IN THE NOTTINGHAM INQUIRY

BEFORE HER HONOUR DEBORAH TAYLOR

OPENING SUBMISSIONS ON BEHALF OF CELESTE AND ELIAS CALOCANE

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1. These submissions are made on behalf of Valdo Calocane's mother and brother, Celeste and Elias.

2. This Inquiry arises from the horrific crimes committed by Valdo on 13 June 2023. He killed Barnaby Webber, Grace O'Malley-Kumar and Ian Coates, seriously injured Sharon Miller, Wayne Birkett and Marcin Gawronski, and devastated the families of the victims.

3. Celeste and Elias wish to express their deep sorrow and condolences to the victims of Valdo's horrendous acts, the families of the victims, and everyone else affected by those acts. They invite the Chair to do all she can to identify what went wrong, and what changes can be made to try to avoid something like this happening again.

4. On the basis of the disclosure provided by the Inquiry so far, Valdo's family have a number of concerns about the conduct of the health, University, police and other authorities that Valdo came into contact with. The concerns are both about the conduct of individuals but also of the systems and procedures that were in place at the time of these events.

5. The family of course remain open minded about everything that follows and are keen to explore these issues further in the oral evidence. What is set out below is an outline of some of the questions Valdo's family have for the witnesses as the Inquiry progresses.

6. These submissions will start with the health services, then consider the University of Nottingham ('UoN') and the police, and the communication or coordination between them all.

The Health Services

7. In order to analyse whether appropriate care and treatment was provided by the health services, it is necessary first to understand Valdo's illness.

Valdo's illness

8. Dr Seedat gave Valdo the primary diagnosis of paranoid schizophrenia on 31.07.20.[1] A number of other psychiatrists who were involved in Valdo's care agreed that he had paranoid schizophrenia, including Dr Lomas,[2] Dr Shoilekova,[3] Dr Gurusinghe,[4] Dr Aziri,[5] and Dr Gibson;[6] as did the Mental Health Tribunal on 24.9.21.[7] The four expert psychiatrists who reviewed Valdo for the purpose of the criminal trial confirmed the diagnosis of schizophrenia.[8] Valdo's treating psychiatrist, Dr Ross Mirvis also explained that the diagnosis was of treatment resistant schizophrenia.[9] Treatment resistant schizophrenia requires the presence of three elements: (1) a confirmed diagnosis of schizophrenia based on validated criteria; (2) adequate pharmacological treatment; and (3) persistence of significant symptoms despite this treatment.[10] It does not follow from that diagnosis, however, that proper treatment and management of Valdo's condition from when it was diagnosed could not have addressed his risk to others.

9. The illness appears to have begun around 2020. Valdo had no history of mental health problems earlier in life.[11] He had never been alleged to be involved in crime.[12] He grew up in Portugal, having moved there from Guinea-Bissau at the age of 3, and has Portuguese citizenship. He

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[1] NHFT0000222/3. References in this document in the form NHFT0000222/3 refer to NHFT0000222_003
[2] NHFT0000168/188
[3] CYGN0000060/3
[4] CQCM0001525/1; NHFT0000068/1
[5] NHFT0000068/1
[6] NHFT0000168/250
[7] CYGN0000056/4 §9
[8] For example, Professor Blackwood: CPSE0000056/1 §5
[9] CPSE0000484/27; WITN0073002/10
[10] NHSE0002287/4
[11] NHFT0000168/2 (Dr Gandhi and Dr Malik)
[12] NHFT0000168/2 (Dr Gandhi and Dr Malik)

moved to the UK in 2007, aged 16, and in 2020 was studying for a degree of mechanical engineering at the University of Nottingham ('UoN').

10. The triggers for him falling ill in 2020 appear to have been stress from university course work and exams, sleep deprivation, isolation and the impact of lockdown. Many clinicians said that sleep deprivation and stress caused his illness, including Dr Gandhi, Dr Malik,[13] Dr Sadraei,[14] and Dr Seedat.[15] It was not caused by drugs. Valdo's blood was tested on 24.5.20 and it was clear of drugs.[16] It was tested again a number of times when he was an inpatient, and there is no evidence that any illicit drugs were detected.[17] The medical notes repeatedly stated that he had no history of use of illicit substances[18] and that there was no indication that the psychosis was drug induced.[19] Elias had never known Valdo to take drugs, except for one occasion when Valdo tried cannabis,[20] and Valdo's flatmate, Sebastian, had never known Valdo to take recreational drugs.[21] Professor Blackwood explained further evidence that the illness was not caused by drugs: namely that Valdo continued to display symptoms for some time after being admitted to hospital, when he would have had no access to illicit substances.[22]

11. Valdo's illness caused him to suffer from a system of delusions, hallucinations and other symptoms, which led him to commit a series of acts of violence against people or property. (We use 'violent' here in the broader sense of being violent to people or property, as used by the LCJ in Attorney General's Reference (No 1 of 2022) [2023] KB 37, §87). His risk was considered by staff and by the CQC experts, to be exclusively driven by his psychotic symptoms.[23] Similarly, Dr Craissati considered "*Risk of violence was only associated with a deterioration in his mental state and active symptoms of psychosis*".[24]

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[13] NHFT0000168/2 (Dr Gandhi and Dr Malik)
[14] NHFT0000168/5
[15] NHFT0000168/11
[16] NHFT0000168/1-2 (Mr Lloyd); CQCM0000753/2 (Dr Seedat)
[17] NHFT0000168/29, 65, 148
[18] NHFT0000168/2 (Dr Gandhi, Dr Malik)
[19] NHFT0000168/7 (Dr Seedat, Dr Ludvigsen, Dr Ibrahim)
[20] WITN0087001/4§14
[21] WITN0151001/2 §6
[22] CPSE000011/22 §97; WITN0308001/20 §43. See also Dr Mirvis CPSE0000484
[23] CQCM0013648/5 §§77, 100-101
[24] NHFT0000482/32 §100

12. Those violent acts included the following:

a. On 24.5.20 he kicked down the door of a neighbour's flat. He told medics what led to this was he heard his mother screaming and heard people telling him that his mother was being raped and was in pain. He heard the screaming in the flat upstairs and this was the reason for trying to break the door down.[25]

b. One hour after he arrived home[26] on 24.5.20 he tried to break down the door of another neighbour's flat. Fearful for her life she jumped out of a first floor window, resulting in serious back injury requiring surgery.[27] Dr Malik noted Valdo said he was: "...a*cting in response to hallucinatory experiences. He believes he could hear his mum screaming in pain and in danger"* and "*hearing voices talking about his mum being raped*".[28]

c. On 14.7.20 Valdo tried to force his way into a neighbour's flat. He was restrained on the floor by a number of residents. Valdo told Dr Seedat and Dr Manzar that he heard unpleasant voices inside his head, discussing him, which were coming from his neighbour's flat, and barged into the flat trying to confront them.[29] He believed "*someone was in danger*".

d. On 3.9.21, when a s.135 MHA warrant was being executed, Valdo "*seriously and repeatedly assaulted a male police officer… He punched and headbutted him several times, and was able to wrestle the handcuffs off a female officer to use as a weapon*". PAVA and a taser were discharged a number of times. It appears the officer needed hospital treatment.[30]

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[25] NHFT0000168/1-2 (Dr Gandhi, Dr Malik); NHFT0000006/2 (Ms Palmer, 24.5.20)
[26] Celeste had asked police to keep him in custody: WITN0085101, §21
[27] NHFT0000168/3 (Mr Todd, 24.5.20); CYGN0000047/2 (Dr Shoilekova); WITN0252001/4 §16 (Neighbour)
[28] CQCM0000977/18
[29] NHFT0000037/4, 6; CHCA0000028/3 (Dr Ibrahim)
[30] NHFT0000168/165, 167 (Dr Lomas, Dr Manzar and Ms Chapman)

e. Dr Shiolekova explained what led to this: "*Prior to current admission [he] accused [the community team] of conspiring against him with the Judiciary to transmit voices into his mind… systematised delusions of conspiracy and persecution persist – subject to psychotronic harassment orchestrated by health authorities…*".[31] Valdo said the induced thoughts were "*continuous, generally unpleasant thoughts and they were in the form of voices and other kinds of stimuli like tactile stimuli of being pierced with pins and needles*".[32]

f. The Mental Health Tribunal on 24.9.21 concluded that "*Valdo's delusions were sufficiently severe and distressing so as to cause him to seriously assault a police officer*" and this was the second time his illness resulted in significant injury.[33]

g. On 15.1.22 Valdo held two flatmates hostage and assaulted one (or perhaps both) of them, "*acting strangely*". This was described by Dr Lomas as "*highly concerning*"[34]. There had been concerns about his presentation for about a month. Valdo had been emitting short screams in his room. He also entered a flatmate's bedroom in the middle of the night, asking "*can you hear that screaming*".[35]

13. As a result, the Mental Health Tribunal and clinicians concluded that "*There is unequivocal evidence that the risks to others when Valdo is unwell are high*".[36] As Dr Shoilekova put it: "*When he is unwell the risks are serious*".[37] Valdo caused serious harm in both May 2020 and September 2021, when he was described as using "*extreme levels of violence*".[38] Indeed on 16.7.20 Dr Seedat said "*perhaps Valdo will end up killing someone*".[39]

14. It was therefore of great importance that Valdo's illness was properly treated and managed.

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[31] CYGN0000061/3-4
[32] CYGN0000060/3
[33] CYGN0000056/5 §12(iii)
[34] NHFT0000168/215, 28.1.22. See also UNIN0000194 (Chris)
[35] NHFT0000168/228 (Chris, 4.2.22)
[36] CYGN0000056/5 §13(i) (MHT, 24.9.21). See also CQCM0001240/2 (Dr Lomas, 3.9.21); CQCM0001661 (Ms Modern and Ms Parker, 28.1.22)
[37] CYGN0000056/3 §3
[38] CYGN0000001/182 (MDT, 21.9.21)
[39] NHFT0000168/64

15. For most of the time, particularly latterly, Valdo had no insight into his schizophrenia. That is, his illness made him believe that the delusions and hallucinations he suffered were real, that he did not have a mental illness, and that he did not need treatment or medication.[40] Dr Burri noted that Valdo explained that "*the voices consist of people from many different departments including MI6, Police, etc… He believes the voices are real experience and not the result of mental illness*".[41] Dr Shoilekova explained: "*He believed voices are transmitted to his mind by the authorities, and were not a symptom of mental disorder, hence … he stopped taking his antipsychotic medication*".[42]

16. His symptoms also included paranoid, suspicious and persecutory delusions that medical professionals (with other agencies) were conspiring against him and harassing him.[43] For example, Ms Birtles and Mr Carter explained Valdo said he "*knows we will have to 'feedback to the higher powers'… [he is] not willing to engage any further with treatment… Appears to believe he is more at risk by engaging with us… didn't trust our intentions so remained very guarded in his responses*".[44] Ms Jacques explained on 24.9.21 that Valdo "*believes that the voices he hears have been manufactured using technology set up by the health professionals to make him believe that he is ill. He was clear that he believed that his CPN was actively involved in this conspiracy*".[45]

17. These symptoms had several important consequences which were well-recognised in the medical notes:

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[40] CYGN0000047/3 (Dr Shiolekova, 17.9.21); CYGN0000001/5, 135 (Dr Shiolekova, Ms Mutonono); NHFT0000190/5 (Ms Birtles, 28.2.22); NHFT0000168/137-8, 191 (Dr Burri, 10.11.20, Ms Birtles, 17.9.21)
[41] NHFT0000168/137-8 (Dr Burri, 10.11.20)
[42] CYGN0000047/3-4 (17.9.21)
[43] CYGN0000061/3-4 (Dr Shiolekova, 21.9.21); CYGN0000054/14 (Dr Manzar); CYGN0000052/13; CYGN0000001/133-134, 173 (Ms Birtles, 31.8.21); NHFT0014619/7 (Ms Birtles, 17.9.21); NHFT0000168/223, 225 (Dr Gibson, 2.2.22; Dr Thangavelu, 3.2.22); NHFT0000288/8 (Dr Manzar, 28.1.22)
[44] NHFT0000168/162, 197 (Ms Birtles, 31.8.21); NHFT0014619/7 (Ms Birtles, 17.9.21); NHFT0000190/5 (Ms Birtles, 28.2.22)
[45] CYGN0000052/13

a. They led him to stop taking medication, and to disengage from medical supervision.[46]

b. They made him disguise or mask his symptoms from medical professionals and others, and to feign taking medication. [47]

c. As the key clinicians recognised, this meant Valdo may not present as overtly psychotic, even when he was very unwell just before an incident of violence.[48]

Risk factors

18. There were a number of risk factors: signs that Valdo's illness was or may have been relapsing and therefore he was a risk of harm.

19. First, not taking medication was a critical risk factor. The clinicians repeatedly emphasised the importance of Valdo taking medication.[49] The Mental Health Tribunal said "*it is essential that medication is maintained and optimised*".[50] The CQC observed that the evidence *"indicated beyond any real doubt that Valdo would relapse into distressing symptoms and potentially aggressive and/or intrusive behaviour if he was not treated with antipsychotic medicine…"*.[51] This reflected the NICE Guideline on Psychosis which said that there was a *"high risk of relapse if people [with psychosis] stop medication"*.[52]

20. Valdo was non-concordant with medication before each of his relapses. On 14.7.20 Dr Seedat recorded Valdo suffered an "*acute relapse due to non-concordance with medication*".[53] He said that Valdo stopped taking medication around the start of July because he believed he was

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[46] CYGN0000047/3-4 (Dr Shoilekova, 17.9.21); NHFT0000190/5 (Ms Birtles, 28.2.22); NHFT0000168/162 (Ms Birtles and Mr Carter, 31.8.21), 197 (Mr Waldron, 3.11.21); CHCA0000028/3 (Dr Seedat, 31.7.20)
[47] NHFT0000168/52 (Ms Baker), 56 (Mr Wade), 138 (Dr Burri), 162 (Ms Birtles), 191 (Ms Birtles), 205; CHCA0000012/5 (Dr Gurusinghe, 21.10.21); CYGN0000054/23 (Ms Staples, 4.9.21)
[48] NHFT0000168/215 (Dr Lomas and Dr Manzar, 28.1.22)
[49] NHFT0000168/79 (Dr Seedat); CHCA0000012/11, 13 (Ms Parton, 21.10.21)
[50] CYGN0000056/5 §12(v)
[51] CQCM0013649/25; CQCM0016518/8, 39. Similarly, see: NHFT0000482/15 §45 (Dr Craissati)
[52] NICE0000015/27 §1.4.6.3
[53] NHFT0000168/81

well, and he then started to hear voices.[54] The same was recognised by clinicians in respect of Valdo's relapse prior to his 3.9.21 admission,[55] and the January 2022 admission.[56]

21. Another demonstration of the importance of medication for Valdo is that when he was reliably medicated in hospital, his condition apparently improved. There was evidence of this during his first,[57] second,[58] and third[59] admissions to hospital. (It should however be noted that, although medication appears to have tackled Valdo's acute psychosis and thereby addressed his risk to others, it did not entirely eliminate his symptoms. There is evidence that he continued to hear voices for much of the time even when medicated.[60] In this sense, he was 'treatment resistant'. An issue to be explored is whether the extent to which medication and other forms of treatment reduced his symptoms, changed as time went on.

22. A second risk factor was Valdo disengaging from services. Disengagement included missing appointments or phone calls, or otherwise refusing to have meaningful contact. There was little engagement with him in the two weeks prior to the violent incident and admission to hospital on 14.07.20: only one brief face-to-face meeting in a car park.[61] He also disengaged prior to each of the violent incidents which led to his admission to hospital in September 2021[62] and January 2022.[63]

23. A third relapse factor was that Valdo was particularly guarded and suspicious prior to previous relapses. For example, he was relatively open and welcoming after discharge on 31.7.20[64] until mid-August 2021. Then from 19 August 2021 until his admission, he was increasingly guarded

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[54] NHFT0000037/6; CHCA0000028/3. See also: CQCM0001367/1-2 (Ms Birtles)
[55] NHFT0000168/181, 185 (Dr Mambro); CQCM0005446/2 (Psychologist 'EG', 22.9.21); CYGN0000054/21 (AMHP Ms Staples)
[56] NHFT0000168/204 (Ms Green), 206 (Dr Skelton), 209 (Mr Crolla), 212 (Ms Baker), 219 and 225 (Dr Stowell)
[57] NHFT0000168/35-36 (Dr Seedat); NHFT0000021/1 (Ms Samila)
[58] CHCA0000028/3 (Dr Seedat)
[59] CYGN0000052/46 §12; NGPF0003464 (21.10.21)
[60] E.g. NHFT0000168/138 (Dr Burri, 10.11.20)
[61] NHFT0000168/54 (3.7.20 to 14.7.20 entries)
[62] NHFT0000168/163 (Ms Masterton, Ms Van Ham); NHFT0014619/5 §16 (Ms Birtles); and he missed some appointments: NHFT0000211/5 and NHFT0000168/161 (Ms Parsonage, 24.8.21)
[63] NHFT0000168/197-203 (Ms Birtles, Dr Lloyd, Ms Pinder), 210-211 (Mr Mahachi), 215 (Dr Lomas and Dr Manzar); and he missed numerous appointments: NHFT0000211/7
[64] NHFT0000168/130 (Mr Chimbi)

and suspicious.[65] He was ever more guarded and hostile from mid-December 2021 until his admission in January 2022.[66]

24. A fourth factor that was a sign that he was relapsing was trespass and/or violent behaviour. This was associated with all of his known acute psychotic episodes.[67] For example, on 24.5.20 he was released shortly after the first violent incident, and almost immediately committed a second, this time resulting in serious injury.

25. Other risk factors may be identified. A fifth risk factor may be strange or unusual behaviour. Shortly before the 14.7.20 incident, Celeste raised concern that Valdo "*wasn't making much sense*" and medics noted he was distracted, with delay in his answers.[68] A couple of weeks before the September 2021 incident Valdo walked into the Rowan Ward, asking to speak to Dr Seedat about the voices he was hearing, and asking whether staff on the ward could hear the voices and whether they communicate with Artificial Intelligence.[69] And in the month before the 15.1.22 violent incident, he prohibited all contact with his mum, was heard to be emitting short screams, and entered a flatmate's bedroom in the middle of the night and asked *"can you hear that screaming"*.[70]

The conduct of the health services

26. The disclosed evidence suggests that there were a number of failures by the health services.

Failure to ensure Valdo received a depot

27. During his third admission, when he was detained under s3 MHA, Valdo should have been placed on a community treatment order ('CTO') with a condition that he take depot anti-psychotic medication. He should have been detained under s.3 of the Mental Health Act 1983

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[65] NHFT0000168/161-2 (Ms Parsonage and Ms Birtles)
[66] NHFT0000168/202 (Ms Parsonage), 205 (Dr Skelton), 207 (Ms McPherson), 208 (Ms Matikiti)
[67] CQCM0013649/26-27
[68] NHFT0000168/54-55 (Ms Coleman and Mr Jackson)
[69] NHFT0000168/160 (Ms Smillie)
[70] NHFT0000168/201 (Ms Birtles), 228 (Dr Gibson)

('MHA') in his fourth admission and then placed on a CTO with a condition that he take a depot.[71]

28. By the time of the third, and certainly the fourth, admission, it was clear that a depot was necessary. Not taking medication was a critical risk factor that led Valdo to become psychotic and in consequence to be a high risk of harm to others. So, it was very important he was properly medicated. Valdo plainly could not be relied on to take oral medication in the community. This was demonstrated by his history, whereby his relapses in July 2020, September 2021 and January 2022 were preceded by him stopping medication. It was evident from his recognised symptoms, including that his delusion meant he thought he was not ill and did not need medication; and his paranoia drove him to think those prescribing the medication were conspiring against him. Thus, as the CQC concluded, it was highly likely that he would not be concordant with medication in the community.[72] Any assurances from Valdo that he would take his medication in the community were plainly not reliable.

29. We invite the Inquiry to consider whether another benefit of a depot is that if Valdo was properly medicated, there was a greater chance that his underlying condition could be managed – whether by CBTp, psychoeducation, or otherwise.

30. As to the mechanism, a Community Treatment Order ('CTO') could have been imposed at the time of discharge from s.3 MHA on 18.10.21. By the time of the January 2022 admission, it would have been appropriate to detain Valdo under s.3 MHA, rather than s.2 MHA, which would have enabled a CTO to be imposed. That is for the reasons given by Dr Craissati[73] and the CQC.[74] He met all the criteria for admission under s.3, and by that stage his condition was already well-known so admission was not necessary for assessment under s.2.

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[71] CQCM0013649/24
[72] CQCM0013649/24. See similarly: NHFT0000482/15 §45 (Dr Craissati)
[73] NHFT0000482/14 §§41-42
[74] CQCM0013649/15-16

31. There is one occasion when the medical notes record Valdo claiming he 'didn't like needles'.[75] That should not have been a barrier to a depot being a condition of a CTO. He was given injections during this period, such as vaccinations for covid in 2021, without any record of a complaint.[76] The medical notes record numerous other occasions when a depot was discussed with him, and in none of them did he mention any phobia of needles.[77] In any event, a depot should have been imposed even if Valdo didn't like needles, because it was so clearly needed. Further, it is doubtful that he had capacity to refuse medication,[78] and this should at least have been assessed.[79] Celeste,[80] Ms Birtles,[81] the community team,[82] and Dr Shoilekova[83] appear to have thought that he should have been on a depot. Professor Blackwood was right to say that, for those such as Valdo, depot was essential,[84] and that this should have been established by longer periods of inpatient care.

Other care and treatment

32. It appears from the records that there was a failure to provide appropriate care and treatment for first episode psychosis and schizophrenia. NICE Guidelines and Standards indicate that within 2 weeks of referral to the Early Intervention in Psychosis ('EIP') team, the patient should be provided with a full range of treatment, including psychological and educational interventions, and Cognitive Behavioural Therapy for Psychosis ('CBTp').[85] Valdo was on the first episode psychosis pathway,[86] and plainly needed treatment. Dr Shoilekova noted that it was essential that this began early.[87] This was in part because Valdo was more open to discussing his illness and receptive to treatment at an earlier stage.[88]

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[75] NHFT0000168/226 (3.2.22)
[76] CHCA0000030/2
[77] Examples are NHFT0000168/64; CQCM0001367/2; NHFT0014619/7 §§19, 29; CYGN0000033/3; NHFT0000198/4
[78] CQCM0016518/18; CQCM0013649/21
[79] Dr Gibson appears to accept this: WITN0205001/37 §98
[80] NHFT0014619/7 §20
[81] NHFT0000168/238-239; WITN0348001/113 §343
[82] NHFT0000168/250-251
[83] CYGN0000047/5
[84] WITN0308001/27 §55(ii)
[85] CQCM0028993/15, 17, 19; NICE0000015/17 §§1.3.1.3, 1.4.4.1
[86] CQCM0001367/2-3
[87] CYGN0000056/3 §3 (Dr Shoilekova)
[88] E.g. NHFT0000168/115, 142-3

33. There is no evidence of an assertive and proactive programme being provided. For example, it appears Valdo was not provided with sufficient psychoeducation and CBTp, either in hospital or in the community. He was offered CBTp on several occasions and was open to it initially.[89] But he does not appear to have been actually provided with it. This was unfortunate since later on, in December 2020, he began to decline CBTp.[90] It does not appear that he was encouraged to change his mind. Further, as the CQC explain "*no ... interventions related to his psychoeducation*[91] *... were offered ... This was a missed opportunity in Valdo's care and goes against NICE guidelines on first-episode psychosis*".[92]

34. There is evidence this may have been a systemic problem. The CQC found that the approach to psychological therapies in community mental health services was inconsistent.[93] As Ms Birtles put it: "*Until this changes further incidents will happen: services need to move nationally to proactive rather than reactive models".*[94] We invite the Inquiry to consider whether this lack of assertive therapy was due to lack of resources, since in some teams, including the EIP team, all psychology posts were vacant at the time of the review.[95]

35. More broadly, there was at times insufficient face-to-face contact and monitoring while Valdo was in the community. An in-person assessment was important to detect if he was unwell,[96] but at times the community contact was by phone, or fleeting.

Discharge planning

36. A linked problem appears to have been inadequate discharge planning after hospital admission. One example is that, as the CQC observed, in both Valdo's third and fourth admissions, discharge planning did not address or take into consideration the previous failures in the community, which had led to him relapsing into psychosis and becoming violent.[97] There was

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[89] NHFT0000168/139 (Ms Birtles, 17.11.20)
[90] NHFT0000168/140-1 (Dr Burri and Ms Birtles)
[91] There is a note of a short informal session of psychoeducation on 7.9.20 (NHFT0000168/63, 65). This was plainly not sufficient to meet the NICE Guidelines.
[92] CQCM0016518/21
[93] CQCM0016517/35
[94] WITN0348001/160 §490(iv)
[95] CQCM0016518/21; CQCM0016517/42
[96] NHFT0000168/51 (Dr Seedat)
[97] CQCM0016518/38

no plan for how to effectively prevent him disengaging and stopping medication, which was inevitable by February 2022. A second example is that there is evidence that the community team[98] were not adequately involved in discharge planning after those admissions. A third example is that the discharge plans[99] were very limited and did not identify substantive ongoing care and support for managing and treating his condition in the community. We invite the Inquiry to consider whether the expertise and knowledge of the inpatient and community teams should have been better brought together to identify a robust care plan at the point of discharge, with at least some communication with the UoN Mental Health Advisory Service ('MHAS').

37. This appears to have been systemic. The CQC found *"little evidence of discharge planning in care plans"* across the Nottinghamshire Healthcare NHS Foundation Trust ('NHFT') community mental health and crisis services.[100] The flaws included people being discharged without any emergency plan or community support in place.[101] Further, the NHFT discharge policy was unfocused and vague.[102]

Risk assessment and crisis planning in the community

38. Five risk factors – that is, signs he was relapsing and his risk was increasing - have been identified above: (1) Valdo stopped medication (the critical factor), (2) he disengaged, (3) he became more guarded and suspicious, (4) trespass/violence, and (5) strange/unusual behaviour.

39. There should have been, somewhere, a clear risk assessment and crisis plan for the community which identified the significant risk factors; the risk associated with relapse; together with an effective plan for how to respond to those risk factors when they arose.[103] There was not.[104]

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[98] Ms Parsonage says they had not been informed prior to discharge: NHFT0000168/193-4
[99] NHFT0000222/3-4
[100] CQCM0016517/30, 37
[101] CQCM0016517/38
[102] NHFT0000045. The 2024 DoHSC policy is a much more helpful document: PHSO0000010/15 16
[103] CQCM0013648/6 §79; NHFT0000482/25 §§78-79 (Dr Craissati)
[104] *Ibid;* CQCM0013649/16; CQCM0013648/4 §75

The written plans were inadequate in Valdo's circumstances.[105] This is particularly surprising since Ms Birtles had recognised the need to identify signs of relapse and how to respond to them.[106]

40. Further, as the CQC noted, the risk assessments minimised or omitted key details relevant to risk.[107] There was a failure to review the risk assessment and care plan in July 2022 or before discharge to the GP.[108] The CQC considered this review "*would have been crucial*" at that time in highlighting the risk of relapse.[109] As will be seen below, there are also concerns that clinicians did not become aware of important information relevant to risk.

41. There appear to have been systemic problems linked to this. The CQC found: "*The quality of care planning and risk assessment [in the Trust] was inconsistent, and we saw limited evidence of patients and their families and carers being involved in their care plans*".[110] Theemis concluded that "*A lack of Trust-wide clinical risk management policy... meant that risk assessment was not based on best practice*".[111] Professor Smith states that the view of the Royal College of Psychiatrists is that "*the principles of best practice set out in*" their 2016 RCPsych "*Guide and Report [CR201] are not well integrated into psychiatric clinical practice*".[112] Those principles include the need to gather as much information as possible including from outside sources, to specify risk factors, and identify a management plan to reduce risk.[113] Professor Smith also considers there is a need for a national, standardised tool for risk assessment, together with minimum training and documentation.[114]

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[105] The last version before the attacks appears to be that dated 14.2.22 (NHFT0000198/5). This was focused on going AWOL from hospital, and did not identify how risk would be managed in the community. The previous version dated 2.2.22 (NHFT0000199/p4) started with "*seek support from family and friends*" even though Valdo said he didn't want his family bothered about his illness, and his records stated "*not in contact with friends*": NHFT0000168/143. See also NHFT0000191 and NHFT0000192
[106] CQCM0001367/3
[107] CQCM0013649/16-19
[108] The last assessment that has been disclosed was 28.2.22, and this stated there would be a review on 28.7.22: NHFT0000190/5. See also CQCM0013648/4; CQCM0016518/18
[109] CQCM0013649/19
[110] CQCM0016517/p30
[111] NHNB0018966/134
[112] WITN0320001/15 §49
[113] WITN0058002/36, 38 (The 2016 RCP Guide and Report)
[114] WITN0320001/17 §§54, 119-120

Failure to recognise signs of relapse and respond appropriately in 2022 and/or 2023

42. There were glaring signs that Valdo was relapsing from early summer 2022. As to the crucial risk factor, Valdo stopped taking his medication. On 18.8.22 Mr Carter noted Valdo "*has not been supplied with medication now for several weeks*".[115] All of the other risk factors that have been identified above were also present:

    a. He disengaged from the community team.[116]

    b. He became very guarded and tried to avoid contact from the team.[117] He also appeared "suspicious/distracted", "looking around".[118]

    c. As to trespass/violent incidents, on 21.4.22 he trespassed at his old Raleigh Park accommodation, and had to be escorted off site.[119]

    d. There was strange or unusual behaviour including an odd call to Ms Birtles on 19.4.22;[120] falsely claiming he was not in the UK and giving a false address.[121]

43. There were other important incidents which it appears the health services did not become aware of: Valdo was found ringing the doorbell of MI5 on 31.5.21, Valdo apparently assaulted, followed or stalked his former flatmate on 5.7.21, 14.7.21,[122] 26.4.22 and 28.7.22;[123] a bench warrant was issued for his arrest in September 2022; and he committed serious violence at work in May 2023. Valdo's family invite the Chair to investigate whether there was a failure by outside agencies to pass on this information to the health services, and/or a failure by the health services to seek input from other agencies.

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[115] NHFT0000168/270
[116] NHFT0000211/9, showing numerous DNAs from 10 June 2022 until discharge.
[117] NHFT0000168/267-270 (Ms Birtles, Mr Carter, Dr Lloyd)
[118] NHFT0000168/268 (Ms Parsonage, 15.6.22)
[119] NHFT0000168/266
[120] NHFT0000168/264-5
[121] NHFT0000168/268-279 (Ms Birtles and Mr Carter)
[122] Valdo was not seen on this occasion but Sebastian's evidence is that he suspected that this was Valdo; WITN0151001/6 §37
[123] CPSE0007848/6

44. Key protective factors had also been lost: Valdo had substantially disengaged from his family, and his long-term Care Coordinator ('CCO') Ms Birtles had been replaced. This was significant to the risk of relapse.

45. There was in consequence a high risk that Valdo was relapsing by August 2022. As was well recognised, when he relapsed into psychosis, Valdo was a high risk of harm to others.[124] This should have been recognised and effective steps taken to protect the public. For example, there should have been an attempt to assess him, and if the team could not be satisfied that he was well and genuinely taking his medication, he should have been assessed for detention in hospital.[125]

46. Instead, the opposite occurred: he was discharged to his GP. This was disastrous, as it meant the assertive monitoring and treatment which he so clearly needed, was entirely absent.

47. The CQC and Dr Craissati[126] drew attention to a number of other apparent failings linked to the discharge from the EIP team. There was a failure to perform a face-to-face assessment prior to discharge,[127] which would have been important to detect if he was unwell.[128] There was a failure to inform or liaise with Valdo's family.[129] It appears there was a failure to consult the GP (or university or police) and failure to provide a handover to the GP, including a risk formulation and crisis plan.[130] The GP was given little information about Valdo's risk, such as the risk associated with non-concordance with medication.[131]

48. There are a number of systemic concerns linked to the discharge. The CQC identified similar failings relating to disengagement and discharge planning in a number of other NHFT cases.[132]

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[124] See §§10-12 above
[125] CQCM0013649/25; CQCM0016518/8,39
[126] NHFT0000482/26 §81
[127] NHFT000168/270 (Mr Carter)
[128] NHFT0000168/51 (Dr Seedat)
[129] CQCM0016518/6; CQCM0013649/25; CQCM0013648/7 §81
[130] CQCM00013648/7 §81
[131] WITN0084002/12 §§65,75 (Dr Baker)
[132] CQCM0016518/28, 31, 37, 39; CQCM0016517/4

It appears that non-engagement with the EIP team had become an accepted reason for discharge,[133] yet in some cases it was a serious risk factor. There was no guidance for the EIP team about how to manage a patient who disengaged.[134] There are resource concerns: Mr Carter seems to have had more cases than he should have had;[135] and there was wider evidence that NHFT community mental health teams did not meet the needs of the local populations.[136]

Failures to involve Valdo's family properly

49. Valdo's family, particularly Celeste, were rightly recognised by doctors to be an important protective factor in Valdo's care. Celeste was heavily involved in his care initially and had daily contact with him until October 2020, in part to prompt him to take his medication.[137] The medical records noted that Valdo said he was able to talk to his family when things are not okay.[138] Celeste had around one hundred separate contacts with the health services about Valdo and gave the clinical teams important information about him and his condition on a number of occasions, for example by raising concerns of a relapse shortly before both the 14.7.20 and 3.9.21 violent incidents.[139] The primary protective factor listed in risk assessments was his supportive family.[140]

50. Unfortunately, from October 2020 Valdo began to disengage from his family.[141] They remained in some contact in 2021 and 2022, and Ms Jacques recorded on 24.9.21 that Celeste was *"taking an active role in care planning. Celeste stated that when he becomes unwell she takes on a caring role*".[142] But from September 2021 Valdo withdrew consent to the medical team

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[133] NHNB0018966/18 (Theemis)
[134] CQCM0016518/27
[135] CQCM0013648/2 §68; NHFT0004711; Mr Carter had more than 20, whereas the recommended caseload maximum is 15: NHFT0004872/05
[136] CQCM0016517/35
[137] NHFT0000168/57 (Ms Birtles, 14.7.20); 126 (Ms Birtles, 6.8.20); 129-130 (Mr Chimbi, 15.8.20); 131 (Ms Birtles, 27.8.20)
[138] CYGN0000001/127 (Mr Ackroyd, 15.7.20)
[139] E.g. NHFT0000168/55-56 (Mr Jackson and Ms Birtles, 11.7.20), 164 (Dr Lloyd and Dr Manzar, 2.9.21); and other occasions e.g. NHFT0000168/134-5 (Ms Parsonage, 9.10.20), 152-3 (Ms Lopez, 29.5.21)
[140] NHFT0000168/127 (Mr Crolla); CYGN0000047/5 §13 (Dr Shoilekova); NHFT0014619/5 §15 (Ms Birtles)
[141] NHFT0000168/135 (Ms Parsonage)
[142] CYGN0000052/14 (Ms Jacques, 24.9.21)

to share confidential information about him with his family.[143] This appears to have reflected his delusions that his family were at risk.

51. The family were not told important information or consulted about important developments in Valdo's health care. For example, they were not told the following information:

    a. Valdo's diagnosis of paranoid schizophrenia, which was first identified in July 2020;

    b. The risk Valdo was considered to pose to other people, such as Dr Seedat's observation on 16.7.20 that "*Perhaps Valdo will end up killing someone*";

    c. The extent to which he was violent or aggressive, particularly in respect of the 2021 and 2022 incidents;

    d. Valdo's discharge from hospital on 22.10.21;

    e. Valdo's detention in hospital from 28.1.22, and his discharge from it[144];

    f. The decision to discharge Valdo to his GP in September 2022;

    g. A warrant for his arrest was issued in September 2022.

52. Similarly, the police did not tell the family about important information, such as the assault by Valdo of his co-workers on 5.5.23.

53. The medical notes recognised Celeste did not feel properly informed. For example, on 23.9.21 Ms Birtles noted Celeste *"doesn't feel she has a full understanding of Valdo's current difficulties due to having no contact with the ward in Darlington… they have never returned*

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[143] PAGR0000159/3 (Dr Gurusinghe: Valdo said "*he did not wish her to worry about him*"); NGPF0003462/1 (Ms Gell); NHFT0000168/200-1 (Ms Birtles), 218-9 (Dr Gibson)
[144] This is to the best of Celeste's recollection

her calls".[145] And on 2.2.22 Dr Gibson noted Celeste *"expressed some frustration about our lack of ability to share information based on confidentiality, but accepted explanations".*[146] The CQC criticised how the Trust responded to concerns raised by the family. [147]

54. This lack of information about Valdo's condition meant his family were unable to properly understand his illness or risk, and to respond. This was compounded by the lack of information given to the family by the police or UoN about Valdo, for example about his violence, or other incidents of concern, during 2021-2023. Celeste explains that if she had known about the true picture, she would have been much more vigilant. She had no mental health training or experience (she was a general - not mental health - nurse). But as a concerned mother, she would have been much more attentive to signs of risk, for example in the documents he sent her in Christmas 2022. Elias gives similar evidence. What Valdo said in the zip file, and on the phone to Elias on 12 June 2023, was the same sort of thing Valdo had been saying to them repeatedly for years. In the absence of further information, the family could not have been expected to know of the risk Valdo posed to others at that time.

55. Indeed what Valdo said then was similar to what Valdo said during the messages and calls between Valdo and Elias that were transcribed and sent to Dr Seedat more than 3 years before, in May 2020. In those messages, Valdo said: "I hear voices in my head… I'm in an apartment, they're in the one above or next to me… yesterday I had a dream and when I woke up someone in the other apartment was telling my dream to other people… There are people here who are monitoring [me]… they rented the apartment to keep an eye on me… [They say] "oh my god" over and over again. And speak about what I'm thinking in real time… Real time summary of my thoughts "he' doing this", "he's talking to himself saying this"..." And in the calls, Valdo said he hears the voices as clearly as Elias's voice. Valdo asked "if there's any technology/AI that could map his thoughts accurately enough to know them in real time." On 18 May 2020 Valdo "barely made sense for the first 15 minutes of the call".

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[145] NHFT0000168/192
[146] NHFT0000168/223
[147] CQCM0016518/25-27

56. Valdo's refusal of consent does not constitute a sufficient reason why his family were not properly informed, consulted or responded to. Firstly, some of the information that was not passed on to the family, such as the schizophrenia diagnosis, was available before September 2021 when Valdo refused consent to clinicians sharing confidential information with his family. Secondly, it is arguable that Valdo did not have capacity to refuse consent, due to his delusions. There should have been an assessment of his capacity, but it appears there was not. Thirdly, disclosure of confidential information may be justified in the public interest.[148] Finally, in any event, as the CQC note, "*the trust could have continued to engage with the family while still maintaining [Valdo's] confidentiality*".[149] The CQC also found that *"Families feeling excluded, not listened to or that staff weren't communicating effectively was an issue we identified in our wider review of care at NHFT"*.[150]

Continuity of care and communication within the health services

57. Ms Birtles was replaced by Mr Carter as Valdo's CCO on 28.4.22. It appears that there was an understandable reason for this.[151] But Valdo's family invite the Chair to examine the extent to which this change meant that an understanding of Valdo and the risks he presented was lost. Ms Birtles apparently had a much better understanding of Valdo, had played an important role in the past,[152] and the notes indicate the standard of supervision markedly dropped after she was replaced.[153]

58. Communication within the health services appears to have been flawed. For example, Dr Shiolekova was able to obtain only a very limited psychiatric history.[154] It appears that not all Approved Mental Health Professionals ('AMPH') could access NHFT records when performing MHA assessments.[155] Ms Parsonage from the Community Team said on 22.10.21

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[148] WITN0058002/33-34
[149] CQCM0016518/28
[150] CQCM0016518/26
[151] NHFT0017809/2 "*I am handing him over to a new CCO… due to the risks with me being pregnant*"
[152] For example, her concerns led to the MHAA on 3.9.21: NHFT0000168/162-3; WITN0117001/12 §33 (Ms Staples)
[153] NHFT0000168/266 onwards
[154] CYGN0000047/2; CYGN0000011/2
[155] WITN0112001/8 §§27-28 (Ms Modern). Compare Ms Staples, WITN0117001/5 §16

that the team had not been informed in advance of Valdo's discharge from hospital[156] (although this appears to be disputed by the Priory).

59. The CQC identified systemic flaws in communication between the health services. Transfer between inpatient and community care sometimes did not ensure continuity of care, and this was made worse by poor communication. The CQC considered that the Integrated Care Board was not doing enough to tackle this.[157] Theemis made similar criticisms.[158]

Other systemic issues involving health services

60. Several systemic concerns have been already outlined. There are a number of others which Valdo's family invite the Chair to examine. They include:

    a. Chronic under-funding of psychiatric services.[159]

    b. The CQC considered that the NHFT did not have enough staff to keep patients safe.[160]

    c. In particular, EIP staff had caseloads above the recommended level, and there was a lack of oversight of this.[161]

    d. Insufficient mental health nurses, particularly experienced nurses.[162]

    e. Insufficient inpatient beds in psychiatric hospitals, obstructing access to hospital for patients who need it.[163]

61. The Inquiry's question 22(e) of 'Questions to be addressed by the Inquiry' is whether restrictions were avoided due to concerns of overuse on Black people. There is no evidence

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[156] NHFT0000168/194
[157] CQCM0016517/4
[158] NHNB0018966/21-23
[159] WITN0308001/26 §55(i) (Professor Blackwood); WITN0320001/15 §49 (Professor Smith)
[160] CQCM0016517/40
[161] NHNB0018966/19 (Theemis)
[162] WITN0270001/18 §§61-3 (Ms O'Brien)
[163] CQC0016517/27; WITN0308001/26 §55(i) (Professor Blackwood); WITN0112001/21 §§76-77 (Ms Modern)

either that restrictions were avoided in Valdo's case, or that they are avoided generally for Black people. To the contrary, there is extensive and cogent evidence to show the opposite: that Black people are subjected to race discrimination in every aspect of mental health service provision, including that they are disproportionately subject to restrictions. For example, Professor Wessely explains that there is robust evidence of disproportionate use of CTOs and MHA detention for Black people.[164] He referred to the Final Report of the Independent Review of the Mental Health Act 1983, dated December 2018. That comprehensive report concluded that *"Profound inequalities exist for people from ethnic minority communities in accessing mental health treatment, their experience of care and their mental health outcomes"*.[165]The authors said *"we were particularly concerned by the excessively poorer experiences and outcomes of individuals from black African and Caribbean communities..."*.[166]The report indicated that the explanations for this included *"stereotyped assumptions not backed up by evidence"*.[167] There are a number of other surveys and reports which demonstrate that Black people experience discrimination throughout mental health services, including by being disproportionately subjected to restrictive practices.[168]

62. More broadly, there appears to have been a failure by NHFT to learn and make changes when flaws in their services were identified. For example:

    a. In its reports from 2019 onwards, the CQC identified a pattern of concerns and breaches of regulations by NHFT's community and inpatient mental health services, and concluded that many services at NHFT were inadequate. They found that people struggled to access the care they needed, putting the public at risk of harm; families were not involved sufficiently; risk assessment was inadequate; and there was poor communication between services.[169]

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[164] WITN0322001/25 §§61-2, 98
[165] WITN0155008/164. See also 11-2, 296
[166] WITN0155008/59
[167] WITN0155008/171
[168] Race Equality Foundations, *Racial disparities in mental health: literature and evidence review* (2020) pp5-6, 23-24; NHS Race and Health Observatory, *Ethnic Inequalities in Healthcare: A Rapid Evidence Review* (2022) pp11, 88-89
[169] CQCM0016517/2-4, 24

b. Conclusions at a number of different inquests also raised similar concerns to those relevant to this case. Examples from inquests in 2021 were lack of involvement of the patient's family; inadequate risk assessment and crisis planning, inadequate communication between inpatient and community services, or with other agencies; and poor discharge planning.[170]

63. Valdo's family invite the Chair to investigate why - if these flaws had been repeatedly identified - did the Trust not ensure they were remedied? For example, was it a managerial problem at the NHFT? Or was there lack of effective monitoring by the CQC? Or was there a wider national issue requiring government intervention?

University of Nottingham

64. Valdo's family had very limited contact with the UoN when Valdo was a student so they are learning many things for the first time. They are saddened to learn that a number a Valdo's roommates and other students had distressing interactions with Valdo and that injuries were suffered.

65. They are also concerned to understand whether better communication within the UoN and also between the UoN, the health services, and the police would have led to a more holistic understanding of the triggers for Valdo's illness and risks, and led to better care, treatment and support being put in place well before the tragic events of 13.5.23.

66. In September 2017 when Valdo started his 4-year mechanical engineering course - which included a Masters - he was slightly older than his fellow students (age 26) as he had worked beforehand to save up money to support himself after he left home in Wales in 2015. Valdo was a hardworking person who wanted to be independent and who worked to fund his study whilst also attending the UoN.[171]

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[170] NHFT0009667/2-3; NHNB0019232/5; NHNB0012044; NHNB0012321/3
[171] WITN0085001/4 §13 (Ms Calocane)

67. Valdo's attendance in his first year was patchy but not in any unusual way. Valdo did not struggle academically, and nobody raised any concerns either academically or from a pastoral perspective, and his second academic year was similar to his first. [172]

68. Valdo did not associate closely with other tutees and kept himself to himself.[173] In 2019 he achieved the necessary grade to move to transfer to a Master's in Engineering (MEng). However, when the first Covid-19 lockdown began in March 2020 Valdo was in his third academic year and his family started to become concerned about him as Valdo seemed stressed, anxious and paranoid.[174]

69. Many of the initial triggers for Valdo's mental ill-health - stress from university course work and exams, sleep deprivation and isolation - remain when Valdo returns to the UoN in 2021-2022.[175] Valdo,[176] Celeste[177] and clinicians[178] voiced that stress (including academic stress), work and exams could trigger a relapse.

70. Valdo failed to complete his master's, but in July 2022 Valdo graduated with a bachelor's, with a grade of 2.1.[179] Valdo's family believe that academic work-related stress remained a significant trigger for Valdo's mental illness up to Valdo's graduation. This was because Valdo was determined to graduate, was studying hard, [180] including when unwell,[181] and was

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[172] WITN0053001/7 §§25, 32 (Dr McWilliam)
[173] WITN0053001/7 §24
[174] WITN0085001/4 §16 (Ms Calocane)
[175] NHFT0000168/205 (19.1.22): "*There are some stresses which may be exacerbating things - Uni exams.*"
[176] NHFT0000168,/79 (21.7.20) "*Valdo says he is worried about his university degree. He is resitting an exam over the summer*"; NHFT0000168/115 (30.7.20) "*heavy studying schedule, anxiety, poor diet, stress ..compounded into episode of psychosis. VC spoke about anxiety and his expression of this - VC spoke about having 'career anxiety' and wanting a 'good career' which means getting good grades. Thus he can experience anxiety*"
[177] NHFT0000168/79
[178] NHFT0000168/239 (Ward round, 10.2.22) "*it was explained to him that if he is under a period of high stress, he may experience some of these symptoms that he had experienced previously and people want to try and help prevent it from happening again*"
[179] UNIN0000497/1
[180] NGPF0002854/4 §16 Valdo achieves 73% in first exam on 1.9.2020
[181] NHFT0000168/67, 86, 111

financially supporting himself and at times working long hours and nights,[182] in circumstances where his mental health was extremely fragile.

71. It is not clear whether anyone in the UoN was told this and/or really considered or understood this.

Support in the University of Nottingham

72. Universities are not subject to a statutory duty of care.[183] However, they do have a general duty of care in the tort of negligence (depending on the circumstances), and duties under the Equality Act 2010 and under the Human Rights Act 1998. It is recognised good practice for universities to "*promote a whole university approach to wellbeing, a collaborative approach between the NHS and universities, information-sharing between the NHS, universities and others, and inclusivity,*" in line with the University Mental Health Charter 2019.[184] The 2019 Charter recognises that whilst universities are not entirely responsible for seriously ill students (as this lies with the NHS) there is a "*clear ethical responsibility for universities to act"* in this area*, "as much of this risk will be presented within the university environment…. institutions do have a responsibility to plan for prevention, intervention and post-vention*."[185]

73. The Inquiry may wish to explore why the UoN did not sign up to the University Mental Health Charter 2019 until September 2022 and whether the sentiment in the 2019 Charter in relation to student wellbeing and risk was commonly accepted and embedded within the UoN from 2019 onwards.[186]

74. In 2020 the UoN was committed to supporting student well-being and mental health. This was largely through the MHAS, the Support and Wellbeing Team ('SWBT'), the Disability Support

[182] WITN0053001/15 §61 (Dr McWilliam); NHFT0000168/144, 150, 152
[183] WITN0066001/7 §22 (Ms Linehan)
[184] *Ibid* §27
[185] WITN0066003/35
[186] WITN0066001/8 §§26 – 28 (Ms Linehan); UNIN0001519/2

Services ('DSS') and Residential Experience team ('ResX').[187] Risk relating to mental illness was managed primarily by MHAS.[188]

75. MHAS was a referral-only service for students experiencing significant mental health difficulties and where they were deemed to be a possible risk to themselves or others, which "*provides advice to help students manage their mental health and liaises with external services, where needed, to ensure support and risk are communicated effectively between the University and relevant statutory mental health services*". MHAS provided this support alongside secondary NHS mental health services.[189] According to the MHAS FAQs, "*Communication, interface and liaison is at the heart of the work we do with students*."[190]

76. Information sharing of confidential medical information by clinicians is permitted in certain circumstances even in the absence of a patient's consent, including between individuals involved in the patient's care.[191] There was clear guidance in place at the time in the UoN that did allow for it to share confidential information where there was a concern about risk to self or others.[192]

Sharing of information between the University of Nottingham, health services and the police

77. The UoN witnesses identify failures by the health services to share information with them about Valdo. These range from not informing MHAS about Valdo's various discharges, not sharing risk assessments and discharges plans, not taking Valdo's risk seriously, not listening to the concerns expressed by the UoN and not sharing information about serious incidents of violence by Valdo.[193] Valdo's family ask the Inquiry to explore whether better communication from the health services to the UoN would have impacted on Valdo's ability to remain in the

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[187] WITN0066001/12 §39 (Ms Linehan)
[188] WITN0054001/7 §19 (Ms Turner)
[189] WITN0050001/3 §9; WITN0054001/2 §5
[190] UNIN0001519/4
[191] WITN0058002/33-34 (2016 RCJ Guide); WITN0288001/64 §§142, 156 (Mr Keene KC); WITN0058001/6 §31 (Professor Morgan); NHSE0000312/80 §§10.11-17 (MHA 1983: Code of Practice)
[192] UNIN0001519/4; UNIN0001812/3-4, 11
[193] WITN0054001/14 §§41- 47 (Ms Turner); WITN0033001/9 §28 (Ms Thompson)

UoN and/or whether it would have led to better support and monitoring of Valdo by his personal tutors and a better appreciation of his triggers and risk.

78. At the time the UoN knew that there were barriers to the sharing of information by the health services to the UoN (for example resource constraints in the NHS and no formal information sharing agreement between the NHS and the UoN).[194] Despite knowing about these systemic difficulties, the UoN did not consistently seek out relevant medical information about Valdo from the health services when Valdo was a student.

79. Between 1.6.20 – 4.8.20, when Valdo experienced his first episodes of psychosis, MHAS spoke to Valdo twice, spoke to Valdo's consultant once, spoke to nurses on the ward three times, sent an e-mail to an AMHP, and spoke once to the EIP team.[195] There was then no further contact between MHAS or the health services (or with Valdo) between August 2020 and January 2022.[196]

80. Not only was there a lack of consistent communication between the UoN and other agencies, but the contact that was initiated was largely reactive and in response to Valdo's risk to others and not consistently focussed on supporting Valdo and understanding his mental ill health.

81. For example, there is no evidence that MHAS:

    a. chased discharge plans and risk assessments for Valdo when initial requests to the health services for communication were ignored in June 2020;[197]

    b. requested a discharge plan and risk assessment for Valdo in July 2020 despite professing to have concerns around Valdo's risk;[198]

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[194] WITN00330001_/5 §14 (Ms Thompson); WITN00540001/6 §§17, 42 (Ms Turner) "*we always ask to see discharge risk assessment, but we are rarely provided with it*"
[195] UNIN0000734; WITN0054001/12 §§33-62 (Ms Turner)
[196] WITN00540001/24 §§64-65 (Ms Turner)
[197] WITN0054001/14 §41
[198] WITN0054001/16 §47 (Ms Turner)

c. requested detailed clarification on diagnosis or a clinical opinion on long term prognosis and risk when it became clear Valdo was not returning to Wales in June /July 2020 (or at any subsequent point);[199]

d. ever knew that Valdo had been diagnosed with paranoid schizophrenia by Dr Seedat on 31.7.2020;

e. properly understood what could trigger Valdo into having a mental health relapse;[200] or

f. ensured there was regular and effective communication with those responsible for Valdo in the health services, in particular Ms Birtles.[201]

82. By July 2020 Eleanor (Ellie) Turner of MHAS knew that Valdo had experienced a first episode of psychosis, had two involuntary admissions under the MHA (and one s.136 MHA detention), was prescribed an anti-psychotic medication, was isolated, was under the EIP and had a CCO, and that there had been two incidents of aggression linked to non-compliance with medication and hearing voices.[202]Ellie Turner remained concerned about risk.[203]

83. Ellie Turner also recognised that Valdo needed support in his recovery from the UoN as she emphasised that "*it will be important for us to think about your wellbeing alongside your studies in a way that supports your recovery and academic goals*".[204]

84. In June 2020 Valdo had refused help and disengaged from MHAS and at that time the view taken by Ellie Turner was that "I *could not make Valdo engage with our service"* and *"I did*

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[199] UNIN0000734
[200] UNIN0001401/3: Dr Seedat "*feels trigger was isolation*".
[201] UNIN0000734/4; UNIN0002083
[202] UNIN0000614/68
[203] UNIN0000734/4 "*E-mail to Geoff Culpin (assessing AMPH) citing concerns around discharge plan and requesting an opinion*"
[204] WITN0054001/22 §61 (Ms Turner)

not feel I could do anything else… as far as I was concerned, NHS services were responsible for Valdo's care and were engaged with him, and he had chosen not to have additional advice and support from MHAS".[205] However, Ellie Turner's view did not change in August 2020 when Valdo refused a referral to DSS for a support plan,[206] even though there has been a second admission to hospital and another violent incident preceding that. Rather it was left to Valdo to contact MHAS should he "c*hange his mind*".[207]

85. That Valdo was able to choose to make these decisions appears not to be questioned by Ellie Turner despite her having observed that when speaking to Valdo in June 2020 he "*lacked insight into the fact that he had been unwell*".[208] Ellie Turner did not try to encourage Valdo to engage with MHAS between August 2020 and January 2022 and she did not ask the health services whether they had any concerns about Valdo's insight into his mental ill-health.

86. Because Valdo did not want MHAS engagement, MHAS did not put a plan in place to ensure that the UoN would remain updated on Valdo's mental health, stability and risk (or how they would obtain this information if it was not forthcoming from the health services). This is curious because, as explained by Ms Birtles in her witness statement to the Inquiry, by early August 2020 the "*CRHT were planning to remain in place as he had upcoming stressors with university*".[209]

Academic year - 2021 – 2022

87. MHAS do not appear to anticipate that returning to academic study in 2021 would be a challenging time for Valdo given the return of academic stress and possible isolation. They also do not consider the possible link between this and a mental health relapse and associated risk or where he would be living. In October 2021 Valdo moved into student accommodation in Raleigh Park.[210]

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[205] WITN0054001/17 §49
[206] WITN0054001/23 §62
[207] UNIN0000734/5
[208] WITN0054001/14 §42
[209] WITN0348001/64 §190 (Ms Birtles)
[210] WITN0178001/2 §9 (Thomas)

88. The UoN had no idea about the serious incident of violence in September 2021 when Valdo was unwell. Ms Birtles could have updated MHAS because on 25.10.21 she became aware (from Celeste) that Valdo had likely returned to the UoN.[211] Why this did not trigger a communication to the UoN/MHAS by Ms Birtles remains unexplained.

89. If Ellie Turner had checked with Ms Birtles at the start of term, the UoN would have been made aware of this incident and Valdo's detention under the MHA.

90. Instead, Dr Emma Barney emailed Valdo on 7.9.21 checking how he was and asking whether he would return to studies which re-start in a couple weeks.[212] Valdo responded on 12.9.21 stating he was, "*in good spirits and quite eager to get back into full time education. I used my time away from uni to work, save some money and earn a few skills*".[213] This communication was nine days after Valdo was forcibly detained under the MHA following a serious assault on police officers when Valdo was very unwell and a day after Valdo had been transferred to a PICU. It is inexcusable that the UoN remained unaware of this

91. The UoN also did not know about various incidents involving Valdo's flatmate Sebastian in 2021 and 2022. Whilst there was communication between Ellie Turner and Stuart Croy (Associate Director of Security Services in the UoN) in June 2020 and requests for information from the police about Valdo,[214] this appears to have been short lived.

92. Valdo's family are concerned that worrying incidents happened in 2021 and 2022 and were not known about by the UoN and communicated to the health services (including by the police who also did not communicate adequately). They ask the Inquiry to consider whether these were missed opportunities to identify that Valdo was unwell and to provide care to Valdo

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[211] NHFT0000168/195 "*have the impression that he was at University*"
[212] WITN004700/10 §32
[213] UNIN0001012; WITN0047001/11 §32
[214] UNIN0001401/1

93. During this period MHAS and the UoN were in an ideal position to work with Ms Birtles to consider Valdo's engagement with services and mental stability. That this did not happen was a missed opportunity to support Valdo and for the health services to remain informed of his academic performance and possible indicators of a relapse.[215] Ellie Turner states that if she had been aware of the September 2021 incidents *"we would have liaised with the ward, tried to engage Valdo and tried to become part of the support on discharge planning"*.[216]

94. Following the events of January 2022, when Valdo assaulted his flatmate Christopher GRO-B communication resumed between the health services and the UoN, with involvement from MHAS and Chris Hoskins, Senior Operations Manager in ResX. It seems that Valdo's flatmates had been concerned about Valdo's mental health for some time prior to this incident.[217]

95. From this point onwards most of the communication from the UoN to the health services appears to be driven by concerns about Valdo's risk to others (as opposed to his treatment or well-being). On 11.2.22 Ellie Turner was informed by the health services that Valdo wanted no further contact between MHAS / UoN and the health services. She was not informed of Valdo's discharge on 24.2.22. Ellie Turner then proceeded on the basis that she did not need to take further action or try to engage Valdo (or share any information about him) and that she would be alerted if *"the NHS thought there were risks*.[218] Valdo agreed that Ellie Turner would remain in the background and that there could be communication from the health services to the MHAS about him if there were concerns in relation to engagement, relapse or other risk.[219]

96. The Inquiry will no doubt wish the explore the appropriateness of this approach and whether it was sufficiently proactive (and whether there was any such communication from the health service) bearing in mind that:

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[215] NHFT0000168/225 – eg 3.2.22 "*Claudia said that Ellie Turner said that he had been submitting work late and turning up for supervision late*"
[216] WITN0054001/24 §67 (Ms Turner)
[217] WITN0178001/6 §31 (Thomas)
[218] WITN0054001/40 §119
[219] NHFT0017913/1

a. Valdo remained a student and was continuing with his academic work at a stressful time, including speaking with his tutors (and they may have had useful information to share about Valdo);

b. was free to attend the UoN campus;

c. MHAS already had concerns that the health services (including Ms Birtles) had not updated MHAS on key events such as decisions on discharge;

d. that only a few days before on 21.4.22 Valdo had returned to the UoN campus in breach of his s.17 leave;[220]

e. that Ellie Turner thought Valdo should not be discharged / needed to be placed on a CTO but the health services disagreed.[221]

97. Whilst there is some information sharing from Ellie Turner to the health services this is limited to the incident at Raleigh Park on 21.4.22. Ellie Turner was aware from the health services that at this time Valdo remained very guarded and his engagement was "*superficial*",[222] all of which was known to the health services and the UoN.[223] Again, it is not clear whether Ellie Turner gave any thought to this and the implications for Valdo's mental health (and any risk he may pose were he to have a mental health relapse).

Internal communication within the UoN

98. Claire Thompson states in her witness statement to the Inquiry that *"MHAS will speak to academic staff as needed, such as when further information about a student is needed to make*

[220] WITN0054001/41 §§121-122 (Ms Turner)
[221] WITN0054001/38 §113 (Ms Turner); UNIN0000734/14; NHFT0000168/242
[222] UNIN0000633
[223] NHFT0000168/238, 263 (ref to exams in June 22 and dissertation due in April 22)

a decision about how best to support them. It is a good relationship"……"I don't identify any particular problem with internal information sharing in relation to Valdo". [224]

99. In Valdo's case, the evidence before the Inquiry suggests there was a lack of effective, consistent and sufficiently detailed communication between MHAS, SSWB and Valdo's academic personal tutors and supervisors at the UoN. Between June 2020 and January 2022 there was no communication between MHAS and Valdo's personal tutors. During this time Valdo's tutors state that they were not aware that Valdo had been seriously unwell or that he may pose a risk to others.[225]

100. This meant that for most of his time at the UoN, Valdo had to navigate his academic study and speak to his tutors and supervisors (e.g. Dr. Stewart McWilliam, Professor Atanas Popov, Dr. Donald Giddins, Dr. James Rouse and Dr Alistair Campbell Ritche)[226] on difficult issues, such as interrupting his studies, transferring from a MEng to a BEng and how to improve his academic work so that he could graduate in the summer of 2022, often when he was unwell.[227] There seems to have been no consideration by MHAS about whether Valdo needed any adjustments or extra support to have these discussions or even whether he had the capacity to make decisions around academic study.

101. For example, following the events of May – July 2020, there was no plan from MHAS to make contact with Valdo in the next academic year aside from a phone call which Valdo did not answer.[228] Oversight for Valdo's well-being appears to be handed back to SWT (engineering).[229] As a result, when Valdo started to struggle with his academic work in the autumn of 2020, he was left to address this himself with his tutors who remained unaware of what had happened.

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[224] WITN0033001/4 §§13, 56
[225] WITN0053001/15 §61 (Dr McWilliam); WITN0051001/6 §23 (Professor Popov); WITN0047001/10 §31 (Dr Barney). Yet Celeste emailed the UoN Engineering department to make them aware of Valdo being unwell in May 2020, through Valdo's student email (UNIN0000966).
[226] WITN0030001/6 §§21-23
[227] WITN0053001/11 §§44-45, 85-95 (Dr McWilliam)
[228] WITN0054001/12 §§36, 64 (Ms Turner) - these calls are not documented
[229] WITN0054001 /23 §63 "*please get in touch if there are any concerns*"

102. This would have likely placed Valdo under a significant amount of pressure and stress as Valdo's tutors sent him e-mails reprimanding him for his lack of engagement.[230] It also meant that his tutors were not in a position to understand the significance of Valdo falling behind in his work or identify other signs that he was unwell.

103. On 26.10.20 Valdo asked to speak with his personal tutor Dr Stewart McWilliam about a '*serious issue*'. He reported that he was struggling with his studies, but he did not specify a reason.[231] Valdo's appearance as quiet and withdrawn left Dr McWilliam with the impression that Valdo was '*lonely*'.[232] Valdo's attendance at meetings was becoming a concern for Professor Popov.[233] When this was addressed with Valdo on 4.11.20 Dr McWilliam states he was trying to *"unpick whether this struggle with his studies was a short- term or long-term issue"*. He formed the view that Valdo was *"struggling because of the pandemic"* and may be isolated. He *"had no idea Valdo had been suffering from serious mental health illness of that he had previously been sectioned under the Mental Health Act"*.[234] Unbeknown to the UoN, around this time Valdo was reporting to the health services that he was hearing voices.[235]

104. Dr McWilliam referred Valdo to the faculty's SWBT in Engineering and Dr Emma Barney to discuss an interruption of studies,[236] but she was equally in the dark about Valdo's mental ill-health despite knowing that Ellie Turner was involved.[237]

105. On 4.11.20 Valdo communicated his decision to interrupt his studies to Dr Barney, copying in Ellie Turner.[238] Ellie Turner appears to remain unaware of why Valdo had taken this decision.

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[230] UNIN0000521
[231] WITN0053001/10 §40, see also e-mail from Dr McWilliam to Dr Barney UNIN0000039
[232] WITN0053001/10 §§41, 44
[233] UNIN0001779, UNIN0001250, UNIN0000380, UNIN0001075, UNIN0000942, UNIN0001153, UNIN0001588
[234] WITN0053001/11 §44
[235] WITN0348001/79 §§231-233
[236] WITN0053001/11 §§44-47
[237] WITN0047001/10 §§30-31 (Dr Barney)
[238] UNIN0000067

106. Dr McWilliam notes that when there is an interruption, the next contact that academic tutors would have with the student is when they return. He did not know whether the SWBT had any contact with Valdo during this period and he did not have any contact with Valdo for the rest of the academic year.[239]

107. When Valdo returned to the UoN in October 2021, he missed several meetings with Dr Rouse and concerns remained about Valdo's work up to December 2021.[240] At this time Valdo's mental health and engagement with Ms Birtles/the EIP was deteriorating.[241] The UoN were unaware.

108. On 5.11.21 when Valdo asked his tutor for a reference for a job in a factory the significance of this (i.e. added stressor at a time when Valdo was working towards his degree) and the fact that he appears "*perhaps less confident ...he seemed down although not worryingly so*"[242] was simply not understood. This was because Valdo's personal tutors had no insight into Valdo's mental ill-health (and triggers for relapse) as there was no liaison between MHAS and the health services.

109. It is difficult to see how such poor communication within the UoN about Valdo *"promote[s] a whole university approach to wellbeing"*.

110. When in January 2022 there was some communication by SWBT to Valdo's personal tutors about how Valdo was engaging in his studies it was lacking in detail so again the significance of Valdo's presentation was missed or not understood by Valdo's tutors.[243] Valdo had not submitted coursework, had failed a test in December 2021 and submitted an exam 8 minutes late.[244]

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[239] WITN0053001/13 §52
[240] WITN0048001/5 §§17, 31; UNIN0001005
[241] WITN0348001/122 §§370 -389 (Ms Birtles)
[242] WITN0053001/15 §§61-68 (Dr McWilliam)
[243] UNIN0000242
[244] UNIN0001641

111. On 20.1.22 Dr McWilliam spoke to Valdo without any understanding of what had been happening with Valdo over the previous 18-months. He comments that Valdo *"did not sound on top of things to me, he sounded aloof and did not seem to have any sense of urgency about his exams..... there were no signs that he was struggling or that I needed to take any action"*.[245]

112. On 24.01.22 Dr McWilliam was contacted by Ellie Turner and he recalls being told that the UoN were *"investigating Valdo's library access as he was going there late at night"* and it was only at this stage that there was a disclosure by Ellie Turner about an incident with a student jumping out of a window. Why this communication appears to have been confused and not properly understood by Dr McWilliam will need to be explored by the Inquiry.[246]

113. Even despite learning of the above and even at this late stage (which was a critical period in Valdo's study when his final coursework was due) Dr McWilliam states that *"I do not recall being asked to do anything by Ellie"*.[247]

114. There seems to have been no curiosity about why Valdo was accessing the library at night and whether this was in fact evidence that Valdo was excessively studying so that he could complete his academic work (and hence was under stress/academic pressure). Rather this incident appears to be viewed simply as a security risk.

115. The first time that academic staff supervising Valdo were given any information that Valdo was seriously mentally unwell was on 31.1.22 when they were told about a detention under the MHA but *"the information provided was limited and I was not aware of the circumstances that led to it and I might expect to be told the severity of what led to the detention"*.[248] This was not the first time that Valdo had been detained under MHA yet why prior detentions had never been communicated to his personal tutors is not clear.

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[245] WITN0053001/17 §68 (Dr McWilliam)
[246] WITN0053001/18 §71 (Dr McWilliam)
[247] WITN0053001/18 §71 (Dr McWilliam)
[248] WITN0053001/19 §74 (Dr McWilliam)

116. As Valdo was reluctant to engage with MHAS, it was again left to Dr McWilliam to communicate directly with Valdo on academic matters in March 2022 when difficult decisions were being taken about Valdo's academic options.[249]

117. It appears from some of the terse and argumentative comments to Valdo from his tutors in e-mails in June 2022 that even at that stage they did not appear to have much understanding of the extent of Valdo's mental ill-health and the circumstances under which he was trying to graduate.[250] It is distressing for Valdo's family to read these e-mails which display a level of irritation with Valdo at a time when he was desperately unwell and trying to complete his degree under extremely difficult circumstances.

118. There appears to be only one reference to a possible practical measure to reduce academic pressure on Valdo during the whole time when he was a student, and this is from early June 2020 when Ellie Turner told Paige Smith *"to see if we could put a halt on chasing emails to Valdo"*, although this is not documented.[251]

119. Valdo's family recognise that there were difficulties engaging Valdo, but they strongly believe that having to manage his academic work with no practical support would have exacerbated Valdo's level of stress and impacted negatively on his mental health and associated risks. They ask the Inquiry to consider whether Valdo could and should have been managed differently in 2021 by the UoN including, for example, whether there should have been a more structured multi-disciplinary discussion about Valdo, including about a longer deferment of his university place or some other reasonable adjustment and which involved his tutors.[252] It appears that a system to facilitate such discussions was set up in the UoN but only after Valdo had left.[253]

120. The Inquiry is referred to the comments made by Dr McWilliam in his witness statement that, *"I think I should have been told…in general I think I should have known about the severity of*

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[249] WITN0053001/21 §§82-85 (Dr McWilliam)
[250] UNIN0000048
[251] WITN0054001/11 §31 (Ms Turner)
[252] WITN0066001/28 §§91, 197-210 (Ms Linehan)
[253] WITN0033001/17 §56 (Ms Thompson)

the situation. The reason I think should have been given this information is so that I could have supported Valdo in the best way possible" and *"I think high level information about Valdo's mental health difficulties should have been shared with me and the Department, by one person who had oversight of the entire situation"*.[254]

Systemic issues

121. There is evidence that the above breakdown in communication may have been contributed to by the following systemic issues/failures to make reasonable adjustments:

a. no structured multi-disciplinary meeting forum in the UoN for 'student cases of concern' to be discussed[255] and a lack of clarity or training on how to use the Fitness to Study Process to manage a risk posed by a student;[256]

b. no information sharing agreement between the health services and the UoN;

c. a lack of clarity as to whether the police can share information with universities;[257] no direct relationship between MHAS and the police;[258] inadequate information sharing agreement between UoN and Nottinghamshire Police;[259]

d. limited training on risk assessing and no formal risk assessment documentation in use at UoN;[260]

e. no formal Emergency Contact Protocol making clear to UoN staff and students when the UoN can contact the family member of a student, including where there is a serious risk to safety / wellbeing.[261]

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[254] WITN0053001/ 27 §§102-103 (Dr McWilliam)
[255] WITN0033001/17 §56
[256] WITN0054001/8 §23 (Ms Turner)
[257] WITN0033001/5 §15 (Ms Thompson)
[258] WITN0054001/3 §8
[259] WITN0066001/42 §142 (Ms Linehan); UNIN0001829; UNIN0001807
[260] WITN0054001/8 §22 (Ms Turner); WITN0050001/5 §13 (Ms Smith)
[261] WITN0066001/49 §163 (Ms Linehan)

Police

122. Some of the violent and concerning incidents involving Valdo in 2021, 2022 and 2023 were not communicated to the UoN, the relevant health services, or Valdo's family, by the police.[262] There were also clear failures within both Nottingham and Leicestershire constabulary to link on-going criminal and other matters (including by the Metropolitan Police Service in respect of Valdo at MI5) and critically there was the failure to execute the warrant of 22.9.22.

123. In this Inquiry Valdo's family are learning about the detail of these incidents and of the police failures for the first time. They are saddened and shocked to see that there were so many lost opportunities to better understand Valdo's illness and risks, and to provide Valdo with the care and treatment that he clearly needed before the tragic events of 13 June 2023.

124. As explained above, there was a great deal of information about Valdo's violence and other concerning behaviour of which his family were unaware. If they had been told about it, they would have been much more vigilant and responsive to signs of concern.

125. The police failures appear to be individual errors[263] as well as systemic inadequacy. Valdo's family ask the following questions:

a. did police officers conduct adequate checks of police databases after each contact with Valdo and did these databases contain sufficient information to flag that Valdo was under the care of health services and/or suffered from mental ill-health?;[264]

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[262] **Health authorities**: WITN0003001/9 §28 (31.5.21); WITN0015001/5 §19 (5.7.21); WITN0151001/7 §40 (14.7.21); WITN0151001/9 §55 (26.4.22); WITN0043001/5 §28 (28.7.22); WITN0009001/23 §92, WITN0010001/11 §35 (5.5.23). **UoN:** WITN0003001/9 §28 (31.5.21); WITN0015001/5 §19 (5.7.21); WITN0151001/7 §40 (14.7.21); WITN0054001/24 §67 (3.9.21); WITN0151001/9 §55 (26.4.22); WITN0043001/5 §28 (28.7.22); WITN0009001/23 §92, WITN0010001/11 §35 (5.5.23)

[263] LEPF0000056/7 (Leicestershire Police PSD Conduct Severity Assessment, 1.2.24); LEPF0000243 (IOPC Operation Penhallow, 25.9.24)

[264] Eg, checks on 31.5.21 and 1.6.21 (FTAC) when Valdo was found ringing the doorbell of MI5 (WITN0004001/3); July 2021 incidents involving PC Amy Pannell and Sebastian (WITN0015001/8-9); 2022 incidents reported by Sebastian; 15.1.22 incident involving Mr GRO-B PC Sarah Barnes in 4-10.8.22; PC Taylor and NICHE on 24.5.23 (WITN0009001/17 §60)

b. should the police have referred incidents/Valdo to their own mental health triage teams[265] and should the police have made more effort to contact Valdo?;[266]

c. did the police share all relevant information and ensure appropriate liaison and communication with the health services?;[267]

d. did a lack of training,[268] poor supervision,[269] excessive workload/ lack of staffing[270] impact on police attempts to contact Valdo and liaise with the health services about Valdo?;

e. were there any/any adequate information sharing agreements between police forces in the different areas where Valdo became known to police?;

f. Should the police have communicated directly with the UoN about Valdo?;[271]

g. were there adequate information systems/training about sharing of information between police and health services?

Post incident issues

126. As the Inquiry knows, Valdo's family remain concerned about how the personal information that they provided to Nottinghamshire police on 14.6.23 came to be reported in the press the

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[265] WITN0015001/8 §30 PC Pannell and Sebastian incident; WITN0043001/5 PC Barnes in July/August 2022
[266] WITN0043001/4 §§21-22 PC Sarah Barnes and contacting Valdo in July 2022 & attending Valdo's address in August 2022, see also Sebastian's witness statement WITN0151001
[267] NGPF0000044/5; WITN0015001/5 §§18-20, PC Pannell and Sebastian incident 5.7.21
[268] WITN0009001/7 §23 (PC Taylor); WITN0015001/8 §30.2 (PC Pannell)
[269] PC Amos-Perkins not checking that PC Taylor had preserved evidence WITN0010001/5 §17 or completed background checks on Valdo in May 2023 WITN0010001/17 §22-23; Temporary Chief Constable David Sandall on identification of organisational improvement including strengthening arrangements for supporting student officers in Leicestershire Police WITN0001001/25 §§83-84
[270] WITN0009001/21 §84 (PC Taylor); WITN0011001/5 §§16–19 (T/PS Mark Read)
[271] WITN0032001/8 §23 "*I would expect the police to have flagged with the University if they were concerned about other students being at risk from VC*" (Mr Hopkins)

following day. They also still have concerns about the adequacy of the IOPC investigation and findings into this issue, which remain unexplained.[272]

Conclusion

127. At this stage it appears that this tragedy was preventable. Valdo's risk came exclusively from his schizophrenia, and effective treatment could have managed his illness and addressed his risk. Valdo's family are grateful for the opportunity provided by this Inquiry to examine in more detail what went wrong and what changes can be made to avoid it recurring in future.

Adam Straw KC

Kirsten Heaven

Doughty Street Chambers

Charlotte Haworth Hird

Bhatt Murphy Solicitors

19 February 2026

[272] WITN0087101/31 §§106-107 (Mr Calocane)