

Thursday, 30 April 2026

1
 2 (10.00 am)
 3 **THE CHAIR:** Yes, Mr Carr.
 4 **MR CARR:** Chair, may I call Abigail Parsonage, please?
 5 **THE CHAIR:** Yes.
 6 **ABIGAIL PARSONAGE (affirmed)**
 7 **Questioned by MR CARR**
 8 **THE CHAIR:** Yes.
 9 **MR CARR:** You have made a witness statement for the purposes
 10 of this Inquiry, haven't you?
 11 **A.** Yeah.
 12 **Q.** It's dated 14 January 2026.
 13 **A.** Mm.
 14 **Q.** Is the statement true to the best of your knowledge and
 15 belief?
 16 **A.** Yes.
 17 **Q.** So far as your professional background, you're a Band 6
 18 Community Psychiatric Nurse.
 19 **A.** *(The witness nodded).*
 20 **Q.** You're employed at the Nottinghamshire Healthcare NHS
 21 Foundation Trust.
 22 **A.** *(The witness nodded).*
 23 **Q.** You've been employed there since your graduation in
 24 2016.
 25 **A.** *(The witness nodded).*

1

1 did, over the course of 2020 to 2022, have number of
 2 interactions with VC.
 3 **A.** Yeah.
 4 **Q.** That was often in the context of covering for his
 5 allocated care coordinator when unavailable.
 6 **A.** Yeah.
 7 **Q.** In your statement, it's page 3, paragraph 9, you set out
 8 the aims and functions of the EIP team, and one of the
 9 points you make, it's the second line into the third:
 10 "... to reduce risk to self and others ..."
 11 If we can put the EIP Operational Policy up, it's
 12 NHFT0000460, and go to page 3. Now, this policy was
 13 discussed in the evidence with your colleague, Claudia
 14 Birtles, yesterday; did you see that evidence?
 15 **A.** Yeah.
 16 **Q.** Do you agree with the evidence given yesterday that in
 17 the "Ten Essential Capabilities", we see at the bottom
 18 of page 3 into page 4, as well as "Aims of the Service"
 19 on page 6, there is no mention of protecting the public
 20 or managing risk to the public?
 21 **A.** Yeah, I agree, and the new policy incorporates that much
 22 more.
 23 **Q.** You say it incorporates much more. This policy doesn't
 24 refer to it, does it, in those sections?
 25 **A.** No, no.

3

1 I just wanted to add a bit of context, sorry, to
 2 paragraph 97 regarding "Related events", that this
 3 individual didn't have a mental illness.
 4 **Q.** That's page 25 of your statement.
 5 **A.** Yeah, paragraph 97.
 6 **Q.** Yes, WITN0317001. You state there:
 7 "I have been involved in the care of one other
 8 patient (other than VC) who, following discharge or when
 9 in the community, killed or seriously injured a member
 10 of the public. This happened in 2022."
 11 You want to add?
 12 **A.** Just a bit of context that that individual did not have
 13 psychosis, schizophrenia, or a mental health condition.
 14 **Q.** Noted.
 15 Going back to your professional background, we
 16 established you're a Band 6 nurse.
 17 **A.** Yeah.
 18 **Q.** Since 2019 you've been a member of the EIP team --
 19 **A.** Yeah.
 20 **Q.** -- working at the Stonebridge Centre. You work in the
 21 EIP team as a care coordinator.
 22 **A.** Yeah.
 23 **Q.** But you were never VC's care coordinator.
 24 **A.** No.
 25 **Q.** You did -- and we will go through the chronology -- you

2

1 **Q.** But in working with patients with psychosis, especially
 2 only where it's a recent and stable condition, their
 3 impact on the public must be a key consideration.
 4 **A.** Yeah.
 5 **Q.** It must be an essential capability.
 6 **A.** Yeah.
 7 **Q.** It should have been contained in this document as such.
 8 **A.** Yeah.
 9 **Q.** If we go back to your witness statement, please, it's
 10 paragraph 62, page 16. You set out there that the role
 11 of the care coordinator involved an assessment of the
 12 patient's risk at each appointment.
 13 **A.** Yeah.
 14 **Q.** If we can look, please, at paragraph 71, page 19, you
 15 deal there with the training that you've had on
 16 assessing risk and, prior to VC's attack, the training
 17 was limited to e-learning.
 18 **A.** Yes.
 19 **Q.** You can't recall when that e-learning took place.
 20 **A.** Yeah.
 21 **Q.** Can you recall what you took away from that training,
 22 what skills, if any, it equipped you with?
 23 **A.** I think it spoke about when we'd escalate to the Crisis
 24 Team, what risk would warrant a Mental Health Act
 25 Assessment. But I think a lot of what we learn about

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1 how to manage risk is almost learnt on the job.
 2 **Q.** Learnt on the job?
 3 **A.** Yeah.
 4 **Q.** By way of trial and error?
 5 **A.** Not trial and error but learning from other colleagues
 6 in university, completing placements where they discuss
 7 how they'd assess risk, and I think working with other
 8 agencies who assess risk like forensic mental health
 9 services and the police.
 10 **Q.** Had you worked with forensic mental health services?
 11 **A.** No, but I had done and I still do refer to the Forensic
 12 Mental Health Team.
 13 **Q.** In what circumstances do you refer a patient to the
 14 Forensic Mental Health Team?
 15 **A.** If they had been charged with a crime and also if the
 16 patient had told us they'd previously been in prison or
 17 there was concerns about potential criminal activity, or
 18 if the risk was such that they spoke about threats to
 19 others a lot, you know, that was a part of their
 20 presentation.
 21 **Q.** You described if they'd been charged with a crime. What
 22 about a scenario where they had exhibited violence and
 23 aggression, but for whatever reason the police hadn't
 24 charged them? Would you feel able then to refer to
 25 forensic services?

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1 And more -- I think we do now look at the pattern of
 2 risk, you know, (*unclear*) document, what are the
 3 triggers, and we incorporate that in the risk
 4 assessment. But I think, at the time, it was more like
 5 a timeline of risks rather than a formulation, if that
 6 makes sense.
 7 **Q.** Please clarify, when you say "a timeline of risks rather
 8 than a formulation", are you describing there just
 9 a list of past events?
 10 **A.** I think -- so for example it would say "risk to others"
 11 and then it would describe the events that happened in
 12 each event of aggression, whereas now, where it advised
 13 to do someone's background, what triggers them to be
 14 aggressive to others? What are we going to do as
 15 a service when there's that risk of aggression to
 16 others? What have we done, you know, have we referred
 17 to the forensic team? Are there, you know, like police
 18 markers on the address? It would just be more of
 19 a formulation.
 20 **Q.** Are you describing now that you understand the need for,
 21 one, assessment of risk of what may occur --
 22 **A.** (*The witness nodded*).
 23 **Q.** -- and two, the need for a plan to mitigate that risk?
 24 **A.** Yeah.
 25 **Q.** Prior to these attacks, you hadn't appreciated those

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1 **A.** I don't think at the time we would. However, I feel now
 2 we would. And also, in the Forensic Mental Health Team,
 3 they have a nurse practitioner who we can have
 4 consultations with, so whilst they may not pick up the
 5 patient and joint work with us, he can give us advice
 6 and I've previously done forensic risk assessments with
 7 the forensic psychologists within the team which is
 8 really helpful.
 9 **Q.** Going back to your statement as on screen, paragraph 72,
 10 you state you're not familiar and have not been given
 11 training on, the Royal College of Psychiatrists'
 12 publication "The Assessment and Management of risk to
 13 others", College report. You have been provided with
 14 a copy of that --
 15 **A.** Yeah.
 16 **Q.** -- for the purposes of preparing to give evidence.
 17 The e-learning that you received and the other
 18 on-the-job experience that you received, do you think
 19 that instilled in you the principles set out in that
 20 good practice guide?
 21 **A.** I think this is much more in-depth and I think other
 22 forensic risk assessments was, I think I've mentioned it
 23 elsewhere, the HCR-20 are much more in-depth in the way
 24 they assess risk to others. They look more at the risk
 25 long term and predictive risk.

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1 elements of risk assessment?
 2 **A.** So I think we did do it in everyday practice and we had
 3 those discussions, but I think they weren't fully
 4 captured in the documentation. But those discussions
 5 and how we'd respond to risk were still the same.
 6 **Q.** If we can look at the Good Practice Guide. There's only
 7 one bit I'm going to take you to. The reference is
 8 NHFT0015099 and then if we turn, please, to page 7 of
 9 that document.
 10 Under the heading "Tips for psychiatrists",
 11 I appreciate you weren't a psychiatrist, but the very
 12 first bullet point under "Tips" requires the assessor to
 13 "Find out all [that] you can".
 14 **A.** Mm-hm.
 15 **Q.** And you understand now the reason for doing that is it's
 16 going to help inform your assessment of risk and how to
 17 manage it.
 18 **A.** Yeah.
 19 **Q.** If we go to your witness statement, please, page 27 at
 20 paragraph 107. You accept there that you don't think
 21 you "ever read VC's care plans ... or risk assessments".
 22 **A.** So I think I have read the risk assessment because when
 23 myself and Adele were arranging a Mental Health Act
 24 Assessment, one of us updated the risk assessment. So
 25 I think I would have seen it, and either myself or Adele

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1 would have updated it. But I don't believe that I
 2 reviewed the care plan.

3 **Q.** In paragraph 106, which is above that, just five lines
 4 down, you say, and this is with the benefit of
 5 hindsight:
 6 "I realise that there is a lot I did not know about
 7 VC as a covering [care coordinator]."

8 **A.** Mm. Yeah.

9 **Q.** Finally on this point, paragraph 237 on page 62, you
 10 accept that you should have looked through VC's notes to
 11 understand his symptomology and likely prognosis?

12 **A.** I think that would be ideal, but due to the staffing and
 13 the pressures on the service, I wouldn't have had
 14 capacity to go through the notes.

15 **Q.** But is it fair to say, on the basis of those paragraphs
 16 that I've taken you to and with the principles of the
 17 Royal College's Good Practice Guide in mind, you did
 18 not, when seeing VC, find out all that you could?

19 **A.** I think I was aware of the risks and his presentation
 20 from MDT discussions, discussions with Claudia, and when
 21 I would see him I'd be aware of what was happening.

22 **Q.** My question was whether you accept that you did not find
 23 out all that you could?

24 **A.** I'd partially agree with that, yeah.

25 **Q.** Which bit do you disagree with?

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1 they're struggling, and I believe during that time as
 2 well there was only three CCOs in the team, whereas now
 3 there's seven.

4 And yeah, we weren't -- I think there was one CBTp
 5 therapist for the whole of the city teams and county
 6 teams and we didn't have a family intervention team like
 7 we do now.

8 **Q.** So two points from that: firstly, was your job more
 9 difficult as a result?

10 **A.** Yeah.

11 **Q.** Secondly, the reference to only one CBT therapist, did
 12 that you mean you weren't able to offer or undertake
 13 therapeutic work with EIP patients?

14 **A.** I think we'd refer to this CBTp therapist, but there'd
 15 be a wait of sort of a year to access the therapy.

16 I think a lot of what we were doing was almost
 17 crisis work rather than deeper recovery work that we
 18 would like to do.

19 **Q.** If we go, please, to page 4 of your statement, it's
 20 paragraph 13, in this paragraph, you address medication
 21 concordance.

22 **A.** Mm-hm.

23 **Q.** You say whilst you "could ask a patient to show [their]
 24 blister pack", that was not routinely done.
 25 You make the point a patient could reduce.

11

1 **A.** I think I had an understanding of his condition to a
 2 degree, but I mean the sort of in-depth symptomology,
 3 I didn't know, but I had enough to complete an
 4 assessment of his presentation in his risk assessment.

5 **Q.** You state, it's the second sentence of this paragraph:
 6 "... at the time we had big caseloads, and [we] were
 7 uncoupling from [the] [Local Mental Health Team], so
 8 there would not have been time to do so".
 9 Referring to reading through the documents.
 10 Is the position that the big caseloads that you had
 11 limited your ability and the amount of attention that
 12 you could afford to each patient?

13 **A.** I think that it's a factor, but I think we still
 14 practise safely, but I think it was, you know, we
 15 weren't running as a fully resourced EIP team, and we
 16 weren't offering the EIP interventions at this time
 17 until we'd uncoupled from the LMHT.

18 **Q.** Was it the process of uncoupling --

19 **A.** (*The witness nodded*).

20 **Q.** -- so going through the uncoupling, or just the fact
 21 that the EIP team was a standalone team that created the
 22 big caseloads and put pressure on your time?

23 **A.** So we were, when -- part of when VC was referred to us,
 24 we were still a part of the LMHT, so we'd still have to
 25 do LMHT duty, which is when their patients ring if

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1 Then you go on, it's the top of page 5, the
 2 continuation of this paragraph, to identify the option
 3 of referring to the Crisis Team, who could do medication
 4 concordance.

5 On that point, what methods could the Crisis Team
 6 employ that the EIP team could not in medication
 7 concordance?

8 **A.** Daily monitoring and asking the patient to take the
 9 medication in front of them.

10 **Q.** Let's deal with both of those. Second first. Asking
 11 the medication to take the medication in front of them:
 12 is that something that the EIP practitioners could do?

13 **A.** Not really because at most we'd see a patient once
 14 a week.

15 **Q.** In terms of visiting daily, was that something that the
 16 EIP team could do?

17 **A.** No. I think it was if we were seeing a patient more
 18 than twice a week then we need to refer to the Crisis
 19 Team.

20 **Q.** The next paragraph, paragraph 14, you say you didn't
 21 receive any formal training in dealing with medication
 22 concordance. Given the significance of that issue to
 23 your role, particularly working with patients with
 24 psychosis, do you consider you should have been given
 25 training on medication concordance upon joining the EIP?

12

1 A. I think, yes, it would be good to have it. I think it's
2 again something that's sort of learnt in the role. And
3 I think there is e-learning, again, about medication
4 concordance.
5 Q. Did you undertake that e-learning?
6 A. Yeah, I would have done.
7 Q. When?
8 A. I can't recall.
9 Q. If we go forward in your statement, page 16,
10 paragraph 60. Sorry, forgive me, it's paragraph 231 on
11 page 60. Dealing there with medication, and this is in
12 the part of your statement where you set out a number of
13 your reflections on this case. But you make the point
14 here, in respect of VC, and the retrospective point that
15 you should have asked to see the box of medication and,
16 where there's a refusal, well that in itself could
17 indicate non-concordance.
18 A. Yeah. So regarding checking the box of medication,
19 I had a look in there and I don't believe in the
20 medication policy it's part of that policy. So again,
21 it was something that some of us might do, some of us
22 not do. I think, regarding doubts about medication
23 concordance and referring to Crisis, there would have to
24 be a change in presentation or a change in risk in order
25 to -- for the Crisis Team to accept that referral.

13

1 medication, you didn't note his presentation or didn't
2 note it in detail.
3 A. Yeah.
4 Q. The importance of that omission is, with that greater
5 detail it would assist others, wouldn't it --
6 A. Yeah.
7 Q. -- who came after you and identifying and recognising
8 a deteriorating condition?
9 A. Yeah.
10 Q. You also state that you did not document MDT discussions
11 or discussions with your manager.
12 A. *(The witness nodded)*.
13 Q. You recognise that should have been done.
14 A. Yeah.
15 Q. And in the EIP team, you were not an isolated case, were
16 you?
17 A. *(The witness nodded)*.
18 Q. None of the members of the team were documenting MDT
19 meetings at all.
20 A. I've looked at other notes and it seems that, on
21 occasion, they were documented.
22 Q. So not routinely or regularly documenting MDT meetings.
23 A. Yeah.
24 Q. They should have been documented.
25 A. Yeah.

15

1 Q. Yes, that's referencing circumstances in which you might
2 refer to Crisis --
3 A. Yeah.
4 Q. -- because they can see a patient more regularly.
5 A. *(The witness nodded)*.
6 Q. But where an EIP practitioner has concerns about
7 medication concordance, earlier in your statement you
8 make the point that EIP practitioners don't routinely --
9 A. Yeah.
10 Q. -- ask to check the medication books, but here it
11 appears one of your reflections is well that could be
12 done, and even if a patient refused, because they had no
13 obligation to do so, then you might draw an inference of
14 non-concordance.
15 A. Yeah, you might. I don't necessarily agree that you'd,
16 from my own statement, that you'd then refer to the
17 Crisis Team. I think it would be continue to monitor
18 their presentation, perhaps increase contact with them.
19 Q. If we go back in this statement to page 57 it's
20 paragraph 217 and again, this is part of your
21 reflections, and you reflect here that your notekeeping
22 was poor.
23 A. Yeah.
24 Q. A similar point is made, paragraph 234, please, page 61.
25 An example of that is on occasions when you gave VC his

14

1 Q. Do you know why there was a practice or an inconsistent
2 practice of documenting or not documenting MDT meetings?
3 A. I'm not sure why it was like that. Perhaps if we'd
4 uncoupled from the LMHT and we were used to having
5 a joint MDT with them, so it almost -- I don't know, it
6 was almost a new service and we weren't told; whereas
7 now we have a template which we follow for MDT, whereas
8 at the time then we didn't.
9 Q. Now, before turning to your interactions with VC, if we
10 can look at another general point, it's just on the
11 previous page, page 60, paragraph 228, at the top of the
12 page. You're making the point there that you, and I'm
13 paraphrasing slightly, you should have done things as
14 a care coordinator even when you were covering, the
15 allocated care coordinator. And is this
16 an acknowledgement that, where a CCO such as yourself
17 was covering, they were not as proactive as they should
18 have been?
19 A. I think, as covering CCO, you're often doing certain
20 tasks, so you might cover medication or you might do
21 a three-day follow-up, but you're not necessarily part
22 of the long-term care plans. And again, how the
23 covering -- the roles and responsibilities of a covering
24 a CCO have changed since all of this.
25 Q. But at the time was your view of the role of a covering

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1 CCO essentially to undertake the visit, or receive
 2 a phone call and pass it on to the allocated care
 3 coordinator --
 4 **A.** *(The witness nodded).*
 5 **Q.** -- rather than being proactive and instigating action
 6 yourself?
 7 **A.** I think I was proactive during this time in that if it
 8 was felt that there was a need for escalation that day
 9 or that week, then I would follow up on that. I
 10 wouldn't not follow up on a change in presentation or
 11 a change in risk.
 12 **Q.** If we can turn then to your interactions with VC, we'll
 13 look at the medical records, it's NHFT0000168 and go to
 14 131.
 15 It's the entry at the top of the box,
 16 21 August 2020, and this was your first direct contact
 17 with VC, wasn't it?
 18 **A.** Yes.
 19 **Q.** In the second line of this entry, you describe him as
 20 being "monosyllabic in his responses but ... polite and
 21 pleasant". What was the significance of his responses
 22 being monosyllabic?
 23 **A.** I think if someone is monosyllabic it can be hard to
 24 engage them or continue a conversation, and it's hard to
 25 explore things deeply with them if it's sort of

17

1 **A.** Yeah, I think so, yeah.
 2 **Q.** The third paragraph:
 3 "[VC] continues to be concordant with his
 4 aripiprazole."
 5 Was that based solely on VC's self-report?
 6 **A.** Yeah.
 7 **Q.** In light of the evidence that you've given earlier about
 8 checking medication boxes, there was nothing that you
 9 did to interrogate that self-report?
 10 **A.** No.
 11 **Q.** If we go forward now to October 2020, your next
 12 interaction with VC, it's page 135, we can see the entry
 13 by you, it's the second box on that page, 9
 14 October 2020. But what appears to lead to that, it's
 15 a visit that you undertake to VC's home address, is the
 16 telephone call in the box above?
 17 **A.** Yeah.
 18 **Q.** Celeste Calocane, that's VC's mother, she's reporting
 19 that VC had told her not to speak to him -- to her for
 20 two months, that she'd been unable to contact him, and
 21 that that was out of character and she wanted the team
 22 to visit him.
 23 Now, firstly, does that report indicate a potential
 24 change in mental state?
 25 **A.** I think so, yeah, as it was known that he had a good

19

1 a one-word response.
 2 **Q.** It makes it more difficult to assess?
 3 **A.** Yeah.
 4 **Q.** You acknowledge that in the note.
 5 **A.** Yeah.
 6 **Q.** When you're conducting these visits, do you undertake
 7 a Mental State Examination?
 8 **A.** Yes.
 9 **Q.** What do you understand that to involve?
 10 **A.** That we're assessing someone's appearance, how they
 11 speak to us, the pressure of their speech, the tone.
 12 Are we able to build a rapport? Do they present as
 13 paranoid? Someone might be distracted or responding to
 14 unseen stimuli, so we'd document that.
 15 **Q.** The second paragraph, second sentence, reads:
 16 "Reports no psychotic symptoms, however may be
 17 masking."
 18 Why were you suspicious of potential masking?
 19 **A.** I think because he'd had an admission, well, I know now
 20 he had two admissions, but people may have -- it's
 21 called residual symptoms, so they might hear a voice
 22 once a week. So perhaps I thought he's gone from having
 23 voices to having nothing, so perhaps he's masking the
 24 experience he's having.
 25 **Q.** Masking would be a concern in a presentation?

18

1 relationship with his mum and they spoke regularly. So
 2 as I've said there, it's out of character.
 3 **Q.** In light of VC's presentation and his history, was that
 4 a concerning development? You've noted that VC gets
 5 very unwell when his mental health deteriorates?
 6 **A.** Yeah, I think it's something that it was important for
 7 us to assess, and, you know, try and speak to him that
 8 day, and discuss more.
 9 **Q.** So you undertake a visit with a colleague, it's the
 10 second entry on the page, and you speak to a housemate
 11 who stated that VC was okay, and that she -- that is the
 12 housemate -- had no concerns, and later say she's not
 13 worried.
 14 Is it fair to say, from reading your note, that your
 15 discussion with the housemate provided reassurance?
 16 **A.** I think at the time it did for that day, but then I sent
 17 an email asking him to be followed up the following week
 18 as I still felt it needed further discussion.
 19 **Q.** Were you able to ascertain from your conversation with
 20 this housemate how close a relationship she had with VC?
 21 **A.** So I don't really call this conversation, I've been
 22 trying to recall it, but I can't. Normally we might ask
 23 someone how they think they are, but it's very
 24 difficult, because they might not know that they're
 25 under mental health services --

20

- 1 Q. That was going to be my next question. Did you even
2 ascertain whether this housemate was aware of VC's
3 diagnosis or mental health problems?
- 4 A. I can't recall on this interaction, but typically we
5 wouldn't ask housemates if they're aware of someone's
6 diagnosis or treatment.
- 7 Q. Is the reality that when weighed against the concerns
8 that had been raised by VC's mother, there was limited
9 assurance that could be provided by a housemate who
10 might not know anything about VC's mental health state?
- 11 A. Yeah.
- 12 Q. You finish that entry by saying that you'd email the
13 manager, Emma Robinson, to follow up with VC next week.
- 14 A. Yeah.
- 15 Q. There's also a copy of the email in the documents that
16 you've provided asks, as you indicated a few moments
17 ago, for follow-up next week.
- 18 If we look at your witness statement, it's page 35,
19 paragraph 137, when dealing with this entry. You say,
20 four lines down in this paragraph:
- 21 "I imagine that as VC's housemate did not raise
22 concerns, we did not feel it was urgent for that day,
23 and it appeared to have been appropriate to take action
24 the following day."
- 25 A. Mm-hm.

21

- 1 indicated, said, "Don't speak to me for 2 months", which
2 is out of character, and she's asked for someone to go
3 to him.
- 4 Why doesn't that indicate the a change or potential
5 change in mental state?
- 6 A. I think it does indicate a change in mental state and
7 presentation that needs to be assessed to understand
8 more. I think it's important that it was followed up
9 the next week and I don't think at that time it would
10 have met the threshold for a Crisis referral, although
11 it is concerning.
- 12 Q. If we look at the entries in the bottom half of that
13 page, it charts the course of events over the rest of
14 October, and we've already heard some evidence on this,
15 but the position is that there is no contact with VC, is
16 there, until the brief interaction on 26 October that
17 Gary Carter has?
- 18 A. Yeah.
- 19 Q. Then on 5 November, if we go over the page, there is the
20 contact from Dr Seedat, or the entry in the notes,
21 rather, from Dr Seedat, after VC has made direct contact
22 with him.
- 23 Now in your statement you say -- it's
24 paragraph 148 -- you cannot recall your conversation
25 with Dr Seedat on 5 November. If you had a conversation

23

- 1 Q. It's in particular the use of the words "the following
2 day" because your note in the RiO records, the email,
3 talk about following up in the following week rather
4 than the following day.
- 5 A. Yeah.
- 6 Q. So is your reference in the statement to "the following
7 day", is that an acknowledgement that this needed much
8 more prompt action than "next week"?
- 9 A. I think it should say "appropriate to take action the
10 following week".
- 11 Q. So notwithstanding the concerns raised by Celeste
12 Calocane, the limited assurance that could be provided
13 by the housemate, and VC's history, you don't think it
14 was appropriate or required to take urgent action the
15 following day.
- 16 A. So I think at that time, no concerns were raised
17 regarding a change in risk, a change in presentation.
18 So if the housemate had said, "He's acting bizarrely",
19 or "He just seems different", then I feel we could have
20 spoke to the Crisis Team.
- 21 Q. Why wasn't the report from Celeste Calocane -- and we
22 can put it on screen again, it's the medical records
23 page 135. She's rang and left several answerphone
24 messages. It's the box at the top of the page. She's
25 expressed or reported that VC has, as I've already

22

- 1 with Dr Seedat, that should have been documented in the
2 notes, shouldn't it?
- 3 A. Yeah. I don't know if I have spoke to him because
4 I know emails were sent from him, so I don't know if
5 I did have a telephone call with him. I don't believe
6 I did.
- 7 Q. In light of what Dr Seedat has reported, this is further
8 evidence, isn't it --
- 9 A. Yeah.
- 10 Q. -- following on from the reports by Celeste Calocane, of
11 a potentially deteriorating patient?
- 12 A. Yeah.
- 13 Q. So if we look at the next entry, 6 November, 3.13. This
14 describes -- it's an entry made by Gary Carter but
15 describes a visit that you undertook with Gary Carter --
- 16 A. Yeah.
- 17 Q. -- to VC.
- 18 A. Mm-hm.
- 19 Q. VC indicates that he wants to speak to a doctor but he
20 was reluctant to tell you what about. And
21 significantly, he discloses that he has ten left of his
22 medication.
- 23 A. Yeah.
- 24 Q. That's in circumstances when he was actually overdue his
25 prescription.

24

1 A. Mm-hm.
 2 Q. That indicates, doesn't it, that he was non-concordant?
 3 A. Yeah.
 4 Q. That -- and you acknowledge this in your statement, that
 5 is something that should have been recorded as an issue
 6 of concern in this note.
 7 A. Yeah.
 8 Q. Whereas the final entry in that box says, "No issues of
 9 concern at this time".
 10 A. Yeah.
 11 Q. Given his history -- and were you aware of the history
 12 leading to the two admissions at this time, VC's two
 13 previous admissions?
 14 A. So I think, from looking at this statement and then the
 15 investigation I did about something else, I think
 16 I thought that was one admission, whereas I can see now
 17 it was two different admissions that were in very close
 18 succession to each other.
 19 Q. Were you unaware that VC had, following his first
 20 admission, ceased taking medication very quickly,
 21 deteriorated, resulting in a second admission?
 22 A. I can't recall if I was aware.
 23 Q. But given that history of requiring the second admission
 24 after becoming non-concordant, the aggression and
 25 violence that had been displayed, this indication here

25

1 Q. There is a reference, it's the third paragraph down, the
 2 main block paragraph at the top, the second line:
 3 "He said that although his 'condition' improve but
 4 he don't think that this was psychosis."
 5 A. Yeah.
 6 Q. He was unsure whether it was the medication that had
 7 caused his voices to calm down. What conclusions did
 8 you draw from those reports by VC?
 9 A. I think it shows his insight, but it's -- at this point
 10 it seems okay, he's able to recognise the voices have
 11 calmed down now, although they're still there, so he's
 12 not completely saying this isn't a mental health
 13 condition. He reports to be concordant with his
 14 medication.
 15 Q. Well, he's saying it's not psychosis.
 16 A. Yeah.
 17 Q. Did you have an understanding of what mental health
 18 condition he could be referring to if not psychosis?
 19 A. I think from everything I've read, I think he doesn't
 20 feel this was ever a mental health condition at all.
 21 Q. Doesn't that show a lack of insight?
 22 A. I think -- so when you look at all the information,
 23 I think some patients don't have insight or they
 24 challenge their diagnosis, and that's where
 25 psychoeducation about the illness and the symptoms they

27

1 of non-concordance was a matter of very significant
 2 concern.
 3 A. Yeah.
 4 Q. If we go on to your next involvement, that comes in
 5 February, into March, doesn't it? And it's at page 146
 6 of the records. This entry has been made by Dr Burri.
 7 We've already heard evidence from him, and this was an
 8 outpatient appointment that you attended.
 9 A. Yeah.
 10 Q. What's the role of a care coordinator at outpatient
 11 appointments with the doctor?
 12 A. To feed back any concerns that have been raised in their
 13 appointments. And to support the patient.
 14 Q. Your ability to feed back, presumably, was limited
 15 because your last contact had been back in November?
 16 A. So prior to this appointment, I would have looked on the
 17 notes, prior to this, to get an understanding of what
 18 was happening at the time.
 19 Q. Do you recall what feedback you provided?
 20 A. I can't recall, no.
 21 Q. Do you agree what has been recorded in this note as to
 22 what was discussed --
 23 A. Yeah.
 24 Q. -- at the appointment?
 25 A. Mm-hm.

26

1 experience is beneficial.
 2 Q. If we look at the next two entries below that, please,
 3 it's 2 February and 17 February. We can look at them
 4 collectively. They're both entries by you and they're
 5 both medication drops, aren't they?
 6 A. Yeah.
 7 Q. But the entry is very brief --
 8 A. Yeah.
 9 Q. -- indeed. Are these examples of entries --
 10 A. Yeah.
 11 Q. -- that, in your reflection, ought to have gone into
 12 more detail as to VC's presentation?
 13 A. Yeah, definitely.
 14 Q. Is there anything that you're able to add to either of
 15 those entries now?
 16 A. I don't think it's in this one -- oh, I've put "He
 17 seemed well", but I think I should have said: well, what
 18 does well look like? How was he engaging? You know,
 19 what's he saying?
 20 And now, if we were to do any contact, we'd put
 21 "Risk" at the bottom, has there been a change in risk?
 22 So I think it just needs more detail on the note.
 23 Q. At the top of the next page, page 147, this is your
 24 entry of 22 February describing a telephone call with
 25 VC.

28

1 A. Yeah.

2 Q. You note that he was bright in his mood and ultimately
3 you conclude low risk to himself and others.

4 A. Mm-hm.

5 Q. How did you arrive at that conclusion?

6 A. So I think at this point he was engaging well with us;
7 he had more insight than he does later on in his time
8 with us. He was honest and open, I think, in that
9 review with myself and Dr Burri, and then a previous one
10 with Claudia. So I think at this point the main concern
11 for him was the negative symptoms of psychosis, so the
12 short-term memory loss. So I think I made that
13 assessment from how open he was being.

14 Q. In the first paragraph of this entry, it states:
15 "Reports he [is] not -- he has noted no changes
16 since the increase in his aripiprazole."?

17 A. Yeah.

18 Q. But then in the third paragraph, it says:
19 "VC's voices are much better, he describes them as
20 quieter and in the distance."

21 A. Yeah.

22 Q. Are those two points consistent?

23 A. Yeah, I think so. So voices can get worse and more
24 intense for various reasons, not just medication. So
25 someone might be more stressed, and their voices might

29

1 first paragraph.

2 A. Mm-hm.

3 Q. In the third paragraph:
4 "I do not think [VC] has relapsed at this point, he
5 appeared well in himself."
6 And in respect of medication you note that he "is
7 adamant that he takes them daily."
8 Now were you aware at this stage that VC had
9 disclosed, during his second admission, having misled
10 the clinicians as to the symptoms he was suffering?

11 A. No.

12 Q. Did you consider that VC might mislead --

13 A. Yeah.

14 Q. -- health practitioners?
15 In light of what VC's mother had reported, and in
16 particular what VC was said to have told his brother,
17 you had reason to be sceptical.

18 A. Yeah.

19 Q. Were you sceptical?

20 A. I imagine so, yeah.

21 Q. Was this an occasion where you could have asked to
22 see VC's medication box?

23 A. Yeah.

24 Q. Is this an occasion when you should have referred to the
25 Crisis Team so that they could undertake daily

31

1 get worse, or lacking sleep. Or someone might have
2 found ways to live with them and to manage them.

3 Q. Then finally on this page, we can see on the screen
4 already, your entry of 8 March 2021, where you send VC
5 a text and then further down on 10 March there is
6 a telephone call --

7 A. Yeah.

8 Q. -- to VC? Did you take any action following those two
9 attempts at contact?

10 A. I don't know without seeing my phone at that time.

11 Q. Your next contact, then, is in June 2021 and we can go
12 to page 153. What is noted, as you can see on the
13 screen in front of you, this is contact that VC's mum,
14 Celeste Calocane, has made to the Crisis Team on
15 22 March at 20:21.
16 We can see in the first paragraph the concerns that
17 she is raising, she thinks he's not doing well, he's not
18 making sense. She reports that VC has told his brother
19 he's not been taking his medication for two to three
20 weeks.
21 It's following that report -- that report by Celeste
22 Calocane that you visit VC, the entry starts at the
23 bottom of the page, 2 June 2021. Going on to the next
24 page, top of page 154, and you describe VC as "bright
25 and reactive in mood". That's the first line of the

30

1 medication concordance?

2 A. I think again it would be about how he presents at that
3 time. So Mum's raised concerns, we've done the visit
4 and we weren't concerned, and there didn't appear to be
5 a change of risk, which is why there wasn't a referral
6 to Crisis at this stage. However, it would warrant
7 closer monitoring.

8 Q. You make the point in your statement that you,
9 individually, and you as a team, were not aware that, on
10 31 May, VC had gone to Thames House in London.

11 A. Yeah.

12 Q. You think you should have been made aware of that?

13 A. Yes.

14 Q. Had you been aware of it, do you think it would have
15 changed the outcome of this attendance?

16 A. I think so, yeah.

17 Q. How so?

18 A. Because we could have asked him about him attending MI5,
19 and I think although it doesn't indicate a change of
20 risk, it's him acting almost on his beliefs. So going
21 to MI5, trying to unpick that further. So I think at
22 that point, perhaps then we could have had a discussion
23 with Crisis. Because again, that's a change in his
24 presentation, him going to MI5.

25 Q. Well, it's an added factor, isn't it?

32

1 A. Yeah.

2 Q. You've got his mother reporting that he's not making
3 sense.

4 A. Yeah.

5 Q. You've got his mother reporting that he's disclosed to
6 his brother he's been non-concordant with medication.

7 A. Yeah.

8 Q. Against that, you're weighing the fact that when you see
9 him, your view is he's bright and he's told you he's
10 adamant he's taking medication.

11 A. Yeah.

12 Q. With the fact of him acting on his delusions, that would
13 have been a stronger indication yet to call for daily
14 medication concordance --

15 A. Yes.

16 Q. -- by Crisis.

17 If we move, please, to August 2021, it's page 160,
18 and if we deal with the entry in the middle of the page,
19 so the 1.01 pm entry by Amanda Smillie. This is
20 describing VC attending Rowan 1 again, and he's asking
21 staff members whether they hear voices on the ward,
22 whether they communicate with artificial intelligence.

23 A. Yeah.

24 Q. Now, that is strange and unusual behaviour.

25 A. Yeah. I think there is psychotic beliefs, so him going

33

1 Q. If we go on to the next page, the top of 161, that has
2 a note of your visit with Adele Pinder on 19 August, and
3 at this home visit your view was that VC was relapsing.

4 A. Yeah.

5 Q. He didn't realise what day it was. So second line, he
6 says he was not expecting you because you said it was
7 a Thursday and in fact it was a Thursday.

8 A. Mm-hm.

9 Q. He paused when you asked him about medication.

10 A. Yeah.

11 Q. And you note that he was guarded and unkempt.

12 A. *(The witness nodded)*.

13 Q. Now under the heading "Impression" you've put:
14 "No risks noted today but difficult to assess due to
15 guarded presentation."

16 A. Mm-hm.

17 Q. Well, in light of VC's history, violence and aggression
18 leading to his previous two admissions --

19 A. Yes.

20 Q. -- wasn't a likely relapse in itself a risk?

21 A. Yeah. I think at this stage he was showing early
22 warning signs but he wasn't at a stage that I've noted
23 here, that the risk had changed. I think, for other
24 patients with similar risk histories, if I knew there
25 was other agencies involved I might ring them, such as

35

1 to the ward, although it's out of character and quite
2 unusual, that's information about what he was struggling
3 with.

4 Q. It's demonstrative of the psychotic symptoms --

5 A. Yeah.

6 Q. -- and further evidence of acting on them.

7 Now, on the basis of those reports, did it require
8 a more urgent intervention, an escalation to the
9 consultant, Dr Lloyd, for instance?

10 A. I think it would have been discussed at the MDT, and
11 she'd be present there.

12 Q. Very shortly after, it's the next entry, you describe
13 a telephone call to VC. Now, he says he's fine, but
14 again you describe him as monosyllabic.

15 A. Yeah.

16 Q. You've agreed to meet him three days later.

17 A. Mm-hm.

18 Q. Why not go and see him more urgently than that? Why was
19 it safe to wait three days?

20 A. I think it would have been seeing other patients,
21 potentially, other cover. I wish now that I had seen
22 him that day.

23 Q. Yes, the concerns raised justified a visit that day.

24 A. Yeah. I think the reason I didn't would have been about
25 capacity for that day.

34

1 the police. Have they had contact with them?

2 Q. But particularly in respect of VC, and again thinking
3 about the approach to risk assessment, in light of what
4 had occurred in the past, a likely relapse was a risk.

5 A. Yeah.

6 Q. And it should have been noted as such.

7 A. Yeah.

8 Q. Had you been more familiar with his history, had you had
9 the opportunity to consider the records, do you think
10 you would have recognised and noted that as a risk?

11 A. Yeah. I'd put "historical risk".

12 Q. Should, in light of this presentation and what had
13 occurred a few days earlier on 16 August, should
14 a Mental Health Act Assessment have been called at this
15 stage?

16 A. Not at this stage, no --

17 Q. Why not?

18 A. -- but closer monitoring, discussions in MDT,
19 discussions as a team.

20 Q. Why not a Mental Health Act Assessment?

21 A. I think at that point he said he'd text us or call us
22 again. Although there was a change in presentation.
23 He's more guarded. It comes down to risk. How I've
24 documented it is that there's no risks at that moment
25 but he evidently needs closely monitoring.

36

- 1 Q. If we look at your statement, page 46, paragraph 175,
2 you state at the end of that paragraph:
3 "I imagine that our plan was to keep contacting VC,
4 and to refer to crisis if our concerns remained."
5 A. Yes.
6 Q. That plan is not documented, is it?
7 A. No.
8 Q. Over the page, page 47, paragraph 179 you make the point
9 you don't know what was discussed in the MDTs, it's not
10 been documented and you can't comment on what decisions
11 were made?
12 A. Yeah.
13 Q. Now, the following month, VC was detained, there was
14 a Mental Health Act Assessment and the assault.
15 Your next involvement comes in October 2021,
16 following the discharge from The Priory. If we go
17 forward -- sorry, go back to the records and see
18 page 194, this is an entry of yours dated 22 October,
19 and you're noting here, aren't you, the confusion around
20 VC's discharge --
21 A. Yeah.
22 Q. -- at the top of the page. Essentially, the EIP team
23 weren't on notice, you weren't aware that VC was being
24 discharged that day?
25 A. Mm-hm, yeah.

37

- 1 have been seen face-to-face after admission.
2 Q. How is that relevant to the issues around discharge
3 planning?
4 A. It's more in terms of the three-day follow-up.
5 Q. Is the reason the three-day follow-up wasn't undertaken
6 because the discharge happened without warning --
7 A. Yeah, yeah.
8 Q. -- and Crisis weren't available?
9 A. Yeah, I think both factors, yeah.
10 Q. Ultimately, it was a mismanaged discharge?
11 A. Yeah.
12 Q. Is this confusion and miscommunication, is that
13 something which is common when you're dealing with
14 out-of-area placements?
15 A. Not often-often, but it's not as seamless as if
16 a patient was in our trust because we can see the notes.
17 We're invited to the ward round every week.
18 Q. In paragraph 181 of your statement, it's page 48, you
19 make the point that when a hospital discharges a patient
20 you would expect EIP to be invited to the discharge
21 meeting, an active part of discharge planning.
22 A. Yeah.
23 Q. That's for obvious reasons: to avoid what occurred in
24 October with VC.
25 If we can look, please, at NHFT0017897, this is an

39

- 1 Q. So no plan had been put in place by your team for the
2 discharge --
3 A. Yeah.
4 Q. -- and attempts to put one in place were unsuccessful.
5 The Crisis Team couldn't see VC for follow-up, could
6 they?
7 A. Yeah.
8 Q. What transpired is that VC, then, was not seen until 5
9 November, which is more than two weeks following his
10 discharge?
11 A. Mm-hm.
12 Q. Now, that is not how post-discharge arrangements should
13 operate?
14 A. Yeah.
15 Q. The transition from one setting to another, and
16 particularly when it's an-out-of-area placement back
17 home, that is a point of particular risk and stress for
18 your patients?
19 A. Mm-hm, yeah.
20 Q. So it was far from ideal?
21 A. Yeah. I think I mention in my statement that perhaps
22 the reason why we weren't as assertive was because of
23 university, because he said he was at university, and
24 that was really important for him and it was seen as
25 a positive and protective factor, but he still should

38

- 1 email from Claudia Birtles and she was, we heard
2 evidence from her, she was VC's care coordinator. Dated
3 15 October, it's sent to a number of people in the EIP
4 team including yourself.
5 A. Mm-hm.
6 Q. If we look at the bottom of the screen, it's in the
7 middle of the page, the section dealing with VC, she
8 says she thinks it's likely VC is going to be discharged
9 "next week" as in fact he was.
10 A. Yeah.
11 Q. "He has a ward review next Thursday I believe, I've
12 attended over teams. If anyone was free to join that
13 that would be amazing or if not maybe just a follow up
14 call to the Priory at Calverton to check what's
15 happening. They usually email ..."
16 A. I don't know if I rang The Priory or if his mum rang me.
17 I'm not too sure. Yeah, I can't recall.
18 Q. But if you did speak to The Priory or VC's mother, you
19 weren't, as a result of that, aware of the discharge,
20 the impending discharge on the 22nd?
21 A. No, I think I spoke to Mum and the ward on the Friday.
22 Q. If we go back to your entry post-discharge, it's
23 paragraph 194 of the records, we've dealt with, as it
24 were, with the confusion, the fact that Crisis weren't
25 able to do a follow-up. In the middle of the page you

40

1 spoke to VC?
 2 **A.** Yeah.
 3 **Q.** Is it fair to say that you were getting monosyllabic
 4 answers and were concerned that his presentation had not
 5 changed?
 6 **A.** I think it seems that it was different from when myself
 7 and Adele visited when he was cagey and guarded.
 8 I think although his answers were short here,
 9 I perceived it as he wants to focus on university, he's
 10 just come out of hospital, rather than him being unwell.
 11 **Q.** If we can get up, please, NOCC0000040, this is the AMHP
 12 report from January 2022, on your referral. But it's
 13 page 2 of this document I want to look at, and the
 14 penultimate paragraph, towards the bottom of the page.
 15 Where it says under the red bit "End of copied
 16 information":
 17 "[VC's] engagement with his mental health team has
 18 been limited. Abi (covering CPN) reports [VC] being
 19 guarded and suspicious on his last two contacts with the
 20 [Local Mental Health Team] in November and December.
 21 Abi questions if [VC] was fully well when discharged."
 22 That's a reference to the October 2021 discharge,
 23 isn't it?
 24 **A.** I believe so, yeah. I think we can question if someone
 25 is not fully well, because I guess there's almost

41

1 **A.** I think I was concerned that he was deteriorating, yeah.
 2 **Q.** Now this entry is from 17 December. The final line
 3 of it says:
 4 "We will update Claudia."
 5 However, the next entry in the records is not until
 6 31 December, and the question is, in light of the
 7 concerns that you're raising and noting in the RiO
 8 records, would you have expected action to have been
 9 taken much sooner than 31 December?
 10 **A.** I don't know what else was going on in the team at the
 11 time so I can't really comment on that.
 12 **Q.** Well, what was going on in the team might explain
 13 reasons why it was impractical --
 14 **A.** Yeah.
 15 **Q.** -- to go and see him, but my question is: in light of
 16 the concerns that you're raising, would you expect, or
 17 did those concerns justify, him being seen much sooner
 18 than 31 December?
 19 **A.** Perhaps, or a conversation with him on the telephone.
 20 **Q.** If we can go forward, the following month, and we've
 21 already looked at the AMHP report, there's a Mental
 22 Health Act Assessment. And if we -- still on page 202,
 23 you had some involvement in the arrangements for that,
 24 didn't you?
 25 **A.** Yeah.

43

1 a spectrum of psychotic symptoms. Someone can live
 2 day-to-day with psychotic symptoms but not be at a point
 3 of needing Crisis or hospital.
 4 **Q.** We can take that down. If we go back to the records,
 5 please, page 202. It's the entry of 17 December. It's
 6 the top box on this page. And this is a medication
 7 collection, so VC has come to the Stonebridge Centre.
 8 Claudia is not there. You -- this your note, and you
 9 describe how VC had his hood up, mask on, "very curt"
 10 with the receptionist, and is it fair to say, from your
 11 description, he was pretty abrupt with you?
 12 **A.** Yeah.
 13 **Q.** In that first paragraph you described him as "fixed in
 14 his staring". What was the significance of being fixed
 15 in his staring?
 16 **A.** I think it's a term that's used for, you know, like we
 17 said earlier about the Mental State Examination, so it
 18 shows sort of hostility and paragraphs paranoia that he
 19 might have felt towards me.
 20 **Q.** So this is an entry which is highlighting your concerns
 21 about VC.
 22 **A.** Mm.
 23 **Q.** And was your concern that he was deteriorating?
 24 **A.** (*The witness nodded*).
 25 **Q.** May have relapsed?

42

1 **Q.** So we need to go forward to page 204. And the entries
 2 of 18 January. Now what occurs on 18 January is that
 3 the University puts your team on notice that VC has
 4 assaulted somebody.
 5 **A.** Yes.
 6 **Q.** And at 11.41 (*sic*) on 18 January we've got your entry:
 7 "[Telephone call] ... to social care to give
 8 information regarding [VC] for a MHA today."
 9 So that's -- you're asking for an assessment to take
 10 place that day.
 11 **A.** Yeah.
 12 **Q.** However, the following morning, 19 January, it's the
 13 last entry on the page, you note that, first bullet
 14 point:
 15 "Rang social care no beds available -- Therefore not
 16 done yesterday".
 17 **A.** Yeah.
 18 **Q.** And we can see in an email that you sent to the
 19 University, it's NHFT0018248, you note that:
 20 "They are awaiting a bed before the assessment can
 21 be done."
 22 That's in the first line.
 23 Then fifth sentence:
 24 "Such a shame there were no beds yesterday."
 25 **A.** Mm-hm.

44

1 Q. So is it the position that the Mental Health Act
2 Assessment on VC had to be delayed because of a lack of
3 beds?
4 A. I think it was probably as well because of what had
5 happened at the previous Mental Health Act Assessment,
6 that they needed police presence, and they needed to be
7 able to take him to a safe place. So I think it
8 probably would have been a few factors, perhaps.
9 Q. Did you experience, have you experienced, in your role
10 as care coordinator or at the EIP team, a problem of
11 assessments or detentions being delayed or not going
12 ahead because of a lack of available beds?
13 A. I think on occasion, yeah.
14 Q. If we can go back to the records and page 268, it is the
15 entry towards the top of the page, 15 June 2022, and
16 this is the last time that you saw VC, wasn't it?
17 A. Mm.
18 Q. It's another medication drop. But you've noted VC's
19 facial hair, head hair, overgrown. Looking suspicious.
20 How was he looking suspicious?
21 A. I imagine he was looking around -- I mean, I've not
22 documented here, but perhaps it was similar to the other
23 time he'd come to the Stonebridge Centre, and perhaps
24 the fixed staring was there as well. I'm not sure.
25 Q. Is this another example of an entry that ought to have

45

1 "What about medication?
2 "Still have some. Won't make much difference."
3 A. Mm.
4 Q. Now, the fact that he still had medication, if he still
5 had medication at this point, that indicated that he was
6 non-concordant --
7 A. Yeah.
8 Q. -- because he should still have medication, and that
9 indicated his aversion to taking medication at this
10 point?
11 A. Yeah.
12 Q. You said in your statement you formed the view that his
13 medication concordance was likely patchy, but in respect
14 of the word "patchy", at best it would be patchy, and at
15 worst not compliant at all with his medication?
16 A. Yeah, yeah.
17 Q. Now, again, and this is part of the reflections in your
18 witness statement, you make the point that you should
19 have rung VC's phone to listen for an international
20 dialling tone?
21 A. Mm-hm.
22 Q. So that would be one way to verify the accuracy of what
23 he was telling you.
24 A. Yeah.
25 Q. You accept you should have rung VC's mum --

47

1 been more detailed on VC's presentation, notwithstanding
2 that it was a medication drop?
3 A. Yeah.
4 Q. It finishes with:
5 "I will update Gary".
6 That's a reference to Gary Carter --
7 A. Yeah.
8 Q. -- who was VC's care coordinator at that point. Were
9 you concerned by VC's presentation?
10 A. I think I was, but I think he'd said to Claudia that he
11 was going to start disengaging from mental health
12 services because he didn't trust us after the tribunal
13 report.
14 Q. That was the last time that you saw VC, but you then had
15 a text exchange with him in July 2022. We can look, we
16 can look at the screenshot from your phone, it's in
17 various forms in the documents we've got. But
18 WITN0317014, and this is 18 July. It's an exchange with
19 your texts on the right-hand side and VC's on the left.
20 A. Mm-hm.
21 Q. You've asked him at the top whether he is coming to
22 collect his medication. He said he's not in the UK.
23 You've asked him when he's going to be back. He
24 says, "Probably around October".
25 You say:

46

1 A. (*The witness nodded*).
2 Q. -- to ask about this, to enquire about this?
3 A. Yeah, yeah.
4 Q. In fact, the position which you -- you handed this over
5 to Gary Carter to follow up on?
6 A. Mm.
7 Q. Now, did you become aware, were you made aware, that
8 subsequently later in the month, Mr Carter spoke to VC's
9 mum and it transpired that VC was not abroad at all --
10 A. Yeah.
11 Q. -- that he was in Nottingham?
12 A. Yeah.
13 Q. So it follows from that that he deceived you, he lied to
14 you?
15 A. Yeah.
16 Q. Again, that would be another matter of concern, given
17 VC's history?
18 A. Yeah.
19 Q. Now, if we can go back to the records, it's the last
20 entry in the records that I'm going to take you to, it's
21 page 271, please.
22 It is the entry at the top of that page. We can see
23 it's the last entry in the RiO notes prior to the
24 attacks, and it records, refers to a discussion in MDT
25 where a decision was made to discharge VC from the EIP

48

1 back to primary care.
 2 **A.** Yeah.
 3 **Q.** Now, in terms of the attendees at that meeting, the MDT
 4 meeting, you were one of them?
 5 **A.** Yes, but I believe I was there for about 15 minutes due
 6 to other cover. I think discharge had been mentioned on
 7 and off since February that year.
 8 **Q.** In respect of that MDT where the decision was made, you
 9 were in attendance?
 10 **A.** Yeah.
 11 **Q.** Were you in attendance for the discussion of VC?
 12 Because an MDT will discuss several patients?
 13 **A.** Yeah. I really can't recall, as I was only there for
 14 a short time.
 15 **Q.** Do you accept that neither Gary Carter nor Claudia
 16 Birtles were at that meeting?
 17 **A.** Yeah.
 18 **Q.** They were the two people in the team who would -- who'd
 19 had the most contact with VC as his team care
 20 coordinators?
 21 **A.** Mm-hm.
 22 **Q.** They should have been there, shouldn't they, before
 23 a decision on discharge was made?
 24 **A.** Yeah, I think definitely they should have been there for
 25 that final discussion, but discharge had been discussed

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1 a significant factor?
 2 **A.** Yeah, I think he'd previously gone back to halls.
 3 I don't know if that was after he was a student, so
 4 I guess that they hadn't raised that he'd been back or
 5 any reports from other students.
 6 **Q.** Given he'd graduated and given his disengagement from
 7 the mental health services, you could not draw an
 8 inference from the lack of contact --
 9 **A.** Yeah.
 10 **Q.** -- from the University that he was well?
 11 **A.** Yeah.
 12 **Q.** It states:
 13 "... Police were not concerned about recent contact
 14 ..."
 15 What was the basis or what would be the basis for
 16 that finding?
 17 **A.** I think that they'd not had contact with him, or nothing
 18 had been raised, but I think from the Inquiry and all
 19 the other information, it's evident that information
 20 sharing wasn't really there.
 21 **Q.** Well, on those first two points, they would be
 22 a reference to an absence of information?
 23 **A.** Yeah, yeah.
 24 **Q.** What wasn't done was to contact either the University or
 25 the police prior to making discharge --

51

1 several times with them both present and there would be
 2 an opportunity to, I guess, challenge that decision if
 3 it was disagreed with.
 4 **Q.** If we look at your witness statement, it's paragraph 211
 5 on page 56, you make the point there that the "Did not
 6 attend policy ... was not discussed ..." --
 7 **A.** Mm-hm.
 8 **Q.** -- at the MDT meeting. That was a serious failing,
 9 wasn't it, not to discuss that policy? In fact, there
 10 were two do not attend policies.
 11 **A.** *(The witness nodded).*
 12 **Q.** Was either of them, were either of them discussed?
 13 **A.** I imagine the principles were discussed, but it wouldn't
 14 have been the DNA policy, it would just be that it's
 15 incorporated into our practice.
 16 **Q.** In the next paragraph you make the point that you can't
 17 recall the meeting, but you set out the points that you
 18 imagine were discussed. Addressing some of those, you
 19 make the point:
 20 "... no concerns raised by the University ..."
 21 But of course at the time of the MDT meeting, VC
 22 had, one, graduated, and two, disengaged from mental
 23 health services.
 24 **A.** Yeah.
 25 **Q.** So the fact that no concerns had been raised was not

50

1 **A.** Yeah.
 2 **Q.** -- and that was an error?
 3 **A.** Yeah.
 4 **Q.** Next it says:
 5 "... VC was engaging via text so Gary would not be
 6 able to report him ..."
 7 Well, firstly, Carter -- Mr Carter was not at the
 8 discharge meeting.
 9 **A.** *(The witness nodded).*
 10 **Q.** But based on the RiO records, it would appear that the
 11 last text exchange was, in fact, the exchange that VC
 12 had with you on 18 July?
 13 **A.** Mm. *(The witness nodded).*
 14 **Q.** So when you refer to VC engaging via text, who was that
 15 with and when?
 16 **A.** I think I hadn't, at this point, read vigorously through
 17 the notes because when I looked I saw that it was
 18 a month after the discharge, after August that he was
 19 discharged.
 20 **Q.** Now, although the notes refer to VC's application for
 21 access to his records, and there's some entries in the
 22 RiO records in early August, 9 August, the actual
 23 application made by VC appears to have been
 24 February 2022.
 25 **A.** Yeah.

52

1 Q. So, in fact, there'd been a complete absence of contact
2 with VC.
3 A. Mm-hm.
4 Q. Direct contact with VC for weeks before this discharge.
5 A. Mm. (*The witness nodded*).
6 Q. And the last contact with Celeste Calocane, VC's mother,
7 that was weeks earlier on 31 August.
8 A. Yeah, and she should have been told about the discharge
9 and her opinion sought.
10 Q. If we look at the discharge policy, please, NHFT --
11 sorry, the Do Not Attend -- Merged Do Not Attend policy,
12 NHFT0004725, and it's at pages 7 and 8 I'm going to go
13 to, page 7 first. We see under the heading, at 7.2.2,
14 "The level of response by the team will be proportionate
15 to the assessed level of risk to the patient".
16 And the point that is being made in the sections
17 that follow is, before taking action in respect of
18 a patient who has not attended, you must understand the
19 risk.
20 A. Yeah.
21 Q. The first entry, 7.2.3.1:
22 "If the patient is not contactable at their address
23 or by phone, the care co-ordinator or other nominated
24 team member should call all recorded contacts to
25 ascertain the patient's whereabouts ..."

53

1 A. I imagine it would have been discussed multiple times,
2 so I know this was the final discharge meeting, but
3 discharge discussions had taken place kind of since
4 February, and I think -- I don't agree with it, but the
5 practice at that time for disengagement of patients, and
6 it's very different now, was if someone wasn't
7 detainable, at that point they'd be discharged back to
8 their GP and be informed, you know, carers, GP, police,
9 they can re-access service, the service, should they
10 require it. But now it's very different how disengaging
11 patients are approached.
12 Q. Yes, we can take that down and to go to your statement,
13 because you make a similar point in your statement.
14 It's paragraph 253 at page 65. Second sentence:
15 "There was an implicit understanding that the
16 patient may re-access services in the event of
17 deterioration."
18 Well, just thinking about that and applying it to
19 VC's case, we know that, in his case, deterioration was
20 marked by violence.
21 A. Mm-hm. (*The witness nodded*).
22 Q. And increasing violence over the course of the
23 detentions.
24 A. Yeah.
25 Q. We know that he wasn't concord -- or you would have

55

1 That was not done, was it, as part of this MDT or in
2 the work up to it?
3 A. No. No.
4 Q. At 7.2.3.3:
5 "If the patient is not at his/her address ..."
6 And there were issues, weren't there, about tracing
7 VC and understanding which address he was at -- it
8 suggests here:
9 "... the care co-ordinator and service team should
10 agree other agencies to be contacted eg, GP, housing
11 departments, works and pensions departments, etc
12 including a discussion regarding contact with family
13 members ..."
14 That wasn't done, was it?
15 A. I don't believe so, no.
16 Q. 7.2.3.4:
17 "If all contacts fail the care co-ordinator should
18 discuss their concerns with the MDT and agree the next
19 steps to be taken. This may include involvement of the
20 police."
21 The police were not involved.
22 A. No.
23 Q. Page 7. At 7.2.3.5 there's a requirement to consider
24 the use of CTOs. Was there any discussion of the use of
25 CTO at the MDT meeting?

54

1 known that he wasn't concordant with medication --
2 A. Mm-hm.
3 Q. -- based on your text messages -- based on him not
4 collecting his medication.
5 A. Yeah.
6 Q. So the risk of deterioration was marked?
7 A. (*The witness nodded*).
8 Q. In circumstances where he was discharged on an implicit
9 understanding, such as this, it's running the very
10 obvious risk, isn't it, of just awaiting further
11 violence in order for him to receive secondary mental
12 healthcare treatment?
13 A. I think there should be -- at that time, a crisis plan
14 should have been done with individuals at that time
15 being told how to re-access the service. I also wonder
16 if the reason it was perceived that he was disengaging
17 was different to the other times he'd disengaged.
18 Because I think, as I've said previously, he said he
19 would disengage from us and he couldn't trust mental
20 health services, and I think in that final admission he
21 acknowledged that he'd had psychosis once before.
22 I don't know for definite, I'm just sort of trying
23 to understand --
24 Q. Speculating -- is it the speculation we see at
25 paragraph 254 --

56

1 A. Yeah, yeah.
 2 Q. -- because there, the third line:
 3 "Perhaps it was considered that VC had achieved
 4 partial stabilisation ..."
 5 Did anybody say that at the final MDT meeting?
 6 A. No, I'm just speculating.
 7 Q. Again, it's part of your recollections in -- sorry,
 8 reflections in the witness statement that starts at
 9 page 62, paragraph 240, into page 63. Yes, there, at
 10 paragraph 240, you state:
 11 "[You] believe that we should have tried to see VC
 12 before he was discharged ..."
 13 You go on on the next page, from paragraph 241, to
 14 accept:
 15 "Should have called [his mother] or ... brother ..."
 16 "... should have tried ... to assess his mental
 17 state.
 18 "There should have been documentation around
 19 consideration around the consideration for an [Mental
 20 Health Act Assessment]."
 21 A. Mm-hm.
 22 Q. The discharge of VC was completely contrary to the
 23 policy that was in place, wasn't it?
 24 A. I think it was, yeah. I think at the time I wouldn't --
 25 I wasn't overtly concerned he was being discharged,

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1 will see someone every day, someone different in the
 2 team will try and see them every day.
 3 Q. That enables medication concordance checks?
 4 A. Yes, I think Assertive Outreach patients may be on
 5 a Community Treatment Order and a depot as well. And
 6 I think how they view disengagement and how they
 7 formulate risk is more similar to how a forensic service
 8 would formulate risk.
 9 Q. Does it follow from all of that, in your view, that VC
 10 was an Assertive Outreach patient, that the EIP team
 11 were inadequately equipped to care for him?
 12 A. So I've worked previously with patients who would fit
 13 the AO pathway, but I think perhaps the reason that we
 14 didn't, as assertively as I know we have and can pursue
 15 a patient, is because it was deemed, you know, he was
 16 working, and I think AO patients, often they have a lot
 17 of other issues such as homelessness, substance misuse,
 18 in and out of prison.
 19 So I think, I do feel he would have benefited from
 20 an AO pathway although there wasn't one at the time.
 21 Yeah, yeah.

22 MR CARR: Thank you.

23 Chair, those are my questions, and it's --

24 THE CHAIR: Yes, does anybody have any questions?

25 MR CARR: Probably time for our --

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1 because there had been similar situations of people
 2 being discharged for disengagement. But like I say now,
 3 it's -- we know now it's not appropriate, and the reason
 4 people disengage is different for each person.
 5 Q. The final point I have for you is in respect of your
 6 paragraph 219, page 57, and it's where you talk about
 7 Assertive Outreach.
 8 A. Yeah.
 9 Q. You say in the second sentence:
 10 "... in retrospect, VC became an AO patient on an
 11 EIP pathway."
 12 Now we know, we've heard evidence, that the Trust
 13 did not have a dedicated assertive outreach team at the
 14 time that you were dealing with VC.
 15 A. Yeah.
 16 Q. What, in light of your view that he was an AO patient,
 17 an Assertive Outreach patient, what would have been the
 18 benefit and the differences in VC's case of having an
 19 Assertive Outreach Team?
 20 A. So I think Assertive Outreach teams, the patients are
 21 team held. So say if, for example, Claudia was off and
 22 I take over, the knowledge I have about VC would be as
 23 in-depth knowledge as Claudia, because it's almost like
 24 a shared caseload. AO teams speak about the patients
 25 every day, they work out of hours. They, if needed,

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1 THE CHAIR: Yes, I think we might take a break now. If we
 2 take a break until quarter to 12. I know that the
 3 timings for Core Participants are short, but I think we
 4 probably just need a short break. Thank you.

5 (11.32 am)

(A short break)

7 (11.45 am)

8 THE CHAIR: Yes, Mr Moloney.

9 Questioned by MR MOLONEY

10 MR MOLONEY: You said in answer to Mr Carr during the course
 11 of questions this morning that you were considering
 12 discharge from around February.

13 A. Yeah.

14 Q. Is that the fairly -- you're fairly confident about that
 15 timeframe?

16 A. Yeah, I believe I've seen emails where discharge has
 17 been discussed around that time.

18 Q. Right. Now, of course, VC only came out of hospital on
 19 24 February, and you've told the Chair during the course
 20 of your evidence about how it was that there was
 21 deterioration in the relationship after the tribunal?

22 A. Yeah.

23 Q. Yes. So was the reason for consideration of discharge
 24 around that time because of the deterioration in the
 25 relationship; did that form part of it?

60

- 1 A. No, we wouldn't ever discharge someone just because
2 a relationship's broken down. Often we'd move them to a
3 different care co-ordinator.
- 4 Q. Yes. But was it in any way part of the atmosphere
5 around it: "Look we're not going to get very far with
6 him here and we've got other stuff that we need to be
7 thinking about"? Was it part of that?
- 8 A. I don't believe so, no.
- 9 Q. Okay. Now, you very candidly accepted that when you
10 were dealing with VC you didn't read his records as well
11 as you might have done?
- 12 A. I think I read the records in terms of what I needed to,
13 in the role of a covering CCO, but I recognise in doing
14 that there will be information that's missed. It's not
15 as in-depth as the CCO.
- 16 Q. Of course you have learnt significant information whilst
17 you have been looking in your statement, looking at the
18 records --
- 19 A. Yeah.
- 20 Q. -- haven't you?
- 21 A. Yeah.
- 22 Q. If we could just look at your witness statement,
23 WITN0317001, paragraph 106 which is on page 27. You say
24 here that you were aware of him as a result of covering
25 him in MDT meetings.

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- 1 enough to see him and assess him and assess risk, but
2 not how detailed it was.
- 3 Q. Yes, and then the same thing in terms of EIP working
4 with the judicial system, some sort of superficial thing
5 of that, yes?
- 6 A. *(No audible answer given).*
- 7 Q. Now, you were present at the MDTs and, as you said
8 earlier, you were aware of his risk assessments and care
9 plans from the MDTs.
- 10 A. Yeah.
- 11 Q. So if his belief in neural mapping and that EIP were
12 working with the judicial system had been discussed in
13 detail at the MDT, you would have been aware of that
14 detail?
- 15 A. I think it would have been discussed but not in depth,
16 I think at that time the MDTs were an hour long and we'd
17 have multiple patients to discuss.
- 18 Now I think we do a formulation meeting for someone
19 like VC where everything would be discovered in detail.
- 20 Q. Yes. But insofar as those MDTs were concerned, that
21 they weren't recorded, were they?
- 22 A. No.
- 23 Q. No. Do you remember saying this in your interview with
24 the trust: that you were asked how would you know what
25 was discussed during the meeting with it not being

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- 1 A. Yes.
- 2 Q. Then there's a reference to what you said in your
3 interview with the Trust at NHFT0004885, page 6:
4 "... it was difficult to build a rapport with him,
5 as he struggled to trust any ... team members".
6 But you said:
7 "As I have read through VC's notes in the course of
8 drafting this statement, I realise there is a lot I did
9 not know about VC, as covering CCo. ... I suspected he
10 had schizophrenia, but not that it had been mentioned
11 several times. I think my knowledge of the true extent
12 of his condition was vague, however, VC's psychotic
13 beliefs were very detailed, and appear to get more
14 entrenched the longer he was with us. I now know that
15 VC believed he was subject to neural remote mapping,
16 which could scan and manipulate his thoughts at
17 a distance; he also felt that EIP were working with
18 the judicial system and Highbury Hospital, and that
19 'voice hearing experiences' had been created to monitor
20 him."
21 So is it when you'd made your statement that you
22 become aware that VC believed he was subject to neural
23 remote mapping.
- 24 A. I think I understood, almost at -- not at a superficial
25 level, but a very basic level what his beliefs were,

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- 1 recorded? And you said, "I think we'd either make notes
2 or just remember."
- 3 A. Yeah, I think I've seen some patients that I've had from
4 that time and I've put an entry on, but very sporadic,
5 and not for every single person.
- 6 Q. Right. Thank you very much.
- 7 **THE WITNESS:** Thank you.
- 8 **THE CHAIR:** Yes, Ms Benyounes.
- 9 **Questioned by MS BENYOUNES**
- 10 **MS BENYOUNES:** Good morning, Ms Parsonage. I ask questions
11 on behalf of the survivors. Just two brief topics.
- 12 The first relates to the escalation process. You've
13 explained that there wasn't any reciprocal communication
14 between the EIP team and The Priory, prior to VC's
15 discharge from his third admission. That was on
16 22 October 2021.
- 17 A. *(The witness nodded).*
- 18 Q. You weren't actually, as a team, aware of that
19 discharge?
- 20 A. I think Claudia sent an email saying there's potential
21 he may be discharged, but we weren't aware he had been
22 discharged.
- 23 Q. We know that there were five failed appointments from VC
24 within a month of that discharge, the first being on the
25 15 November 2021, and the fifth from 17 January 2022 so

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1 over those couple of month period.?

2 **A.** Mm-hm.

3 **Q.** You've explained that a referral to the Crisis Team

4 would have been necessitated when there was a change in

5 risk or change in presentation.

6 **A.** Yeah.

7 **Q.** Can I be clear: the time that VC came to collect

8 medication, and you were there, on 17 December 2021, you

9 were concerned that he was deteriorating.

10 **A.** Could I see the note, please?

11 **Q.** Yes. If we could go to NHFT000168 (*sic*).

12 **THE CHAIR:** It's four zeros.

13 **MS BENYOUNES:** Sorry, NHFT0000168. Can we go to page,

14 I think it's page 203, please. I'm just going to pull

15 that up. (*Pause*)

16 I'm sorry, I'm just double-checking I'm taking you

17 to the correct document.

18 Sorry, I think I've given you a reference from just

19 before that.

20 Actually, can I go to a second reference, please.

21 Can I go, please, to NHFT0018957. This is a document

22 that you haven't been taken to before. It's of the same

23 date, 17 December 2021.

24 This is an email that came from Claudia Birtles to

25 members of your team; is that correct?

65

1 communicated to your team.

2 **A.** Yeah.

3 **Q.** And by that point there had been three missed

4 appointments --

5 **A.** Yeah.

6 **Q.** -- with the Responsible Clinician. That was Dr Lloyd,

7 wasn't it?

8 **A.** Yeah.

9 **Q.** Do you consider that there should have been a referral

10 to Crisis Team at that point, in light of the missed

11 appointments, but also the concern from both you and

12 also from the care coordinator, Ms Birtles?

13 **A.** I think, again, it would require closer monitoring, low

14 threshold for Crisis.

15 **Q.** Because it appears there that Ms Birtles is articulating

16 "not sure what else I can do in the meantime."

17 **A.** Mm.

18 **Q.** Was that a view of the team: that they didn't know what

19 to do in respect of VC's missed appointment, apparent

20 disengagement, and altered presentation?

21 **A.** I think there was, as I've said before, we can be quite

22 creative in how we might engage someone. So I think

23 Claudia here is wondering what else she can do until the

24 next outpatients appointment. And she's wanting that

25 team discussion about any other actions that can be

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1 **A.** Mm-hm, yeah.

2 **Q.** This was regarding cover for the following week. This

3 I think is after VC has collected medication from you.

4 **A.** Yeah.

5 **Q.** And she has mentioned VC within that document to say:

6 "I don't know whether it's worth discussing him in

7 MDT, I am concerned about him, he is very angry ... told

8 me not to contact his mum under any circumstances but is

9 not fully engaging with us. He has collected his

10 medication from Abi today and I've texted him about the

11 OPA on 10th Jan[uary] but not sure what else I can do in

12 the meantime."

13 Can I be clear: in respect of the presentation of

14 being angry, you said in evidence that he was abrupt, he

15 was short with the receptionist.

16 **A.** Mm-hm.

17 **Q.** And was it that presentation that gave you rise for some

18 concern?

19 **A.** I think it did but I think the anger here was after the

20 admission where he said he was angry with Claudia, angry

21 with mental health services, and felt that admission was

22 unnecessary. So perhaps the anger was viewed as anger

23 in relation to mental health services rather than this

24 being an early warning sign he's becoming unwell.

25 **Q.** But there was concern there from Claudia that was

66

1 taken.

2 **Q.** Because what is being arranged is yet further

3 appointments are being offered.

4 **A.** Yeah.

5 **Q.** And we know that VC contained to fail to respond to

6 telephone calls, that was on 31 December, also 6 and

7 7 January, and also two appointments he missed with

8 Dr Lloyd on the 10th and 17th.

9 **A.** Mm-hm.

10 **Q.** What in fact resulted in an escalation was contact from

11 the University on 18 January. If we just go to the RiO,

12 it's the NHFT0000168 document, it is the 203 this time.

13 Thank you. And it's the entry of 18 January 2022.

14 Ms Adele Pinder. And this is the contact from

15 Ms Turner --

16 **A.** Mm-hm.

17 **Q.** -- at the University where she reports the incident with

18 VC.

19 **A.** Yeah.

20 **Q.** Why was it that it took until the University making

21 contact about this incident for any sort of escalation

22 process to take place?

23 **A.** I'm not sure. I think perhaps, again I'm just

24 speculating, it could have been how this disengagement

25 was viewed. I think maybe it was viewed differently to

68

1 the different disengagements, and actually a more
2 long-term risk assessment could have been done, looking
3 at the notes wholly. And, again, I think the way an
4 Assertive Outreach Team would approach disengagement
5 versus how we had approached it at this time would have
6 been different.

7 **Q.** Because the plan there is to find out VC's flat number?

8 **A.** Yeah.

9 **Q.** To obtain an update from the CPN, contact the police to
10 find out further information --

11 **A.** *(The witness nodded).*

12 **Q.** -- and obviously contact with Dr Lloyd and the team to
13 see whether the Mental Health Act Assessment, and we
14 know that's what happened?

15 **A.** Yeah.

16 **Q.** But do you agree that this was very much a reactive
17 response to what was coming from the University, when in
18 fact some proactive steps were needed here, weren't
19 they?

20 **A.** I can agree that he would benefit from close monitoring,
21 yeah.

22 **Q.** Just, finally, second very short topic in relation to
23 information sharing. Can your witness statement please
24 be displayed, WITN0317001, page 21, paragraph 81.

25 Thank you. You're talking from paragraph 81 about
69

1 capacity to go through the notes that you did have
2 access to --

3 **A.** Mm. *(The witness nodded).*

4 **Q.** -- the RiO notes. So can you really say you would have
5 had access and capability and capacity to review records
6 from other sources?

7 **A.** I think I would have capacity to review sort of ward
8 rounds with the doctor present where decisions are made
9 about medication. I think what I'm referring to there
10 is sort of every contact or every entry in someone's
11 admission, we would struggle to read every one, but we
12 would seek to look at the main events of that admission.

13 **Q.** But when you didn't even have the full picture in
14 respect of diagnosis, is it realistic for you to say
15 that, Ms Parsonage, that you would have been accessing
16 information from other sources?

17 **A.** I think I would try, yeah, especially a discharge
18 summary.

19 **Q.** So a discharge summary is effectively the reliance?

20 **A.** Yeah.

21 **Q.** Just the final question, it's page 23 right at the
22 bottom, paragraph 91. You're responding to a question
23 about barriers to sharing of information relevant to
24 clinical treatment and risk assessment. You say that
25 that limited the effectiveness of multi-agency working?
71

1 information sharing with various agencies.

2 **A.** Mm-hm.

3 **Q.** You've described that PNC checks can take a month to
4 come back.

5 **A.** Yeah.

6 **Q.** You also set out, I summarise, but really the limits of
7 the information that's contained.

8 **A.** *(The witness nodded).*

9 **Q.** Can I check: was it the practice of the EIP team not to
10 seek information due to the knowledge that it would take
11 a period of time, it would be delay before any response,
12 and also because they knew that there would be a limit
13 to what actually was received?

14 **A.** No, I think we would request a PNC check regardless of
15 the time it takes to come back, and the limitations
16 within that.

17 **Q.** So it would be requested but in full knowledge, there
18 would be a delay?

19 **A.** Yeah.

20 **Q.** Just moving down to paragraph 88, please, it's on
21 page 23, you talk about access to other systems in
22 private hospital. You wouldn't have their running
23 records, so you wouldn't have day-to-day presentation,
24 so you're relying on the discharge summary.

25 You've already said in evidence that you didn't have
70

1 **A.** Yeah.

2 **Q.** So the lack of access, the delays and the lack of
3 information being available to you, is that your
4 contention at the time, that that limited the access --

5 **A.** Yeah.

6 **Q.** -- and the effectiveness of your working practice?

7 **A.** I think so, yeah, because had we known all the
8 information that we have now, a community forensic
9 referral, you know, could have been done, and joint
10 working could have been done. Their risk assessment
11 that they used within forensic services, we could have
12 used.

13 **Q.** So there were things that could have been done?

14 **A.** Yes, but we wouldn't have been able to do that without
15 the information about other incidents that had occurred.

16 **MS BENYOUNES:** Thank you very much, Chair. Those are my
17 questions.

18 **THE CHAIR:** Yes. Mr Straw.

19 **Questioned by MR STRAW**

20 **MR STRAW:** Thank you.

21 Could we have the NHFT0000168 document on screen,
22 please, page 134.

23 Ms Parsonage, I represent VC's family.

24 So this is a page you were taken to earlier which
25 will come up in a moment. It refers to the entry at the
72

1 top is your entry, we saw it earlier, on 9 October 2020,
2 when Celeste, so VC's mum, rings in with her concerns
3 and asks if someone from the team can go out to see him.

4 Then further down the page, please, the bottom half,
5 on 15 October 2020 --

6 **A.** I think this is the wrong page.

7 **Q.** Sorry, it's 135. So there's the top there with the call
8 with Celeste's concerns and then further down the page,
9 please, 15 October. Telephone call to Celeste and she
10 asked again if someone from the team has made contact
11 with VC, and I think that's passed on to you, isn't it,
12 because do you see that a little bit further down,
13 23 October 2020, there's an entry that you make, and
14 where you're asked to call VC's mum?

15 **A.** Yeah.

16 **Q.** Do you see that?

17 Then we know that there is -- the first time that
18 someone does see him is 26 October 2020 when Gary Carter
19 sees VC --

20 **A.** Yeah.

21 **Q.** -- very briefly. Now, you didn't call VC's mum after
22 that visit, did you, to inform her that VC had been
23 seen?

24 **A.** No, I think it would be appropriate, if Gary has seen
25 him, to then ring back and feed back to Mum.

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1 **A.** I can't recall as I've not documented it.

2 **Q.** Yes, there's no note of it, is there?

3 **A.** No.

4 **Q.** Then finally 270, please, page 270. This is 31 August
5 now. At the bottom of the page there's Gary Carter's
6 entry noting that concern -- again, Celeste has been
7 spoken to: "she has not seen [VC] face to face for many
8 months ... she had a telephone conversation with him in
9 the last week. [She] ... attempted to go and see [VC]
10 but he was not at [his] ... address ..."

11 Gary Carter explains that he was very concerned at
12 this point and he considered that a face-to-face
13 assessment was necessary.

14 **A.** Mm-hm.

15 **Q.** Now was that then handed over to you? Did you then
16 become the responsible CCO who was expected to perform
17 that face-to-face assessment?

18 **A.** There was no discussion about who was covering CCO. My
19 understanding was that the main discharge discussion was
20 earlier on in the month, I think that's 16 August.

21 **Q.** In terms of the visit to VC, that Mr Carter thought was
22 necessary at this point, it's right, isn't it, that no
23 one updated Mum again between that date and discharged
24 to the GP about anything that was going on?

25 **A.** I don't believe so, no. But, as I've said, it's

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1 **Q.** Can we go forward, please, to page 153 -- I'll ask

2 Mr Carter about that when we come to him.

3 Again we saw this earlier, this is the entry

4 29 May 2021, Mum calls again, "believes her son is
5 becoming unwell", not "making sense", and that led to
6 your visit, which we can see on the bottom of the page,
7 2 June 2021. And go over the page, please, to the next
8 one where you describe that visit.

9 Again, after that visit, did you call Mum to tell
10 her that VC had been visited?

11 **A.** No, and I should have done.

12 **Q.** Can we go forward, please, to page 193. Right at the
13 bottom of the page there's an entry on 22 October 2021.
14 And then can we go over, please, which is discharge from
15 The Priory at this point. And you note at the top there
16 that:

17 "[VC] was discharged this morning, mum rang and was
18 annoyed she had not been informed."

19 You explained earlier that after that, you then
20 looked into it and, as we can see I think a bit further
21 down the page, ultimately the plan was to ask the CCO to
22 ring VC on Monday to make a plan. Do you see that?

23 **A.** To complete the three-day follow-up, yes.

24 **Q.** Again, did you ring Mum at any stage to tell her what
25 the plan was?

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1 important to contact family members and include them in
2 any discharge planning.

3 **Q.** Because if family members are repeatedly phoning up
4 raising their concerns about someone, and then they're
5 not giving any information about what happens in
6 response, that's not a good way to encourage them to do
7 so, is it?

8 **A.** No.

9 **MR STRAW:** Okay, thank you very much.

10 **THE CHAIR:** Yes, Mr Beer? Thank you.

11 **Questioned by THE CHAIR**

12 **THE CHAIR:** Yes, can I just ask you about one matter.

13 If we can just have the RiO notes NHFT0000168 and at
14 pages 134 and 135, if we can just have both of those up
15 first together. So if we can just look at 135, you've
16 told us that you went to visit on 9 October, and you
17 spoke to a housemate.

18 **A.** Yes.

19 **THE CHAIR:** But obviously you said you didn't feel able to
20 share your concerns about his mental health.

21 **A.** Mm-hm.

22 **THE CHAIR:** So what were you able to say to the housemate?

23 **A.** I can't recall what I said in this instance, but what
24 I'd normally say is "How have they been? Have you
25 noticed any changes?" We wouldn't be able to say, "This

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1 individual has had multiple admissions, he's got this
 2 diagnosis," due to confidentiality.
 3 **THE CHAIR:** Do you think she knew who you were?
 4 **A.** Normally we would introduce ourselves.
 5 **THE CHAIR:** Or why you were there?
 6 **A.** I think we would have asked if VC was there and if we
 7 could -- yeah, if we could visit him.
 8 **THE CHAIR:** Do you know how long that flatmate had been
 9 there?
 10 **A.** I didn't, no.
 11 **THE CHAIR:** Because, in fact, it looks, on the previous
 12 page, as if some -- if we look at 1 October, some had
 13 only arrived in the previous week.
 14 **A.** Mm. I think there are limitations to asking a housemate
 15 for feedback. But I think it's like they'd seen him
 16 most recently. So whilst it didn't require action on
 17 that day, we were still concerned, and I asked for it to
 18 be followed up the following week.
 19 **THE CHAIR:** Because you'd had a notification from Celeste
 20 Calocane, hadn't you?
 21 **A.** Yes.
 22 **THE CHAIR:** She felt that he was getting very unwell?
 23 **A.** Yeah.
 24 **THE CHAIR:** So in deciding what to do about it, you have
 25 spoken to a flatmate without saying what the real reason

77

1 **Q.** You qualified as a Registered Mental Health Nurse in
 2 March 1989, working in both private and public sector
 3 between 1989 and 2015; is that right?
 4 **A.** Yes, that's right.
 5 **Q.** 2015 to 2017 you had a career break?
 6 **A.** That's right.
 7 **Q.** Did you maintain your registration as a mental health
 8 nurse at that time?
 9 **A.** Yes, I did, yes.
 10 **Q.** So did you continue keeping up to date with any
 11 developments or training at that time?
 12 **A.** Yes, yes.
 13 **Q.** You worked between 2017 and 2020 in various roles before
 14 joining the EIP service in 2020; is that right?
 15 **A.** That's correct, yes.
 16 **Q.** The roles between 2017 and 2020, did they assist you in
 17 your work for the EIP service?
 18 **A.** I wouldn't say so, no. They were a different kind of
 19 field. I spent some time working with the elderly, some
 20 time working in addictions, although some of the clients
 21 in EIP had addiction problems, but besides that, no,
 22 they were different, really.
 23 **Q.** When you joined the EIP service in 2020, did you receive
 24 any formal training prior to doing so?
 25 **A.** Prior to doing so? No, no.

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1 was, or the extent of the reason, and you had his
 2 mother, who was --
 3 **A.** *(The witness nodded).*
 4 **THE CHAIR:** -- very well aware of the past situation. How
 5 did you weigh up the information you were given by the
 6 flatmate?
 7 **A.** I think it would be about considering what the options
 8 are. So can we refer to Crisis at this point? There
 9 hadn't been a change in risk, but there was clearly
 10 a change in presentation. So at this stage, I would
 11 have felt it needed further assessment and unpicking.
 12 **THE CHAIR:** Yes, thank you.
 13 Right. Thank you. That's the end of your evidence.
 14 I think we'll just go straight on to the next witness.
 15 **MS LANGDALE:** Mr Carter.
 16 **THE CHAIR:** Yes, thank you.
 17 **MS LANGDALE:** May the witness be sworn. Thank you.
 18 **GARY CARTER (affirmed)**
 19 **Questioned by MS LANGDALE**
 20 **THE CHAIR:** Yes.
 21 **MS LANGDALE:** Mr Carter, you have prepared a statement for
 22 the Inquiry dated 22 December 2025. Can you confirm the
 23 contents are true and accurate as far as you're
 24 concerned?
 25 **A.** Yes, they are.

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1 **Q.** While you were there, did you get any training about
 2 risk assessment or relevant Trust policies?
 3 **A.** Yes, yes. There was an ongoing training programme for
 4 all people working in the EIP, such as myself.
 5 **Q.** What sort of matters were covered in training and how
 6 were they covered? Face-to-face? Online?
 7 **A.** It could be everything from infection control, right up
 8 to, you know, risk assessment, care planning, various
 9 subjects in between, delivering emergency first aid as
 10 an example. It was a pretty broad range, really.
 11 **Q.** And how much training in a year, in an annual period?
 12 **A.** Well, we had a kind of matrix. There must have been at
 13 least, I would say, two dozen kind of training
 14 programmes covering different kind of areas, really.
 15 And we had to complete -- we had a certain time to
 16 complete the training, and once the training was
 17 coming -- was about to expire, it would be flagged up
 18 and then if it had expired -- some training had to be
 19 every year, some training you could do every
 20 three years. But most of these training every year, you
 21 get a kind of amber warning saying, "It's still valid
 22 but it's coming to the end, you need to book in
 23 a course."
 24 And then if it went to red, it's expired. So that
 25 became a must-do ASAP training.

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- 1 Q. And you did it online, did you?
- 2 A. Some of it was done online, certainly. Some of it was
- 3 face-to-face, like the CPR training as an example. That
- 4 was obviously face-to-face. But I would say the
- 5 majority was online, yes.
- 6 Q. Can we have a look at your witness statement,
- 7 paragraph 100, please. So WITN0368001, page 24.
- 8 A. Page 24.
- 9 Q. It'll come on to the screen as well, Mr Carter,
- 10 whichever is easier for you.
- 11 A. Okay. Thank you, that's very good. Yeah, lovely.
- 12 Q. If you look at the screen, paragraph 100, you state:
- 13 "The typical risks encountered by the EIP team
- 14 included non-concordance with medication and patients
- 15 failing to engage with services. Sadly, some of our
- 16 patients died by suicide, and we were given regular
- 17 training on suicide prevention. This was important and
- 18 made us better at spotting and handling suicide risk.
- 19 However, as far as I can recall, I never had any
- 20 training on when someone is dangerous to other people or
- 21 on forensic investigations ..."
- 22 A. Mm-hm.
- 23 Q. Was there a real difference in the training you had
- 24 about self-harm and spotting self-harm, compared with
- 25 risks to the public and other people?

81

- 1 bring it up with my line manager in supervision,
- 2 certainly.
- 3 Q. How often did you speak to Dr Lloyd, the Consultant
- 4 Psychiatrist, about patients?
- 5 A. Well, we saw her every week at MDT. Well, I'm saying
- 6 every week, most weeks, certainly. There were times
- 7 when obviously she was on annual leave, things like
- 8 this, but yes, in between weekly MDTs, if I had
- 9 a concern about a patient, I could usually make
- 10 an appointment to see her, even if it just involved me
- 11 walking upstairs to her office and knocking on her door,
- 12 and --
- 13 Q. Did she have an open-door policy?
- 14 A. Yes, yes, I certainly felt that way. I felt it was
- 15 quite easy to just, as I say, knock on her door. And if
- 16 she had time she would be happy to listen to any
- 17 concerns I had. And that's what I felt with, I would
- 18 say, all the doctors that I've dealt with in EIP, which
- 19 is very good, which is good.
- 20 Q. Before we start to go through the records of your
- 21 dealings with VC and within the team, we know, and you
- 22 tell us in your statement, you've resigned and you faced
- 23 disciplinary proceedings. You resigned, I think, on
- 24 30 April 2025; is that right?
- 25 A. That's right, yes.

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- 1 A. There was, in my opinion. Sadly, some of our patients
- 2 did die of suicide, and with regards to training around
- 3 identifying factors which may lead the public to be
- 4 a threat -- is that the point you're making?
- 5 Q. Yes.
- 6 A. Yeah, I don't --
- 7 Q. Where a patient is a threat to the public, violent.
- 8 A. Yeah, yeah, that's right. Yeah, I don't really think --
- 9 I cannot recall receiving any kind of extensive training
- 10 on that, basically. Suicide prevention was an issue
- 11 within the Trust, definitely. And it's an issue
- 12 nationwide. But certainly when it comes to identifying
- 13 people who are a potential risk to the public, now
- 14 that's a different ballgame. That's different. And
- 15 I wouldn't say that -- I certainly don't think
- 16 I received enough training around that particular issue.
- 17 Q. You had supervisions, didn't you, on a monthly basis; is
- 18 that right?
- 19 A. Yes, that's right, yeah.
- 20 Q. Was that kind of risk assessment discussed in those
- 21 sessions? How you'd assess risk to others, or not? The
- 22 risk of someone being violent to others.
- 23 A. If I had concerns about a patient who I felt might be
- 24 exhibiting risky behaviour or might have the potential
- 25 to indulge in that type of behaviour, I'd certainly

82

- 1 Q. What do you think went wrong with VC's care in the
- 2 community?
- 3 A. Most of what I know about VC, I would say 95% of him,
- 4 I've learnt in the last -- well, since the sad tragedy
- 5 in June 2023. What went wrong? Basically I think this
- 6 man, in a nutshell, he lied, he deceived, he
- 7 out-manoeuvred the medical staff in particular, both on
- 8 the ward, in the community. He wasn't honest. I think
- 9 he basically -- I think Dr Seedat summed it up very
- 10 well. He is saying all the right words. And I don't
- 11 think people fully appreciated that at the time.
- 12 I think it's very easy to see this now, where at the
- 13 time, without the benefit of hindsight, he
- 14 out-manoeuvred medical and nursing services within the
- 15 Trust.
- 16 Q. At a personal level, what should you have done
- 17 differently? What should you have done differently, do
- 18 you think?
- 19 A. What, when I was a CCO, for example?
- 20 Q. Yes.
- 21 A. Yeah?
- 22 Q. Yes. In your dealings with him.
- 23 A. I feel that I did as much as I could possibly do with
- 24 him, really. I met him twice as his CCO, each time for
- 25 less than five minutes.

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1 At that time, the feeling in the office, the team,
2 was because of his history of aggression, violence,
3 which was exhibited on his third admission, and because
4 of how he was when he was discharged, that this man
5 should only have been seen at the Stonebridge Centre.

6 I personally, personally, felt this was really
7 unacceptable because I wasn't willing to kind of just
8 sit back and wait for him to arrive and hope and pray
9 for the best. I felt as though we had to go out and
10 find this man, but there was problems around his moving
11 from one address to another. We were never quite sure
12 where he was at any given time. That was an issue in
13 itself.

14 When I visited VC or attempted to visit him with one
15 of my colleagues, we knocked on his -- what we thought
16 was his home address, and another gentleman answered the
17 door and told us straight that no one by that name was
18 living here. That may well have been the case, that may
19 well have been the case, but if you look after admission
20 three, an address was given that my colleagues visited.
21 Shortly afterward, Dr Lloyd and Abi visited, knocked on
22 the door, no one answered, but then I recall from the
23 notes that a couple of -- less than a couple of weeks
24 later, he came into Stonebridge and said, "Who was that
25 knocking on my door the other day?"

85

1 A. No.
2 Q. Would you not have looked back in the records?
3 A. Not that far back. I recall looking back to, I would
4 say, around admission three, because both myself and
5 Claudia, his CCO at that time, had visited him, and this
6 had prompted his Mental Health Act Assessment subject to
7 a third admission to --
8 Q. In 2021?
9 A. That's correct.
10 Q. So you looked around then, but 2020 --
11 A. 20 no --
12 Q. -- did you ever look back and understand what had
13 happened leading to those admissions in 2020?
14 A. No, I didn't go that far back.
15 Q. So you did not know that he had gone to premises at
16 Brook Court on three occasions requiring arrest, on
17 a second occasion a woman jumping from a first-floor
18 window requiring back surgery as a consequence, and on
19 the third occasion in July, requiring a number of people
20 to restrain him, a number of men to restrain him? You
21 didn't know that?
22 A. No.
23 Q. Wasn't that important information, that you should know
24 those background factors relating to his violence and
25 aggression?

87

1 So I interpreted that as meaning he'd been there,
2 but he'd just not answered the door.

3 Q. Let's go through events chronologically, shall we --

4 A. Yeah.

5 Q. -- so we can unpack a number of things you've said
6 there.

7 First of all, before you dealt with him, did you
8 look in the RiO notes for the background? The
9 background about him? And did you in particular -- I'm
10 going to ask to have on the screen NHFT0000168,
11 page 64 -- did you see note of Dr Seedat's, made on
12 16 July 2020? So this is on the RiO system, "Patient
13 record", "Patient comments" in the middle, if we can
14 have those two paragraphs of "Patients comments",
15 please, enlarged?

16 "Dr Seedat [speaking with VC] observed that there
17 seems to have been no insight or remorse and that the
18 danger is that this will happen again and perhaps [VC]
19 will end up killing someone."

20 Did you see this record before you dealt with VC at
21 all?

22 A. Before I became his CCO?

23 Q. Yes.

24 A. No.

25 Q. Not at all?

86

1 A. Ideally, I should have started on page 1 and started
2 reading about this man, but he -- it just didn't work
3 that way. You know, like his notes amount to 273 pages
4 in length. I arrived as his CCO at 267. And basically,
5 yes, it would have been fantastic if I'd have started on
6 page 1 and worked my way through, but that would have,
7 I'm sure you agree, would have taken quite some time.
8 Q. What about searching a doctor's name, for example,
9 Dr Seedat, and seeing what he said? Because if we look
10 at a summary he's put in of various texts at
11 NHFT0000168, page 21, page 21, he's describing VC
12 hearing voices and various texts that he's sent to his
13 brother.
14 Would you be interested to know what messages he had
15 sent to his brother telling him about how he wanted to
16 hurt people he was hearing, for example? Would that
17 have been relevant to you to know that? Paragraph 4,
18 please.
19 A. Well, yes, it would have been relevant. All this
20 information would have been relevant. You know, like
21 the text messages I'm led to believe, because I haven't
22 seen them, but the text messages are very -- well,
23 forthcoming, basically, with various statements
24 indicating that this man was very poorly. So yes, that
25 would have been extremely useful.

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1 Q. So you know now about text messages saying, "I think
2 they are watching", "I know I can break their heads with
3 my hands", "feeling immense anguish, paranoia, anger and
4 hatred", and in that state of mind "thinking about 'red
5 rum". That's the context of the text messages.

6 So you understand that now but you didn't have any
7 summary or knowledge of those at the time?

8 A. No, no.

9 Q. If you had have done, would they -- how would they have
10 influenced your thinking about his risk?

11 A. Well, considering that I attended a meeting -- well,
12 a meeting with him, with Claudia prior to his third
13 admission in which I actually saw -- this was a man on
14 that meeting that unnerved me.

15 Q. Let's come to that chronologically. We're going to see
16 that.

17 A. Yeah, yeah --

18 Q. Can I take you to 2020 first.

19 A. Right.

20 Q. Let's go to NHFT0000168, page 134.

21 A. 134, right.

22 Q. So it's going to come on the screen. And when we get to
23 that meeting I'll remind you about the text messages.

24 A. Okay.

25 Q. But if we look at this chronologically, please,

89

1 thinking?

2 A. I used my assessment based upon my experience over the
3 years, basically. Yes, certainly with regards to this
4 gentleman, like with regards to masking his symptoms, if
5 he was masking his symptoms, or, assuming he had some
6 symptoms, he did a good job, in my opinion, at that
7 time. And both me and Claudia left the building feeling
8 that there was -- he had been agreeable and that we had
9 no major concerns.

10 Q. The care plan, if we can go to that, please,
11 NHFT0000202, page 1, the care plan you took to him was
12 dated 1 September and it will come up on screen. And he
13 asked you to leave that with him. In his own time, he
14 was going to look at that, wasn't he?

15 So if we look at this care plan, please, Mr Carter.
16 There's nothing recorded under "Diagnosis". Were you
17 aware that he had a diagnosis of likely paranoid
18 schizophrenia at this time?

19 A. I can only assume Claudia will have at least given me
20 a basic update about this gentleman. I don't --

21 Q. So you would have known that?

22 A. I don't recall the conversation, but I can't imagine her
23 inviting me to come with her and not at least tell me
24 something about him that might be -- might give me a
25 feeling for who he was and what he was.

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1 15 September, if that goes to the top. We see there you
2 go with Ms Birtles to that visit, don't you?

3 A. Yes, that's right, yeah. Yeah, I remember it, yeah.

4 Q. What do you remember about it?

5 A. Basically I was new to the service. I'd been with the
6 service 15 days by then, and I think Claudia asked me to
7 come out and visit Valdo -- I'm sorry, VC, I beg your
8 pardon -- visit VC with a view to -- I think with a view
9 to giving him his care plan and risk assessment. And
10 when I met him, we met him in the kitchen and he seemed
11 like a pleasant chap. He seemed interested in what
12 Claudia had brought him. He asked questions. And
13 I personally had no concerns about his mental state. He
14 looked fine, he sounded fine. He said he was doing
15 well.

16 I think I did ask him what he was studying at
17 university, and he told me it was mechanical
18 engineering. But he looked comfortable. He looked
19 comfortable.

20 Q. Do you have any training in how to conduct mental state
21 examinations?

22 A. Direct training, no.

23 Q. So when you say he looked comfortable, were you skilled
24 in assessing any signs around whether someone was
25 masking what was going on or how they were really

90

1 Q. It would be important to know, it's not simply early
2 episode psychosis, the diagnosis of a functional
3 illness, paranoid schizophrenia has been made; do you
4 think that's important to know?

5 A. Yes, I think it is important to know, yeah.

6 Q. If you go to page 3, please, reference under "Actions"
7 if we can make that box larger.

8 A. Yeah.

9 Q. "For mental health services to maintain an assertive
10 approach in continuing to work with [VC]."

11 What did you understand that to mean?

12 A. I would have interpreted that as meaning regular contact
13 with this gentleman, face-to-face, at least weekly.
14 More often, if necessary, if there were any concerns.

15 Q. More often to do what?

16 A. Sorry?

17 Q. Why would -- what would more often do? What has to
18 happen at visits to make it assertive?

19 A. If basically he was kind of expressing some odd ideas or
20 behaving in an odd way, or if, say, for instance,
21 I don't know, his mum had contacted us and said, "look,
22 he's -- there's something not right with him, you need
23 to go and see him", type of thing, then I think we could
24 have escalated it up, to become more regular.

25 Q. So more regular meetings?

92

1 A. Yes.

2 Q. Also reference here to:

3 "Rapid response if [VC] or family report sudden

4 changes in ... mental state."

5 A. Yes.

6 Q. So it's the same section under "Actions", please, just

7 a couple of lines down from the assertive approach.

8 Rapid response. What does "rapid response" entail?

9 A. Well, it means just that, it's rapid. It's a case of,

10 if we have -- if I have some concerns about this

11 gentleman and I thought there was serious concerns of

12 him, his condition deteriorating rapidly or if he became

13 a perceived threat to whoever, his flatmates or the

14 public or perhaps even other healthcare workers, then

15 that would be a rapid response. That would mean

16 basically I'd increase my contact with him and maybe

17 even consider inviting Crisis in to help me, basically.

18 Q. Or a Mental Health Act Assessment?

19 A. Yes.

20 Q. -- looking at detention?

21 A. Yes, certainly, yes. That could certainly be

22 considered.

23 Q. Further down the same page, "Risks and safety" under

24 "Actions":

25 "Review level 2 Risk assessment on a regular basis."

93

1 down the page.

2 "On-going monitoring of concordance due to increased

3 risk of relapse."

4 Were you aware, as the care plan stated, that there

5 was a need to monitor whether he was taking medication

6 in the community?

7 A. Yes, I was, because this man, throughout the time before

8 I became his CCO, had been brought up in various MDTs on

9 a regular basis, and concordance was regarded -- or

10 non-concordance was regarded as an issue, and basically

11 I'd at least a basic knowledge that this man was

12 non-concordant with his medication.

13 Q. You had that knowledge, that he --

14 A. Yeah, I had a basic knowledge based upon the discussions

15 I'd heard in MDTs, and my discussions informally with

16 other members of the team, including Claudia.

17 Q. And that's true at September 2020, when we are looking

18 at this care plan, making that clear: ongoing monitoring

19 of non-concordance?

20 A. Yes.

21 Q. "Due to [the] increased risk of relapse", increased risk

22 of relapse if he doesn't take his medication.

23 A. Yes, yeah.

24 Q. That's what that sentence means, does it?

25 A. Yes, yeah. Non-concordance is -- is just all the way

95

1 We know, and Ms Birtles accepted yesterday, that the

2 formal risk assessment document was not updated until

3 August 2021 and the Chair has seen in which way it was.

4 Do you agree that recordkeeping around risk

5 assessment was effectively non-existent?

6 A. Judging by what I've heard over the last couple of

7 months, watching various people give evidence, I would

8 think that was probably a fair statement.

9 Q. You, indeed with this care plan, didn't update it, did

10 you --

11 A. No.

12 Q. -- or risk assessments when you became CCO in

13 April 2022?

14 A. My -- when I became his CCO, the handover process was

15 inadequate, basically.

16 Q. Well, whatever that process was like, it was your

17 responsibility, just as it was Ms Birtles' before you,

18 to keep this care plan updated and risk assessments, and

19 neither of you did because that's not what was done

20 then?

21 A. Well, if it had been -- if it had been updated when it

22 was handed over to me, the risk assessment may well have

23 been appropriate for several months. The risk

24 assessment will be changed if the circumstances change.

25 Q. If we go, please, to page 4. Under "Actions", halfway

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1 through his notes, basically, it's a major issue. In

2 fact it's probably the issue, really.

3 Q. And you knew that from this care plan from the off: that

4 he could get worse if he wasn't taking his medication.

5 A. Yes.

6 Q. And monitoring meant he needs to take his medication --

7 A. Yes.

8 Q. -- to keep well?

9 A. Yes.

10 Q. And to keep others safe; would you agree with that?

11 A. Yes, yes.

12 Q. That's not expressed, is it, that it's important to keep

13 other people safe? It's not expressed in any risk

14 formulation or generally.

15 A. Well, if it's not expressed it was certainly understood.

16 Q. So your evidence is it was understood in the team that

17 he would be a risk to others if relapsed, because of the

18 history, what happened in May, what happened in June.

19 A. Yes, it could be because -- you know, again I keep going

20 back to this admission three meeting we had with him.

21 You know, I'd seen him in a way -- I remember comparing

22 him then with how he was in September 2020, and he

23 looked and sounded differently. He was behaving

24 differently. You know, in September 2020 he looked

25 pretty good. He looked well. He looked comfortable.

96

1 And towards -- prior to admission three, he looked like
2 a different man, sounded like a different man. He was
3 behaving differently.

4 **Q.** Let's get to the few visits before you see him in 2001,
5 if we can go, please, to NHFT0017917, page 1. This is
6 an email that Abigail Parsonage sends to the team,
7 including yourself:

8 "... Mum worried as [VC] has stated he does not want
9 to see his mum for 2 months. Mum has asked we see him.
10 [VC] can get very unwell quickly. Anthony and I went
11 round and housemate stated he was in town ... she had no
12 concerns."

13 We've heard evidence about that this morning.

14 But just as you said earlier, within the team it was
15 known very well that he could get unwell quickly and it
16 was serious -- (*overspeaking*) --

17 **A.** Yeah, absolutely, yeah, yeah. Absolutely.

18 **Q.** And you're all being sent that message --

19 **A.** Yes.

20 **Q.** -- that he could deteriorate very rapidly.

21 **A.** Mm.

22 **Q.** Can we have, please, NHFT0000168, page 135. This is
23 a period of time when we've heard from Ms Birtles, she's
24 off work, and VC's mum has telephoned. If we go to the
25 top of 135. She's "spoken to VC and [he's] ... stated

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1 "says [he's] ... spoken with [VC], who says [he's]...
2 fine."

3 **Q.** Yes. So VC says he's fine.

4 **A.** Yeah. "I will try to call in on VC tomorrow to chat
5 with him."

6 **Q.** You didn't do that, did you, the next day?

7 **A.** Possibly not, no.

8 **Q.** The records suggest they don't. And your records are
9 very short, aren't they, compared with other entries
10 from the team, Mr Carter. It's one or two lines.

11 **A.** I keep it short and sweet. I haven't got time to write
12 essays. I just like to kind of put down what I feel is
13 of use.

14 **Q.** It's very difficult for people picking up after you,
15 though, to know what are concerns or to identify matters
16 that you may have seen or are concerned about, and
17 that's important, isn't it, in patient care?

18 **A.** Yes, yes, it is, yes.

19 **Q.** And when assessing risk to others, to have an accurate
20 history?

21 **A.** Yeah.

22 **Q.** It's important for people to know what the history is;
23 do you agree?

24 **A.** Yes, I agree.

25 **Q.** Did you realise at this point that VC had not been seen

99

1 'Don't speak to me for 2 months'."

2 So a red flag there. He's been speaking to his
3 mother or his family and he doesn't want to speak to
4 them for two months.

5 **A.** Yeah.

6 **Q.** You, if we go halfway down the page, on 19 October, are
7 the person that returns the call; is that right? And we
8 see there you actually spoke with Mr Calocane on that
9 occasion:

10 "He says he has spoken with [VC] who says he is
11 fine."

12 And you said you'd "try to call in tomorrow morning
13 to chat with [VC]."

14 Can you see that?

15 **A.** Yes.

16 **Q.** 19 October. That was the only time I think we see in
17 the record someone spoke to Mr Calocane. Were you
18 phoning the home when you spoke to him?

19 **A.** Yes, I must have been -- spoke to Mr-- yeah. It's
20 a good question, and I'm not quite sure. I don't recall
21 the exact nature of the conversation, the words that
22 were used, and as you rightly point out, I was the only
23 one who actually spoke to Mr Calocane in, well, a few
24 years. I don't recall the details of the conversation
25 but yes, he spoke -- basically -- (*overspeaking*) --

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1 in person since 1 October. If you look back in the
2 records, you'll have seen that there had been
3 a significant gap in the time he'd since been seen?
4 Were you aware of that?

5 **A.** No.

6 **Q.** So when you didn't go and see him the next day, it's
7 already getting over three weeks before anyone's seen
8 him and you said at the beginning it's important if
9 you're monitoring, in three weeks -- it's not enough, is
10 it?

11 **A.** Yes, I agree. I agree entirely with you.

12 **Q.** So do you think the importance of monitoring concordance
13 with medication was taken seriously enough when there
14 was that gap in time at this point about actually seeing
15 him?

16 **A.** Well, it would appear not, you know, I cannot disagree
17 with what you've said. You know, like, going what,
18 three weeks, did you say, something like that?

19 **Q.** Mm-hm.

20 **A.** And, you know, like there are concerns being expressed
21 about, from his mum, according to Mr Calocane, VC says
22 he's fine. So yeah, I would probably agree with you.

23 **Q.** You're accepting at surface level what VC said about
24 himself there, aren't you, instead of going to assess
25 him for yourself, and making --

100

1 A. Yeah.

2 Q. -- an attempt at a mental state examination for
3 yourself?

4 A. Yes, yes. I didn't go and see him. It's quite obvious
5 I didn't. And all I can say is that I was probably
6 dealing with other issues with other clients, on my
7 caseload.

8 Q. Did you raise that with anyone in the team and say,
9 "Look, someone needs to get out there quickly, I've got
10 too many visits, can you do it?"

11 A. I don't recall.

12 Q. Well, it doesn't look like you did, did you?

13 A. No, I don't recall that, no.

14 Q. Because if we go to 26 October, that's when you visit,
15 after another call with his mother on the 24th.

16 A. Yeah.

17 Q. So she's still worried and you visit on the 26th?

18 A. That's right, yeah, I remember that.

19 Q. You record:
20 "I explained his mum and dad were worried about him
21 and asked him to consider giving them a ring [and he]
22 said he would."

23 A. Yes.

24 Q. "He ... went back into his room without another word."
25 So what do you remember about that?

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1 Q. A known fact, when we look at the records here.

2 A. Yes, yes, that's right.

3 Q. Following on from the communication on 6 November, you
4 did visit VC with Abigail Parsonage and you took one
5 month's supply of medication?

6 A. That's right.

7 Q. Third paragraph. Because they were due, overdue,
8 indeed.

9 A. Yeah.

10 Q. VC said he had about ten left?

11 A. Ten, yeah.

12 Q. So that told you he was not taking his medication as
13 prescribed, didn't it?

14 A. That's correct.

15 Q. So, again, very clear at this point he is not doing what
16 he is being asked to do, take the medication?

17 A. Yes, I agree with you.

18 Q. Did you at that point want to escalate that issue? That
19 he wasn't taking his medication, there were concerns at
20 this point from his mother, from Dr Seedat, that he was
21 relapsing, becoming unwell, and you knew when you went
22 there that he was not taking medication.

23 A. I'm sure I would have talked to Abi about this meeting,
24 and the fact that he had ten left. I don't recall
25 talking to her, but I'm sure I would have done. And it

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1 A. Basically knocked on his door, I think someone else
2 answered the door, it was a shared house. I asked if
3 I could see VC, I think the chap shouted VC, who was
4 upstairs? He appeared at the top of the stairs, and
5 I just explained to him that his mum was a little bit
6 concerned and it might be a good idea just to perhaps
7 give her a ring and reassure her that he was okay. And
8 he said, he said, "I'll do that".

9 Q. You didn't telephone and update his mother about that,
10 did you, that you'd visited and he said he would call
11 her? It doesn't record that, does it?

12 A. No, no.

13 Q. Should you have phoned her back? She's raised concerns,
14 phoned her back and said how you found him to be?

15 A. Probably so, yes.

16 Q. If we go to page 136 of the notes, so NHFT0000168, 136
17 at the top: Dr Seedat, on 5 November, has had
18 a telephone call with VC, and he says at paragraph 4:
19 "I feel based on the interaction that he needs more
20 close monitoring and recording visits otherwise [he]
21 will end up in hospital."
22 So again, that commonly accepted principle that if
23 he isn't taking his medication, he relapses and isn't
24 well, yes?

25 A. Yes.

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1 would appear that we didn't kind of take it much further
2 than that, really.

3 Q. Well, worse than that, it says, "No issues of concern at
4 this time". Look below that paragraph.

5 A. Yeah, yeah.

6 Q. That wasn't the case, was it?

7 A. No, it wasn't. That's completely wrong on my part.

8 Q. Did you write this note?

9 A. Yes.

10 Q. And Ms Parsonage approve it or you just did it --
11 (*overspeaking*) --

12 A. No, I must have wrote the note, and yeah, that was my
13 mistake. Obviously having ten tablets left, that's
14 concerning. He's non-compliant, simple. Or at least
15 partially non-compliant. So yeah, that was my mistake.

16 Q. In a history of somebody who has been non-compliant
17 previously and readmitted to hospital, yes?

18 A. Yeah.

19 Q. If we go, please, to WITN0163009, page 1, we see
20 communication between Dr Seedat and Dr Lloyd, and you're
21 CC'd. We see it's at the bottom of the page,
22 Dr Seedat's email. The one that's further down, that's
23 right, thank you:
24 "I was surprised that the a patient with above ...
25 number ... rang my PA asking me to call him back which

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1 I did."
 2 So Dr Seedat pointing out that he'd been contacted
 3 and didn't expect it. And he says at the bottom:
 4 "Can I please urge you that you visit him face to
 5 face ..."
 6 Yes?
 7 **A.** Yeah.
 8 **Q.** Importance of email, ranked as high, and if we go to the
 9 top of the page, Dr Lloyd, CC'ing you, it says this:
 10 "It looks like the team have been making a concerted
 11 effort to visit and follow up this patient but the
 12 patient has not been in/engaging. Attempts have been
 13 made to see him weekly and mum has also been contacted
 14 to get further support. His CPN Gary Carter has now
 15 seen him. As you can imagine patients with psychosis
 16 can sometimes behave in quite erratic ways ..."
 17 It wasn't right that he'd been seen weekly, was it?
 18 We've gone to the notes previously and there was
 19 a three-week period where he wasn't seen in October.
 20 Yes?
 21 **A.** Yes. I'm just looking at this, "His CPN Gary Carter".
 22 **Q.** Yes.
 23 **A.** I'm not sure why Dr Lloyd made that entry. I think --
 24 because I was not his care coordinator.
 25 **Q.** It's been sent to you though, hasn't it, and it looks as
 105

1 different.
 2 **Q.** So you've got two consultants now communicating with
 3 each other, copying in, whether you're the lead
 4 coordinator or not, all those visiting under the scheme,
 5 being told: it's really important, check he's well.
 6 **A.** Yes, yeah.
 7 **Q.** We also see, if we go to NHFT0017810, page 1, Dr Lloyd
 8 at the top, wants to book in an assessment of his mental
 9 health, and Dr Burri, and you send an email, 9 November:
 10 "I took 28 days of meds out for [him] ... on Friday
 11 ... he said ... about 10 left? Needless to say I kept
 12 the new meds and will liaise with Claudia about going
 13 out ... again."
 14 So it's a matter for Dr Lloyd, but on its face
 15 raising that there were more pills left than were needed
 16 to be there --
 17 **A.** Yeah.
 18 **Q.** -- and you were questioning that.
 19 **A.** Yeah.
 20 **Q.** Were you aware, in September 2021, after he'd assaulted
 21 the police officers, at his home, seven-months' of
 22 medication had been found that hadn't been taken?
 23 **A.** No, I wasn't aware, no.
 24 **Q.** But you knew he was non-concordant, and that was
 25 the issue?
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1 though it's been sent to a number of members of the team
 2 including Abigail Parsonage, who wasn't, and Claudia?
 3 **A.** Yeah.
 4 **Q.** So he's sent it to the whole team.
 5 **A.** Yeah, I'm not doubting that. I'm just saying that
 6 I don't recall it, although it's there in black and
 7 white, so it was sent. But it's kind of putting -- he's
 8 putting the onus on me as, well, as if I'm his CCO,
 9 which I wasn't at the time.
 10 **Q.** That's understood. But all of you who have visited
 11 him --
 12 **A.** Yes.
 13 **Q.** -- are being told in this email, "attempts have been
 14 made to see him weekly", and all of you, presumably,
 15 then see Dr Seedat saying, "Visit him face-to-face,
 16 assess his mental state, and make sure he's okay."
 17 **A.** Yeah.
 18 **Q.** To put this in context, you say you had 15 to 20 cases.
 19 How many times did you get emails from an inpatient
 20 doctor, like Dr Seedat, saying that, "See him
 21 face-to-face", in the middle of your programme of
 22 assisting someone in the community?
 23 **A.** Rarely, I would say. Rarely.
 24 **Q.** So was this a standout? Here he is saying --
 25 **A.** Yes, it's definitely different. Yeah, it's definitely
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1 **A.** Yes, yes, judging by all this, yes. I think the whole
 2 team knew this. But September 2021, so this was, yeah,
 3 we're talking a year later.
 4 **Q.** Yeah, you found out a year later that he'd done that.
 5 **A.** A year later. No, I wasn't aware of that fact.
 6 **Q.** 10th -- sorry, go on.
 7 **A.** I was just about to say again. 95% of what I found out
 8 about this man I've found out in the last -- well, since
 9 this tragedy occurred.
 10 **Q.** But even without that knowledge you were querying "10
 11 left".
 12 **A.** Yes.
 13 **Q.** You knew that meant he couldn't have taken them.
 14 **A.** Yeah.
 15 **Q.** And you knew the history that he hadn't taken them
 16 between two admissions.
 17 **A.** Yeah, that's right.
 18 **Q.** And that he'd been violent in relation to events leading
 19 to admissions --
 20 **A.** Yeah.
 21 **Q.** -- in the first place.
 22 **A.** Yeah.
 23 **Q.** If we go, please, to NHFT0000168, 138, this is
 24 10 November, Dr Burri's assessment. Third paragraph:
 25 "I asked him what he wants to tell me today ... He
 108

1 said that just before his discharge from admission at
2 Highbury Hospital back in July, he told the ward doctor
3 that he no longer hears voices but he said that is not
4 the case and he only said that because he was tired for
5 being in the hospital."

6 Did you read this at the time, this record?

7 **A.** At this time, no.

8 **Q.** Yes, or subsequently, around the time of November 2020,
9 no?

10 **A.** No, no, no. At the end of the day, I don't mean to
11 emphasise this, but I wasn't his CCO. If the CCO had
12 pointed this record out to me and said, "Look, Gary,
13 what do you make of this? What do you make of this?"
14 then I would have given him my view and opinion. And it
15 would have been certainly interesting --

16 **Q.** Why is it interesting? What's the key fact you take
17 from that?

18 **A.** Well, basically he's saying something -- well, I asked
19 him what he wants to say. He said that just before he's
20 discharged from admission. He told the ward doctor he
21 no longer heard voices, but he only said that because he
22 wanted to get out of hospital, which is reinforcing what
23 I'm saying about him deceiving inpatient staff,
24 deceiving staff generally, saying things that are not
25 true.

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1 asked that question, both of us were quite wrong not to
2 do so.

3 **Q.** Because that's the main issue, isn't it: monitoring for
4 medication?

5 **A.** Yes, yes, definitely.

6 **Q.** You have caught him out on that.

7 **A.** Yes.

8 **Q.** You've got too many tablets.

9 **A.** Yes, absolutely.

10 **Q.** You can explain why you know he can't possibly have
11 taken them.

12 **A.** Yeah, if he's got ten tablets left, it's a clear
13 indication he's not been fully concordant, or he's not
14 been concordant.

15 **Q.** He's got away with it because you don't challenge him?
16 You don't call him out?

17 **A.** Yes, yes, if you want to look at it that way, certainly.

18 **Q.** How else can you look at it?

19 **A.** We just didn't ask him the question. We didn't do that
20 deliberately. We just did not ask him the question.
21 You know, like, because neither of us were his CCO; we
22 were helping Claudia out, basically. And in a situation
23 like this, what I've noted on more than one occasion,
24 whilst I was with EIP, is that you've got to organise
25 yourself properly. So that perhaps one CPN takes a bit

111

1 **Q.** Is that something in your role you should be equipped to
2 test for to see when that's happening?

3 **A.** If somebody is lying you mean?

4 **Q.** Yeah.

5 **A.** You can make a judgement. When you meet someone, you
6 can make a judgment as to whether they're lying to you.

7 Like, I suppose, every human being can. I suppose
8 meeting the man and if he said X, Y and Z to me, I could
9 then make a judgement as to whether I think he might be
10 misleading me or he might just be wrong. He might be
11 confused in some way. It's a very difficult position to
12 be in.

13 **Q.** Did you ask him on 6 November, when he said the ten
14 tablets that were left: "Why have you got ten? Have you
15 been taking them?"

16 **A.** I think Abi asked that.

17 **Q.** Because there's no note of that or an answer to that, is
18 there, whether any of you tested him on that?

19 **A.** No, I don't recall asking him.

20 **Q.** Ms Parsonage hasn't given evidence that she did either,
21 but it's the first question, isn't it?

22 **A.** Right, mm.

23 **Q.** "How have you got that many? You can't have been taking
24 them."

25 **A.** Yeah, it's a good question, yeah, and if neither of us

110

1 of a lead and the other one kind of backs that person
2 up, but if you don't organise it, then basically you
3 start confusing each other or you don't do things that
4 you should do.

5 **Q.** If you look at this impression of the document on the
6 screen, the impression of Dr Burri -- further down,
7 please.

8 **A.** "Came across" -- oh, right.

9 **Q.** "Came across psychotic with escalation of symptoms (2nd
10 & 3rd person auditory hallucinations with some
11 underlying perplexity with partial insight)."

12 This was four days after you and Ms Parsonage had
13 seen him and you have both recorded, or the record says,
14 "No issues of concern", and by 10 November, Dr Burri is
15 stating "Came across psychotic".

16 Do you think it's likely you didn't detect psychotic
17 symptoms? Didn't ask questions around hallucinations
18 and know that he --

19 **A.** The likelihood is that we probably didn't detect any
20 psychosis or psychotic symptoms as you described them.

21 **Q.** Did you do a mental state examination, either of you, on
22 the 6th?

23 **A.** I don't recall. I don't recall.

24 **Q.** But you agree it's likely you didn't see anything or
25 record anything?

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1 A. Yes, I think, I think if he'd have been -- well, if he'd
 2 have been psychotic, I think we'd have at least picked
 3 some of that up, and Dr Burri seemed to pick it up
 4 pretty quickly --

5 Q. You don't record that though.

6 A. No, we don't, no, no.

7 Q. Again, the problem with that is, one, it's difficult to
 8 know if you did or didn't, now looking at it; but
 9 secondly, the overriding impression from your note is
 10 "No issues of concern" because that's how you conclude
 11 it on the 6th. It's misleading, isn't it?

12 A. I understand what you're saying, yeah. I can see where
 13 you're coming from.

14 Q. Page NHFT0000168/153, please, it's 29 May 2021. This is
 15 an entry by Juliet Lopez and it's simply to ask you
 16 whether you would have looked at this, you may say
 17 because you were not his care coordinator at that stage
 18 you didn't. But we see 29 May at the top:

19 "Mum [is advising] she believes her son is becoming
 20 unwell. She reported she has been speaking to him over
 21 the last few days and she has sensed he is not doing
 22 well and he wasn't making sense."

23 There's a telephone call made, if we go three lines
 24 down, and when asked, VC says no difficulties:

25 "... no difference to his normal self. ... reported
 113

1 Q. Didn't know that at all when you --

2 A. No. No, I didn't, no.

3 Q. Did you know that VC had visited MI5 premises and been
 4 spoken to by the police at the end of May on 31 May?

5 A. No, no.

6 Q. Would you have liked to have known that: what he had
 7 said to police officers or why he was there?

8 A. I would have liked -- I would have liked to know
 9 everything that's in his documents from page 1 onwards.
 10 Everything. Including what you've just described. Yes,
 11 I know about his visit to MI5 now, but then, no, I don't
 12 know that.

13 Q. But you could have known what was in the documents by
 14 reading them or in your Multi-Disciplinary Team meeting
 15 saying, amongst you as a group, "Does someone want to go
 16 through these notes and see what's going on?"

17 A. Right. So why would I have wanted to start reading
 18 through the case notes of a client who was not on my
 19 caseload? Yeah, like -- if I did that, you -- you could
 20 say, by extension, I have to read through the case notes
 21 of everybody in the office. You know, like, it just
 22 doesn't make sense.

23 Q. Let's have a look, please, at NHFT0000168/154 is your
 24 visit on 8 June, so it's just after events in May
 25 when --

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1 everything is fine."

2 So speaking to different people in this way, he can
 3 deflect, can't he, and push professionals off because
 4 he's speaking to different people at different times and
 5 there's something about the way he's speaking that they
 6 accept.

7 A. "[Telephone call] from mum." Who is his mum calling?

8 Q. She calls Crisis, Juliet Lopez.

9 A. Right, so she rings -- why is she ringing --

10 Q. Sorry, it may not be Crisis. It's another professional,
 11 not a care coordinator --

12 A. It's just that I've never --

13 Q. It is Crisis, yes, it is Crisis.

14 A. Yeah, it's just that I don't know exactly, to be honest
 15 with you.

16 Q. No, you don't know, but the records here, contact with
 17 Crisis, mother is worried he's "becoming unwell".

18 A. Yeah.

19 Q. He again deflects, says everything is fine. Did you
 20 know that she had called Crisis? Because we know you go
 21 out --

22 A. No.

23 Q. -- on 8 June, so I'm trying to assess what you know
 24 before you go out in June.

25 A. No, I didn't know she'd contacted Crisis.
 114

1 A. 8 June, yeah.

2 Q. Can you see?

3 A. Yeah.

4 Q. Second box, paragraph.

5 A. "... looked good, sounded positive ... said he was
 6 feeling fine."

7 Q. Yeah, what do you note there? You've just read it out.
 8 Do you want to tell us what --

9 A. I delivered his aripiprazole, he "looked good, sounded
 10 positive ... said he was feeling fine."

11 Q. It's another short note, isn't it?

12 A. It is a short note, yeah.

13 Q. Did you try to assess his mental state?

14 A. Not in depth, no. No, no, I wouldn't say so.

15 Q. What about his medication concordance? Any questions
 16 about "What are you taking?"

17 A. No.

18 Q. "What did you last take?"

19 A. No, I must admit there's no record of that here.

20 Q. If you go to NHFT0000168/157 on 6 August. 6 August,
 21 please, so it's further down, the box. Thank you. That
 22 one. You phone him to say his medication is due and you
 23 deliver it in Claudia's absence. How did you find VC on
 24 that occasion?

25 A. "... seemed a little abrupt ... told me to deliver it
 116

1 'anytime I wanted'. He seemed a little rude when he
 2 broke the phone call off without a goodbye."
 3 Yeah, "Arrived at [VC's] at 2pm", yeah. Fine.
 4 Yeah.
 5 **Q.** Were you concerned about relapse or increase of risk,
 6 anything of that nature?
 7 **A.** Why, because he was a bit rude with me?
 8 **Q.** Yes, different from his presentation before, or as you'd
 9 seen it, and because you knew he hadn't taken all the
 10 tablets on your earlier visit.
 11 **A.** It didn't raise a red flag at that moment in time, to be
 12 honest with you.
 13 **Q.** If we go, the last one before the break,
 14 NHFT0000168/161, there's a note from your colleague
 15 Abigail Parsonage, 14 August:
 16 "Impression - Likely relapsing. No risks noted
 17 today but difficult to assess due to guarded
 18 presentation."
 19 What do you understand she meant by "guarded
 20 presentation"?
 21 **A.** Basically, he looked like a man who was probably
 22 thinking carefully about what he said, might not have
 23 been telling the truth entirely, might have been perhaps
 24 covering something up.
 25 **Q.** Do you think, when he said to you he was fine back on

1 6 August, that was the same, or not?
 2 **A.** I think it was different to this.
 3 **Q.** In what way?
 4 **A.** Well, this -- well, this was conducted by -- the visit
 5 was by two CPNs, I believe. And, again, I come back to
 6 this idea of, you know, like two views of the same
 7 situation, which is always useful. So yeah, I think
 8 that is probably the better way of doing things, really.
 9 **MS LANGDALE:** Chair, I think this might be a good moment for
 10 a break.
 11 **THE CHAIR:** All right, we'll stop there, Mr Carter, and
 12 we'll start again at -- I think we'll start again at
 13 2.00, thank you.

14 (1.06 pm)

15 (The short adjournment)

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