

Witness Name: Dr Karthik Thangavelu

Statement No: WITN0206015

Dated: 2 July 2026

## THE NOTTINGHAM INQUIRY

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### SECOND WITNESS STATEMENT OF DR KARTHIK THANGAVELU

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I, Dr Karthik Thangavelu, will say as follows: -

#### **INTRODUCTION**

1. This is my second witness statement, which is made to assist the Nottingham Inquiry (the "Inquiry") with the matters set out in the Rule 9 Request dated 5 June 2026 (the "Request").
2. I am a Consultant Psychiatrist, currently employed by the Nottingham Healthcare NHS Foundation Trust ("NHFT"), on employment break from NHFT commencing 22 October 2025. Full details of my qualifications, career, and role can be found in my first witness statement dated [WITN0206001].
3. This witness statement was drafted on my behalf by the external solicitors acting for the Trust in respect of the Inquiry with my oversight and input, following discussions in writing, by email and by video conference. Where matters are based on my direct knowledge, I say so. Where they are based on information shared with me by others or on my understanding of relevant documentation, I have indicated that accordingly.

#### **Background**

4. I have been asked to provide information relating to my knowledge of the Trust's Early Intervention in Psychosis ("EIP") service, which was through my roles as Lead Consultant (now known as "Deputy Clinical Director") and Adult Mental Health ("AMH") Clinical Director. Both of these roles were carried out in addition to my clinical work as a consultant psychiatrist.

5. As explained in further detail below, a substantial amount of time in both roles was dedicated towards recruitment and retention, as this has been a persistent problem since I took up the roles.

#### Lead consultant role

6. I held the role of Lead Consultant between 1 February 2019 and 31 July 2022. The Lead Consultant serves as the first tier line manager for consultants and Trust appointed Specialty, Associate Specialists and Specialists (SAS) doctors and as first point of contact for medical professionals related operational issues within the relevant service area, as well as supporting the clinical directors, nursing managers and operational managers regarding matters relating to medical professionals. A significant proportion of the role involved managing consultant vacancies, whether arising from sickness absence or recruitment difficulties. This included preparing job descriptions, advertising posts, getting approvals and participating in interview panels.
7. The Lead Consultant also had responsibility for consultant job planning, which was an annual requirement; in this capacity, Lead Consultants acted as first-line managers for consultants in respect of their annual job plans (see, for example, [WITN0206016]).
8. Lead Consultants also deal with day-to-day issues related to their job, such as secretarial support, office space, complex case discussion, leave approval, local rota management and supporting return to work after period of sickness. If the Lead Consultant could not address the issue, they would go to the Clinical Director for additional advice and support. Lead Consultants do not hold regular supervision meetings with consultants; matters are raised directly as needed, or in the AMH Consultants monthly forum.
9. Lead Consultants would also spend time investigating complaints concerning medical staff, including patient complaints and complaints arising from within the services, as well as addressing any conduct or capability issues relating to medics. This would involve input from Clinical Directors and/or Medical Director.
10. In addition, Lead Consultants provided strategic input to assist the Clinical Directors and attend management or governance meetings deputising for Clinical Directors (see, by way of example, [WITN0206017]; [WITN0206018]; [WITN0206019]), although the responsibilities I have described above constituted the bulk of the role.

11. There were a number of Lead Consultants, each covering a different geographical area and type of service. My own area of responsibility was for the City Community Mental Health teams in AMH: initially covering City East and South and subsequently the whole of the city patch. There were other Lead Consultants covering areas such as inpatient services, crisis teams and department of psychological medicine divided by City, County South and County North. The time allocated to the Lead Consultant role was typically around four hours per week, equating to approximately one Programmed Activity ("PA", and described further below). I was originally allocated 1 PA for this role in February 2019, but this was increased to 2 PAs in February 2021 when my role expanded. It therefore constituted only a small proportion of my overall workload.
12. There was a monthly group supervision for all Lead Consultants with the Clinical Directors at the time (Dr. Seedat and Michelle Malone). These meetings were not minuted.

AMH Clinical Director role

13. I held the role of AMH Clinical Director between 1 August 2022 and 30 June 2025.
14. The role of Clinical Director has a considerably broader remit than that of Lead Consultant. By the time I commenced the role, we were operating under a triumvirate model, whereby the Clinical Director worked alongside the Operational Manager and the Nursing Manager at directorate level for Adult Mental Health.
15. There were two Clinical Directors within the directorate: a medical Clinical Director and a non-medical Clinical Director. The medical Clinical Director focused primarily on matters relating to medical staff. During my tenure as Clinical Director, Dr. Gareth Foote was the non-medical Clinical Director. He is a psychologist by background. We operated what was in effect a job-share arrangement.
16. The Clinical Directors were line managed by the Associate Medical Director and Executive Medical Director and had regular supervision meetings with both of them.
17. The (not exhaustive) responsibilities of the Clinical Director included:
  - a. Medical Workforce management in AMH directorate: to facilitate adequate staffing levels from a medical workforce perspective, managing gaps and vacancies, recruitment and retention.

- b. Medical staff budget oversight and regular meetings with Trust finance partners to manage medical expenditure for AMH.
- c. First-line sign-off of Lead Consultant job plans.
- d. Second-line sign-off of consultant and SAS doctor job plans.
- e. Managing Conduct and capability issues relating to medical staff, which are referred to the Clinical Director.
- f. Managing complaints received by PALS or patient safety team about consultants, SAS doctors and occasionally resident doctors (this also involves input from Director of Medical Education and Health Education England).
- g. Participating in safeguarding meetings involving medical professional (PiPOT meetings) that requires Clinical Director input.
- h. Strategic input into service developments e.g. Community Transformation project
- i. Input into Quality and Risk meetings and other governance meetings
- j. Other governance meetings such as medicines optimisation group which encompasses matters relating to the Trust's pharmacy, implementing prescribing guidelines, audit of prescribing practices and cost improvement
- k. Liaise with Clinical Governance team on matters such as coroner's inquest request, input to Internal Working Instructions
- l. Input to Quality Oversight Group, Business and Performance meetings.
- m. Triumvirate meetings with senior management team comprising of nursing managers, operations managers and general manager in the directorate.
- n. Input to Senior Medical Staffing Committee meetings regarding matters relating to AMH
- o. Input to Interface meetings with external stake holders such as primary care, Integrated Commissioning Board and internally with other directorates and divisions on matters relating to AMH
- p. Meeting with Mental Health Act (MHA) lead and liaison with MHA / MCA office as required and allocation of Section 49 reports request from court.

- q. Patient flow and bed management meeting; this involved managing delayed inpatient discharges and supporting bed management team, facilitating complex case discussions etc.
  - r. Medical education and resident doctor-related matters: This involves close working with Director of Medical Education and Post graduate office to ensure as supervision arrangements are in place for resident doctors.
  - s. Facilitating academic research, Quality Improvement and service development projects
  - t. Supervising Lead Consultants
  - u. Occupational Health Referrals of medical staff where required
  - v. Supporting Human Resources and medical staffing team on matters related to recruitment, retention and on-call management
  - w. Approval of annual leave, study leave and authorisation of claims
18. Each component of the service presented its own distinct challenges for e.g. inpatient services were subject to persistent bed pressures, social barriers to discharge, workforce retention; community services faced issues of workforce retention, primary care interface, caseload management and throughput.
19. I was allocated 6 PAs for this role. I had 3.5 PAs for my clinical role as in-patient psychiatrist.

#### **EIP restructure**

20. As set out above, my responsibilities as Lead Consultant in 2019-2022 and Clinical Director 2022-25 were primarily line management of consultant psychiatrists and SAS doctors in Adult Mental Health.
21. Between 2019-2021, I was aware of the changes happening with the EIP team relating to its reorganisation as a standalone service as part of the Community Transformation project. I recall Dr. Adamson leading this project, although I do not recall having any conversations directly with Dr. Adamson during this time. I had just commenced my role as Lead Consultant and was not working directly with the EIP service and had no involvement in the relevant decision-making. I was not directly involved in any discussion or provided strategic input in a formal management role as it was primarily the Clinical Directors at the time who were directly involved in this.

22. I believe that the reason behind the project was that concerns had been raised regarding the performance of the EIP service, in that it was not meeting the relevant performance indicators at the time. My understanding is that Dr. Adamson was appointed to look at the existing EIP service model and its functionality and set up an alternative model. I believe this was also happening in the context of new funding that had become available through the community mental health transformation programme. I recall that Dr. Adamson prepared a business case for a new model which enabled certain funding streams to be earmarked for the EIP service.
23. My awareness of these developments would have been from AMH management meetings, AMH consultant forums (see for example, [WITN0206020]), and from supervision sessions with the Clinical Directors. I recall Michelle Malone, who was the Clinical Director at the time, mentioning this in meetings. I do not recall having direct involvement in this work.

#### Medical staff provision to EIP teams

24. Medical staff budget for all posts in AMH are based on financial plans set out in advance of the financial year. My understanding and experience is that there is little flexibility with the budget and I had very little influence over it other than to manage within the financial envelope. When I took over as Clinical Director in August 2022, the EIP medical model based on sessional input and the medical budgets were already set in place based on the plan as per the agreed service delivery model.
25. It was my understanding that the establishment budget allocated to EIP medical sessions were 3.5 Whole Time Equivalent (WTE) in the integrated model but with the Transformation Project and the new model there was some additional funding obtained for 1.0 WTE additional consultant time. However, this additional money was used to recruit senior pharmacist prescribers ([WITN0206021]; [NHFT0020192]; [NHFT0020200]). I was not involved in this decision, however it was my understanding at the time that the decision was made due to difficulties in recruiting and the distributed nature of the work between different EIP teams.
26. As a Lead Clinician, I was often asked to provide data on the medical sessions that EIP consultants had in their job plan (see, for example, [WITN0206022]; [WITN0206023]).
27. From time to time I was made aware of concerns relating to emerging short term EIP medical cover vacancies e.g. when a consultant is off sick or when a locum is

about to leave and I acted promptly to ensure cover is arranged without delay (see, for example, [WITN0206050]; [NHFT0020208]; [WITN0206024]; [WITN0206025]; [WITN0206026]). In relation to the example of Dr Burri (who was working as an agency locum consultant psychiatrist, which was a high cost pressure for the Trust), we subsequently managed to successfully recruit a Trust appointed acting consultant to the post.

28. Service Lead Kelly Simpson raised a request for utilization of medical budget to recruit to a Band 7-8A pharmacist post to replace a vacancy as per the previous arrangement. As above there was no additional money in the medical budget available to be used for EIP.

Caseload of EIP consultants:

29. EIP consultants had lower caseloads of Direct Clinical Care ("DCC") compared to a Local Mental Health Team ("LMHT") consultant. For example, a WTE EIP consultant (7.5 DCC sessions) would have approximately 150 -160 patients (see, for example, [WITN0206051]) whereas a WTE LMHT consultant would typically have a caseload of approximately 225 to 250 patients, sometimes higher. This equates to approximately 20-25 patients per DCC for EIP as opposed to 30-35 patients per DCC for LMHT consultants. All patients under EIP also had allocated Care Coordinator which is not the case for patients under LMHT
30. As per Dr. Adamson's email, which has a table of Trust wide EIP caseload of 650 patients, the calculation was for 4.5 WTE consultants for EIP across the whole patch [WITN0206022; WITN0206027]. Also, all EIP patients will have a dedicated care coordinator who also have a capped case load around 15-20 [WITN0206028]. There will always be minor variations to the actual numbers depending on the referral and discharge rates and time of the year.
31. The principal reference document for Consultant Psychiatrist job planning purposes that was in place at the time was the Royal College of Psychiatrists' report (CR 207) [WITN0206029], but that document did not specify caseload numbers for EIP and LMHT consultants. This absence of clear benchmarking created significant difficulty in practice. EIP consultants invariably carried a smaller caseload than their LMHT counterparts. However, to overcome the issue of no clear benchmarking, I developed a local guidance document for consultant job planning for Adult Mental

Health to use as a guide for job planning and presented it at the AMH consultants forum for approval and ratification [WITN0206030].

Job planning for Dr. Lloyd

32. As indicated above, in my roles as Lead Consultant and Clinical Director I was involved in the job planning for EIP consultants, including Dr. Lloyd, who was the consultant psychiatrist for City South EIP. Job planning meetings are typically held on an annual basis but could be arranged in between if necessary. The discussions held at the job plan meetings are recorded in the prescribed job plan document and once agreed it is signed by the clinician, the Lead Consultant and the Clinical Director or Associate Medical Director.
33. Consultant job plans are divided into two categories of PA: (1) DCC, which includes all direct clinical patient input such as clinics and multidisciplinary team discussions, clinical administrative time; and (2) Supporting Professional Activities ("SPA"), which covers training, supervision, and other non-clinical professional activities. A standard full-time job plan is ten PAs.
34. To the best of my recollection, Dr. Lloyd was working seven PAs on a part-time basis, comprising five DCC sessions and two SPA sessions. She had additional roles such as Less Than Full Time (LTFT) work champion and a role with Health Education England but gave up those roles. Of her five DCC sessions, the broad division was three sessions allocated to EIP work and two sessions to LMHT work. Her LMHT caseload was limited to patients with psychosis (some were previously under Assertive Outreach teams under a Cluster 16/17 and some would be under Cluster 11-15 as per the Mental Health Clustering Tool) who had allocated care coordinators.
35. Dr. Lloyd's job plan was signed off by Dr. Eileen O'Regan in 2019 [WITN0206031]; [WITN0206032]. I approved her subsequent job plans [WITN0206033] and exhibit to this statement the job plans agreed in 2021 [WITN0206034] and 2022 [WITN0206034].
36. Dr. Lloyd was part of the City South LMHT and EIP team. There were other LMHT consultants in the team. The EIP work was managed by Dr. Lloyd and supported by her higher specialty trainee at ST4-6 level. Higher trainees run clinics independently (take patients who are under consultant) but will receive supervision from their consultants.

37. Dr. Lloyd maintained a spreadsheet of all her patients as per the Mental Health Clusters. As per the spread sheets I received prior to her job plan meetings, her case numbers under EIP team (Cluster 10 patients) ranged from 68-88, averaging 78, her case numbers under LMHT ranged from 60-70. Her overall case load ranged from 140 – 150 [WITN0206036]; [WITN0206037].

Concerns raised with me by Dr. Lloyd

38. I recall Dr. Lloyd raising during her job planning meeting in 2020 a concern related to inadequate Supporting Professional Activity time (2 PAs). She requested not to be a named medical students' supervisor as a result. I requested her to liaise with the Director of Medical education and consider medical student to be placed in EIP team for experience but to relinquish named clinical supervisor responsibility. [WITN0206038]. She also raised with me the issue of cover when on leave [WITN0206039]. There was a duty consultant on-call rota in place as a backup for urgent matters.
39. In the 2022-2023 job plan meeting, she raised concern about not having capacity to see new referrals in EIP team due to clinic slots getting filled up [WITN0206040]. However, my understanding was that this was not to the extent of compromised waiting time for assessment or service performance indicators falling behind, new referral to EIP is expected to be assessed by an EIP worker (not necessarily a consultant) within 2 weeks of referral [WITN0206041]. Dr. Lloyd raised it in this context: that when she had a higher trainee placed with her this was manageable, but when there was a period of trainee vacancy this was difficult. Higher trainees are supernumerary and their allocation can vary every six months, which was not within the purview of clinical directors (Health Education England responsibility). Dr. Lloyd requested that she is not allocated any patient in LMHT without a Care Coordinator in order to limit her case load, and I agreed with this to enable her to manage the workload effectively. I believe all the patients under Dr. Lloyd's care had Care Coordinators. The job plan meeting discussion concluded that *"Overall the workload was felt to be manageable and cover arrangements have become easier"*
40. I was already aware that there are no additional sessions in medical budget for EIP as I review this regularly so I could not have allocated anymore resources to

address this unless there were any acute concerns like no capacity to see within the waiting time target which would have required escalation.

41. A separate concern was raised through an email from Dr. Lloyd about the medical secretaries not arranging appointments and sending letters but instead expecting Care Coordinators to arrange one [WITN0206042]. I replied to it explaining why it might be advantageous to arrange appointments through Care Coordinators.
42. For completeness, I also exhibit an email from Dr. Lloyd dated 30 April 2019 raising an issue about the discharge of Assertive Outreach patients, prior to the EIP restructure described above [WITN0206043]. We did not have Assertive Outreach teams at the time, but there was a Cluster 16/17 patients pathway which was referred to as Assertive Outreach. Dr Lloyd was replying to an email from Dr O'Regan (also one of the lead consultants for City community teams at the time) on a slightly different topic regarding caseloads.
43. I do not have any further memory about the issues being raised by Dr Lloyd and I did not discuss this with her directly. I am unaware whether Dr O'Regan spoke with Dr Lloyd. I also do not recall this issue being raised with me directly by any other colleagues, whether by email or in any meetings or forums. I am not sure who Dr Lloyd is referring to when she says "managers" or what she means by "pressures". I can confirm that I have never personally put pressure on anyone to discharge non-engaging patients. Consultant psychiatrists should be able to employ all checks and balances before discharging patients, and discharge will only be appropriate if all clinical factors are taken into consideration.
44. I asked the Trust to search my inbox for any other emails related to the email sent by Dr Lloyd. This resulted in the Trust locating a reply sent by another consultant (Dr Bert Park) to Dr Lloyd suggesting a meeting to discuss [WITN0206052]. I do not know whether this meeting took place. I also note that this email was sent around the same that the Trust's Programme Board made the decision to create 3 different referral pathways for the Local Mental Health Teams [WITN0206053] and, as discussed above, further structural changes were then made in late 2020.
45. In terms of reducing the overall burden of caseloads for all consultants in LMHT, I worked with the Transformational Lead Louise Randall and produced a business case for three additional Specialty Doctors post in the community mental health teams. The bid was successful and approved by the commissioners and we

appointed three additional specialty doctors in total across the LMHTs including for City South LMHT. This arrangement also helped the workload and cover arrangements in LMHTs particularly for less than full time consultants.

#### ARMS pathway

46. Kelly Simpson also asked for medical sessions to allocate towards a pilot service pathway called At Risk Mental State (ARMS) service, I facilitated conversations with the finances department about the need for medical session to the At Risk Mental State (ARMS) pathway, there were no dedicated EIP budget available that was unused and hence we agreed to use some slippage money to allocate medical time to the ARMS pathway (0.5 PA per week) [NHFT0020192]; [WITN0206044].

#### Performance

47. The oversight of performance of EIP team largely rested with the Divisional directors along with the General Manager of the AMH directorate and supported by the service leads, EIP manager, nursing manager, operational manger and clinical director.
48. I received regular updates from EIP team manager Ms. Kelly Simpson with EIP dash boards and my recollection was that the performance during the period of 2022-2023 were mostly in the level 2 or level 3 performance for KPI (see, for example, [WITN0206041])
49. In October 2024, Dr. Seedat also discussed with me his concerns about the waste of resources in EIP [WITN0206045].

#### **Recent changes made to the EIP service**

50. Following the tragic events on 13 June 2023, the Trust commissioned Jonathan Warran to conduct a review of the EIP service. I am aware that the Trust has set out the findings of that review in its corporate witness statement [WITN0133001] and I do not repeat those findings here. I also have not set out in this statement the details of all of the discussions and meetings that happened since the review for the purpose of this statement.
51. In brief, the Trust arranged feedback sessions to discuss the findings of the review (see, for example, [WITN0206046]; [NHFT0008990]).

52. One of the recommendations was to bring together the EIP teams to create two unified teams: one for City and one for County [NHFT0020090]. This required a major overhaul of the job plans of existing consultants. I had initiated the conversation amongst consultant bodies in the AMH consultant forum and in the EIP consultant peer group meeting on 13 March 2024 [WITN0206047]; [WITN0206048]. This would involve some consultants giving up the EIP role and expand their role in LMHT in order to make up for the sessions given in EIP, and likewise some EIP consultants taking up additional EIP work in order to fill up the session given by others. There was no consensus view reached within the time period I was a Clinical Director, and I stepped down from this role in 2025. I am not privy to any further recent discussions or outcomes in this regard.
53. I was also aware the EIP independently considered what changes needed to be made, such as admin support for MDT meetings [WITN0206049].

Statement of Truth

I believe the content of this statement to be true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

**GRO-B**

Signed: \_\_\_\_\_

Dated: 2 July 2026

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| 3.  | WITN0206017    | Email correspondence re: AMH Strategy on recruitment and retention of consultants             |
| 4.  | WITN0206018    | Email correspondence re: LMHT issues                                                          |
| 5.  | WITN0206019    | Email correspondence re: LMHT issues                                                          |
| 6.  | WITN0206020    | Email correspondence re: DRAFT guide to team and consultant job planning                      |
| 7.  | WITN0206021    | Email correspondence re: EIP medic money allocation                                           |
| 8.  | NHFT0020192    | Email correspondence re: ARMS pathway, pharmacy structure and EIP consultant money allocation |
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| 10. | WITN0206051    | Email Correspondence re: caseloads                                                            |
| 11. | WITN0206022    | Email correspondence re: Confirming medical sessions that T. Lloyd had on job plan            |
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| 20. | WITN0206029    | Royal College of Psychiatrists' report (CR 207) - Safe patients and high-quality services     |

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| 22. | WITN0206031 | Email correspondence from Tuhina Lloyd requesting sign off for job plan                                 |
| 23. | WITN0206032 | Dr Tuhina Lloyd Job Plan, Work Programme and Objectives<br>Schedule 2019-2020<br>Dated: 17 July 2019    |
| 24. | WITN0206033 | Email correspondence re: Tuhina Lloyd's Draft job plan                                                  |
| 25. | WITN0206034 | Dr Tuhina Lloyd Job Plan, Work Programme and Objectives<br>Schedule interim 2022<br>Dated: 21 July 2021 |
| 26. | WITN0206035 | Job Plan Jul 2022 - Jul 2023 (complete) Dr Tuhina Lloyd                                                 |
| 27. | WITN0206036 | Cluster Spreadsheet                                                                                     |
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| 29. | WITN0206038 | Email correspondence from Tuhina Lloyd re: Clinical supervisor for medical student                      |
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