragraph 91 – 92, Page 35, WITN0205001

³⁶⁴ Dr Karthik Thangavelu, 13 May 2026, Page 63, Line 15 – 25, Page 64, Line 1, INQT0000083

³⁶⁵ Dr Karthik Thangavelu, 13 May 2026, Page 84, Line 9 – 18, INQT0000083

- a. this was VC's fourth admission and seventh MHA assessment in less than 2 years;
- b. each admission occurred following a instance of violence and aggression, although the severity of each instance was not fully understood at the time in all cases;
- c. following each admission, concerns arose regarding VC's concordance with his medication during the early stages of each period of community care;
- d. VC had very recently (less than 4 months previously) been detained under sections 2 and 3 for a period of 7 weeks, and the discharge and treatment plan following that third admission had not been successful in light of his fourth admission;
- e. in the months leading up to the fourth admission, Ms Birtles was clearly concerned about VC's increasing disengagement and lack of insight;
- f. it was unclear why treatment in the community this time would lead to any different result.

Assessment of risk

237. A Core Risk assessment was completed and VC's Risk & Safety Assessment was updated on admission.³⁶⁶ However, the Trust accepts that more could have been done during this period to understand and record the nature of VC's risk to others. In particular:

- a. Dr Manzar accepted that he should have elaborated further on the chronic nature of his psychotic symptoms and explicitly linked these to his history of violence and aggression. This would have strengthened the risk formulation and supported a more robust inpatient management and safeguarding plan, clearly outlining the risks arising from his persecutory beliefs in the context of his previous violent incidents.³⁶⁷

³⁶⁶ NHFT0000191

³⁶⁷ Dr Mohammad Omar Manzar, 17 December 2025, Paragraph 295, Page 70, WITN0350001

- b. It was accepted by Stephen Quartey³⁶⁸ that information around complex delusional beliefs should have at least been tracked into VC's risk assessment at the point of admission.
- c. Whilst Ella Harrison made updates to VC's Summary Care Plan during the period of his fourth admission, she accepted that she failed to document his views on medication.³⁶⁹
- d. Dr Gibson did not record fully his conversations with VC's former flatmate (Christopher)³⁷⁰ on 4 February 2022, or his subsequent discussions with Dr Thangavelu about the incident.
- e. Dr Thangavelu accepted he should have contacted the police to learn more about the incident with Christopher.
- f. Although an incident was reported³⁷¹, Dr Thangavelu accepted that when VC breached his section 17 leave conditions on 3 February 2022, this should have informed an updated risk assessment being created in RiO.
- g. Dr Thangavelu accepted that he didn't consider asking to see the medical notes from the Priory or Cygnet.

Inter-agency working

238. The Trust accepts that more should have been done during this period to keep the University updated, particularly in relation to VC's approved section 17 leave and his discharge.³⁷²

Discharge

239. A discharge meeting was held on 24 February 2022 and VC was discharged that day. He confirmed he had appropriate accommodation in place and gave the address "209 Ilkeston Road, Nottingham, NG7 3FW". He was also given 14 days of medication.³⁷³

³⁶⁸Mr Stephen Quartey, 12 May 2026, Page 18, Line 1 – 7, INQT0000081

³⁶⁹Ms Ella Harrison, 12 May 2026, Page 56, Line 19 – 25 and Page 57, Line 1 – 13, INQT0000081

³⁷⁰Dr Jonathan Gibson, 12 May 2026, Page 27, Line 12 – 18 & Page 65, Line 9 – 15, INQT0000082

³⁷¹NHFT0007527

³⁷²Dr Karthik Thangavelu, 12 May 2026, Page 105, Line 12 – 25, Page 106, Line 1 – 5, Page 112, Line 13 – 25, Page 113, Line 1 – 18, INQT0000083

³⁷³NHFT0000168_0258

The Trust accepts that there was more to do to be satisfied that this address was somewhere where VC did have a valid tenancy³⁷⁴ and there was no risk to him or others.

240. The Trust also accepts the finding by the Theemis Review that more could have been done generally to ensure shared decision making across all teams involved in VC's care³⁷⁵. This could have included Dr Seedat providing more support to Dr Gibson, given VC's complexity, prior to VC's discharge on 24 February 2022.

Forensic services

241. As Dr Taylor explained in his evidence, where a referral is made to the Forensic Services there are options for forensic clinicians to become involved in a patient's care even if the case is not fully transferred (i.e. through Level 1-3 support). Forensic Services may therefore become involved in an EIP patient's care in an advisory or joint working capacity, even where they have not fully taken over the care of the patient.³⁷⁶ Given VC's complex history, the Trust agrees that this was a missed opportunity.

Episode 12: 25 February-23 September 2022: community treatment and final discharge

242. The issues that arise in connection with this event include:

- a. Operation of City South EIP team
- b. Risk management, care planning and record keeping
- c. Response to poor engagement
- d. Policies and procedures governing disengagement
- e. Discharge decision-making, including compliance with policies and record-keeping

243. Additional aspects arising in connection with these key issues are:

³⁷⁴ Ms Ella Harrison, 12 May 2026, Page 71, Line 24 – 25, Page 72, Line 1 – 4, INQT0000081

³⁷⁵ NHNB0018966_0157

³⁷⁶ Mark Taylor, 10 February 2026, paragraph 112, WITN0388001_0036

- a. Inter-agency working
 - b. Involvement of VC's family
244. Following VC's discharge from hospital, the EIP team should have reviewed and revised VC's written care plan and risk assessment, including consideration of how future non-concordance with medication, disengagement from services and deteriorating mental health should be addressed.³⁷⁷ This was required by the EIP team's Service Operational Policy.³⁷⁸
245. VC was seen by his then Care Coordinator, Claudia Birtles, the day after he was discharged. Ms Birtles was concerned about his insight and willingness to engage moving forwards at this stage,³⁷⁹ although VC subsequently attended appointments with Ms Birtles on 1 March and 29 April 2022. He was also seen by Dr Lloyd on 14 March and 22 April 2022.
246. On 28 April 2022, VC's case was discussed in the EIP team's weekly MDT meeting. It was decided to transfer to another care coordinator (Gary Carter) when Ms Birtles went on maternity leave. Ms Birtles updated the risk assessment for VC following this meeting and discussed the case with the University. An alert was also added to ensure that no home visits occurred without two healthcare professionals being present³⁸⁰. The Trust accepts that this information should have been shared with the university³⁸¹.
247. Although it was recorded that it would be preferable for two care coordinators to be assigned to VC,³⁸² Ms Birtles evidence was that this related to two persons attending home visits rather than two care coordinators being assigned to VC generally.³⁸³
248. The evidence from Mr Carter's supervisors was that his patient caseload was not particularly high at the time he became VC's care coordinator - his average daily caseload during the period June 2020-September 2023 was 18.7 patients, and 19.7 for

³⁷⁷ NHFT0000451_0025

³⁷⁸ CQCM0009938_0016, section 10.1

³⁷⁹ NHFT0000168_0262; Claudia Birtles, 29 January 2026, Page 149, paragraph 452, WITN0348001_0149

³⁸⁰ NHFT0000168_0266

³⁸¹ Claudia Birtles, 29 April 2026, Page 27, INQT0000068

³⁸² NHFT0000168_0266

³⁸³ Claudia Birtles, Claudia Birtles, 29 January 2026, Page 149, paragraph 453, WITN0348001_0149

the period May-September 2022 (the national recommended caseload being 15).³⁸⁴ Emma Robinson also explained that the volume of cases was at least in part due to Mr Carter's reluctance to handover patients to others in the team.³⁸⁵

249. Mr Carter's evidence was that he did not review the entire RiO record for VC when becoming his Care Coordinator.³⁸⁶
250. Mr Carter met VC in person on 13 and 27 May 2022.³⁸⁷ Mr Carter also had a discussion with VC about his medication on 24 June 2022.³⁸⁸
251. VC failed to collect his medication on 10 June³⁸⁹ and missed an outpatient appointment with Dr Lloyd on 13 June 2022,³⁹⁰ but he did attend the Trust to collect his medication on 15 June³⁹¹ and 4 July 2022³⁹². Ms Parsonage also had a text exchange with VC on 18 July 2022, during which VC indicated that he would be out of the country until October 2022³⁹³.
252. Mr Carter attempted to contact VC by telephone on 27 July, 29 July and 3 August but there was no answer.³⁹⁴ However, Mr Carter was able to speak with VC's mother on 27 July, who confirmed that VC remained in Nottingham.³⁹⁵
253. VC failed to attend an appointment with Dr Lloyd on 1 August 2022.³⁹⁶
254. Mr Carter attended 209 Ilkeston Road on 4 August 2022 but was informed by someone at the premises that VC did not reside at this address.
255. The Trust accepts that throughout the period between June-August 2022 there was a pattern of evidence to demonstrate that VC had ceased meaningfully to engage with the EIP team.

³⁸⁴ NHFT0004872_0114-0115, paragraphs 7.8.63-7.8.65

³⁸⁵ NHFT0004872_0039, paragraph 5.304

³⁸⁶ Gary Carter, 30 April 2026, Page 69, INQT0000070

³⁸⁷ NHFT0000168_0267

³⁸⁸ NHFT0000168_0268

³⁸⁹ NHFT0000168_0267

³⁹⁰ NHFT0000168_0267

³⁹¹ NHFT0000168_0268

³⁹² NHFT0000168_0268

³⁹³ NHFT0000168_0269

³⁹⁴ NHFT0000168_0269

³⁹⁵ NHFT0000168_0269

³⁹⁶ NHFT0000168_0269

256. Mr Carter sent a letter to VC on 17 August to what had been recorded as a "new address" on 9 August, 15 Madison Court³⁹⁷. In fact, this address had been provided by VC in early February 2022 when making a subject access request³⁹⁸ and the records indicate that he gave up the tenancy for this address that month.³⁹⁹ Mr Carter did not attend this address prior to VC being discharged.⁴⁰⁰
257. However, the evidence before the Inquiry shows that Nottinghamshire police did attend 15 Maddison Court on 4 and 11 August, but there was no answer.⁴⁰¹
258. Mr Carter discussed VC's case at the weekly EIP MDT meeting on 18 August 2022. During this meeting, Mr Carter informed the team that he would attempt to contact VC's mother for help in locating VC.⁴⁰²
259. On 19 August 2022, the police closed the case of VC stalking his former flatmate, relating to incidents that had taken place in April and July 2022.⁴⁰³ The Trust was not told about these incidents or the subsequent police investigation.
260. Mr Carter spoke with VC's mother on 31 August 2022. She informed Mr Carter that she had spoken with VC during the preceding week, but had not seen him for several months and he was not at the address she had been given. Mr Carter recorded in RiO that he would arrange a visit with VC to check on his welfare.⁴⁰⁴ This visit did not take place.
261. On 22 September 2022, a warrant for VC's arrest was issued due to his failure to appear at Nottingham Magistrates' Court, following a charge for assaulting an emergency worker on 3 September 2021.⁴⁰⁵ The Trust was not told about the existence of this warrant.

³⁹⁷ NHFT0000122

³⁹⁸ WITN0163002

³⁹⁹ INQY0000002_0008

⁴⁰⁰ NHFT0004872_0129, paragraph 7.10.58

⁴⁰¹ NGPF0000003

⁴⁰² NHFT0000168_0270

⁴⁰³ NGPF0007824_0004

⁴⁰⁴ NHFT0000168_0270

⁴⁰⁵ NGPF0007824_0004

262. The EIP team held its weekly MDT meeting that same day. It remains unclear who attended that meeting, although the RiO entry made by Sharon Heath the following day expressly states as follows:

*Discussion within MDT on 22.09.22, as no contact has been made with [VC] for a period of time despite attempts to make contact and having done cold calls, decision made within team to discharge back to GP due to non engagement...*⁴⁰⁶

263. Dr Lloyd's oral evidence that the decision to discharge was made on some earlier date in August⁴⁰⁷ is not corroborated by any other witness or documentary evidence. Indeed, it is contradicted by the RiO notes which showed that Mr Carter was taking further steps in respect of VC in late August 2022.⁴⁰⁸

264. It is also noted that the rationale recorded in the RiO record by Ms Heath for the discharge appears similar to Dr Lloyd's earlier thinking on 17 January 2022⁴⁰⁹.

265. The Trust accepts that the decision to discharge VC didn't follow the right processes and should not have been made in the circumstances. The EIP Service Operational Policy required the team to have regard to the Trust's "Did Not Attend" policy when considering discharge.⁴¹⁰

266. The following day, a discharge letter was sent by the Trust to VC's GP.⁴¹¹

267. The Trust accepts that there were several administrative failures and instances of poor clinical practice during this period of VC's care. Specifically during this period:

- a. The RiO record was not properly updated to reflect discussions with VC and the assessment of risk⁴¹². There was also no risk management plan in place.
- b. Mr Carter did not make any amendments to VC's core assessment, care plan or risk assessment when he was VC's care coordinator between May and September

⁴⁰⁶ NHFT0000168_0271

⁴⁰⁷ Dr Tuhina Lloyd, 6 May 2026, Page 72, INQT0000074

⁴⁰⁸ Dr Tuhina Lloyd, 6 May 2026, Pages 104-108, INQT0000074

⁴⁰⁹ See paragraph 206 above

⁴¹⁰ CQCM0009938_0021

⁴¹¹ NHFT0000123

⁴¹² Claudia Birtles, 29 April 2026, page 51 (am) INQT0000067, p.43 (pm) INQT0000068; Abigail Parsonage, 30 April 2026, pages 14-15 and 28, INQT0000069

2022.⁴¹³ The Trust accepts that Mr Carter's record-keeping and clinical practice did not meet the expected standards of professionalism,⁴¹⁴ or comply with the EIP's Service Operational Policy.⁴¹⁵

- c. Mr Carter should have been aware from the RiO records that VC had not resided at 15 Marston Court since his fourth admission. In any event, he should have initiated a further 'cold call' to the address prior to discharge as this would have alerted him to the fact that VC did not reside here and he therefore would not have received the letter dated 17 August. He also should have contacted the police to seek their help in locating VC.⁴¹⁶
- d. Mr Carter, or another member of the EIP team, should have seen VC in person September 2022 to determine his mental state prior to discharge. Although he may not have met the threshold for a MHA assessment, this could not have been ruled out without such a visit.
- e. An updated risk summary or review of the level of risk should also have been undertaken before VC was discharged.⁴¹⁷
- f. There should have been more robust supervision in place in respect of Mr Carter's caseload.⁴¹⁸
- g. Dr Lloyd should have been fully informed about VC's care, either by speaking with VC's care coordinator or reviewing the RiO notes again, before the MDT meeting on 22 September as clinical lead when the decision was made to discharge VC. This would have revealed that Mr Carter had spoken with VC's mother on 31 August and was seemingly taking further steps to locate VC.⁴¹⁹

⁴¹³ NHFT0004872_0114, paragraph 7.8.61

⁴¹⁴ NHFT0004872_0145, paragraph 7.12.39

⁴¹⁵ NHFT0004012_010-11

⁴¹⁶ Gary Carter, 30 April 2026, Pages 85-86, INQT0000070

⁴¹⁷ WITN0155033_018

⁴¹⁸ Emma Robinson, 26 November 2025, paragraph 92, page 30, WITN0315001; Emma Robinson, 5 May 2026, Page 108, Lines 3-10, INQT0000071

⁴¹⁹ Dr Tuhina Lloyd. 6 May 2026, Page 106, INQT0000074

- h. The decision to discharge VC should not have been made in the absence of Gary Carter and/or Claudia Birtles being present at the MDT meeting and inputting into the decision.⁴²⁰
- i. A record should have been made of who attended the EIP MDT meeting on 22 September, and VC's RiO record should have been updated to reflect any discussion that took place regarding his discharge.⁴²¹
- j. The decision to discharge VC back to his GP in September 2022 did not adequately consider or mitigate the risks of relapse, violence or his lack of engagement with services.⁴²²
- k. The discharge letter was lacked sufficient detail and failed to enclose the key documents relating to VC's care and risk. It was not appropriate for Ms Heath to oversee the drafting of this letter given she hadn't attended the discharge meeting and had no knowledge of VC's prior care.⁴²³
- l. VC's family was not informed about the discharge. VC's GP, the police and the university were also not consulted about the appropriateness of this decision.⁴²⁴
- m. Whilst the trust had an appropriate 'did not attend' (DNA) policy in place, the following provisions were not followed in respect of VC: 7.2.3.1, 7.2.3.3, 7.2.3.4 and 7.2.3.10.⁴²⁵ The EIP team's Service Operational Policy further required such compliance and a clearly documented care plan to be in place regarding VC's non-engagement.⁴²⁶

⁴²⁰ Abigail Parsonage, 30 April 2026, Page 49, Lines 24-25, INQT0000069

⁴²¹ NHNB0018966_211

⁴²² NHNB0018966_208

⁴²³ Sharon Heath, 5 May 2026, Page 86, Lines 5-15, INQT0000071

⁴²⁴ NHFT0000530_208, 209

⁴²⁵ NHFT0004725_007-8

⁴²⁶ CQCM0009938_0021, section 24

Episode 13: 24 September-13 June 2023: treatment by primary care

268. The issues that arise in connection with this event include:

- a. The care and treatment provided to VC by other NHS services prior to the attacks.
- b. Inter-agency working.

269. After the Trust sent the discharge letter to VC's GP on 23 September 2022 it did not have any further interactions with VC prior to the attacks on 13 June 2023.⁴²⁷

270. The evidence before the Inquiry shows that VC's GP Practice sent a message to VC by text on 29 September 2022 asking him to make a GP appointment for a mental health review. A second message was sent on 30 September 2022 asking VC to attend a long-term condition annual review. As no reply was seen, follow up messages were sent on 11 and 21 November 2022.⁴²⁸

271. The GP practice managed to speak with VC on 1 March 2023 but VC declined to attend any appointments. The Trust was unaware of these developments at the time, but it recognises that information sharing between primary and secondary care can be improved to mitigate the risk of patients falling between the cracks.

272. On 5 May 2023, Leicestershire Police were called to attend an incident after VC was alleged to have punched a man and pushed over a woman at Arvato. No contact was made with the Trust following this incident. Had the Trust been informed, it could have provided information and advice to Leicestershire Police and/or made arrangements for a further MHA assessment to be conducted.

⁴²⁷ It is noted, however, that Ms Bailey was employed by the Trust when contacting VC on behalf of the Cripps Medical Centre during this period: WITN0324001

⁴²⁸ Dr Timothy Baker, 1 December 2025, Page 13, paragraphs 69-70, WITN0084002_0013

Episode 14: 13-20 June 2023 - Liaison & Diversion involvement following arrest

273. The issues that arise in connection with this event are:

- a. The Assessment of capacity and need for (and responsibility for arranging) an MHA assessment.
- b. Responsibility for drug testing.

274. Shortly after VC was arrested, Nottinghamshire Police made a referral to the Trust's Liaison & Diversion service due to concerns about VC's mental health.⁴²⁹ VC declined a triage assessment.

275. The critical issue at this stage was VC's fitness to be interviewed.⁴³⁰

276. Liaison & Diversion are not commissioned to provide consultant psychiatrist support. Any clinical support required in custody is provided by Mitie Care and Custody Health ("Mitie") who would be responsible for undertaking any capacity assessment necessary for VC. The role of Liaison & Diversion in these circumstances was to support information sharing between the NHS and police.⁴³¹

277. The Trust supports the evidence given by Dr Taylor that there can be value in having a forensic assessment of mental state as close to the time of the events as possible. Whilst it may have been the case that, historically and only in some areas, a forensic psychiatrist could be brought into the police station at the time as someone was capable of being interviewed to assess their mental state, it is unclear whether this occurred nationally and/or still occurs in those areas mentioned in the evidence. This is something that the Department of Health and Social Care and/or Home Office may wish to consider commissioning nationally moving forwards. It was not, however, the role of Liaison & Diversion to facilitate such an assessment for the purposes of use in the criminal justice process.

278. The evidence before the Inquiry demonstrates that the Mitie nurse was uncertain what steps to take given the unusual circumstances. Liaison & Diversion correctly informed

⁴²⁹ Louisa Hagan, 4 December 2025, paragraphs 11-12, WITN0346001_0004

⁴³⁰ Mark Taylor, 8 May 2026, Page 75, INQT0000078

⁴³¹ Louisa Hagan, 4 December 2025, paragraph 22, Pages 8-9, WITN0346001

Mitie that they should consider their own escalation processes given that the serious nature of the incidents meant VC could not be transferred to Highbury hospital pursuant to the usual MHA Assessment process. Ms Draper did not escalate matters as she did not consider an MHA Assessment was needed based on her assessment of VC's presentation at the time.⁴³²

279. The Trust was also not involved in any decisions taken in relation to drug testing after VC was brought into custody.

280. The Trust locked down VC's medical files on 13 June 2023 to ensure there were no data breaches. The evidence before the Inquiry demonstrates that this was the prudent step to take given the high-profile nature of the events and media reporting.

281. On 15 June 2023, Dominic Lloyd completed the criminal justice referral form in preparation for VC appearing in court. Again, this was clearly the appropriate route to take given admission under the civil route would have been inappropriate and wrong.

282. On 20 June 2023, VC was referred to HMP Manchester and the Trust has not been responsible for the clinical care of VC since this date.

C. The broader landscape

283. The Inquiry has heard evidence about the broader landscape in which the Trust operates. This legal, policy and regulatory landscape determines what services are commissioned (funded) from the Trust and how they are delivered (the service specification). This landscape itself is not static.

284. Since the publication of the Ritchie Report in 1994, there have been numerous changes to the legal framework governing mental health and the way services are structured, funded and delivered. As an example, the Inquiry has heard evidence about the national shift away from standalone Assertive Outreach and EIP services,⁴³³ as part of a wider shift through the course of the period from the mid-2000s towards more integrated community care.

⁴³² Rosie Draper, 18 March 2026, pages 19-20, INQT0000030

⁴³³ William Vineall, 21st November 2025, , Paragraph 10, Page 3, WITN0155001

285. NHS England's Five Year Forward View for Mental Health⁴³⁴ was published in February 2016 and contextualises the EIP-related activity at the Trust that the Inquiry has heard evidence about. The Five Year Forward View for Mental Health described the plan for improvements to Early Intervention in Psychosis services, recognising NHS England and Health Education England's role in supporting the staffing needs identified as being required for EIP.⁴³⁵ It also set a recommendation for NHS England to ensure by April 2016 that 50 per cent of people experiencing a first episode of psychosis have access to a NICE approved care package within two weeks of referral, "rising to at least 60 per cent by 2020/21".⁴³⁶ There is minimal reference to schizophrenia but the Five Year Forward View did contain this core vision as one of the "Priority Actions" for the NHS by 2020/21:

*"People want care in the least restrictive setting that is appropriate to meet their individual needs, at any age, and is close to home. People living with severe mental health problems, such as schizophrenia or personality disorder, should not be held in restrictive settings for longer than they need to be. The NHS should expand proven community-based services for people of all ages with severe mental health problems who need support to live safely as close to home as possible."*⁴³⁷

286. The Government is currently in the process of developing a new strategy for mental health care,⁴³⁸ with the stated intention being to drive a shift from crisis intervention to preventative care. The Trust returns to this in its section addressing potential recommendations.

287. Other examples of the relevance of this wider landscape in the context of the Inquiry is the evidence heard about:

- a. Funding limitations. Funding for the delivery of services provided by the Trust comes from NHS England and the ICB. Proposals for service change and

⁴³⁴ NHSE0000002, see also Dale Bywater, 8th December 2025, Paragraphs 231-232, Page 69, WITN0310001

⁴³⁵ NHSE0000002, Page 45; see also William Vineall, 21st November, Paragraph 44, Page 15, WITN0155001

⁴³⁶ NHSE0000002, Page 71

⁴³⁷ NHSE0000002, Page 12

⁴³⁸ RLIT0000129

transformation are subject to commissioner approval and funding, with national policy influencing prioritisation of funding. Targets are set in a similar way. The lack of any additional funding for standalone Assertive Outreach services today is a powerful illustration of the practical realities of funding constraints; in order to implement the changes that have been identified as being needed, the Trust must divert resources from other services to create additional service capacity. The Royal College has also repeatedly highlighted the sustained problem of NHS mental health services being over-stretched and under-resourced and how this impacts clinical decision-making.⁴³⁹

- b. The de-coupling of the Trust's EIP service from the wider Local Mental Health Service in the period from 2018. This evidence draws out the shared role that the Trust, the ICB (and its predecessor CCG(s)) and NHS England played in monitoring performance; working to improve under performance against nationally set standards and targets (including through a formal Recovery Action Plan); service change and transformation, including the process of developing options for service delivery; and obtaining ICB and associated funding to enable implementation.
- c. The blend of legislation, policy, and professional guidance that informs clinical decision making and the role the Trust has in supporting implementation of this, through the development and implementation of its own policies and procedures and through training and audit.
- d. The governance of the Trust and the role of NHS England, the CQC and the ICB in providing oversight and support to the Trust. The Inquiry has heard evidence about the CQC's role in inspecting the Trust and the outcome of those inspections in the period from 2019 to date.
- e. The process through which incidents, and specifically mental health homicides, are reported, investigated and responded to, and the shared but distinct responsibilities that the Trust, the ICB, NHS England and the CQC have in this respect.

⁴³⁹ Dr Shubulade Smith, 28th May 2026, Paragraph 14, Page 4, WITN0320036

288. The Trust's clinicians were also practicing in an environment influenced by legislation, established national policies⁴⁴⁰ and practice, and periodic changes to these, including the lengthy process of legislative reform in relation to the MHA.⁴⁴¹

- a. Detention under the MHA is a restriction of liberty. No other medical specialty has the power to restrict a person's liberty on health grounds as part of their usual practice.⁴⁴² The position of the Royal College of Psychiatrists is that this is a responsibility that should not be taken lightly and must be done with careful thought.⁴⁴³ Coercive treatment can induce negative experiences of psychiatric care, which reduces the likelihood of patient engagement in the future and increases the risk of relapse and harm to others.⁴⁴⁴
- b. The Independent Review ("the Review") of the MHA was published on 6 December 2018. It has taken over 5 years for this to result in legislative change and the process for commencement and the Inquiry has heard evidence about the need for a clear Code of Practice to enable clinicians to make decisions on the ground.⁴⁴⁵
- c. Recommendations arising from the Review included making the least restrictive option appropriate to a person's circumstances the default option and requiring better clinical justification for continuing CTOs in any given patient.⁴⁴⁶ Serious consideration was given by the panel to abolishing CTOs altogether.⁴⁴⁷

289. As Dr Gibson aptly described in his oral evidence to the Inquiry:

"there was and there remains a culture and a climate that emphasises the least restrictive approach to patients with mental disorder and to enhance their autonomy wherever possible. And that's the context for the 2025 amendments to the Mental Health Act, but it was also -- the general climate whenever you would go to a conference, for most of the information you'd get from the government, from the CQC, from the Royal College, that we are being overly coercive, we are

⁴⁴⁰ WITN0320004

⁴⁴¹ Alex Ruck Keene KC, 19th November 2025, WITN0288001

⁴⁴² Dr Shubulade Smith, 28th May 2026, Paragraph 12, Page 3, WITN0320036

⁴⁴³ Dr Shubulade Smith, 28th May 2026, Paragraph 12, Page 3, WITN0320036

⁴⁴⁴ Dr Shubulade Smith, 28th May 2026, Paragraph 12, Page 3, WITN0320036

⁴⁴⁵ Alex Ruck Keene KC, 19 November 2025, WITN0288001, pages 70, 77-78,

⁴⁴⁶ WITN0155008

⁴⁴⁷ Professor Sir Simon Wessely, 4th December 2025, Paragraph 41, Page 18, WITN0322001

not respecting patients' wishes, we should reduce coercion wherever possible, and in particular there is disparate coercion in particular demographic groups, particularly young ethnic minority males".⁴⁴⁸

290. Mr Majid described in oral evidence the positive support that the CQC gives to least restrictive practice in its inspection reports.⁴⁴⁹
291. All of the Trust's clinicians confirmed that race did not play any part in their decision-making; they assessed the individual in front of them. For them VC's level of risk was not extraordinary and the established practice in such circumstances was that coercive measures would not be consistent with the established application of the least restrictive principle.⁴⁵⁰ The awful incidents on 13 June 2023 have undoubtedly changed established practice in the profession in this regards.⁴⁵¹
292. The Inquiry has heard evidence about what is done nationally to collate, disseminate and learn from incidents of mental health homicide and attempted homicide⁴⁵². National understanding of incidence was also explored.⁴⁵³

The Trust

293. The Trust is a Foundation Trust. Aspects of its structure are determined by statute (the Board and its mandatory roles; the Council of Governors; reporting and assurance arrangements; and its financial duties, amongst others). The Inquiry has heard evidence about the role of the Board; key individual roles on the Board (the Chair⁴⁵⁴, the Chief

⁴⁴⁸ Dr Jonathan Gibson, 12th May 2026 (PM), 43/2-43/14, INQT0000082

⁴⁴⁹ Iftikhar Majid, 18th May 2026 (AM), 11/17-12/21, INQT0000088

⁴⁵⁰ Dr Jonathan Gibson, 12th May 2026 (PM), 44/19-45/13, INQT0000082

⁴⁵¹ Dr Jonathan Gibson, 12th May 2026 (PM), 44/4-44/18 44, INQT0000082

⁴⁵² First Witness Statement of Professor Sir Louis Appleby, 24th October 2025, Paragraphs 7 to 9, Pages 2-3, WITN0069001; Julian Hendy, 2nd November 2025, Paragraphs 36 to 52, Pages 8 to 11, WITN0258001

⁴⁵³ Professor Sir Louis Appleby, 24th October 2025, Paragraphs 7 to 9, Pages 2-3, WITN0069001

⁴⁵⁴ Dean Fathers, 6th February 2026, Paragraphs 17 to 21, Pages 5 to 7, WITN0410001; Paul Devlin, 12th February 2026, Paragraphs 45 to 57, Pages 14-20, WITN0390001

Executive Officer⁴⁵⁵ and executive directors⁴⁵⁶) and how the Board operated, including its unitary nature.⁴⁵⁷

294. The Inquiry has heard evidence about the Trust's internal governance and operating structure and about:

- a. Committee structure, role and remit and how these have changed over time.
- b. Divisional governance and the organisation of the Trust into service groupings (whether divisions, directorates or, as currently, Care Groups).
- c. The process through which ward-to-board oversight, assurance and escalation was enabled.
- d. Risk management and the distinction between different types of risk and how they are managed, escalated and accounted for: individual risk (including an individual clinical risk), operational risk, corporate risk and strategic risk. Collectively, this is known as the internal control framework. The role of the Board Assurance Framework in managing corporate and strategic risk has been explored, as have the routes for internal and external accountability for risk. The Trust complies with its requirements in terms of internal and external audit and reports annually to NHS England, through its annual accounts and annual report.
- e. Incident reporting, investigation and response.
- f. Staffing.

CQC and NHS England oversight

295. The Trust is required to hold a provider licence, with compliance monitored and assured by NHS England.

⁴⁵⁵ Dr John Brewin, 15th January 2026, Paragraphs 20 to 24, Pages 7-8, WITN0380001; First Witness Statement of Iftikhar Majid, 7th January 2026, Paragraphs 14 to 22, Pages 4 to 5, WITN0263001

⁴⁵⁶ Anne-Maria Newham, 25th January 2026, Paragraphs 27 to 33, Pages 3 to 6, WITN0354001; Julie Attfield, 16th January 2026, Paragraphs 8 to 9, 12, 15 and 17 to 24 in particular; Pages 2-5, WITN0329001; First Witness Statement of Dr Susan Elcock, 27 January 2026, Paragraphs 18 to 33, Pages 5 to 8, WITN0356001

⁴⁵⁷ Paul Devlin, 12th February 2026, Paragraphs 102 to 104, Pages 38 to 39, WITN0390001

296. Since 2024 the Trust has been in receipt of enhanced support and oversight from NHS England, through its Recovery Support Programme. This has involved putting in place an Integrated Improvement Plan to make significant and sustainable improvements to how the organisation operates and the care it provides. Progress against this plan has been overseen by the Improvement Oversight and Assurance Group, whose role has recently come to an end, as the integrated oversight arrangements for the Trust evolve to reflect the next stage of its improvement work. IOAG was a multi-stakeholder body that is co-chaired by the NHS England Regional Medical Director and the CEO of Nottingham and Nottinghamshire Integrated Care Board. It brought together interested parties from across the local health and social care system to provide strategic oversight of the Trust and its implementation of improvement actions whilst it was in segment 4.⁴⁵⁸
297. In addition, the Trust is required to maintain registration with the CQC and its compliance with the CQC's fundamental standards set by the CQC. The CQC rates providers like the Trust and the Inquiry has heard evidence about the numerous inspections (planned, unplanned, focussed or routine) carried out by the CQC in relation to the Trust in the period from 2019 to date.
298. Throughout this period, the Trust's overall rating was either Requires improvement or Inadequate. The Trust is not alone in this position. 30 out of 46 mental health trusts in 2025 were rated as requiring improvement.⁴⁵⁹
299. The Inquiry has heard evidence from a range of the Trust's management (current and former) about the Trust's response to the CQC's inspection reports, as well as how those coming into management roles at the Trust used these reports, alongside other material such as the NHS National Staff Survey results, as part of their "due diligence", to help understand the Trust's performance position.⁴⁶⁰ Although the "headline" rating for a provider like the Trust is important, it is also important to look beyond this and understand the individual service ratings as this provides a fuller understanding of the concerns identified by the CQC and can help understand progress that has been identified through inspection, even where no change occurs to the overall rating or the overall domain rating.⁴⁶¹

⁴⁵⁸ RLIT0000130

⁴⁵⁹ Julie Attfield, 20th May 2026 (PM), 91/20-91/25, INQT0000092

⁴⁶⁰ Dr John Brewin, 15th January 2026, Paragraph 18, Pages 6-7, WITN0380001

⁴⁶¹ Dr John Brewin, 15th January 2026, Paragraph 61, Pages 20-21, WITN0380001

Services utilised by VC

300. The Inquiry has heard evidence about VC's interaction with a range of the Trust's services, particularly his care and treatment as an inpatient at Highbury Hospital and in the community by the Crisis team and the EIP service.
301. The Inquiry has sought to understand VC's experience in the context of what the Trust's performance was more widely during the period he was accessing care. To this end, a range of evidence has been heard, including about:
- a. The safety and effectiveness of Highbury Hospital and the Trust's EIP service in particular.
 - b. The Trust's understanding and response to concerns, including those raised by the Coroner about reoccurring themes, including through quarterly meetings between the Trust and the Coroner and in Prevention of Future Death reports.
 - c. The Trust's response to incidents of mental health homicide, attempted homicide or other serious violence.
302. Underpinning all of these issues is the fundamental issue of whether the Trust was governed in a way that enabled it to operate as an effective learning organisation and, if not, what the factors were constraining its effectiveness in this respect.
303. The Trust has accepted that its overall performance has been challenged in the period from 2019 to date. This is reflected in the CQC's inspection reports in relation to the Trust through the course of this period.
304. Dr Brewin, who started in post as Chief Executive Officer of the Trust in January 2019, agreed in oral evidence that the CQC's 2019 findings had serious implications for patient safety at the Trust, particularly the Inadequate ratings for acute wards for adults and psychiatric intensive care units, and the concerns highlighted by the CQC about safe staffing and risk assessments.⁴⁶²

⁴⁶² Dr John Brewin, 18th May 2026 (AM), 19/18-20/4, INQT0000087

305. Ms Attfield, who was Executive Director of Mental Health Services at the time of the CQC inspection report (but with the inspection occurring before she took on that particular role)⁴⁶³ accepted that her "chief aim and purpose" in that capacity "would be to address the concerns about the quality and safety of services".⁴⁶⁴ She accepted that as a result of the CQC inspection report, she had an indication "that risk assessments weren't being conducted to the required standard and that action needed to be taken to improve the assessment of risk".⁴⁶⁵ Ms Attfield described the work that was done to understand the problem, including through audit.⁴⁶⁶
306. By the time of Dr Brewin and Ms Attfield's retirements in 2022, improvements were identified by the CQC in their 2022 inspection of acute inpatient services⁴⁶⁷, with the CQC finding that "*The trust had improved the management of risk to patients since the last inspection in 2019. Staff now ensured that risk assessments were in place and that they contained all relevant risk information...*".⁴⁶⁸
307. The more recent leadership team have carried out further work in relation to risk assessment and Ms Hull, the current Executive Director of Nursing, Allied Health Professionals and Quality, described in her evidence why a central policy setting out core expectations and responsibilities in relation to Clinical Risk and Safety was essential, notwithstanding the content included in the earlier period in each service's Standard Operating Procedure or equivalent.⁴⁶⁹ The Trust wide policy was introduced in 2024.
308. The evidence heard by the Inquiry from current and former members of the Trust's leadership team seeks to explain and contextualise what the challenges were; what the Trust's response was and the sustained work that is needed to address fundamental issues such as culture, staffing and estates. Under different circumstances, both Dr Brewin and Mr Majid found themselves leading the Trust through periods of top-down, operationally focussed times, Dr Brewin in response to the Covid-19 pandemic and Mr

⁴⁶³ At the time of the inspection, Julie Attfield was Executive Director of Nursing: Julie Attfield, 16th January 2026, Paragraph 5, Page 2, WITN0329001; Julie Attfield, 20th May 2026 (PM), 1/18-1/20, and 2/10-2/16, INQT0000092

⁴⁶⁴ Julie Attfield, 20th May 2026 (PM), 3/12-7/6, INQT0000092

⁴⁶⁵ Julie Attfield, 20th May 2026 (PM), 3/12-7/6, INQT0000092

⁴⁶⁶ Julie Attfield, 20th May 2026, 9/1-11/3, INQT0000092

⁴⁶⁷ CQCM0019736

⁴⁶⁸ See also Julie Attfield, 16th January 2026, Paragraph 115, Pages 27-28, WITN0329001

⁴⁶⁹ Diane Hull transcript 14/7-14/22 – 15/5-18/1, INQT0000093

Majid in response to the actions needed in light of the issues identified by the CQC, NHS England and the Trust itself in the aftermath of 13 June 2023.

309. Mr Devlin agreed that when Mr Majid joined the Trust at the end of 2022, Mr Majid's initial impressions were similar to those he had identified in 2019.⁴⁷⁰

Highbury Hospital

310. Those in post at the time who gave evidence to the Inquiry agreed that there were serious questions over the safety of Highbury Hospital in the period from around June 2021 and that these came to a head in October 2021.
311. The Trust has evidenced the prompt implementation of a multi-factorial action plan that built on the work already underway to address concerns about staffing in particular but the evidence also suggests that the ability to embed long-term sustainable improvements was mixed and the Trust acknowledges that problems remain at the current time, including in relation to staffing and learning culture.

EIP services

312. The Inquiry has gathered a significant volume of evidence about the Trust's EIP service, which needs to be understood in the context of the broader landscape.
313. As set out earlier in this section, NHS England's Five Year Forward View for Mental Health was published in February 2016. One of the main national priorities became a strengthened approach to prevention and early intervention through new models of care. Funding from commissioners was aligned accordingly to implement this priority.
314. It was this context that led to the Trust carrying out a piece of transformational work, working with the then CCGs, to explore options around the way in which the AMH Directorate provided mental health services in the community (as distinct from in-patient services and outpatient services). One consequence of this change was that it was determined that the previously standalone teams providing EIP and AO should be integrated into one overall grouping of Local Mental Health Services ("LHMTs").
315. It did not take long, however, for concerns to emerge about the integration of EIP into LMHT and by late 2018, the Trust had recognised issues, including a dilution of the

⁴⁷⁰ Paul Devlin, 19-May-2026 (AM), Page 77, Lines 13-18, INQT0000089

specialist nature of this service. Poor results in the 2017 National Clinical Audit of Psychosis ("NCAP") for the Trust added to the clear view that action was needed and a Recovery Action Plan for EIP was developed, in conjunction with the then CCGs. Expert support was brought into the Trust, with Dr Vidyah Adamson being appointed to lead a programme of review and transformation in relation to EIP. Her work to develop options for the EIP service began in mid-2020 and, following the ICB's commissioning approval, de-coupling was implemented.⁴⁷¹

316. The Inquiry has received evidence explaining the difficulties associated with the uncoupling process over the next 3 years, owing in particular to recruitment challenges and the Covid-19 pandemic. Ann Wright⁴⁷² and Michelle Malone⁴⁷³ explain in their evidence the actions taken to try and address the concerns, which remained a constant focus of the EIP management team throughout this period.
317. Those managing the de-coupling responded to resourcing concerns, carrying out detailed modelling of both CCO and medical case loads and staffing; involving clinicians in service design and implementation; and agreeing a slower pace of implementation for the City South EIP team, after specific concerns about staffing capacity for that team were raised.
318. The primary focus during this period, quite rightly, was on maintaining the safety of patients and staff, including the management of infection control on inpatient wards and when conducting community visits, and the adaptation of services to meet rapidly changing requirements. Senior leaders were required to take a holistic view in order to ensure safe and effective service delivery on a daily, weekly and monthly basis.
319. The concerns raised by staff concerning the EIP service after the decoupling were issues faced common to most NHS services, such as caseload pressures, staffing gaps and administrative difficulties. Where issues were capable of being addressed locally, the EIP team worked with the wider service leadership to identify options. Where the issues were outside local control, for example medical staffing, the evidence shows that these were escalated through the appropriate management and governance routes. However,

⁴⁷¹ Dr Vidyah Adamson, 27th May 2026 Paragraphs 15-25, Pages 3-7, WITN0459001

⁴⁷² WITN0478001_0010-0011, paragraphs 38-41

⁴⁷³ WITN0462001_0008, paragraph 39

the Trust's EIP consultants did not have high caseloads compared to Local Mental Health Team ("LMHT") consultants.⁴⁷⁴

320. The lack of psychological support was one issue in particular that was an ongoing concern and source of frustration within the EIP leadership team and the wider adult mental health service. Julie Atfield,⁴⁷⁵ Michelle Malone⁴⁷⁶ and Ann Wright⁴⁷⁷ explained to the Inquiry in their evidence the difficulties the Trust had in recruiting specialists in this area, as well as recruitment more generally, and the steps they took in response. The national support required from NHS England and Health Education England to support this staffing need is reflected in the 2016 Five Year Forward View⁴⁷⁸.
321. Whilst there was varied practice across the EIP service in terms of recording minutes of MDT meetings, the expectation was for healthcare professionals to take on the responsibility for recording discussions of their respective patients. In recognition that this was not being done consistently across the EIP service, the Trust has introduced guidance on recording MDT meetings.
322. At present the Trust continues to provide an integrated AO model within the LMHT and still has an EIP resource that is separate from the LMHTs. Whilst the Trust has planned on having dedicated standalone AO teams by October this year, the implementation of this plan is at risk unless additional funding is received.⁴⁷⁹

Patient safety

323. Underpinning much of the evidence the Inquiry has heard about Highbury Hospital, the Trust's response to concerns raised (including those by the Coroner) and its response to incidents of mental health homicide or attempted homicide is the fundamental issue of whether the Trust was an effective learning organisation or not.
324. At the outset of this part, the Trust would reiterate that it has openly acknowledged that its patient safety function, including its incident response, did not operate as effectively

⁴⁷⁴ Dr Karthik Thangavelu, 2 July 2026, paragraph 29, WITN0206015_0007

⁴⁷⁵ Julie Atfield, 16 January 2026, paragraph 178, page 45, WITNO329001

⁴⁷⁶ WITN0462001_0008, paragraph 39

⁴⁷⁷ WITN0478001_0010-0011, paragraphs 38-41

⁴⁷⁸ NHSE0000002

⁴⁷⁹ First witness statement of Glen Owen, WITN0490001

as it should have done through the period 2019-2023. The Helen Collins report,⁴⁸⁰ commissioned in May 2023, confirmed the Trust's concerns about patient safety incident investigation and response and the impact that this consequentially had on the Trust's ability to learn and embed learning.

325. The historic reasons for the shortfalls in relation to patient safety are not entirely clear.

326. Ms Attfield explains in her written evidence, mental health services were impacted by a post-pandemic surge in demand and increased acuity of clinical presentation by those seeking care. Ms Attfield candidly reflects that:

*"What had not been anticipated on the back of Covid and the contingencies and redeployment of staff, and in tandem with the staffing pressures in AMHS [Adult Mental Health Services] was the build-up of investigations, although this was flagged throughout Covid. The leadership capacity of the professional leads and managers who undertook the oversight of improvement plans from SIs [Serious Incidents] was impacted...this had a consequential impact in investigation capacity and the implementation of lessons learnt from incidents into 2022."*⁴⁸¹

327. Reflecting on the changes made to strengthen the patient safety function with the Trust, Ms Newham describes the need for additional capacity identified in 2022.⁴⁸²

328. Ms Newham, who was Director of Nursing through this period, has candidly recognised in her written evidence to the Inquiry that: *"During the Covid-19 pandemic, my ability as Executive Director of Nursing to fully review and assure the Trust's quality and safety structures was constrained. Routine oversight, in-depth audits, and detailed performance reviews could not be undertaken as usual due to operational pressures and staff redeployments. To mitigate this, we prioritised critical risks, streamlined reporting, and maintained focused executive oversight to ensure accountability and transparency for patient safety."*⁴⁸³

329. Dr Brewin, however, concludes that at the end of his first year at the Trust (end of 2019) there were *"clearly some significant improvements"*, with improvements in the NHS staff

⁴⁸⁰ NHFT0000423

⁴⁸¹ Julie Attfield, 16 January 2026, Paragraphs 180-183, Pages 45-46, WITN0329001

⁴⁸² Anne-Maria Newham, 25 January 2026, Paragraph 55, Page 12, WITN0354001

⁴⁸³ Anne-Maria Newham, 25 January 2026, Paragraph 33, Page 6, WITN0354001

survey results and *"a real sense that the Board had started to become more effective and had begun to focus on key issues"*.⁴⁸⁴ New posts were created to *"address shortfalls and sharpen focus"*, including in relation to staffing, family liaison, sub-contracted services and quality. Ms Newham, in her written evidence, describes these important new roles, reflecting that when she joined in her *"opinion, for the size of the Trust the quality team was very small, and capacity was an issue. I was concerned at the absence of several functions, namely: safer staffing, deputy director of nursing, family liaison team, suicide lead, quality lead for subcontracted beds, and restrictive practice lead, plus a need for more roles within CQC compliance. Over the period of 2020 and 2021 these posts were approved by the ELT and recruited to"*, with further additions being approved in 2022, particularly for patient safety.⁴⁸⁵

330. These reflections do not neatly correspond with the findings of the Helen Collins review, which found a *"noticeable lack of Trust-wide safety incident investigation, learning (i.e. quality improvement) and family liaison capacity and capability"* and *"a lack of standardised quality governance structures and processes"*. Although some excellent practice was found, *"thematic analysis was spare"*.⁴⁸⁶ The devolved governance in place at the time was felt to have compromised senior oversight of Trust-wide improvement projects.⁴⁸⁷ Ms Collins found a good safety culture within the middle and senior management level in the organisation⁴⁸⁸ but concluded that the *"lack of Trust-wide quality improvement projects has/had led to repetitive safety problems and serious incidents."* The Coroner's findings and views in this respect are noted by Ms Collins and the Trust accepts that the evidence heard by the Inquiry supports this view.

331. Reflecting on the concerns raised in the period from 2021 by the Coroner, the Trust's Executive Medical Director Dr Elcock accepted in oral evidence that the actions implemented by the Trust did not bring about the change required.⁴⁸⁹ Ms Attfield similarly accepted in oral evidence that the concerns raised by the Coroner in the period from 2021 were very similar to those raised by the CQC in 2019; that the Trust had not succeeded in *"sustainably"* addressing them by 2022 when she retired from the Trust and that the *"standards"* in terms of risk assessment, for instance, had not *"sufficiently improved to the extent that we would have wanted"*. However, Ms Attfield did not feel

⁴⁸⁴ Dr John Brewin, 15 January 2026, Paragraph 49, Page 16, WITN0380001

⁴⁸⁵ Anne-Maria Newham, 25 January 2026, Paragraph 55, Page 12, WITN0354001

⁴⁸⁶ NHFT0000423, page 8.

⁴⁸⁷ NHFT0000423, Pages 7-8

⁴⁸⁸ NHFT0000423, Page 6

⁴⁸⁹ Dr Susan Elcock, 20 May 2026 (AM), 51/19-53/22, INQT0000091

that this was "a reflection of inaction"; she felt that there were "underlying systemic issues" that impacted on the extent of improvement.⁴⁹⁰

332. Finally, when reflecting on the Trust's patient safety arrangements and the areas for improvement identified in relation to thematic analysis, it is important to recognise the wider changes implemented across the NHS through the introduction of the Patient Safety Incident Response Framework (PSIRF), which replaced the Serious Incident Framework and was introduced to place stronger focus on learning, systemic improvement and compassionate engagement with a wider range of stakeholders. A 12 month transition period was provided for following publication of PSIRF, recognising the work required to fully implement. The Trust, while a late adopter of PSIRF, has now fully implemented it, although it agrees with the CQC's assessment that work remains to ensure it is fully embedded.⁴⁹¹

333. The Trust is not complacent about the ongoing work it needs to do to ensure sustainable, long-term change in terms of patient safety but the progress reflected in the CQC's January 2026 Well Led inspection report is worth recognising:

*The patient safety team had recently made positive strides to embed learning from incidents. The trust had invested in the expansion of the team and there had been a realisation that patient safety was the business of everyone in the trust. Feedback from freedom to speak up cases, and complaints had led the organisation to invest in this area. Three safety managers were in post, one for each care group, and 8 clinical reviewers had been recruited specifically to review incidents. Family liaison posts had strengthened relationships with families and carers. The new and improved systems to learn from deaths, inquests, patient safety incidents and alerts from national bodies were more effective and better highlighted learning that was disseminated in a more co-ordinated way and used to improve the quality and safety of care and treatments. The trust's revised governance, oversight and processes for learning from deaths and incidents now focussed on a holistic review of patients who had been harmed or died whilst in the care of the trust. More recent reports from incident investigations and death reviews showed that action plans, quality improvement and learning was identified and used to bring about improvements for other patients.*⁴⁹²

⁴⁹⁰ Julie Attfield, 20 May 2026 (PM), 15/19-17/19, INQT0000092

⁴⁹¹ CQCM0029106

⁴⁹² CQCM0029106

Other cases of mental health homicide or attempted homicide involving the Trust

334. The Inquiry has heard evidence about a small number of cases of mental health homicide or attempted homicide other than VC's involving the Trust that occurred in the period from late 2022 onwards.
335. While the Trust agrees that there are common areas of improvement identified in some of these cases as in VC's, particularly around the formulation of risk assessments, inter-agency working and the triangle of care, it is important that the facts of each case are carefully considered before any overarching 'similarities' are drawn out.
336. The first of these, Case 1, occurred in [GRO-C] 2022. The Trust has disclosed to the Inquiry the Nottingham Crime and Drugs Partnership Domestic Homicide Review that sets out the relevant facts.⁴⁹³
337. The Domestic Homicide Review concluded that although there was evidence of good practice (such as between primary and secondary care), there were several lessons to be learnt regarding record-keeping, the need for comprehensive risk assessments, and the triangle of care.
338. Whilst some of these issues do overlap with those identified in relation to the care provided to VC, Patient 1 had not been assessed or treated as an inpatient by the Trust nor had he been under the care of EIP services. NHS England, Nottinghamshire ICB and the CQC all received the Initial Management Review form completed by the Trust on [GRO-D] 2022 following the serious incident.⁴⁹⁴ None of those bodies raised concerns about systemic issues beyond the focussed action agreed as being required to strengthen the process for mental health assessment in an A&E context. The [GRO-C] Review was shared with NHS England when it was finalised.⁴⁹⁵ The ICB was involved in the [GRO-C] Review as a safeguarding partner.
339. The Trust was informed of Case 2 on [GRO-D] 2023. The incidents themselves had occurred [GRO-C] and the Trust's response is set out in its corporate witness statement.⁴⁹⁶ [GRO-D]

⁴⁹³ NHFT0014940

⁴⁹⁴ NHFT0017666

⁴⁹⁵ NHFT0024160

⁴⁹⁶ Diane Hull, 5th December 2025, Paragraphs 459-465, Pages 162-164, WITN0133001

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340. As appropriate and required under both the Trust's policies and procedures and the national framework for investigation of such incidents, the Trust completed an Initial Management Review,⁴⁹⁷ which recorded that the clinical risk assessment had considered all identified/documented risks and that no medications issues were identified in the patient's records. No immediate recommendations/lessons were identified at this stage but the IMR does state that "as further details become clear there may be potential for further learning". The incident was reported to NHS England⁴⁹⁸. Executives were briefed on 16 February and the incident was discussed at the Serious Incident Review Group meeting on 21 February, at which the ICB was in attendance⁴⁹⁹.
341. Further discussions were had with the CQC,⁵⁰⁰ Nottinghamshire ICB⁵⁰¹ and NHS England⁵⁰² about this incident over the following 12 months, including the decision made by the Trust to proceed to a Level 2 Serious Investigation to be conducted by Psychological Approaches.
342. A Level 2 Comprehensive Investigation was commissioned with an Independent Chair. This was completed in July 2024 and approved in November 2024. Overall, the panel concluded that the care and support provided by EIP to patient 2 was good - the team responded quickly to the referral from inpatient services, identified the need for a community forensic assessment, negotiated fortnightly appointments when patient 2 was reluctant to engage, and were quick to respond with texts and phone calls when patient 2 cancelled or did not attend.⁵⁰³
343. However, the report did also make several recommendations, including around risk formulation, inter-agency working and the triangle of care. In relation to the former, the report found that risk formulation was limited and did not meet the standards set out by

⁴⁹⁷ NHFT0017669

⁴⁹⁸ NHFT0015790

⁴⁹⁹ NHFT0024195

⁵⁰⁰ NHFT0024140

⁵⁰¹ NHFT0024111

⁵⁰² NHFT0024065

⁵⁰³ NHFT0015791

the Royal College of Psychiatrists. This finding applied to both inpatient and EIP. Crisis and contingency plans also needed to be individualised. It suggested that the Trust could make progress in this area with a combination of a Trustwide clinical risk policy; a case-study based workshop programme; and, enhanced supervision opportunities in this area. The Trust has accepted these recommendations.

344. Case 3 concerned a patient who was arrested for Grievous Bodily Harm with intent after stabbing a member of the public [GRO-C] 2023. The Trust's response to this incident is ongoing, although the initial steps are set out in its corporate witness statement.⁵⁰⁴ The Trust accepts that the initial investigation into this case was not of a high quality and that is why it has re-opened it for further review.
345. The Trust had contact with patient 3 between [GRO-D] and was still providing care to [GRO-B] at the time of the incident. This was therefore not a case where the patient had been discharged from the service. The Initial Management Report was completed on 11 April⁵⁰⁵ and the Serious Incident Report was completed on 18 April,⁵⁰⁶ which would have also alerted the ICB, CQC and NHS England. The incident was also discussed in SIRG on the 18 April 2023⁵⁰⁷ in which the ICB were represented and the SIRG list and details shared in advance.
346. It is therefore the case that in each of these three cases the most comprehensive investigation report was not concluded and available to Trust until after VC had been discharged from the Trust. Further, none of the cases raised a potential systemic issue regarding discharge such that would have triggered an audit of EIP discharges in the proximate period.

D. Improvements and accountability

347. The Trust has set out in its corporate witness statement the organisational changes made since 2023. These have included improvements in Trust governance, learning from incidents, near-real time patient safety data, interagency working, clinical leadership, services and risk, equality and diversity, and engagement with families.⁵⁰⁸

⁵⁰⁴ Diane Hull, 5th December 2025, Paragraphs 472-474, Page 169, WITN0133001

⁵⁰⁵ NHFT0015865

⁵⁰⁶ NHFT0015672

⁵⁰⁷ NHFT0024212

⁵⁰⁸ Diane Hull, 5th December 2025, Section I, Pages 188-208, WITN0133001

The development of the SafeNow dashboard in particular has brought about real progress by enabling robust triangulation of metrics that were previously held separately across different systems, drawing on multiple digital platforms including Rio, AMAT and Ulysses.⁵⁰⁹

348. As described above, the Trust has worked closely with NHS England and Nottinghamshire ICB in identifying and implementing the changes needed.

349. The CQC's September 2025 inspection report⁵¹⁰ demonstrates that this journey is not complete. The Trust's former Chief Executive, Ifti Majid, acknowledged in his evidence that the CQC's report provides a fair assessment of an organisation that has made progress in establishing quality and safety systems, but has not moved quickly enough on culture, staff experience, and equality and diversity.⁵¹¹ Again, the Trust has been committed in acting on every area identified as requiring improvement.⁵¹²

350. The Trust recognises the importance of organisations and individuals being held to account for any failings identified during the course of this Inquiry. The Trust has already started this process, instigating a comprehensive review into the fitness to practice of those staff who have provided evidence to the inquiry.

E. Recommendations

351. The Inquiry has heard a wide range of thoughtful suggestions for recommendations. The Trust has distilled its proposals down to these targeted proposals it considers would be genuinely impactful:

Topic	Recommendation
Risk assessment	Timely development and implementation of national best practice guidance on risk assessment for use outside of forensic settings. Such guidance should

⁵⁰⁹ Diane Hull, 5th December 2025, Paragraphs 521-526, Pages 205-207, WITN0133001

⁵¹⁰ CQCM0029106

⁵¹¹ Iftikhar Majid, 23rd February 2026, Paragraph 5, Page 2, WITN0263132

⁵¹² Iftikhar Majid, 23rd February 2026, Paragraphs 12-26, Pages 5-12, WITN0263132

	guide the identification and management of high risk patients through: • use of appropriate risk tools, as part of an overall structured professional judgement • appropriate openness to seeking forensic input in complex cases • use of Assertive Outreach
Police / NHS inter agency working	A renewed commitment to partnership working across the Police and NHS to support those experiencing mental illness, including: • Formalisation of a Potentially Dangerous Persons pathway • Joint training for Police and mental health teams (modelled on the Street Triage training and partnership working)
NHS/Police/the Higher Education sector	Clear arrangements to encourage appropriate information sharing, use of safeguarding frameworks and partnership working more broadly on a multi-agency basis, incorporating case study guidance to guide practical application of principles Nottingham could lead the way on a model to be rolled-out nationally
Mental health homicide and attempted homicide repository	A nationally maintained repository of investigation reports and an accompanying mechanism to ensure recommendations are implemented
Assertive Outreach	Ring-fenced funding to ensure that a fully funded Assertive Outreach service can be implemented across England
National and regional support for EIP	Retain dedicated national and regional NHS support for EIP, reflecting the crucial impact this can have through bringing strategic leadership, standardising care quality, and driving efficiency. It helps promote uniform clinical standards, preventing local duplication and accelerates learning systematically across the country.

Psychiatric assessment in custody	The provision of consultant psychiatric assessment to persons in police custody for serious offences, with a view to the assessment product being used for later evidential (rather than the current therapeutic) purpose.
Information sharing	A stronger and clearer legal framework for information sharing between Police / NHS and other bodies, with mandatory sharing of risk information between some organisations (such as NHS mental health services, primary care and the Police).

352. In addition, while not the subject of a recommendation as such, the Trust's Medical Director explained the potential issues arising as a result of the amended MHA.⁵¹³ A clearer and more practical Code of Practice that seeks more effectively to bridge the gap the Inquiry has heard between law and clinical practice will be essential.

353. NHS England is currently in the process of drafting the new Mental Health Strategy and the Trust understands this is expected to be completed over the autumn. The Trust considers this represents an opportunity for early learning from the Inquiry to be reflected on and incorporated into the Strategy, which the Trust would support as an opportunity to signal a commitment to translate the evidence heard into tangible action.

F. Further reflections

354. The Trust has set out its reflections on VC's care in its Corporate Witness Statement, through the evidence of its staff to the Inquiry and in Part B of these Closing Submissions. The Trust's Recommendations for the Chair's consideration incorporate the Trust's further reflections on VC's care and it is committed to continuing to learn and improve in light of what it has heard.

355. This Inquiry is not just exploring VC's care. It is also about what happened after the events. Throughout the evidence given to the Inquiry we have reflected on our values as a Trust, especially in relation to respect and compassion. The Trust continues to recognise that its engagement with those who were impacted by VC's crimes fell short

⁵¹³ Dr Susan Elcock, 20 May 2026, pages 124 to 127, INQT0000091

of these values and it acknowledges that its actions in the aftermath of 13 June 2023 added to the suffering experienced by the victims of VC's crimes.

356. Recommendations for change must extend to improving the compassionate inclusion and support for victims after a mental health homicide or attempted homicide.
357. An example of this is that there is no clear multi-agency protocol to guide how such crimes are responded to, despite the evidence heard by the Inquiry about the national rate and impact of mental health homicide and attempted homicide. The NHS's investigation of such serious mental health-related crimes has, for too long, placed the focus on the patient and their family. There is insufficiently clear national guidance that:
- a. places all those victimised by such an event at the heart of any investigation process;
 - b. recognises the multi-agency response to such events and provides a clear explanation about which agency is responsible for what at each stage and how they will work with other partner agencies so that everyone can work together to minimise the requirement for victims to navigate a complex and overwhelming system and interact with multiple people; and
 - c. provides practical trauma-informed written guidance / assistance on common topics.
358. Co-designing such guidance with lived-experience involvement would be a tangible action to address a small part of the harm that has occurred following the events of 13 June 2023.
359. From the outset the Trust has apologised for its role in the events, acts and omissions being scrutinised by this Inquiry. In presenting this closing statement and having heard all of the evidence given, the Trust wishes to further apologise to the families, victims and people of Nottingham for the loss, trauma and missed opportunities in how we delivered care, worked with partners and responded to the events of 13 June 2023.

14 August 2026 (updated on 24 August 2026)