

Wednesday, 29 April 2026

1  
2 (10.00 am)  
3 **MR CARR:** Good morning. May I call Dr Craig Murphy?  
4 **THE CHAIR:** Yes.  
5 **DR CRAIG MURPHY (affirmed)**  
6 **Questioned by MR CARR**  
7 **THE CHAIR:** Yes, Mr Carr.  
8 **MR CARR:** Thank you, Chair.  
9 Dr Murphy, you have prepared a statement for the  
10 Inquiry, haven't you, dated 17 October 2025?  
11 **A.** That is correct.  
12 **Q.** There's a correction you wish to make at paragraph 44 of  
13 that statement.  
14 **A.** Yes, that is correct.  
15 **Q.** What is the correction? It's page 12.  
16 **A.** The first sentence of that paragraph explains that  
17 I sought to arrange blood tests for VC at six months and  
18 also a cardiovascular risk assessment at 12 months.  
19 What that sentence is inferring that I sought to arrange  
20 a cardiovascular assessment at 12 months; I did not  
21 formally put it into the diary as such.  
22 **Q.** So the correction, the change you would make is what?  
23 **A.** Is "I sought to arrange a cardiovascular risk assessment  
24 at 12 months".  
25 **Q.** Subject to that correction, is the statement true to

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1 they are allocated a GP, one of the GP partners is  
2 allocated as their named GP. However, unless there is  
3 a specific role or task of that individual GP, then care  
4 in the primary care setting is shared between all GP  
5 members of the Cripps Medical Centre team. So although  
6 yes, there is in primacy(?) a named GP, the function of  
7 that is only used in specific circumstances.  
8 **Q.** So what was the system that was in place for acting on  
9 correspondence that was received at the practice in  
10 respect of one of its patients?  
11 **A.** My understanding is that when correspondence was  
12 received, it was reviewed by the duty doctor on that  
13 day. This would be a role shared amongst all qualified  
14 GPs at the practice. All letters coming into the  
15 practice would be reviewed, and if there were any action  
16 points, such as inviting the patient for an appointment  
17 to discuss the contents of the letter or discharge  
18 summary, then a task on the electronic case management  
19 system, EMIS, would be sent to the admin team who would  
20 then contact the patient and invite them in.  
21 **Q.** So it was actioned, essentially, by the duty doctor?  
22 **A.** Yes.  
23 **Q.** Right. If we can turn to your consultation on  
24 17 August. In your statement, you've explained that,  
25 ahead of that consultation or as part of the

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1 your best knowledge and belief?  
2 **A.** It is, yes.  
3 **Q.** By way of professional background, you are a GP, aren't  
4 you, a general practitioner?  
5 **A.** That is correct.  
6 **Q.** In August 2020, you were a trainee GP on placement at  
7 the Cripps Health Centre in Nottingham.  
8 **A.** Yes.  
9 **Q.** That's the GP practice where VC was registered at the  
10 time.  
11 **A.** Yes.  
12 **Q.** For your training you were supervised by Dr Sarah  
13 Hamlyn.  
14 **A.** Yes.  
15 **Q.** You had a single consultation with VC which was on  
16 17 August 2020.  
17 **A.** That's correct.  
18 **Q.** And it was by telephone?  
19 **A.** By telephone, yes.  
20 **Q.** That followed, didn't it, his discharge from his second  
21 admission?  
22 **A.** That's right.  
23 **Q.** You were not VC's named GP. Did he have a named GP?  
24 **A.** My understanding of the process of having a named GP is  
25 that when patients are newly registered to the practice

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1 consultation, you considered the discharge summaries  
2 from the two recent admissions?  
3 **A.** Yes.  
4 **Q.** Was that, in fact, all of the documentation that had  
5 been received at the practice in respect of VC's mental  
6 health up until that point?  
7 **A.** Pertaining to the mental health complaint, yes, this was  
8 all which was received at that time.  
9 **Q.** Did the practice have access to RiO records in respect  
10 of its patients?  
11 **A.** I certainly don't have access to RiO and my  
12 understanding is that the practice did not have access  
13 to that electronic record system.  
14 **Q.** So the extent of the available information was what was  
15 contained in those two discharge summaries?  
16 **A.** Entirely.  
17 **Q.** If we can look at those, please. The first one, it's  
18 CHCA0000027 and this was a discharge summary following  
19 the first admission. We can see on page 1 there are  
20 background details, Dr Murphy.  
21 **A.** Yes.  
22 **Q.** Then if we go forward, please, to page 3, we have, in  
23 that main box, background leading to the first  
24 admission, don't we?  
25 **A.** Yes.

4

1 Q. In the first paragraph about halfway down, it sets out  
2 that VC had been "hearing voices and responding to  
3 unseen stimuli"?

4 A. Yes.

5 Q. So that's a reference to psychotic symptoms or symptoms  
6 of psychosis?

7 A. I believe so, as per this discharge summary, yes.

8 Q. Then, towards the end of the paragraph, the final two  
9 lines, it sets out that a neighbour whose flat he had  
10 broken into had jumped out of the first floor window?

11 A. Yes.

12 Q. Then on the third paragraph on that page, it notes,  
13 final sentence, that VC had been started on  
14 aripiprazole, 5 mg.

15 A. Yes.

16 Q. If we can turn to page 4, please. This sets out,  
17 doesn't it, the post-discharge planning?

18 A. Yes.

19 Q. We can see in the middle of the page under "Physical  
20 Health Plan" there are a couple of entries for which the  
21 GP would be responsible, annual health check, and  
22 investigations following bloods and ECG?

23 A. Yes.

24 Q. Then further down, the penultimate box is titled "Action  
25 for GP" and it states:

5

1 A. Yes.

2 Q. Then actions for GP includes:  
3 "... please ensure that his medications are  
4 prescribed on his repeat prescriptions."

5 A. Yes.

6 Q. So if we just pause there and consider the information  
7 that was available to you ahead of 17 August  
8 consultation, you were aware that on two occasions VC  
9 had been admitted following psychotic episodes in which  
10 he'd accessed neighbours' flats?

11 A. Yes.

12 Q. On one occasion a neighbour had jumped out of a window  
13 in fear?

14 A. Yes.

15 Q. Between his first and second admission he stopped taking  
16 his medication?

17 A. Yes.

18 Q. When he stopped taking his medication following the  
19 first admission, his symptoms returned leading to the  
20 second admission?

21 A. Yes, that's right.

22 Q. Both discharge summaries required the GP practice to  
23 ensure his medication was prescribed?

24 A. Yes.

25 Q. Now in fact, following both admissions, the Local Mental

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1 "Please ensure he receives an annual health check,  
2 and please ensure that his medications are prescribed on  
3 his repeat prescriptions."

4 A. Yes.

5 Q. That would be a reference to the aripiprazole?

6 A. Yes, in addition to the vitamin D.

7 Q. Then if we'd look at the second discharge summary  
8 following the second admission, CHCA0000028. Again, on  
9 page 1, we have the background details. If we go to  
10 page 3 of this document, that provides a summary leading  
11 to the second admission?

12 A. Yes.

13 Q. You will have seen in that first box, fourth line again:  
14 "[VC] had gone to a neighbour's flat ... [and]  
15 barged in ..."

16 A. Yes.

17 Q. The following paragraph sets out that VC had decided to  
18 stop taking his medication two weeks after discharge?

19 A. Yes.

20 Q. He was started on aripiprazole again?

21 A. Yes.

22 Q. Then, finally in this document, if we go to page 4 and  
23 look at the action plans, it's similar to before, not  
24 identical, but again, physical health plan, GP to be  
25 responsible for the annual health check?

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1 Health Team ultimately took over prescribing VC's  
2 aripiprazole. Was that communicated to the GP practice?

3 A. No, that wasn't clear to us at this time. All the  
4 information regarding what the Local Mental Health Team  
5 or the Community Mental Health Team would do was  
6 articulated within the discharge summaries and that  
7 included a three-day follow-up prior to being handed  
8 over to the Local Mental Health Team. There was some  
9 additional information which I gained from VC during my  
10 consultation.

11 Q. If we look at the practice's medical records it's  
12 CHCA0000030. If we start at page 10. Thank you. So we  
13 can see entries, can't we. 17 June and 31 July is when  
14 the discharge summaries have been received by the  
15 practice.

16 A. Yes.

17 Q. But between those two dates, nothing seems to have been  
18 done by the practice, does it?

19 A. No.

20 Q. Following the first discharge, the next entry is the  
21 second discharge.

22 A. Yes.

23 Q. In light of your answer earlier as to the system that  
24 was in place, is the position that on receipt of that  
25 first discharge, the duty doctor, whichever duty doctor

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1 was on, had the responsibility for acting on the first  
 2 discharge?  
 3 **A.** That would be my understanding of the process at the  
 4 practice, yes.  
 5 **Q.** Then if we go up above 31 July we can see the next three  
 6 entries all describe text messages sent to VC asking him  
 7 to make an appointment for a review and to discuss  
 8 medication.  
 9 **A.** Yes.  
 10 **Q.** Does it follow that, following receipt of the second  
 11 discharge summary, a duty doctor has, prompted by that  
 12 discharge summary, arranged for those text messages or  
 13 the first text message to be sent?  
 14 **A.** That is my understanding, yes. It may also have been  
 15 the admin team who interpreted the discharge summary as  
 16 well, and noted the need for GP follow-up.  
 17 **Q.** VC ultimately responded -- responds to the texts, and  
 18 that is what leads to your appointment.  
 19 **A.** Yes.  
 20 **Q.** Where a patient does not respond, what happens?  
 21 **A.** My understanding of the process at the practice would be  
 22 numerous attempts would be made via text message  
 23 initially, and that this could be escalated ultimately  
 24 to a printed out letter sent to their home address.  
 25 **Q.** If we look at the note of your appointment it starts at  
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1 aripiprazole and he's currently receiving it from the  
 2 CMHT. That's a reference to the Crisis Team, isn't?  
 3 **A.** I would say in my records that's a mention to the  
 4 Community Mental Health Team.  
 5 **Q.** You've noted your impression was that VC was stable --  
 6 **A.** Yes.  
 7 **Q.** -- and that he demonstrated understanding and insight of  
 8 medication and need for monitoring. How did he  
 9 demonstrate that understanding and insight?  
 10 **A.** I can't recall the entire contents of the conversation  
 11 on the day but, given that I've documented it, the  
 12 inference would be that we discussed his condition as  
 13 paranoid schizophrenia, as per the discharge summary, we  
 14 would have discussed his medication which the -- the aim  
 15 of which is to control symptoms, that he needs to take  
 16 it once a day. We may have touched on, as noted in the  
 17 discharge summary, that when he stopped taking his  
 18 medications, he experienced the auditory hallucinations  
 19 again. And from this documentation, I can only assume  
 20 that he would have confirmed what we were speaking about  
 21 and was able to follow that in a real, genuine  
 22 conversation.  
 23 **Q.** As for the plan that you have documented at the bottom,  
 24 four numbered points, point 1:  
 25 "Has adequate supply of aripiprazole. I have  
 11

1 the bottom of page 9 running into page 10. Now it was  
 2 a telephone appointment. Were it not for the pandemic,  
 3 would this have been a face-to-face appointment?  
 4 **A.** I believe so, yes.  
 5 **Q.** Your statement describes the process of a consultation  
 6 such as this; there's restricted time both to see the  
 7 patient and to consider the documents.  
 8 **A.** Yes, the constraints of time are always a consideration  
 9 in the primary care setting.  
 10 **Q.** Is there any ability to allocate further time to an  
 11 appointment where the circumstances demand greater  
 12 consideration?  
 13 **A.** Yes, absolutely. Often GPs will have some control over  
 14 their own clinic list, and may book patients for double  
 15 appointments or back-to-back appointment, that would  
 16 open up to 20 minutes. The admin team can do that as  
 17 well. But it is usually with some forewarning that that  
 18 takes place.  
 19 **Q.** Well, in light of VC's diagnosis, his recent history,  
 20 two admissions in quick succession, was a longer slot or  
 21 a double slot required for him?  
 22 **A.** That's not what was allocated on the day. However, it  
 23 would have been useful to have that, yes.  
 24 **Q.** Now, at the appointment itself, VC tells you, and it's  
 25 right at the top of page 10, that he's been started on  
 10

1 advised p[atien]t that when he begins to run low he must  
 2 contact us -- p[atien]t understands."  
 3 And the purpose of him contacting the practice would  
 4 be with a view to prescribing more aripiprazole?  
 5 **A.** It would have been one of two things. It would have  
 6 been, number 1, to support VC in obtaining  
 7 a prescription if that was being provided from the  
 8 Community Mental Health Team. We could have engaged  
 9 with them on his behalf in order to support him, so  
 10 there was a-- a continuity of him taking his medication.  
 11 A second purpose would have been liaising again with  
 12 the Mental Health Team to understand if we could  
 13 prescribe that directly to him at this stage, given  
 14 that, on his second admission, his dose of aripiprazole  
 15 had been increased, so that's the dose change, and this  
 16 was only really done two, maybe three weeks before we  
 17 saw him. So he would have still been, to our  
 18 understanding, stabilising on that particular dose of  
 19 medication.  
 20 **Q.** On the basis of the two discharge summaries we looked  
 21 at, they required, didn't they, the GP practice to  
 22 continue the prescriptions of aripiprazole?  
 23 Was it your understanding from your discussion with  
 24 VC that the GP practice would not be responsible for  
 25 prescribing aripiprazole?  
 12

- 1 A. That specifically wasn't my understanding of the  
2 responsibility for prescribing the aripiprazole. What  
3 was clear was that he was getting it from the Local  
4 Mental Health Team. He had in adequate supply. The  
5 discharge summary does say put his medications on  
6 repeat, but it doesn't specifically say aripiprazole as  
7 a specialist medication.
- 8 Q. In circumstances where you have a patient with first  
9 episode psychosis, the two recent admissions, the second  
10 of which was caused by the patient stopping medication,  
11 is it safe practice to have the onus on the patient to  
12 come back to you?
- 13 A. I think that ultimately one needs to make an assessment  
14 there and then. That's that snapshot in time, those  
15 ten minutes which I spoke to VC on the phone. You need  
16 to understand his level of insight, that he understands  
17 the need for medication, he understands what has  
18 happened to him. And we need to take ultimately that  
19 into account when we assess his comments and taking him  
20 at face value.
- 21 Q. But in light of the history, what the plan sets out is  
22 when he begins to run low, he must contact the practice.  
23 And my question is whether a more proactive approach was  
24 required which was, for instance, you determining when  
25 his supply was likely to run out; was that determined

13

- 1 height recorded?
- 2 A. Yes, that's right.
- 3 Q. Looking through those notes, he -- that is VC -- doesn't  
4 seem to apply to reply to it, does he?
- 5 A. No.
- 6 Q. Where there is a failure to reply to an invite such as  
7 this, whose responsibility is it to do something, to  
8 follow it up?
- 9 A. Ultimately in this case the onus would have been with  
10 the patient but also he was having that follow-up from  
11 the Local Mental Health Team, so he was having a form of  
12 follow-up, but given that the patient had engaged with  
13 us initially, following his discharge, following my  
14 assessment of him on the 17th, we had no reason to  
15 believe that he wouldn't engage again.
- 16 Q. The records can come down now.  
17 Dr Murphy, for the purposes of preparing to give  
18 evidence today, you have been sent, haven't you, the  
19 AMHP reports ahead of VC's admissions?
- 20 A. Yes.
- 21 Q. They weren't sent to the practice, were they?
- 22 A. Not that I'm aware of. And I would note from the GP  
23 notes, which were available for this Inquiry and as  
24 representation of what was available at the time, these  
25 were not uploaded to those notes, and so no, I wouldn't

15

- 1 during the discussion?
- 2 A. Not that I can recall from these notes.
- 3 Q. Liaising with secondary mental health, so Community  
4 Mental Health or EIP to get clarity as to who was going  
5 to be responsible for prescribing his medication. Was  
6 that done?
- 7 A. That was not done.
- 8 Q. Did you have any discussion with the Local Mental Health  
9 Team following this consultation?
- 10 A. No.
- 11 Q. Did the practice ever prescribe aripiprazole to VC?
- 12 A. It's my understanding from the remainder of the notes  
13 which were available to me for this Inquiry that  
14 aripiprazole was never prescribed by Cripps Health  
15 Centre.
- 16 Q. VC's second admission had been a Section 3 detention.  
17 The note doesn't contain any reference to discussion  
18 about Section 117 aftercare. Is that something that you  
19 as a trainee GP would have been aware of?
- 20 A. No.
- 21 Q. If we go to the next entry above the notes of the  
22 consultation, it's also dated 17 August. It's a little  
23 bit later. It's under your name. It describes a text  
24 message sent to VC, and it's asking him, isn't it, to  
25 make an appointment to have blood pressure, weight and

14

- 1 have.
- 2 Q. Typically, in your experience, do GPs receive copies of  
3 the AMHP reports?
- 4 A. I have not in my practice encountered these.
- 5 Q. When dealing with patients of yours who have been  
6 detained or have been assessed and not detained, would  
7 it be helpful to receive those reports?
- 8 A. I think it's always helpful to have additional  
9 information available. I note that the AMHP reports  
10 made available to me for this Inquiry did contain some  
11 good granular detail regarding the background  
12 circumstances, that there was discussion with the family  
13 and I think, critically, a highlight of the risk that VC  
14 posed to himself and others, in addition to the impact  
15 of that.
- 16 Had it, or would it, rather, have changed my actions  
17 on the 17th? I have reflected on this in the build-up  
18 to the Inquiry and I would say no. The reason for that  
19 is because VC had been taken into hospital and had been  
20 given treatment which he seemed to respond to.
- 21 MR CARR: Thank you, Chair. Those are my questions for this  
22 witness. I understand there are --
- 23 THE CHAIR: Yes. Mr Moloney, thank you.
- 24 Questioned by MR MOLONEY
- 25 MR MOLONEY: Dr Murphy, just a couple of questions in

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1 clarification, no disagreement with anything that you've  
 2 said.  
 3 **A.** Yes.  
 4 **Q.** For the purposes of this, could we please have  
 5 Dr Murphy's witness statement up, which is WITN0077001.  
 6 The first aspect I'd like to ask you about,  
 7 Dr Murphy, if I may, is your review of the discharge  
 8 summary for VC before you spoke to him on  
 9 17 August 2020?  
 10 **A.** Yes.  
 11 **Q.** You were taken to a small part of it. Can I just ask  
 12 you to elaborate in relation to a couple of details in  
 13 relation to that discharge summary and take you to  
 14 paragraphs 26 and 27 of your statement, please. That's  
 15 Great.  
 16 At the top there we see that there was, in  
 17 paragraph 26, a detailed summary, but if we go seven  
 18 lines down:  
 19 "VC reported during assessment in hospital that he  
 20 had decided to stop taking his medication two weeks  
 21 after his first discharge from [the] hospital, believing  
 22 himself to be well and that his medication was slowing  
 23 him down when studying for an upcoming university exam."  
 24 Then in paragraph 27, we see there that:  
 25 "... established on Aripiprazole ..."

17

1 **Q.** You speak to him on 17 August.  
 2 **A.** Yes, correct.  
 3 **Q.** You've said in response to Mr Carr that he was  
 4 insightful as to his condition and understood the need  
 5 for further medication.  
 6 **A.** He did to me, yes.  
 7 **Q.** Absolutely. You were asked how you came to that  
 8 conclusion, and you gave an answer and it's difficult,  
 9 when sitting there, to think of everything, but at the  
 10 time you make your statement then of course you have  
 11 time to reflect.  
 12 Could I please just take you to paragraph 34 of your  
 13 statement and just see if this that's contained in your  
 14 statement is still your recollection. There we see at  
 15 the bottom of the page:  
 16 "My impression was that VC presented on the  
 17 telephone as insightful as to both his condition and the  
 18 need for him to continue his medication."  
 19 Here we go:  
 20 "This was evidenced to me during our consultation  
 21 and discussion of these, further supported by his calm  
 22 tone, articulate speech and polite manner. There were  
 23 no long pauses in our conversation and no tangential  
 24 speech; he remained focussed on our conversation  
 25 throughout the time on the phone. His comments to me

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1 Just to clarify, that essentially it had helped his  
 2 condition such that he was no longer suffering with the  
 3 same symptoms that had led to his admission.  
 4 **A.** Yes, that's the information from the discharge summary  
 5 available to me.  
 6 **Q.** That:  
 7 "... he had improved both his insight into his  
 8 mental health condition, and 'fully' understood the need  
 9 for, and importance of, his medication."  
 10 **A.** Yes, and these are critical comments from the secondary  
 11 care team which help us in primary care --  
 12 *(overspeaking)* --  
 13 **Q.** Absolutely.  
 14 **A.** -- inform -- *(overspeaking)* --  
 15 **Q.** All of that detail was readily apparent to you from the  
 16 discharge summary.  
 17 **A.** Yes, very much. In fact, I've even quoted it in my  
 18 statement here, it's in black and white.  
 19 **Q.** Absolutely. Then just one further point of  
 20 clarification, if I may, please, Dr Murphy.  
 21 **A.** Of course.  
 22 **Q.** When you spoke to VC, it was only 17 days after the  
 23 release from his second admission. So 31 July, he is  
 24 released.  
 25 **A.** *(The witness nodded).*

18

1 were considered and appropriate in nature and he came  
 2 across as insightful."  
 3 Is that concordant with your recollection?  
 4 **A.** Yes, and I'll just expand, if I may.  
 5 **Q.** Certainly.  
 6 **A.** Is that this was almost six years ago and I really have  
 7 tried hard to try to remember this phone call.  
 8 I suppose what stands out to me, and the reason for me  
 9 remembering some of the vagaries of this is that this  
 10 was actually quite a big learning event for me as  
 11 a trainee.  
 12 **Q.** Of course?  
 13 **A.** The discussion with my supervisor following a day-to-day  
 14 prompt, reflection and learning. So I was trying really  
 15 hard to remember. It's almost as if I could remember  
 16 his voice but I couldn't remember specifically what was  
 17 said. Very much as is written here, as is what's  
 18 recorded in the notes: calm tone, articulate speech,  
 19 polite manner. He had that insight. My practice is,  
 20 especially on a first contact with a patient, is to try  
 21 and establish that rapport with them.  
 22 **Q.** Yeah.  
 23 **A.** He's obviously been in hospital, these were major life  
 24 events from him, and the role of primary care is really  
 25 one often support. But the key to that, the

20

1 fundamental, is establishing rapport. So having  
2 a conversation with someone is important. And from what  
3 I've written here in paragraph 34, that was what I drew  
4 from that conversation with him.

5 **MR MOLONEY:** Thank you very much, Dr Murphy.

6 **THE WITNESS:** Thank you.

7 **THE CHAIR:** Thank you, yes.

8 I think that's time for a short break, at this  
9 stage.

10 **MR CARR:** It is. The next witness is being live linked so  
11 if we can have a short five-minute break.

12 I will say before we do that, Dr Sarah Hamlyn, the  
13 GP who was supervising Dr Murphy, the Inquiry has  
14 a witness statement from her. She addresses the  
15 discussion she had with Dr Murphy and we will be  
16 uploading that to the website later today, and the  
17 Inquiry also intends to call to give oral evidence  
18 Dr Tim Baker. He was the senior partner at the GP  
19 practice and will be addressing primary care involvement  
20 with VC more broadly.

21 **THE CHAIR:** Thank you. Right, well, we'll stop there and  
22 we'll start again -- I think it needs ten minutes, in  
23 fact, to set up the link so we'll start again at 10.40,  
24 thank you.

25 (10.29 am)

21

1 Intervention Psychosis Team as a Band 5 on a secondment  
2 basis; is that right?

3 **A.** Yes, that's right.

4 **Q.** You tell us initially the EIP service was a standalone  
5 service working with first episode psychosis patients,  
6 but between 2017 and 2018, the service was disbanded and  
7 the pathway put into the Local Mental Health Teams. You  
8 mainly kept an EIP caseload; is that right?

9 **A.** Yes, that's right.

10 **Q.** You took maternity leave in July 2017. The EIP  
11 disbanded into the LMHT in 2018 and when you returned  
12 you came back to the LMHT holding mainly an EIP  
13 caseload?

14 **A.** Yes.

15 **Q.** Can you, in that context, please, tell us your  
16 responsibilities as care coordinator in the community?

17 **A.** Yes. So I'm the person kind of responsible for  
18 coordinating the care throughout that individual's  
19 pathway in the EIP. So it might start off with the  
20 initial assessment, moving on to kind of the care  
21 planning, and then reviewing the care planning,  
22 monitoring the mental health, assessing the risk, and  
23 offering kind of therapeutic interventions as required.

24 **Q.** So your role does include monitoring, risk assessment,  
25 liaison with families and agencies, and care planning?

23

1 (A short break)

2 (10.40 am)

3 **MS LANGDALE:** Chair, may I call the next witness, please,  
4 Claudia Birtles?

5 **THE CHAIR:** Yes.

6 **CLAUDIA BIRTLES (affirmed)**

7 **Questioned by MS LANGDALE**

8 **MS LANGDALE:** Ms Birtles, you have prepared a statement for  
9 the Inquiry dated 29 January 2026. I believe you have  
10 one matter to correct which is that at paragraph 363 you  
11 refer at a particular time to this being VC's first time  
12 on a Section 3 when in fact it was his second time on  
13 a Section 3.

14 **A.** Yeah.

15 **Q.** Subject to that amendment, are you satisfied the  
16 statement is true and accurate as far as you're  
17 concerned?

18 **A.** Yes, I am.

19 **Q.** You set out your background career and your role. You  
20 qualified as a mental health nurse in May 2010, having  
21 completed a diploma in Mental Health Nursing at  
22 Nottingham University; is that right?

23 **A.** Yes.

24 **Q.** 2010 you began work as a Band 5 Community Psychiatric  
25 Nurse, and in 2013 moved to work in the Early

22

1 **A.** Yes.

2 **Q.** What was the training undertaken to become a band 6  
3 Community Psychiatric Nurse with EIP team?

4 **A.** I don't recall any specific training around the shift  
5 from a five to a six. I had to go through an interview  
6 process to demonstrate my ability to do the band 6 role,  
7 but there wasn't -- there was -- if I can recall, there  
8 was perhaps some -- a bit more training around the  
9 assessment of mental health conditions because that was  
10 something that I hadn't done as a band 5. So there was  
11 a bit of a difference when you moved up to band 6. So  
12 they offered us some training around the assessment of  
13 EIP patients, but nothing in -- no particular training  
14 to go from a five to a six, if that makes sense.

15 **Q.** What was the training for band 5, then, just so we can  
16 understand training relevant to risk assessment  
17 monitoring and the like?

18 **A.** I think everybody -- everybody accesses the same risk  
19 assessment training in the Trust on an e-learning  
20 package, every three years. So that's something that  
21 everybody would do, regardless of their kind of banding.

22 **Q.** We've seen the Royal College of Psychiatrists provides  
23 guidance to psychiatrists around managing risk and risk  
24 assessment. Do you have anything, as nurses, from the  
25 Royal College? Any guidance to assist you? We haven't

24

1 found any, but you may tell us --

2 **A.** No, not that I'm aware of. I haven't seen anything, not  
3 particularly for nurses, no.

4 **Q.** So where would you look to, if anywhere, for  
5 professional guidance around tips for monitoring or  
6 assessing?

7 **A.** I guess within the team, you know, within members of the  
8 MDT team. So colleagues who have different experiences  
9 working with risk, medical staff, psychology, if we had  
10 access at the time to psychology. So kind of leaning on  
11 other people's experiences, really.

12 **Q.** The consultant in the time we're going to be examining  
13 later that you were working with in respect of VC, was  
14 Dr Lloyd; is that right?

15 **A.** That is right.

16 **Q.** So what's her role in respect of yourself?

17 **A.** I guess ultimately she's the responsible clinician,  
18 ultimately is responsible for that person's care.  
19 I kind of feed into that as the care coordinator doing  
20 the more day-to-day regular work with somebody and then  
21 feeding back to her. So they've got a good  
22 understanding of what's happening day-to-day, but  
23 I think ultimately she's the highest level of  
24 clinical --

25 **Q.** She's responsible clinician?

25

1 if there was any new referrals, allocate who would be  
2 assessing them, then any feedbacks from referral --  
3 assessments the previous week, and then we'd look at our  
4 caseload and whether there's any cover needed or people  
5 are off or any concerns about any risk or any changes.  
6 So that was generally the kind of pattern that we  
7 followed.

8 **Q.** How long were the meetings, roughly, those weekly  
9 meetings?

10 **A.** I think in 2020 we probably would have had about an  
11 hour, an hour and a half. Sometimes it might go over.

12 **Q.** How many professionals present for that, apart from  
13 Dr Lloyd and yourself?

14 **A.** Depending on how many -- it would be the care  
15 coordinators in the team, and then if there was support  
16 worker, but obviously that -- over the period of time  
17 that I worked with VC, that there was obviously changes  
18 within the team and he was there and how many, so it did  
19 vary -- (*overspeaking*) --

20 **Q.** Four or five?

21 **A.** No, it could be more, depending on the number of care  
22 coordinators.

23 **Q.** There's no action plans recorded at the end of an MDT.  
24 Is there a reason for that? Do you have action plans  
25 and they're just not recorded, or ...?

27

1 **A.** Yeah.

2 **Q.** She's the psychiatrist?

3 **A.** Yeah.

4 **Q.** In terms of how often you saw her, we've obviously seen  
5 the RiO records, we've seen when there's  
6 Multi-Disciplinary Team meetings and we're going to go  
7 to a number of those later, but how often, roughly, did  
8 you see Dr Lloyd in a formal meeting session to discuss  
9 VC, do you think?

10 **A.** We would have MDT weekly, so the opportunity was there  
11 to discuss face-to-face weekly. If there was any other  
12 concerns or I might be worried, then there'd still be  
13 ways to access the consultant, either by email or in the  
14 office, depending on working days. So I guess formally  
15 weekly but there is other opportunities.

16 **Q.** That weekly MDT meeting, does it have an agenda, is it  
17 specific patients that you're talking about, or ...?

18 **A.** Back then, largely from what I recall, we would have  
19 a board with our patients' names, initials, and  
20 generally we would go through our caseload and if there  
21 was anything significant or anything we needed to bring  
22 up, the care coordinator would do that.  
23 I think there's changes now in how the MDTs were,  
24 but back at that point there wasn't a particular agenda,  
25 we tended perhaps to talk about new referrals initially,

26

1 **A.** Following a discussion that we've had about a patient,  
2 for example?

3 **Q.** Yes, when we see your notes of MDTs, we see entries but  
4 nothing that says, "Action plan" or who's doing what  
5 afterwards. Is there a reason for that?

6 **A.** I think at that point we didn't have an agenda and we  
7 didn't have a system whereby it was documented, for  
8 example, like with a template. So it was -- I guess at  
9 that point it wasn't done that way. So we didn't -- it  
10 wasn't something that was in our practice that we were  
11 regularly doing.

12 **Q.** So it was more like an informal discussion between  
13 healthcare professionals about caseload and what was  
14 going on; is that a fair summary of how it was?

15 **A.** It was a formal meeting in the sense that it had to be  
16 every week and we had to all attend and there was an  
17 expectation to attend, but I think it was just the  
18 documentation afterwards. So the discussions were  
19 there, but the documentation obviously didn't end -- you  
20 know, it wasn't there on RiO. So it was formal, I would  
21 say.

22 **Q.** So you say it's changed now. What happens now, in terms  
23 of MDT meetings?

24 **A.** I mean I'm not currently on work, so I'll just go from  
25 what I knew this time last year, but there's an agenda,

28

1 and there's somebody who's taking kind of basic notes  
2 and who's discussed and what the plan might be, and then  
3 the care coordinator will document the -- in more  
4 detail, the discussion and the plan. And then there  
5 would be somebody who would be checking that that was  
6 done, auditing it, in a way, to check that those  
7 discussions were documented on RiO.

8 **Q.** What about not just the writing of the discussion, but  
9 the auditing of the actions or the steps taken? Who  
10 does that now?

11 **A.** Yeah, so that would be followed up on an action log,  
12 which the clinical lead or the manager would have on  
13 almost like a spreadsheet so the action, if there was  
14 a specific action that needed following up, that could  
15 then be looked at the following MDT to make sure that  
16 action had been done. So it wasn't just a case of  
17 getting it on the notes; it was --

18 **Q.** That structure isn't just creating paperwork, is it?  
19 It's important to have actions, outcomes, so that you're  
20 not going round the houses with the same issues and just  
21 having conversations, effectively.

22 **A.** Yeah, and a timeframe and kind of when you're kind of  
23 expecting a certain -- because it might not be that the  
24 action can be done within a week, but having  
25 a discussion about what we expect and whether that needs

29

1 the number of care coordinators we were quite a small  
2 team and we were, as the EIP team initially before this  
3 was set up where you had a much bigger team, there's  
4 more resources to share things amongst the team if  
5 there's issues with cover or sickness and things like  
6 that.

7 So in some ways it got slightly easier but obviously  
8 in other ways we were then just quite a fairly small  
9 group of people trying to manage everybody on that  
10 pathway.

11 **Q.** We see examples where you've missed a message over  
12 a weekend and pick it up on a Monday. It's inevitable,  
13 when you've got a smaller team, isn't it, that there's  
14 not the same flex or ability to respond immediately to a  
15 patient over a period of 24 hours, if necessary; is that  
16 fair?

17 **A.** Yeah, although I think the occasion you're referring to,  
18 maybe they had contact with the Crisis Team, and then  
19 that would come through to the LMHT on the Monday and  
20 then we would follow up. So it wouldn't necessarily  
21 stop that happening, but obviously we were a much  
22 smaller team and (*unclear*) office, it is more difficult.

23 **Q.** It requires more communication across another team,  
24 doesn't it?

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

31

1 to remain on an action log or, you know, so it's --  
2 there's something actually happening following the  
3 action.

4 **Q.** Exactly. In 2020, 2021, you tell us the EIP team split  
5 from the Local Mental Health Team resulting in the loss  
6 of the duty system and a reduction to four care  
7 coordinators. You nod. That's right, isn't it, there  
8 was a reduction then?

9 **A.** Yes, so we were separate, just the EIP care  
10 coordinators.

11 **Q.** What effect did that split have on the EIP team as  
12 a whole and on your role individually, if any?

13 **A.** I'd worked in the EIP services before we joined with the  
14 LMHT, so I'd seen how an EIP, a standalone service,  
15 worked and obviously I'd been through some of the  
16 difficulties of working as an EIP CPN on the EIP pathway  
17 but within the LMHT.

18 So in some respects those things had got easier  
19 because we weren't required to do some of the roles that  
20 the LMHT staff were doing and we were included in  
21 initially. So we, I suppose, in that way it allowed us  
22 to refocus on the EIP pathway rather than some of the  
23 responsibilities we were expected to do within the LMHT.

24 But equally we were quite a small locality, so we'd  
25 covered -- so there was five teams, so when it comes to

30

1 **Q.** You're right, someone picks up on a Monday but from  
2 a different team, not -- (*overspeaking*) --

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

4 **Q.** -- (*unclear*) meetings, passing on.

5 The EIP is commissioned to work with patients up to  
6 three years from their first EIP service. Do you think  
7 it's an appropriate service for users who may be  
8 suffering repeated psychosis and mental health issues  
9 multiple times within those three years.

10 **A.** Yes.

11 **Q.** You think it still can work for those people?

12 **A.** Within the three years?

13 **Q.** Yes.

14 **A.** Yes.

15 **Q.** If they have repeated admissions within the three years,  
16 when is it too complex to be taken on by the EIP team?

17 **A.** I don't think it is. I think we would be the right  
18 service for somebody who had repeated psychosis.  
19 I think the three years cut-off, I know that's based on  
20 evidence of the importance of working with somebody for  
21 that period of time, but some people do need longer, and  
22 other people might need less time. It really does  
23 depend on what kind of they're experiencing.

24 **Q.** You, in some of your notes, note a risk that VC was  
25 downplaying his symptoms. How do you balance what

32

1 a patient tells you compared with their physical  
2 impression and your observations during meetings with  
3 them? What weight are you giving to what they say  
4 versus what they look like? How do you assess them?

5 **A.** It's tricky. I think ultimately I suppose I try and  
6 build a therapeutic relationship with somebody in order  
7 to build that trust with people, so they might then  
8 feel, if they are feeling uncomfortable about sharing  
9 things, I would hope that I'd have that relationship  
10 eventually for them to feel like I'm somebody they can  
11 talk to about their experiences.

12 If -- I wouldn't say -- I don't take everything on  
13 face value. If somebody is telling me one thing,  
14 there's always that thing in the back of my mind, they  
15 might not realise there's another problem or there's  
16 other issues. They might be wanting to hide that from  
17 me for various reasons. So that scepticism is there,  
18 but I'd have to kind of look around and think: well,  
19 what's the other evidence that maybe is contrary to what  
20 they're telling me, in order for me to kind of do that  
21 assessment?

22 **Q.** Do you do Mental State Examinations?

23 **A.** I guess our visits, generally that -- our visits will --  
24 that is a Mental State Examination. Not in the way the  
25 doctor might do it and document it in their records from

33

1 hearing anything" and then me saying, "Okay", that's it.  
2 So there's more to it, if I can see there's some other,  
3 maybe some other things going on.

4 **Q.** When would you escalate a case to the consultant for the  
5 purposes of a Mental Health Act Assessment and suggest  
6 one was necessary?

7 **A.** I think that would be based on my assessment having been  
8 with the individual. For example, if I'd been on a home  
9 visit and I felt somebody might meet the threshold for  
10 a Mental Health Act Assessment or I had concerns about  
11 risk or there was new information that I'd received from  
12 the family and I was worried and I'd seen them, then the  
13 first port of call would be to have that discussion with  
14 the team.

15 **Q.** Have you done that frequently?

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

17 **Q.** Not in VC's case, necessarily, generally?

18 **A.** Yeah.

19 **Q.** Do you do that?

20 **A.** Yeah, I'd come back to the team base, and I wouldn't  
21 wait for MDT, it would be a case of speaking to the  
22 clinical lead or the consultant, if they're around, and  
23 then having a discussion with the Crisis Team or the  
24 AMHPs, and then coming together with a decision about  
25 what the next step would be.

35

1 an outpatient appointment, for example, but we are  
2 looking at their appearance, their behaviour, their  
3 speech, anything that seems out of ordinary that doesn't  
4 quite fit with what we might expect, then those kind of  
5 things, although on the face of it it might look like  
6 I'm visiting and just asking questions to see how they  
7 are, I think there's more going on for me in that  
8 assessment. So I think it does constitute a Mental  
9 State Examination.

10 **Q.** So if someone saying to you "Everything is good, I feel  
11 brilliant, I'm fine", what other markers might you be  
12 looking for to test that assertion?

13 **A.** I think typically there can sometimes be indications  
14 that somebody is not as well as they say they might be.  
15 Like with voice hearing experiences, someone might say,  
16 "Yeah, I've not heard anything, I'm not hearing  
17 anything", but when I look at them, objectively I can  
18 see that they might be looking around or responding, or  
19 there might be delayed responses, or they might appear  
20 a bit confused, or maybe not be following what I'm  
21 saying. So there's things that I'd probably pick up on.

22 And then if that was the case, I could say, "Well,  
23 hang on, I notice you just looked around, was it because  
24 you heard something?" and that would open up that  
25 conversation, rather than them just saying, "I'm not

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1 So I suppose it's more of a -- for me, it's like  
2 a suggestion based on what I'd seen that things have  
3 changed and we need a bit more of a closer, thorough  
4 assessment.

5 **Q.** Would you ever do that in circumstances where you were  
6 worried the person was a risk to the public, to the  
7 safety of other people?

8 **A.** Yes, yes. Obviously if I thought there was an immediate  
9 risk, I suppose that would be preceded by contacting the  
10 police, if that makes sense. So it depends on --

11 **Q.** So it would need to be immediate for you, if there's an  
12 immediate risk --

13 **A.** Yes.

14 **Q.** -- you'd consider contacting the police?

15 **A.** Yes, yeah.

16 **Q.** When a patient who you are working with in the community  
17 is detained in hospital for a period of admission, is  
18 there a process or any guideline for you to follow in  
19 terms of how you stay in contact with that patient while  
20 they're an inpatient?

21 **A.** I think the guidelines are just around the continuity of  
22 care, so me continuing to liaise with the person, the  
23 family, if appropriate, and the ward. So still being  
24 involved. It's not a case of: well, they're in  
25 hospital. You know, I can leave that for a bit. It's

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1 been part of the planning, especially around discharge  
 2 when it gets to that point.  
 3 **Q.** It's important, isn't it, for discharge for the  
 4 continuity of understanding, apart from anything else,  
 5 between for inpatient teams and the Community Team.  
 6 **A.** Yes, yeah.  
 7 **Q.** What do you do if there are circumstances where you  
 8 disagree with the inpatient discharge in any way?  
 9 **A.** We can raise that. I can raise that, or I can speak to  
 10 my team, my MDT, and then that can be escalated via  
 11 management, for example, with the ward.  
 12 So if there was -- and that kind of -- there can be,  
 13 there can be differences of opinions on what care plan  
 14 is best when somebody is in hospital and then what might  
 15 be best when they're out of hospital. That's not  
 16 unusual. But that's something we would discuss and then  
 17 escalate, if necessary.  
 18 **Q.** When you say it's not unusual, why isn't it unusual?  
 19 **A.** I think we obviously -- we have a different relationship  
 20 with the patient in the community than we might when  
 21 they're an inpatient. And then obviously they see  
 22 things that we wouldn't necessarily see, and vice versa.  
 23 So I suppose it's us feeding in, into their knowledge  
 24 about what it's like managing somebody with A, B and C  
 25 difficulties in the community.

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1 document, page 64. It's a 72-hour review for VC in  
 2 July 2020, and you'll no doubt have followed this, will  
 3 be aware of this. "Patient comments", and it's  
 4 Dr Seedat observing: "... there seems to be no insight  
 5 or remorse" in the top paragraph under "Patient  
 6 Comments":  
 7 "... and that the danger is this will happen again  
 8 and perhaps [VC] will end up killing someone. [VC] ...  
 9 responds by saying 'it will not happen again'. Police  
 10 are not intending to press charges."  
 11 Did you see that or review that note at the time  
 12 when you first were working with VC?  
 13 **A.** I don't recall read -- I don't recall reading it at that  
 14 time, but I will have read it because I --  
 15 **Q.** You will have read it?  
 16 **A.** Yeah, I think.  
 17 **Q.** If you had read it, would that concern you in any way?  
 18 **A.** The bit about --  
 19 **Q.** Yes.  
 20 **A.** -- all of that paragraph?  
 21 **Q.** Yes. How would you feel about that?  
 22 **A.** Yeah, well, I guess the kind of lack of remorse and the  
 23 lack of insight would be something I take into  
 24 consideration. It wouldn't be something I'm not  
 25 familiar with, it's -- (*overspeaking*) --

39

1 **Q.** Do you think they're over-optimistic about what can be  
 2 done in the community and what community means, in  
 3 practice, for some?  
 4 **A.** I don't think so, I think they recognise there's  
 5 limitations when somebody is in the community,  
 6 especially regarding concordance with supporting  
 7 somebody with medication. I do think they acknowledge  
 8 that we're limited in what we can do around those  
 9 things.  
 10 **Q.** How much information do you get from the period of being  
 11 an inpatient; do you see the notes, access to the  
 12 records?  
 13 **A.** If they remain kind of within the Trust and they're in  
 14 hospital in Nottingham, then we obviously have access to  
 15 all the RiO records, and then we read the entries when  
 16 they're in. I might check it, like, every day to see  
 17 what's been happening. Obviously when they're out of  
 18 area we don't have access.  
 19 **Q.** When you take a patient on, you look at the records, do  
 20 you --  
 21 **A.** Yeah.  
 22 **Q.** -- you see what's written about them?  
 23 **A.** Yeah.  
 24 **Q.** Can I ask you if you saw this and if it was significant  
 25 to you in any way, if you did. It's a NHFT0000168

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1 **Q.** Would you be concerned about the observation that he  
 2 could perhaps end up killing someone?  
 3 **A.** Yes, yeah.  
 4 **Q.** Can we have a look, please, at page 21 of the same,  
 5 NHFT0000168, and this is a summary of text prepared by  
 6 Dr Seedat, 3 June 2020. He says in the text, if we can  
 7 highlight from that, please, through to the end of "He  
 8 comments", that paragraph as well.  
 9 So he's setting out here text. Just reading that,  
 10 reading that at the time, is there anything about those  
 11 texts:  
 12 "... telling my thoughts to someone else. He said  
 13 the people would not mock him ... and made some remark  
 14 ... wanting to hurt these people he was hearing."  
 15 Would that concern you in any particular way, the  
 16 way that's set out, or not?  
 17 **A.** It's -- I would say it's important to note, yeah.  
 18 I think it gives some idea about what VC might have been  
 19 experiencing. But it's not unusual for those kind of  
 20 things to be said when someone is psychotic. So it's  
 21 not like it's completely out of the realms of what I'd  
 22 expect somebody to say.  
 23 **Q.** And we see at the second paragraph under "In Summary":  
 24 "Clear evidence of auditory hallucinations 3rd  
 25 person, passivity and persecutory delusional beliefs ...

40

1 suggest[s] more of a functional illness rather than it  
2 being precipitated by stress or isolation."

3 Would you have read that, that it seems more  
4 suggestive of a functional illness?

5 A. Yes.

6 Q. You read that at the time?

7 A. Yes.

8 Q. We know from texts that Dr Seedat was sent that there  
9 were other texts that were not summarised in this  
10 document --

11 A. Yes.

12 Q. -- where VC had made reference to "breaking their heads  
13 with my hands, had the darkest thoughts [I]... could  
14 [have] imagine[d]", refers to feeling immense anger and  
15 hatred and thinking about "red rum". You didn't know  
16 about those texts, presumably, at the time?

17 A. No.

18 Q. Have you read about them since? I don't know if you've  
19 been following the Inquiry or not, but have you read  
20 those texts --

21 A. I have seen them, yes, yeah.

22 Q. You've seen the document, haven't you, as well?

23 A. Yes.

24 Q. We sent you that. Would that have been interest to you  
25 to know what that document said?

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1 this and the nursing team update. Can you see at the  
2 bottom? If you can highlight that.

3 A. Yes.

4 Q. The bottom paragraph, how VC was "chaotic on the ward",  
5 "responding to unseen stimuli", "been running around the  
6 ward listening into the walls ... peering into rooms  
7 around the ward", "kicking doors trying to get into  
8 different rooms ... stating he can here a woman who  
9 needs help and is locked in a room", "been shouting" his  
10 mother's name "asking what she was saying".

11 He's "nursed on 1:1 eyesight observations due to  
12 chaotic presentation", and needing "to be restrained  
13 because verbal de-escalation was not working ... causing  
14 damage to a door trying to get off the ward."

15 Very unwell, and requiring restraint; is that what  
16 you would deduce from that?

17 A. Yes, Yes.

18 Q. We see from page 2, at the top, "refused physical  
19 observations", "been suspicious of the equipment ...  
20 staff did manage to get a temperature reading on  
21 admission ... have also managed to monitor  
22 respirations."

23 "Referral to LMHT EIP pathway to support [him] ..."

24 A. Yes.

25 Q. We also see, please, if we have 168, page 45. 15 June,

43

1 A. Yes, I think -- yes, I think seeing it in that format  
2 from the individual in that text kind of --

3 Q. Mm, exchange.

4 A. -- format, yeah, it was -- it's -- I think it gives  
5 a good insight into what that person's experiencing.

6 Because obviously we can summarise ourselves, as  
7 healthcare professionals, what that is, medically,  
8 I guess, symptom-wise, but I think seeing it it just  
9 gives you a little bit more -- a little bit more context  
10 about it, and the nuances in the messages and where it  
11 was kind of going. I think that's quite useful to see.

12 Q. We know he'd seen a video or talked about a video of  
13 capital punishment. These matters, were you aware of  
14 them or did you get a sense of where his thoughts were,  
15 right from this first admission?

16 A. Not to that degree, no, I don't think so. I could see  
17 that there was psychosis and that what we would normally  
18 expect with somebody experiencing a first episode, but  
19 maybe not the level of, I suppose, like the anger and  
20 the frustration and the feelings that I could see in the  
21 text messages, maybe hadn't come across there.

22 Q. That can come down, please.

23 Can we have WITN0196002, page 1. This is the  
24 referral letter to the Local Mental Health Team sent on  
25 9 June 2020. And I'm assuming, Ms Birtles, you did see

42

1 Dr Seedat clarifying the discharge plan.

2 Page 45, if we can highlight:

3 "Explained ... this presence not isolated, appears  
4 to be going towards an illness. Dr Seedat explained ...  
5 VC and the family have not taken the news very well."

6 Did you see that, and did you understand that?

7 A. Yes, I think so, yeah.

8 Q. When you say you think so, did you understand --  
9 (*overspeaking*) --

10 A. Regarding seeing it, I will have -- it's just I don't  
11 have the recollection of actually reading it or when  
12 I read it, but I will have read it.

13 Q. What's being highlighted there is that the patient is  
14 finding this really difficult, and his family.

15 A. Yes.

16 Q. And the presentation isn't isolated, going towards  
17 a functional illness.

18 A. (*Witness nodded*).

19 Q. Were you aware that by July he had said "likely  
20 diagnosis, paranoid schizophrenia"?

21 A. Yes, from the records, yes.

22 Q. And did you, from the records, ascertain this is what he  
23 was referring to here, this is where it was going?

24 A. Yes.

25 Q. This was really serious, wasn't it, from the patient's

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1 perspective --

2 **A.** Yes.

3 **Q.** -- and the family?

4 **A.** Yes.

5 **Q.** Just so we're clear, why is it so significant that

6 that's what he was identifying, as opposed to an early

7 episode of psychosis?

8 **A.** He was -- I guess he was suggesting this is potentially

9 more longer term or, like with schizophrenia, that the

10 level of symptoms and things, it wouldn't be one

11 episode, he's recovered. This is where we're at, this

12 is thinking about this as a longer picture.

13 **Q.** Did you take that understanding on as the care

14 coordinator? This wasn't going to be one of those cases

15 that we've heard about where he could have an early

16 episode, it resolves and it doesn't return. That wasn't

17 the situation you were being presented with, looking at

18 this, was it?

19 **A.** No, not -- no.

20 **Q.** If we go to NHFT0000168, page 53, please. This is your

21 first meeting, 30 June. You do a joint meeting.

22 I think you've introduced yourself, if we see at 26 June

23 over telephone to introduce yourself earlier, and on

24 30 June you go, in attendance, I think, with Daisy

25 Coleman?

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1 contacted the GP and they haven't got back to me yet".

2 So I suppose in that sense he didn't come across like he

3 was worried about how he'd get hold of that medication.

4 But with some people that wouldn't worry them, so, yeah,

5 it's difficult to know what was driving it at the time,

6 but I did notice.

7 **Q.** You say there:

8 "There are some concerns that [VC] may play down

9 some of his symptoms."

10 Was that from your reading of the notes or that

11 meeting that made you say that?

12 **A.** I think that's from reading of the notes, because I know

13 people had said it previously in the admissions and when

14 he was seen by Street Triage.

15 **Q.** So if we go to page 55, that's NHFT0000168, 55, we see 9

16 July, second box, VC is telling you everything was good:

17 "... going through his studies and had been out for

18 a run. ... usually likes to go to the gym and looking

19 forward to these reopening."

20 Just on that point, were you aware whether he had an

21 interest in physical fitness, in particular lifting

22 weights and staying fit?

23 **A.** No, I think at that -- no, I think that was just what he

24 told me about the gym, he just liked to go to the gym.

25 **Q.** Over your time of seeing him, did he get stronger and

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1 **A.** Yeah.

2 **Q.** If we see the notes on page 54 at the top:

3 "[VC] stated ... everything was okay ... felt okay

4 being back at the flat after his admission."

5 And if we go towards the end of that next larger

6 paragraph:

7 "... doesn't feel he has experienced any side

8 effects from the Aripiprazole.

9 "He believes he has couple of doses left but didn't

10 appear clear on how he was going to ensure he gets

11 a further supply."

12 That's already suggesting, isn't it, a lack of

13 insight and potential problem with medication

14 concordance, isn't it?

15 **A.** Yes, and I think I thought that at the time as well.

16 **Q.** Did you? So you assessed the fact that he didn't seem

17 to have arrangements for medication in such a serious

18 situation, you've been discharged, you're supposed to be

19 on medication. Right from the off, this was a red flag;

20 do you agree?

21 **A.** Yes, because I think if I compare it to somebody else

22 I might be working with, some people might be more

23 anxious about how they're going to get their medication.

24 Other people might not, but some people might be "Can

25 you let me know how I get it?" You know, and "I've

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1 fitter in the way people do when they embark on fitness

2 programmes?

3 **A.** Not that I would have noticed.

4 **Q.** So no different from the beginning, from your

5 perspective?

6 **A.** Not from my perspective, no.

7 **Q.** 11 July, we see the next box below:

8 "[VC's] mother ... called and asked to speak to

9 someone."

10 Halfway down the first paragraph:

11 "... she thinks [VC] may not be taking his

12 medication as prescribed, she was asking for an update

13 on [VC's] care."

14 This is really significant, isn't it, when you get

15 that kind of information from a concerned family member;

16 do you agree?

17 **A.** Yeah.

18 **Q.** You say, this not actually you, it's Mr Jackson, isn't

19 it, who's recording:

20 "... I could not discuss [VC's] care without his

21 consent"?

22 **A.** Yes.

23 **Q.** It's your colleague who takes that call?

24 **A.** I think that's the Crisis Team.

25 **Q.** Yeah.

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1 A. Yeah.

2 Q. So you see that record. Did you speak to VC's mother?

3 Well, we know you did. So when did you first speak to

4 her to get consent around discussing issues about VC?

5 A. I would have spoken to VC at some point around -- at

6 this point, I would have explained the situation with

7 carer contact. It's usually when I first meet people,

8 I'll explain around confidentiality, just as part of the

9 initial appointments, really. So -- and he was okay

10 with that at that point.

11 Q. He was okay with you speaking with his mother?

12 A. Yeah, it was only later he withdrew that.

13 Q. We'll come to that. This is the call that the Crisis

14 Team takes and you say this, you didn't pick that up

15 until over the weekend.

16 We know if we go to page 56, NHFT0000168/56,

17 14 July, there's another episode, isn't there, where VC

18 is breaking or attempting to break into a property at

19 Brook Court and has to be restrained by three residents.

20 Do we see 14 July?

21 A. Yeah.

22 Q. "The Police were contacted [top paragraph] by residents

23 ... [he's] been banging on the door and when someone

24 opened it, he immediately forced his way in, attempting

25 to push past the resident. [Happens to have been]

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1 can't always recall if it was raised; is that right?

2 A. Yeah, I generally -- I discuss medication at every

3 visit, really. So I suppose it's -- it is routine.

4 I'll be asking how people are getting on with it, to see

5 if there's any change in what they're feeling around it.

6 Q. So you do check in with them about it, but you don't

7 always necessarily note anything about it?

8 A. Yeah.

9 MS LANGDALE: Chair, that's probably a good time for the

10 morning 15-minute break, I think.

11 THE CHAIR: Yes.

12 All right. Well, we'll break there, Ms Birtles, and

13 come back at 11.35. Thank you.

14 (11.21 am)

15 (A short break)

16 (11.35 am)

17 MS LANGDALE: Ms Birtles, we were at 14 July and if we can

18 have NHFT0000168, page 57, please. We've already looked

19 at the document that showed what happened on that

20 evening, and we know that VC was arrested and

21 subsequently detained, and you make a telephone call to

22 VC's mum, halfway down the page, and she's upset:

23 "... [VC] had become unwell again and she had

24 noticed some 'red flags' [at] ... the weekend during

25 a call ... [she's] unsure whether [VC] has been taking

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1 restrained ... by a number of residents ..."

2 But from your perspective when looking at that, that

3 is very serious conduct, isn't it, because he doesn't

4 know who is behind the door, they don't know who he is.

5 This is really serious behaviour, isn't it?

6 A. Yes.

7 Q. With consequences that we already know: somebody has

8 jumped out of a first-floor window injuring their back?

9 A. Yes.

10 Q. So when you read that record, were you concerned that he

11 had been back there again and done that?

12 A. Yes, I think obviously it was similar to the previous

13 incident, so I suppose it fits that he was perhaps still

14 unwell.

15 Q. We see:

16 "A box of his Aripiprazole had been obtained by

17 Police and there was one 14 tablet strip left."

18 So your concerns on that first meeting, immediately

19 borne out, confirmation of non-concordance, wasn't

20 there?

21 A. Yeah.

22 Q. Straight from the off.

23 A. Yeah.

24 Q. On a number of visits to VC you note that you don't

25 document whether you asked about medication, so you

50

1 his medication despite calling him everyday to prompt

2 him. She believes he may mask some of his symptoms and

3 has denied that he is experiencing any auditory

4 hallucinations."

5 So she's pointing out two things very early on,

6 isn't she: ability to mask. What it did you understand

7 by that? Masking or denying symptoms?

8 A. Whether he had been -- (*overspeaking*) -- at that point

9 he's denied things to Mum and maybe not been on --

10 I think she was worried he wasn't honest with us about

11 his experiences still.

12 Q. Did she use that word: not "honest" with her, probably

13 not honest with you?

14 Because we see all of these masking symptoms but to

15 a layperson it's not telling you what's going on, it's

16 not being honest, not being frank.

17 A. I don't remember using that particular word as such, but

18 I think from what I've written there, I think that's

19 what she was implying around that.

20 Q. So in terms of your approach as his care coordinator,

21 did that influence you about how you might approach VC?

22 A. Yeah, I guess the fact that this could be happening

23 would always be in the back of my mind and was always in

24 the back of my mind that potentially he wasn't sharing

25 ongoing symptoms, and feeling comfortable sharing them,

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1 for whatever reason. So that would be there and part of  
2 my assessment would be trying to elicit if there's still  
3 symptomology, are the symptoms there for him and how  
4 they might be impacting him.

5 **Q.** And what kind of training have you had for that  
6 situation? We've heard a lot in this Inquiry about the  
7 importance of the therapeutic relationship or the  
8 therapeutic alliance, building a rapport with patients  
9 and the like. What training have you had about where  
10 the balance is with that and actually getting accurate  
11 information?

12 **A.** I wouldn't say we've had specific training around how --  
13 because it was very difficult. I don't think there's  
14 necessarily an answer on how you kind of get that  
15 information, if somebody is not sharing it. It's quite  
16 a-- almost quite a creative process, trying to build  
17 that relationship and then, like I said before, you  
18 would hope that they would feel comfortable sharing what  
19 they're experiencing.

20 But I know people can not share for a number of  
21 different reasons, and I don't think I really at that  
22 point knew why he wouldn't be sharing it, or what the  
23 reasoning behind it was.

24 **Q.** Sorry --

25 **A.** I was just going to say, the -- I think the training

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1 of what that -- what the reason behind why somebody  
2 might not be sharing it. But unless they're admitting  
3 to not sharing it, it's difficult to know for sure and  
4 a lot of that will be kind of guesswork on my part,  
5 piecing together what I do know, to try to work out why  
6 somebody might not feel comfortable sharing.

7 **Q.** And the point about masking is whether you know they're  
8 hearing voices still. So he's not sharing with you, so  
9 do you know if he's hearing voices or not?

10 Regardless --

11 **A.** No --

12 **Q.** -- regardless of the reasons for not sharing.

13 **A.** No, not unless I can see it (*unclear*) in that he might  
14 be responding -- again it's a bit of guesswork but if  
15 somebody looks like they're responding to something  
16 that's not in the room and might be looking around, that  
17 sometimes that can be an indication that they are, and  
18 then that might prompt a discussion about that. But if  
19 I'm not seeing things like that, then it's -- and  
20 they're denying it, it's very difficult to know what  
21 they're experiencing.

22 **Q.** Well, VC's mum in this entry is saying he may mask  
23 symptoms, he's denying he's experiencing auditory  
24 hallucinations. She's telling you that. She's not  
25 a mental health nurse, she's also a nurse, isn't she?

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1 around voices and voice experiences and that, talking to  
2 people about voices and voice experiences is fine as  
3 long as they're sharing it. I think it's the bit where  
4 you're trying to get that information in the first place  
5 that's the difficult bit and I don't know whether  
6 there's necessarily an answer on how you do that. It  
7 depends on the person and the relationship. The  
8 therapeutic relationship is important in that, I think.

9 **Q.** And when you say "the reasons", what are the potential  
10 reasons? And does the reason for not sharing it make  
11 any difference in terms of the treatment required?

12 **A.** Possibly. I think -- I kept a bit of an open mind about  
13 why he might have not wanted to talk about what he was  
14 experiencing. Some people are very embarrassed about  
15 what they're experiencing or have experienced, and what  
16 they did when they were poorly, and it can be quite  
17 difficult.

18 Some people are frightened about what the  
19 implications might be if they share things, especially  
20 if they've been to hospital before. Some people might  
21 not think that what they're experiencing is even an  
22 issue, and this is kind of normal, or they might just  
23 desperately want it to go away and be trying to  
24 ignore it.

25 So I think there's -- it's -- I try and get a sense

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1 And she's saying he's denying it, she's concerned that  
2 he's denying it.

3 **A.** Mm.

4 **Q.** Yes?

5 **A.** Yes.

6 **Q.** So did that raise your level of concern? You are only  
7 concerned because you think someone's still hearing  
8 them, don't you, you're worried they're hearing them and  
9 they're not telling you that you're hearing them.

10 **A.** Yes, but I think it wouldn't be uncommon for somebody to  
11 still be hearing voices after they've come out of  
12 hospital and when they're in the community and even when  
13 they're on treatment.

14 **Q.** When they're on treatment?

15 **A.** Yeah.

16 **Q.** Because you had concerns about treatment. We've gone  
17 from the off, didn't you, whether he was taking  
18 treatment?

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

20 **Q.** So you'd have every concern if someone was not taking  
21 treatment, that that might still be the case, wouldn't  
22 you?

23 **A.** Yes, yes. But I think it can be ongoing regardless, so  
24 it's more about what impact that -- those experiences  
25 are having on that person, what are the potential

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1 implications of that might be if they're still hearing  
2 voices. It's much easier to assess that, I guess, if  
3 they're really open about what they're experiencing.  
4 **Q.** Can we go to NHFT0000168, 79, please. This is the ward  
5 review on 21 July, and you're there via Teams, and we  
6 see top box "Family/Carers involvement", second  
7 paragraph:

8 "[VC's] mother queried about starting [VC] on  
9 a depot, [VC] said ... he doesn't think he needs to make  
10 that decision now. [And] Dr Seedat stressed to [VC's]  
11 mother ... staying in hospital won't make a difference  
12 to [VC] whilst he is well. The important thing is that  
13 he continues to take his medication on discharge."

14 Dr Mona Ahmed, an expert appointed by the CQC to do  
15 a report, gave evidence that it was striking to her that  
16 the first suggestion of adopting -- or a depot came from  
17 VC's mother and this wasn't common. Had you discussed  
18 that with her prior to the ward review or is that the  
19 first time depot was mentioned?

20 **A.** I can't remember whether I spoke to her before. But  
21 I know she's a health professional, so I know  
22 potentially she might know about those things.  
23 **Q.** Yes, so she's raised it and in the discussion you say in  
24 the middle you're "happy with the plan to go for oral  
25 tablets for now. We are going to focus on accommodation

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1 have factored into your reasoning?  
2 **A.** I think I would have considered it, but I think just  
3 explaining how I would have seen it at that point is  
4 that this would have felt quite early in the pathway and  
5 that's not something we're used to within EIP. Not to  
6 say that doesn't happen, it does, but I think I wrote  
7 for now, and I guess I must have thought that this,  
8 there must have been some kind of scepticism, but not  
9 enough for me to think a depot is the only answer now at  
10 that point.  
11 **Q.** The past is a pretty good indicator of the future, isn't  
12 it, in terms of assessing risk? It's a good place to  
13 start?  
14 **A.** Yeah, I think I saw the two episodes as one part of one  
15 episode, if that makes sense, although he'd come home in  
16 between, he'd almost, maybe he hadn't got as well as we  
17 thought he had, and this was kind of now we were seeing  
18 it was almost like we needed to see how it went going  
19 forward, whether he has one more chance to show that he  
20 can take his medication and be concordant.  
21 **Q.** Well, you knew from his last admission he'd stopped  
22 taking his medication two weeks after it --  
23 **A.** Yeah.  
24 **Q.** -- so you had the history of his previous admission.  
25 Here he is on the second admission, and Dr Seedat is

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1 ..."

2 Given what VC's mother had raised, why were you  
3 happy with the plan for oral tablets and given what you  
4 knew earlier about worries about concordance?

5 **A.** I think on reflection, it was -- from what we knew at  
6 the time, it was, albeit he'd been -- he was clearly  
7 poorly at that point and had these two admissions in  
8 very short succession. I'm thinking of the EIP pathway,  
9 he's still quite early on within the pathway. So  
10 I would, in my experience, it's more unusual that  
11 somebody might be on a depot that early on, despite the  
12 fact that there was some issue with concordance, in  
13 between the two admissions. So I think that's probably  
14 why it was focusing on, like, the kind of least  
15 restrictive treatment at that point and what was felt  
16 appropriate at that point because we were only a couple  
17 of months into working with him.

18 **Q.** The least restrictive principle doesn't trump safety of  
19 others, does it?

20 **A.** No.

21 **Q.** The difference for this patient, who was non-concordant,  
22 you knew of the events and harm he had caused at Brook  
23 Court to neighbours, yes?

24 **A.** Yes.

25 **Q.** So didn't that factor into your reasoning, or should it

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1 saying in the last paragraph:

2 "... explained to [VC] ... his view ... if he had  
3 not stopped taking his medication, he probably would not  
4 be here again. [VC] understands ... he must take his  
5 medication regularly. It was explained that [it would]  
6 be followed up by both the LMHT and Crisis."

7 So really serious, not just for him, but for the  
8 impact he's had on others at this stage. We've had  
9 somebody who has had back surgery, we've had three  
10 people who have been able to restrain him, but it's  
11 quite clear from the 999 call they've had enough, with  
12 him going round to the premises.

13 Do you think that his impact of his conduct on  
14 others wasn't fully appreciated in this ward review?

15 **A.** Um --

16 **Q.** Not just by yourself, generally. The impact that he was  
17 having on others, untreated in the community?

18 **A.** I guess, knowing what we know now, it would seem that  
19 way, the severity of what happened, it was almost: oh  
20 well, we'll let this individual have another chance to  
21 demonstrate they can do it, almost.

22 **Q.** So it was all about him, not about the Brook Court  
23 residents? There's no voice in here representing how it  
24 had been for other neighbours?

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

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1 Q. He posed a risk to neighbours, he was causing serious  
2 upset to neighbours and serious injury to one of them,  
3 and this doesn't feature in the reasoning when VC's  
4 mother reasonably queries a depot?  
5 A. Yes.  
6 Q. Do you think that the fact it wasn't just she'd raised  
7 a depot and the logic with the first admission, but that  
8 she was his mother raising that, wasn't afforded the  
9 respect it should have been in that meeting? Dr Seedat,  
10 we see what he says in response "Won't make a difference  
11 whilst he's well."  
12 We see later on you support oral tablets. It goes  
13 away, doesn't it, the depot, where if other  
14 professionals had supported that, it may have been  
15 different.  
16 A. Yeah, possibly. I think, yeah, um -- yeah, I think we  
17 possibly focused a lot on his opportunity to take the  
18 tablets again and to demonstrate that he can do it.  
19 Q. His autonomy, least restrictive principle. We're  
20 hearing that a lot. We know why it's there, but it  
21 doesn't seem to take into account the need for safety,  
22 does it, and the protection of others?  
23 A. Not from the way you're reading it there, no.  
24 Q. Well, you say the way I'm reading it. Please correct me  
25 if I'm wrong and it's important you have the time to see

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1 assessment document, perhaps not so much, but the risk  
2 assessment is reviewed within the MDT records, but as  
3 a risk assessment document, you know, I appreciate that  
4 should have been done when he was discharged. I think  
5 it's important to do that when he's discharged. And  
6 then obviously update it if there's any changes  
7 within -- within the following year (*unclear*) the  
8 importance of that.  
9 Q. If we look at page 3, "Risk factors and Safety Plan",  
10 under "Others":  
11 "he believed others were trying to control him/spy  
12 on him/torment his mind ... has broken into his  
13 neighbours' flats multiple times to confront them, there  
14 have been no incidents of violence yet but this would be  
15 a potential concern if acutely unwell."  
16 Then it says:  
17 "One of his neighbours jumped out of her window as a  
18 result of fear and severely injured her back."  
19 No incidents of violence, clearly that's a slight  
20 contradiction with what is stated later, but in any  
21 event both misstate the position in terms of impact on  
22 others; would you agree?  
23 A. Yes.  
24 Q. And it does record it "would be a potential concern if  
25 acutely unwell". There's no attempt within this

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1 the document. We can see what happened everybody says,  
2 and apart from his mother, no one is going down the  
3 route that he really needs treatment now, he's been  
4 sectioned twice, he's caused harm, the police have been  
5 called out, he needs treatment?  
6 A. Yeah.  
7 Q. Can we have, please, the discharge summary, NHFT0000222.  
8 This the discharge summary on 31 July after that second  
9 admission. I think you perfectly candidly state you  
10 didn't update risk assessments on discharge. You should  
11 have done, shouldn't you? That was the purpose --  
12 A. Yeah.  
13 Q. -- of these documents, and it's a constant theme here  
14 that recordkeeping and risk assessments are poor and  
15 virtually non-existent. Not just in the community, in  
16 the Trust as well. Do you agree with that at the outset  
17 that the way risk assessment is completed and where we  
18 find assessment of risk is inadequate?  
19 A. Yes, I would agree with that.  
20 Q. Has that improved, as far as you're aware?  
21 A. I think there's more support around auditing risk  
22 assessments and making sure they're updated, and  
23 healthcare professionals are instructed when something  
24 might be out of date.  
25 I think we do review whether it's put on the risk

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1 assessment to consider what would happen if he became  
2 unwell, is there? What to do, quickly?  
3 A. Um --  
4 Q. In the community?  
5 A. Not in that part, no, no.  
6 Q. But there were serious concerns about him in the  
7 community, just if we read this, isn't there -- even as  
8 it has been expressed, "would be of potential concern if  
9 acutely unwell."  
10 A. Yes, based on what happened before, yeah.  
11 Q. Did you consider a forensic services referral at this  
12 time?  
13 A. No, I mean I've reflected on that a lot. I don't recall  
14 ever having a conversation or a consideration for that  
15 at this point, or I don't think any point that I was  
16 working with VC, and whether that -- I don't have any  
17 recollection of that being discussed in MDT or any --  
18 during any admission.  
19 Q. Because events had been triggered, hadn't they,  
20 assessments because of call-outs to the police?  
21 A. Yes.  
22 Q. Emergency call-outs. Obviously he hadn't got  
23 a conviction at that point, but have you had patients  
24 where you've been sufficiently concerned to refer to  
25 forensics or to at least discuss with the Consultant

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1 Psychiatrist whether you should?

2 **A.** Yes, Yes.

3 **Q.** Did you discuss that with Dr Lloyd at any point?

4 **A.** Not that I remember, no.

5 **Q.** Why was that?

6 **A.** Um, I honestly don't know why that wasn't discussed as  
7 a potential option, even if he hadn't met the threshold  
8 for forensic input from the service, I guess we could  
9 have had a conversation with them. But I'm not --  
10 I don't know why, at that point, that wasn't considered.

11 **Q.** That admission was only 14-31 July, wasn't it? Were you  
12 concerned at the length of that admission?

13 **A.** I think I remember -- I think I wrote in my statement,  
14 I remember thinking: goodness, this is fairly short.  
15 But again, it's not unusual for people to have a fairly  
16 short admission if they're improving, and they're no  
17 longer experiencing any symptoms.

18 So it's not uncommon but I probably do remember  
19 thinking: oh, he's home already.

20 **Q.** Can we go, please, to NHFT0000168, page 126. And this  
21 is you returning a call to his mother on 6 August. And  
22 if we can mark up the second box, please, at the end.  
23 "During the admission [VC] spoke of his concern ..."  
24 We don't need the date of that, thanks, just the box  
25 itself.

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1 and lots of people might come out of hospital and think  
2 "Actually, I'm feeling better now, I don't necessarily  
3 need this medication," despite doctors often talking  
4 about the length of time somebody might need to take  
5 medication.

6 So I think it's -- it's not necessarily around the  
7 denial; it's potentially he wants to come off and live  
8 a normal life not on medication, which again, lots of  
9 people will say that after their first admission.  
10 That's quite -- something we often expect.

11 **Q.** So even if a patient has insight you still have to be  
12 concerned about whether they're going to take  
13 medication.

14 **A.** Yes, yeah.

15 **Q.** In this case there was no insight and he wasn't taking  
16 medication.

17 **A.** Well, I didn't have -- I had concrete evidence with the  
18 medication that was found between the two admissions but  
19 I think obviously, coming back out the second time,  
20 I don't have at that point have confirmation that he  
21 wasn't taking it. But obviously I was aware that this  
22 was Mum's impression and we needed to be mindful of it.

23 Lots of people do feel better and then just think: I  
24 don't need to take it anymore, within the first few  
25 months or weeks.

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1 "During the admission [VC] spoke of his concern that  
2 he isn't where he expected to be at 28 years of age,  
3 comparing himself to peers and siblings. Celeste has  
4 offered [VC] reassurance about this however she believes  
5 that coming out of hospital on the first occasion he  
6 stopped the medication to try to prove he could lead  
7 a normal life off medication. There is therefore a risk  
8 this could happen again."

9 Again, a significant contribution to your  
10 understanding of this patient, wasn't it?

11 **A.** Yeah, that's quite useful. I think family members know  
12 their loved ones best. So I think that's important, to  
13 acknowledge that that's their impression of maybe how,  
14 you know, their loved one would feel about us being in  
15 hospital and how that would affect their identity going  
16 forward. So that's really -- it is really useful.

17 **Q.** It means they're in denial, they don't want to take  
18 their medication as well, doesn't it? So in practice,  
19 that is informing your understanding of the likelihood  
20 of him taking medication, isn't it?

21 **A.** Yes, but I think -- I mean I wouldn't necessarily say he  
22 was -- I know there was issues with him not agreeing  
23 with the diagnosis, but again, lots of people might just  
24 come out of hospital and think that was just a blip, for  
25 example, albeit we might view it slightly differently,

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1 **Q.** NHFT0000202, page 1, the summary and the care plan, so  
2 your responsibility to draw the care plan together and  
3 this is 1 September 2020.

4 Underneath "Diagnosis" it didn't include, did it,  
5 paranoid schizophrenia? Why not? Because that was the  
6 diagnosis by then, wasn't it: functional and most likely  
7 paranoid schizophrenia?

8 **A.** Yes, that could have been in there -- yes, it wasn't.

9 **Q.** If it should have been, shouldn't it?

10 **A.** Yes.

11 **Q.** Are you aware, we've heard expert evidence from  
12 Professor Fazel, of the association, greater association  
13 with risks of violence for those with paranoid  
14 schizophrenia?

15 **A.** Yeah, I was aware there was a risk, but yeah, I guess it  
16 was interesting to hear the experts' view on that as  
17 well.

18 **Q.** Greater for men --

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

20 **Q.** -- and particularly younger men.

21 **A.** Yeah.

22 **Q.** So seeing that diagnoses, understanding association of  
23 risks, and knowing it was interactions with the police  
24 leading to the Mental Health Act Assessments, it's  
25 important in the care plan for that to be right up at

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- 1 the front, isn't it, for people to know and have the  
2 benefit of their understanding of that diagnosis?  
3 **A.** Yes, Yes.  
4 **Q.** So why wasn't it in there?  
5 **A.** Again, I've reflected on this a great deal. I think --  
6 I don't know why I didn't at that time put a diagnosis  
7 on there. I think the working within the EIP, we work  
8 with diagnostic uncertainty, although I can appreciate  
9 that Dr Seedat had formulated a kind of working  
10 diagnosis, and that's why we could have written that in  
11 there as kind of the working diagnosis and this is what  
12 we were thinking. I don't know why I wouldn't  
13 necessarily -- I wouldn't have put that in there. It  
14 wasn't a denial of the diagnosis or a disagreement about  
15 it or anything like that. I don't know. I think --  
16 **Q.** Did you think stigma or shame attached to it and  
17 therefore you didn't want to put that -- (*overspeaking*)  
18 --  
19 **A.** I guess, reflecting myself, that is something I'm  
20 conscious of and I'm aware of. And I know about how  
21 that might be perceived when people read that. But  
22 I was also aware that he'd been spoken to about that, so  
23 it wasn't coming out of nowhere. So --  
24 **Q.** Would he see the care plan?  
25 **A.** Yes.

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- 1 paragraph under "Care Plan Details":  
2 "Ongoing monitoring of mood and mental state."  
3 "For mental health services to remain an assertive  
4 approach in continuing to work with [VC]."  
5 What do you mean by "assertive approach"?  
6 **A.** I guess it's one of the principles of EIP that we'll try  
7 and, if there's some difficulties around engagement, be  
8 flexible and creative in how we might work with somebody  
9 who might be having difficulties identifying that there  
10 might be issues, for example. And it's knowing your  
11 patient, knowing what -- why they might be behaving  
12 a certain way and then knowing how you can assertively  
13 engage them without pushing them away too far; that  
14 balance between engagement and building that  
15 relationship.  
16 So it's generally how -- it's not a case of "Oh  
17 we'll pick somebody up" and then we'll not see them for  
18 a while. It's an assertive approach --  
19 (*overspeaking*) --  
20 **Q.** It's about meeting them.  
21 **A.** -- contact and seeing them regularly, and keeping an eye  
22 on how things are.  
23 **Q.** The Inquiry has heard evidence about something called  
24 Assertive Outreach, which is different from what you're  
25 describing, which involves seeing patients flexibly

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- 1 **Q.** So you'd be worried about him reading that and being  
2 stigmatised by that, or you -- (*overspeaking*) --  
3 **A.** I think -- that's not -- I don't think that's why  
4 I didn't write it because, like I said, he had had those  
5 discussions, from what I could see, on the ward. But  
6 whether that was something in me that at the time that  
7 I felt it wasn't comfortable but, I mean, because of  
8 that reason, potentially, because I do -- I agree that  
9 there is a lot of stigma around the diagnosis. But  
10 I can't -- I don't know why I didn't put it on there at  
11 that point.  
12 **Q.** You say you've seen discussions around that. Do you  
13 know -- have you seen a discussion where somebody has  
14 actually told him or his mother at this point, "It's  
15 paranoid schizophrenia", that's likely the case,  
16 "a functional illness, paranoid schizophrenia"?  
17 **A.** Only from what I'd read around his discussions with  
18 Dr Seedat in the -- (*overspeaking*) --  
19 **Q.** So you'd rely on whatever Dr Seedat said to him to  
20 support that he, VC, was told that, or his mother?  
21 **A.** Yes, I didn't have a discussion with --  
22 **Q.** No.  
23 **A.** -- VC or his mum about that diagnosis. Not that I  
24 recall.  
25 **Q.** If we go to page 3, please. Second paragraph, large

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- 1 around the clock, across a whole team, a whole-team  
2 approach, and effectively where there are difficulties  
3 with medication, hitting them head on, and if needs be,  
4 applying for detention and treatment, if that's the  
5 right thing to do.  
6 You didn't do that at any stage, did you, as the EIP  
7 team? You didn't apply or suggest there should be  
8 a Mental Health Act Assessment to ensure treatment via  
9 depot, for example. You didn't take that approach to  
10 the medication issues.  
11 **A.** Well, on occasions we had to, because although we might  
12 not have had evidence he wasn't taking his medication it  
13 was clear he was unwell, so at that point it would have  
14 been escalated. But generally, just suspecting somebody  
15 might not be taking their medication wouldn't --  
16 (*overspeaking*) --  
17 **Q.** Wouldn't trigger that?  
18 **A.** (*The witness nodded*).  
19 **Q.** So if you suspected it, that wouldn't be something you  
20 would do.  
21 **A.** I guess it would depend on a lot of other things around  
22 that. If there was kind of safeguarding or risks then  
23 obviously that would inform what the action would be,  
24 but just, just a suspected or a prediction that someone  
25 might not adhere with the treatment wouldn't be enough.

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- 1 Q. You'd need to look at the safety, the safety of the  
2 person --
- 3 A. Yeah.
- 4 Q. -- the safety of others around them.
- 5 A. Yeah.
- 6 Q. Here there's a reference to rapid response as well, a  
7 "Rapid response if [VC] or family report sudden  
8 changes", in that same paragraph in the middle.
- 9 A. Yeah.
- 10 Q. What is a rapid response? What did that mean in the  
11 context of the care plan?
- 12 A. I think for me personally as the CCO it would be having  
13 contact with the person on the same day or the following  
14 day, if that allowed, with the patient, and within the  
15 restraints of the service.
- 16 So having the ability to see somebody fairly  
17 quickly, although we're not a crisis service, if there  
18 was concerns from family, or from them, it would be  
19 following it up. And I guess that's the idea of having  
20 slightly lower case loads than other Community Mental  
21 Health Teams that allows you to have that flexibility.
- 22 Q. On the next page, page 4, "Actions":  
23 "On-going monitoring of concordance due to increased  
24 risk of relapse."
- 25 A. Yes.

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- 1 medication to say, "Look, we've got concerns you're not  
2 taking medication, can you show me where it is, show me  
3 how much you're taking?"
- 4 A. Yes, that is possible but I guess it's only going to  
5 show us so much, because if they really wanted to hide  
6 the fact they weren't taking it, they could easily take  
7 it out of the box. But we can ask, but I guess it  
8 doesn't -- that still doesn't demonstrate concordance.
- 9 Q. It doesn't, but it shows you're taking it really  
10 seriously and there might be consequences.
- 11 A. Yeah.
- 12 Q. And reinforces to the patient why it's important --
- 13 A. Yeah.
- 14 Q. -- every time, if you're asking about it.
- 15 A. Yeah.
- 16 Q. If you look at who's responsible for these actions it  
17 says a list of names, VC himself of course, Dr Lloyd as  
18 the consultant, yourself and the GP. Did you know who  
19 his GP was, and what was their role? Did they see this  
20 care plan?
- 21 A. The care plan would have gone to the GP. I don't know  
22 why GPs -- I think initially the GP was prescribing but  
23 then we took over. So that wouldn't necessarily need to  
24 be on there. I don't know why that was on there. But  
25 they do get a copy, they should get a copy of the care

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- 1 Q. How was that going to be done? Underneath "Actions",  
2 the fourth bullet.
- 3 A. It's difficult. I think it's largely down to a CCO  
4 having those regular discussions about medication, every  
5 visit. We took over prescribing so it just -- that  
6 allowed us a little bit more knowledge of when he was --  
7 somebody was getting the medication, when VC was getting  
8 his medication, when he might be due, keeping an eye on  
9 that, making sure it kind of link -- like, linked up,  
10 and just having really honest discussions about their  
11 concordance and how they feel about medication.
- 12 Q. Of course getting the medication isn't the same as  
13 taking it, is it?
- 14 A. No.
- 15 Q. We know in September 2021, seven months' worth of  
16 medication was found. So that's one part of it, knowing  
17 it's being collected or obtained, but knowing whether  
18 it's taken is the crucial part.
- 19 A. Yeah, it only tells you so much, but if -- I guess if  
20 there's somebody who's not picking up or not collecting  
21 or seems to have medication left, that opens up that  
22 dialogue around well, "Why have you got some left? Have  
23 you missed some? Is there a problem with remembering to  
24 take them?" And having those kind of discussions.
- 25 Q. Would you ever ask to see somebody's supply of

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- 1 plan, yeah.
- 2 Q. You mentioned the University on the care plan too, under  
3 "Actions":  
4 "Liaise with University support services with [VC's]  
5 consent to do so."
- 6 We see later, interactions that you have with Ellie  
7 Turner. What was the role of the University's mental  
8 health advisory team, as far as you were concerned, in  
9 his case.
- 10 A. In his case?
- 11 Q. Yes.
- 12 A. I can't recall when he first liaised with the University  
13 support team. Sorry, that's difficult to know.
- 14 Q. Well, generally, then. More generally, have you dealt  
15 with the Nottingham University Mental Health Advisory  
16 Team?
- 17 A. Yes, frequently. They -- it's useful for students who  
18 are kind of suffering with mental health issues, and  
19 expected in their university experience. They're there  
20 to support them and put things in place around the  
21 education side of it. But we'll often say if we meet  
22 people and they're a university student, that we can  
23 liaise with the team if they like. Sometimes they might  
24 ask for some evidence about their mental health, and if  
25 they consent, we can pass that to the team so they're

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1 aware of what's happening.

2 **Q.** Only with consent? Do you only pass that with consent?

3 **A.** If it's not something that's related to kind of

4 a significant risk, yes. If it's just related to maybe

5 their diagnosis or details about their health, then that

6 would -- we'd want to get their consent to do that.

7 **Q.** In terms of VC, we see as matters progress, and even

8 from the point when you've been involved, that he's been

9 a risk to neighbours, a risk of causing them harm.

10 Would you, or did you, in those circumstances share

11 information with the University about the risk he posed

12 to those around him?

13 **A.** I don't think I -- I don't recall at that point I did,

14 no.

15 **Q.** Because it seems pretty astonishing that, in

16 September 2021, the University did not know about him

17 assaulting the police officer or the detention?

18 **A.** Yes.

19 **Q.** Do you find that astonishing, that they wouldn't be

20 aware of that?

21 **A.** I probably didn't realise they weren't aware of it at

22 that point. I only found out about that through the

23 Inquiry process. I don't think that had occurred to me

24 at the time.

25 **Q.** Whose job would it have been to let them know about

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1 On that subject, did you ever approach that with him;

2 what he did and the impact on others?

3 **A.** I couldn't recall -- again, that's something I've

4 thought about a lot since. I can't recall what I spoke

5 about regarding those incidents. And because there was

6 nothing in the records to say that happened, I just

7 can't remember whether -- it's unusual. We would --

8 it's unusual if I didn't, because we would normally go

9 back, with anybody, kind of go back to what was

10 happening before, how, you know, the triggers and

11 potentially what might be some of the difficulties might

12 have been, and what happened in an incident.

13 So it's unusual that I wouldn't have. But I can't

14 remember the difficulties -- I can't remember that

15 conversation or how that -- (*overspeaking*) --

16 **Q.** When we come to the social circumstances report, it's

17 clear that you're communicating to the police around

18 whether or not he has a caution that you're concerned

19 it's triggering for him to discuss those issues because

20 they're related to the time of admission. Does that

21 ring a bell for you, or shall we look at that later?

22 **A.** I think that was obviously later, as in later down the

23 pathway, so I can't remember after the first or second

24 admission what I spoke about with him, about what

25 happened in that -- (*overspeaking*) --

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1 that? Obviously the police know about it, you know

2 about it as mental health. Who should have told them?

3 **A.** Well, obviously at that point he was just an inpatient

4 in hospital, so I don't know whose responsibility that

5 would have been. I'm sorry.

6 **Q.** You then say in the care plan, page 5:

7 "Actions:

8 "Mental health services to build non-judgmental,

9 therapeutic relationship with [VC] allowing him a safe

10 space to discuss any possible past experiences."

11 What do you mean "non-judgmental"? Because some

12 behaviours need to be judged, don't they, discussed and

13 judged candidly, even if they're driven by mental

14 illness?

15 **A.** I guess we're aware of the stigma around mental health

16 conditions and how that can affect people, and it's

17 being aware of that in order to build that therapeutic

18 relationship.

19 **Q.** Part of trusting relationships is that people are able

20 to tell you the unpalatable truths and discuss them

21 openly with you?

22 **A.** (*Witness nodded*)?

23 **Q.** So there were two things here, his diagnosis and also

24 his behaviour towards others, and we've seen Dr Seedat

25 address behaviour towards others and what he says to VC.

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1 **Q.** Might you have been deflected because you thought it

2 would be triggering? Because you don't record anywhere

3 about those neighbours, what happened in the flat, the

4 woman who was injured, what he thought about that.

5 **A.** I think it was -- I don't -- I wouldn't say I would be

6 worried about raising things with people. It's not

7 something that -- I'd be mindful that it's sometimes

8 difficult for people to talk about things. And he

9 was -- I know he -- I knew he was keen on moving

10 forward, and perhaps not -- I could appreciate he didn't

11 want to talk -- not that he said he didn't want to

12 specifically talk about it, because I don't recall that,

13 but he didn't engage particularly well during

14 appointments, and offer much information, despite me

15 trying. But that -- I can't say that I didn't ask or

16 I did ask, and this is what he said because there's

17 nothing documented about that.

18 **Q.** In the end, do you agree that this care plan failed to

19 include any violence and risk management as part of his

20 ongoing treatment plan?

21 **A.** Yes, but I think a lot of it would have been -- well, it

22 should have been captured in the risk assessment.

23 **Q.** And the care plan. The summary in the care plan is the

24 plan; what are you going to do. Addressing issues of

25 insight and danger associated with his lack of insight.

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- 1 A. Yeah, I think, I guess the plan was focusing on the  
2 medication and the concordance and potentially thinking  
3 about some CBTp, and maybe that was the things that  
4 would, you know, keep risks low and have -- and in order  
5 to have those more frank discussions about what had  
6 happened.
- 7 Q. It didn't have a plan for testing for non-concordance,  
8 given the risks that arose from it, did it? It didn't  
9 have how you were going to do it, what the programme was  
10 going to be?
- 11 A. No, although I guess -- I mean, we are fairly limited in  
12 that respect. It's difficult. We're monitoring  
13 concordance, but we're not there with them every day  
14 taking the medication. I guess the plan for everybody  
15 would always be if we were told they'd stop medication  
16 or they were flatly refusing it, then we would be having  
17 discussions about what the next step would be, or  
18 whether we'd be involved with the Crisis Team or Home  
19 Treatment Team.
- 20 Q. Well, you could have, as in fact occurred later, even at  
21 this stage, suggested that the Crisis Team went out  
22 every day and watched that he took the medication, and  
23 if he didn't, there would be consequences of that.  
24 That's one way, isn't it, of in the community  
25 monitoring, close monitoring, as to medication?

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- 1 the time.
- 2 Q. Two paragraphs along:  
3 "... compliant with his medication with no reported  
4 side effects. He mentioned ... he would like to try to  
5 have a medication free trial but I reflected ... he had  
6 tried it in the past ..."
- 7 Did that request raise any red flags to you?
- 8 A. I think ... yeah, um, ... again it's something that lots  
9 of people will say. So it's not that I wouldn't take  
10 that seriously. I would -- that's an indication that  
11 somebody's perhaps thinking they might not need it or  
12 they don't want it or they're wanting to be off it  
13 sooner than we think. Because often when you say to  
14 somebody "We think you need to be on this 12 months to  
15 two years," for example, lots of -- most people are  
16 shocked by the length of time. It's not what they  
17 perhaps would have anticipated.
- 18 But I thought -- in a way, I think I thought during  
19 that appointment it was positive that he was at least  
20 letting us know what his thoughts were around  
21 medication, rather than, you know, I'll just keep  
22 continuing to take it, and then me thinking: you  
23 probably don't feel that.
- 24 So I thought, in a way it's a helpful thing because  
25 at least it opens up that discussion about well no,

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- 1 A. Yes, but that can't be done indefinitely, and the  
2 risks -- that is about -- more about preventing  
3 admission and using the concordance to get somebody well  
4 in order to, you know, not rely on an inpatient  
5 admission. So we couldn't indefinitely offer the Crisis  
6 Team. They'd have to be -- the threshold is fairly high  
7 for that involvement.
- 8 If I thought he was unwell and, you know, he was  
9 demonstrating that he was unwell and he was  
10 demonstrating risky behaviour, that is when we'd come  
11 together and have that discussion about whether we'd  
12 either do a Mental Health Act Assessment or we'd do some  
13 home treatment.
- 14 So yeah, it depends when -- there couldn't be  
15 a blanket "this is how you deal with non-concordance or  
16 suspected non-concordance".
- 17 Q. Can we have NHFT0000168/133, please, and this is 7  
18 September 2020, Dr Burri's note. We see in the sixth  
19 paragraph reference to:  
20 "There is no genetic loading for mental illness as  
21 such that he can think of."
- 22 Did you know about reported mental health concerns  
23 about VC's grandfather? He had mental health --
- 24 A. I don't know, I don't know when I knew that, whether  
25 that was before or after. I don't know what I knew at

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- 1 because we know what happened last time, and this is  
2 what our recommendation is, for you to continue for this  
3 length of time.
- 4 Q. The following month, if we go to 135, NHFT0000168, 135,  
5 top of the page. This is 9 October. Ms Parsonage takes  
6 this call.  
7 VC's mother has spoken to VC:  
8 "... he ... stated 'Don't speak to me for 2 months'.  
9 "She has ... been unable to contact him."  
10 That's a significant red flag, isn't it?
- 11 A. Yeah, that's unusual I'd say, yeah.
- 12 Q. Why not elevate the situation at this stage to the  
13 consultant and say: "We need to have a look at this.  
14 He's been asking for medication-free trials. He's asked  
15 his mother not to speak to him. She hasn't spoken to  
16 him."  
17 You knew she was a prompt in the past around  
18 medication; was that a time to get consultant input?
- 19 A. I wasn't at work at that point so I don't know whether  
20 that was discussed with Dr Lloyd at that point.
- 21 Q. You didn't --
- 22 A. Obviously I was off work, so I don't know what was  
23 discussed or with who at that point. -- (*overspeaking*)  
24 --
- 25 Q. Looking at it now, do you think that would be a really

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1 concerning call?

2 **A.** Yeah, without knowing the context it's difficult.

3 Obviously he's just said don't -- obviously we've only

4 heard that he said, "Don't speak to me for 2 months."

5 We don't know why. But that would be something that we

6 would then ask him and then have a discussion about,

7 just because it, I suppose it's out of -- from knowing

8 the family, that would be out of character for that

9 family.

10 **Q.** And you could receive that information from his mother.

11 You don't just have to ask him, do you? You can ask her

12 why he's said that.

13 **A.** Yes.

14 **Q.** Do you receive information from extended family? Even

15 if you haven't got consent to share information about

16 a patient, are you happy and willing to receive what

17 people tell you about a patient?

18 **A.** Yes, always, yeah, it's really helpful. Even if we're

19 unable to share specific details around someone's care,

20 I'll always let people know that if they're wanting to

21 share things with us --

22 **Q.** The following month, in November, we see NHFT0018155,

23 page 1. 1 and 2 can probably fit on one page. It's an

24 email that you send to Dr Burri. This is the request to

25 speak to Dr Burri. You say in the email:

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1 **Q.** Because if we look at NHFT0000168/138, paragraph 2. He

2 tells you, at paragraph 2, that:

3 "He told [the] ward doctor [that's on his admission]

4 that he no longer hears voices but he said that is not

5 the case and he only said that because he was tired for

6 being in the hospital."

7 Significant, isn't it? He's telling you he simply

8 said that for secondary gain to get out the hospital.

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

10 **Q.** So you learnt at that appointment, didn't you, that he

11 was hearing voices and, furthermore, he had said he

12 didn't hear them just to get out of hospital?

13 **A.** Yes, yes --

14 **Q.** So you knew this was somebody who knew where he wanted

15 to be and would say what suited that purpose.

16 **A.** Yes.

17 **Q.** So at that point, didn't that need serious escalation?

18 You had all the proof you needed about what he was going

19 to tell you.

20 **A.** I think we -- Dr Burri and I, from our impression, was

21 that yes, he was still experiencing symptoms with the

22 partial insight. But we -- you know, at his assessment

23 at that point was that the risks were fairly

24 contained -- well, were contained, and nothing had

25 changed in that respect. So it was a case of

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1 "He has told his mum not to call for 2 months which

2 is out of character ... spoken to his brother ... told

3 him he has something to share, but hasn't said what."

4 We know if we go to page 137, NHFT0000168, 137,

5 that's your note of the conversation.

6 "[VC] politely requested a face to face appointment

7 ... When I enquired as to why he may need a sooner

8 appointment he said he had something very important to

9 discuss."

10 Why not involve the Crisis Team, who could monitor

11 this daily for a period at this point?

12 **A.** I think at this point we didn't really know, I didn't

13 really know what -- what it kind of was indicating,

14 because it was quite a brief phone call.

15 So my first step was to get him reviewed by one of

16 our medics, to see -- that was going on kind of,

17 I suppose, a gut instinct that lots of people might ring

18 up and say, "I need to see the doctor today." It's not

19 always possible. So that -- I suppose for me that was

20 like I think this would be useful that we do facilitate

21 this appointment at this time --

22 **Q.** Sure -- *(overspeaking)* --

23 **A.** -- because he's asked for it.

24 **Q.** It's what you do next, isn't it?

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

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1 monitoring, and if anything changes then we would have

2 to consider what the next step would be.

3 **Q.** It almost appears, doesn't it, that there needs to be an

4 episode of violence to a member of the public before

5 it's escalated? That seeing these risks as they

6 develop, the flags, the emphasis where it lands here,

7 that he's going to say what he needs to say, and it's

8 a 'wait and see', see if anything happens.

9 **A.** Well, I think the hope for us is that we would -- it

10 wouldn't get to that point and we would notice a real

11 change in someone's presentation in that kind of crisis

12 point. We would get to that point and know him well

13 enough in order to put the next step in place, like you

14 said putting the Crisis Team in place at that point.

15 And it wouldn't be a case of just waiting for something

16 terrible to happen; it would be trying to manage it in

17 order to intervene when was -- when we felt it was

18 appropriate and legally we could do that, if we're

19 looking at the Mental Health Act.

20 So I, actually -- I actually felt the discussions we

21 had in that session, or the discussions he had with

22 Dr Burri, I remember feeling quite optimistic that he'd

23 been honest with us and he'd felt like he could have

24 been honest with us. So I thought that was --

25 I actually left thinking this is positive, because it's

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1 him acknowledging that he's been dishonest about it and  
2 that hopefully now this would open up some conversations  
3 about his medication, about his beliefs about his  
4 medication, and beliefs around his illness.

5 So we were aware of it, but we weren't ignoring the  
6 risks. It's being aware of them, but at that point,  
7 we -- I guess it wouldn't have met the threshold for  
8 involving the Crisis Team based on how he was presenting  
9 and the risks currently.

10 **Q.** He really sets out for you, doesn't he, a very complex  
11 set of delusional beliefs --

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

13 **Q.** -- hallucinations, how they're impacting on him. They  
14 consist of many "people from ... different departments,  
15 MI6, Police ... speak[ing] in clear words ... that he  
16 should be punished for ... crimes [he's] ... committed".

17 You haven't seen, as you gave evidence earlier, his  
18 messaging from before, that's been available since 2020,  
19 commenting on what he wants to do when he hears voices.  
20 But when you put this together, he's saying here "I'm  
21 not -- it's not the result of mental illness." Not only  
22 is this complex belief system in place and long  
23 established at this point, he's saying it's not mental  
24 illness.

25 **A.** Yeah, that was -- I think that was his interpretation

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1 **A.** Yes.

2 **Q.** Can we have, please, CPSE0000011, page 8. And this is  
3 an extract of Dr Blackwood's report, paragraph 28 when  
4 he is being:

5 "... managed by the [EIP] ... [this is an interview  
6 with VC] Community reviews typically took place with  
7 his care coordinator Claudia Birtles and psychiatrist  
8 Dr Lloyd (or her trainees). He told me that he had  
9 stopped taking his medication in October 2020 because  
10 voices told him so to do. However, in a clinic review  
11 in December 2020 with Dr Lloyd's team, he stated that he  
12 was compliant with aripiprazole 15mg daily and, despite  
13 continuing to experience auditory hallucinations, was  
14 working in a warehouse. In clinic in February 2021, his  
15 aripiprazole was increased to 20mg daily."

16 Now, there's plenty of other evidence, apart from  
17 VC, about what he wasn't taking, but reading that now,  
18 he's telling a psychiatrist that he stopped taking it in  
19 October 2020.

20 **A.** Yes.

21 **Q.** Is your evidence that you had no sense of the extent of  
22 non-concordance at the time?

23 **A.** I think it was really difficult to assess. I think  
24 there was a suspicion that he wasn't, but we never --  
25 until the point you told me he'd stopped taking it and

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1 of it throughout.

2 **Q.** Did you think about issues of capacity at that point;  
3 whether he had capacity to make decisions around  
4 treatment? He didn't think he was ill and yet here he  
5 was describing hallucinations, belief systems that made  
6 it clear he was ill?

7 **A.** Yeah, but I think at this point he wasn't saying "I'm  
8 not going to take my treatment. I'm not taking  
9 medication because I don't think I'm unwell". so I guess  
10 it was difficult to assess his capacity around the  
11 treatment side of it, because he was, on the face of it,  
12 like, complying with that treatment.

13 **Q.** This, I'm going to suggest, Ms Birtles, was  
14 a significant moment in November 2020 because close  
15 monitoring in the community by the CCO is the plan and  
16 to increase aripiprazole, and:

17 "If risk escalates or compliance ... we may need to  
18 involve crisis team."

19 At the very least, that number 3 should have been  
20 first and foremost, shouldn't it, at this point? The  
21 Crisis Team going every day at the very least?

22 **A.** I don't think we felt that at the time that that was the  
23 first step at that point.

24 **Q.** His medication concordance should have been monitored  
25 rigorously, just to see what was happening?

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1 he wasn't taking it prior to the third admission, there  
2 was -- although there might have been the odd days he  
3 had extra, it wasn't concrete evidence that he hadn't  
4 been concordant.

5 **Q.** If we go back to NHFT0000168, page 140, 1 December, you  
6 do discuss the voices with him. We see that in the  
7 bottom box at page 140:

8 "[VC] continues to believe the voices are quite  
9 powerful. Remains unsure whether they are symptoms of  
10 psychosis."

11 You offer VC:

12 "... some reassurance that we didn't want him to  
13 have to go back to hospital and [VC] confirmed he did  
14 not want to go back either."

15 Was he fearful about going back to hospital, and  
16 what was your view about that?

17 **A.** I think -- I think I thought at the time he was worried  
18 about that and I was trying to offer some reassurance  
19 that we would -- that's not what we were here for, just  
20 to take people back to hospital as soon as we hear they  
21 might be experiencing symptoms of psychosis. So I was  
22 trying to offer reassurance around that in order for him  
23 to then feel comfortable sharing it.

24 I would say I know some people are really worried  
25 about that, but it's better we know what's going on than

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1 not know, because it just -- it helps us support you.  
 2 So I do think he was probably worried about that.  
 3 I think most people are. I think especially if they've  
 4 been in hospital, and had that experience before, there  
 5 is a worry that that will happen again.

6 **Q.** Would you ever think in those circumstances to say,  
 7 "Well, if you need to be, you'll be there, and you'll be  
 8 better for that"? Or was that not your role to be  
 9 supportive of an inpatient hospital setting if a patient  
 10 needs it and to help demystify that, even if they've had  
 11 a bad experience?

12 **A.** No, I wouldn't -- no, it's not that we're anti-hospital  
 13 as such, it can be really helpful for people  
 14 therapeutically, and so if -- I would always say, you  
 15 know, if somebody requires hospital, you know, that's  
 16 a consideration and we would support that, and continue  
 17 to support them whilst they're in hospital, if that was  
 18 necessary. So it's not like "Oh no, we don't want you  
 19 ever to go to hospital and this will never happen", you  
 20 know, "You'll stay with us". It's being realistic about  
 21 it. It is necessary, sometimes, if the risk is there.

22 **Q.** Relapse prevention plan. If we go to NHFT0000168,  
 23 still, at page 145, you did some work, didn't you, with  
 24 VC starting to explore early warning signs and relapse  
 25 prevention and VC completed a card sorting exercise and

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1 discussion around the dishonesty and the fact he'd  
 2 acknowledged the voices in those appointments. So it  
 3 felt natural to then look at a relapse plan at that  
 4 point.

5 **Q.** So even though he was saying he was still hearing  
 6 voices, which is what he'd said to you in the December,  
 7 and the concerns over medication, that wasn't a bar to  
 8 looking at relapse, because on one view, he continually  
 9 had this, didn't he? What he was describing to you was  
 10 continual voices?

11 **A.** Yeah, although it's a relapse benchmark, I think it is  
 12 looking at symptoms in general and what people might be  
 13 experiencing and I really just use it as an opportunity  
 14 to open up those discussions that sometimes are  
 15 difficult to have with people who are reluctant to talk  
 16 about it. It can be helpful to say, "Look, this is what  
 17 other people might have experienced, a list of these  
 18 symptoms, what was relevant to you." And kind of  
 19 normalising that and having discussions about each  
 20 symptom.

21 **Q.** If we look at the relapse signature box, then:  
 22 "Feeling depressed and low  
 23 "Feeling violent, angry, aggressive or pushy  
 24 (although never acted on these feelings."  
 25 You knew he'd acted on feelings leading to his

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1 identified the following. So these were warning signs  
 2 that he identified; is that right?

3 **A.** Yes.

4 **Q.** You record here:  
 5 "[VC] was unable to identify anything specific that  
 6 had triggered the episode but does feel stress,  
 7 especially University workload/exams may have  
 8 contributed."  
 9 Yes?

10 **A.** Yes.

11 **Q.** Then you create, at NHFT0000270, page 1, on 18  
 12 January 2021, a Relapse Prevention Plan. Is there any  
 13 reason -- I think this is -- the care plan has been  
 14 created, hasn't it, 1 September, and this is 2021, a  
 15 Relapse Prevention Plan. Is there any reason why  
 16 there's such a delay between the two documents?

17 **A.** No, I often will do the Relapse Prevention Plan when it  
 18 feels like it's the right time to do it. You get  
 19 a sense that somebody's perhaps wanting to think about  
 20 what happened prior to becoming unwell, what led up to  
 21 it, and what the triggers might be.

22 **Q.** You obviously thought he was well enough to engage with  
 23 this work when he did the cards exercise, did you?

24 **A.** I think I did at that time. I think I thought it was --  
 25 we'd had that -- from my feeling, the positive

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1 admissions to hospital, didn't you?

2 **A.** Yeah, I think that's what he said. I think that's why  
 3 I noted that.

4 **Q.** So a relapse signature is what someone says, and do you  
 5 contradict that? Did you say, "Well actually you have"?  
 6 Because that's no insight at all, is it, to say, "I've  
 7 never acted on these feelings"?

8 **A.** I think the -- at this point I suppose it was the  
 9 incidents were around going through the doors and then  
 10 obviously the unfortunate event with the female  
 11 flatmate. But I think what he was saying is "I've not  
 12 been violent towards somebody or potentially hurt  
 13 somebody physically", and that's why I noted it down  
 14 there.

15 **Q.** There's then a gap, I think, of three months before you  
 16 see him again, isn't there? You see him next in April  
 17 of 2021; is that right?

18 **A.** Um --

19 **Q.** January is the relapse plan and then 13 April, if we go  
 20 to NHFT0000168/150.

21 **A.** Yeah.

22 **Q.** This is April 2021. And you go and see him at home.

23 **A.** Yeah.

24 **Q.** He's been "reassured", paragraph 3:  
 25 "There[s] ...no obvious issues with his memory

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1 following ... memory assessment".

2 The next paragraph, you'd received an email, hadn't

3 you, from PC Gail Collins regarding an incident at

4 Brook Court and he had been, VC, taken aback at

5 the expected cost of £600 for the damage caused to

6 a door; is that right?

7 **A.** Yeah.

8 **Q.** What was VC's reaction to that?

9 **A.** I think he was shocked -- I think he was shocked at the

10 cost, and I think he said he was surprised that it was

11 just a bit of damage to the door and how much it would

12 cost, and I think I queried that, but I can't remember.

13 They described -- it was one of the -- like a fire door

14 or it had regulatory things that would have meant it

15 cost so much money to replace and fix.

16 **Q.** And you queried that with the police, the cost of the

17 door, yes?

18 **A.** Yes.

19 **Q.** And you also said, it could be very difficult to be

20 discussing that issue with him because it precipitated

21 his detention; is that right?

22 **A.** Yes, I wrote that, yeah.

23 **Q.** VC didn't accept that caution, "he wanted his day in

24 court". Do you know anything about why he wanted his

25 day in court or didn't accept that caution? What did he

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1 sense. She felt he had not [been] ... taking his

2 medication, she hadn't called his CPN ... [VC] has

3 [since]... been talking to his brother and ... has

4 reportedly told his brother he hasn't been taking his

5 medications ..."

6 "Asked if he had any concerns ... reported no ...

7 reports no difference to ... [himself]."

8 This is VC. So he gets a telephone call after this

9 report from his mother, doesn't he?

10 **A.** Yes.

11 **Q.** A telephone call. Do you think, and I know this is

12 Juliet Lopez, not you, do you think there should have

13 been a face-to-face meeting after this?

14 **A.** Well, in light of the situation, yes, but I don't know

15 what, in regards to the Crisis Team, what their capacity

16 would be to do that, and whether that would be something

17 they would offer.

18 **Q.** And we see at the bottom:

19 "[He] ... is polite and cooperative throughout the

20 telephone assessment."

21 This is far too complex to assess down a telephone,

22 isn't it?

23 **A.** It is difficult, yeah.

24 **Q.** With the history, with the seriousness of the position.

25 **A.** Yes.

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1 say?

2 **A.** I think I wrote it in another entry but I can't remember

3 what he said. I think I asked him about it, and I think

4 he said one line, like I said, "he wanted his day in

5 court". And I remember thinking: does he know what that

6 means? And I queried a bit more about what that might

7 entail, and he did. Because I was -- I did wonder

8 myself why he might have said that. But --

9 **Q.** He did know it meant going to court and what it

10 entailed --

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

12 **Q.** -- and he was content for that.

13 **A.** Yeah.

14 **Q.** He didn't want the caution --

15 **A.** Yeah.

16 **Q.** -- and he didn't agree with the amount of money of the

17 door, the damage was.

18 **A.** Yeah.

19 **Q.** So he was able to clearly set out his position and

20 perspective on that criminal process.

21 **A.** Yes, yeah.

22 **Q.** Can we go, please, to NHFT0000168, page 153, 29 May.

23 "T[elephone]/C[all] from Mum to advise she believes

24 her son is becoming unwell ... over the last few days

25 she sensed he is not doing well and ... wasn't making

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1 **Q.** Were you aware of this contact at the time?

2 **A.** Not at the time, because I think I was off work at that

3 point.

4 **Q.** Okay. We know that VC went to Thames House on 31 May.

5 So immediately following this telephone call. Do you

6 know about that at all? When did you learn that he'd

7 gone down to London and spoke to police outside MI5?

8 **A.** That was only as part of the Inquiry. We weren't

9 involved.

10 **Q.** Would it have been important to have information from

11 the police about that, what he'd said to police

12 officers, why he was there? Would you have wanted to

13 know about that at this time?

14 **A.** Yes, definitely.

15 **Q.** Why would you want to know that?

16 **A.** I think he -- well, he'd mentioned before about MI5 in

17 a previous appointment, so to me that seemed

18 significant. I know people are interested in MI5 and

19 might want to go and take pictures of the building or

20 have a genuine interest. But I think because we'd known

21 some of his beliefs -- well, we'd known he'd mentioned

22 their involvement elsewhere. I would -- I'd want to

23 know if he'd taken steps to go down there.

24 **Q.** Do you ever ask patients that you're visiting, or

25 individuals in the community, about what they're looking

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1 at on their phone? If anything is disturbing them?  
 2 Stuff like that? Or is that a no-go zone for you?  
 3 **A.** I would if there was something to suggest that there was  
 4 a worry, some people might say, and then you would say,  
 5 "Do you want me to have a look?" Or "Can I have  
 6 a look?" Or we'll often ask about social media use,  
 7 although that's more common now than perhaps back in  
 8 2020 and 21, but ordinarily --  
 9 **Q.** And it's important now, isn't it? It's important to  
 10 understand what people get access to on the Internet,  
 11 what they're looking at, what might be influencing them?  
 12 **A.** Yes, yes.  
 13 **Q.** Do you think in your work you're abreast with that, what  
 14 goes on in social media and generally on the Internet,  
 15 as group of care coordinators?  
 16 **A.** I think probably not to the extent that maybe we could  
 17 be. I think it's -- I think generally the population  
 18 might not -- I wouldn't have an idea about the depths of  
 19 the Internet and how -- what people are accessing,  
 20 because it's not something we're seeing every day.  
 21 I think obviously the police have a better understanding  
 22 of that, but it's difficult for us, I think.  
 23 **Q.** Care plan and NHFT0000201, page 1. You respond with  
 24 this care plan 29 June 2021.  
 25 It remains the same, doesn't it? It doesn't really

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1 but wouldn't come in the home. Were you told about that  
 2 by his family?  
 3 **A.** No.  
 4 **Q.** Generally, did you ever phone the family for  
 5 information, to request it?  
 6 **A.** Yeah, at that point we was in close contact, I would  
 7 say. If there'd been any change, it wasn't uncommon for  
 8 Mum to ring if she was concerned about something or  
 9 wanted to let us know.  
 10 **Q.** 9 August 2021, if we could have NHFT0018991, you send an  
 11 email to Dr Lloyd. You say:  
 12 "[VC] DNA'd [didn't attend] his appointment ...  
 13 today so we discussed the possibility of a HV due to  
 14 some concerns that he may be relapsing."  
 15 What's HV?  
 16 **A.** Home visit.  
 17 **Q.** Home visit:  
 18 "... provisionally booked [one] ... tomorrow...  
 19 "... due to go [to]... leave next week and [but] ...  
 20 worried about leaving him in case he is relapsing."  
 21 So you were concerned at this point that he was  
 22 relapsing.  
 23 **A.** Yes. There was a change in his kind of, I guess, his  
 24 engagement, I think, at the time, and he wasn't --  
 25 I couldn't be sure he was going to attend the

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1 refer to patterns of non-concordance and masking. No  
 2 reference to how treatment is going to be implemented.  
 3 Is that fair? You've seen it. I don't need to take you  
 4 to any particular sections, it's similar to the one  
 5 before.  
 6 **A.** Yeah.  
 7 **Q.** If we go, please, to NHFT0000168, page 156. 8 July.  
 8 This visit is in fact three days after VC has  
 9 assaulted his flatmate, Sebastian. He pushes him  
 10 against a wall. And another day trying to get into his  
 11 room, which was locked, so he wasn't able to get into  
 12 the room.  
 13 So VC is visited at home, said he'd forgotten about  
 14 the visit, "feels he is 100% back his usual self and  
 15 denied any concerns regarding his current mental health.  
 16 When asked about how his family were doing, [VC] said  
 17 ... they don't discuss it as they don't want to worry  
 18 him."  
 19 So we see again, don't we, incidents of violence in  
 20 the community, him saying everything is well three days  
 21 later. Did you know about that Sebastian incident? The  
 22 police had received a call from him. Did you know about  
 23 that?  
 24 **A.** No, I didn't know about that, or the assault.  
 25 **Q.** On 11 July we know that VC drove down to his family home

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1 appointment, the outpatient appointment, and he'd  
 2 obviously DNA'd the one previously with Dr Lloyd --  
 3 (*overspeaking*) --  
 4 **Q.** And we know around this time he's attended Rowan 1 Ward  
 5 asking to speak to Dr Seedat, wanting to know about  
 6 whether staff communicated with AI?  
 7 **A.** Yes.  
 8 **Q.** Can we go, please, to NHFT0000168, page 162. Concerns  
 9 about relapse, take you to a home visit. And we see in  
 10 the penultimate paragraph -- actually, two up at the  
 11 bottom of that paragraph:  
 12 "We did not feel it was safe to continue to push the  
 13 assessment at this time as [VC] appeared increasingly  
 14 frustrated and mistrusting of us. I was also concerned  
 15 ... it was potentially quite difficult to get out of the  
 16 flat due to a long corridor/hallway to the exit should  
 17 we have needed to leave promptly."  
 18 **A.** Yes.  
 19 **Q.** "[VC] agreed it would be a good idea if we left it  
 20 there, [and] ... showed us out of the flat and abruptly  
 21 closed the door behind us."  
 22 Was this the first time you hadn't felt safe or were  
 23 concerned in the way you set out there?  
 24 **A.** Yes.  
 25 **Q.** So what was different about this point in time? It was

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1 August 2021.

2 **A.** He was -- at that point our impression that he was  
3 clearly unwell, and quite obviously unwell. I know he'd  
4 continued to have symptoms, and he'd admitted to still  
5 hearing voices. But at this point I felt like it had  
6 kind of tipped over slightly. He was quite  
7 confrontational, agitated. He was talking about our  
8 involvement with other agencies, and at that point  
9 I didn't think he obviously he appreciated his  
10 presentation, how he was coming across. I don't think  
11 he recognised there was an issue. He said he wasn't  
12 going to engage, he wasn't going to take his tablets,  
13 and that was the first time those kind of things --  
14 those things -- those are things he'd said.

15 So there was just a real shift in how he was  
16 presenting, and I hadn't seen that before.

17 **Q.** "Discussed with Dr Lloyd", that was the plan. What did  
18 she say?

19 **A.** Just -- obviously, she -- I think she agreed that this  
20 was an indication that the risks had escalated slightly,  
21 he wasn't going to engage with us in the community. He  
22 said he wasn't going to work with us, so obviously  
23 wanted to speak to the Crisis Team regarding options,  
24 Mental Health Act-wise if necessary, or whether we do  
25 home treatment. Having those discussions, basically.

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1 paragraph:

2 "[VC] appears to be relapsing. Appears quite  
3 suspicious/paranoid, little bit confrontational although  
4 no evidence of any aggression. ... has stopped  
5 treatment ..."

6 No evidence of any aggression? Was there evidence  
7 of intimidation? What was there?

8 **A.** He wasn't making threats to harm us or ... I guess  
9 I felt intimidated by the fact he was unwell and we were  
10 in his house, and at that point you're quite vulnerable,  
11 but he wasn't saying, "I'm going to hurt you", or "This  
12 is what I'm going to do". So it feels intimidating in  
13 that environment when you're with somebody who is unwell  
14 in their home, but no specific threats to hurt us at  
15 that point.

16 **Q.** We know the assault, a violent assault on the police  
17 officer; would you agree?

18 **A.** Yes.

19 **Q.** Who did you get information about that assault from?

20 **A.** Just the notes from the assessing team, so the doctors  
21 that had done the Mental Health Act Assessment, from  
22 their impression of what had happened on RiO.

23 **Q.** What did you consider about that, in terms of risk?

24 **A.** Well, I thought that was a really significant assault.  
25 I was quite shocked to read about it.

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1 **Q.** What was the plan? Never mind discussions, what was the  
2 plan? This was an occasion where you had felt unsafe.

3 **A.** Yeah.

4 **Q.** You've discussed it with Dr Lloyd. If you felt unsafe,  
5 isn't it likely other people are going to feel unsafe,  
6 even if you don't know about what had happened to  
7 Sebastian a month before?

8 **A.** Yes, so it wouldn't -- when I say discussions, they have  
9 to look at all the options. So as soon as -- the Crisis  
10 Team would gatekeep kind of a Mental Health Act  
11 Assessments as such, and you'd have to liaise with them  
12 first, and you'd have the discussion with the  
13 practitioner there. Then they would either agree it was  
14 necessary and it was unlikely that home treatment was  
15 going to work, and then he would refer for a Mental  
16 Health Act Assessment. So in my eyes, from that  
17 perspective, from seeing him, it was highly likely that  
18 we're not even going to consider home treatment at that  
19 point because it wouldn't work. So we would be going  
20 the next step to a Mental Health Act Assessment.

21 **Q.** Which is what subsequently happens?

22 **A.** Yeah.

23 **Q.** If we go to the risk assessment, risk and safety  
24 assessment, NHFT0000194, page 2, that has been updated  
25 on this occasion, and we see at page 2, second

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1 **Q.** If we go, please, to WITN0348003, page 2, you sent an  
2 email to John Laverick, who is a senior nurse, where VC  
3 is detained, and you're asked to do a social  
4 circumstances report, aren't you, because he's seeking  
5 release from the detention?

6 **A.** Yes.

7 **Q.** You say here:

8 "How is VC doing? Is a depot being considered?"

9 This was discussed following his second admission  
10 however he declined it at the time. This is obviously  
11 his third admission and concordance remains an issue.  
12 Reflecting on things now I don't think VC has ever truly  
13 acknowledged he has a mental health issue and insight  
14 has remained poor."

15 If it's not obvious, why are you raising a depot  
16 now?

17 **A.** For that reason, really, that we were still in the same  
18 position that we had been back after the first  
19 admission, that he was potentially -- not taking his  
20 medication -- well, he told me at that appointment he  
21 wasn't taking it, so that was the first time he'd  
22 actually said, "I'm not taking my tablets, I'm not going  
23 to, I've got no intention of doing that". So, you know,  
24 it was going on that, really, that this clearly wasn't  
25 going to work with oral, unlikely to anyway.

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1 Q. You sent an email to Dr Lloyd, NHFT0018143, page 1. On  
2 17 September.

3 "VC has a tribunal next Thursday. I'm going to  
4 suggest consideration of a depot, hope that's okay.  
5 This was a consideration after his last admission  
6 however Dr Seedat gave him the benefit of the doubt and  
7 agreed to continue with orals. He remains on a PICU in  
8 Darlington and appears to be accepting orals however  
9 still no insight."

10 Had you discussed that with Dr Lloyd before then?

11 A. The depot?

12 Q. Yeah.

13 A. Possibly. I can't remember if there was any specific  
14 discussions about it, but depots are talked about quite  
15 a lot when there's issues with non-concordance. We  
16 would have -- everybody knew there was an issue with  
17 concordance or we suspected there was an issue and then  
18 it was kind of confirmed at that point. So it could  
19 have been.

20 Q. You get a response from her higher specialist trainee  
21 saying:

22 "I do agree with depot especially him having no  
23 insight."

24 A. Yeah.

25 Q. You then did the Social Circumstances Report and if we  
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1 honest, open discussion between the three of us in that  
2 appointment. So it's not like I found it out secondhand  
3 or anything. He was aware that he'd said it, but it's  
4 probably unfortunate, but it's just a bit of an  
5 oversight.

6 Q. You have expressed at box 15:

7 "No prior history of violence and aggression towards  
8 others, usually a calm, peaceful, and law-abiding  
9 citizen."

10 That's, given the history, given what we know at  
11 this point about events in May, you don't know about  
12 events with Sebastian but you certainly know about the  
13 police officer.

14 A. Yeah. Yeah, I think I meant the fact that the police  
15 (unclear) later, but yeah, it's not something I would --  
16 I don't think it -- I wouldn't put that now.

17 Q. Well, should you have put it then, is my question?

18 A. I don't think so because it was violence and aggression,  
19 obviously the police incident was, but I think even  
20 reflecting on the acts with the breaking through the  
21 flat and those first incidents, that would constitute  
22 violence and aggression in my eyes, yes.

23 Q. So that was wrong?

24 A. Yeah.

25 Q. If we look at paragraph 16, were you aware that that bag  
111

1 can go to NHFT0000275, page 5. When you prepared this,  
2 did you know he was going to read it?

3 A. Yes.

4 Q. Does that influence how you have put things, sometimes?

5 A. I'm aware of it, but I guess I've got to get everything  
6 down on there, so I've -- I will speak to the patient as  
7 well and I'll obviously have to let them know what my  
8 opinions are. So that normally happens before I've done  
9 the report.

10 Q. Because one of the things, perhaps a key thing, you  
11 don't include, is that you don't flag he'd previously  
12 told you he said he'd take medication and wasn't hearing  
13 voices, just to get out of hospital?

14 A. Yes.

15 Q. That's a significant thing, isn't it, the entry that we  
16 went to before. When you put it as bluntly as that,  
17 here he is in hospital, trying to get out of hospital,  
18 and he's already told you that he'll say something to  
19 get out.

20 A. Yeah -- (*overspeaking*) --

21 Q. That's not included. Is that because you didn't  
22 remember that or you wouldn't have let him read that or  
23 not?

24 A. No, no, possibly, but that's an oversight. There's no  
25 reason why I wouldn't have. Because that was a really  
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1 of medication, unused medication, dated back to  
2 February 2021? So when you're speaking about being  
3 non-concordant for a while, this was several months,  
4 isn't it?

5 A. I can't recall when I was aware of the medication.  
6 I was probably documenting from my discussions in that  
7 appointment about him saying he'd stopped it, not what  
8 I knew about the several months. I can't recall when  
9 I knew about that.

10 Q. At page 9, please. You do set out there:

11 "VC has previously broken into a neighbour's flat  
12 believing someone was screaming inside causing the  
13 neighbour to flee the property by jumping from a first  
14 floor window."

15 You don't mention her injuries there, do you, but  
16 you go on to say:

17 "He has also seriously assaulted Police Officers..."

18 A. Yes.

19 Q. "[He] ... experience conspiratorial delusions and  
20 probable auditory hallucinations. ... remains  
21 suspicious and paranoid of others and presents a risk to  
22 others when feeling under threat."

23 His description of his auditory hallucinations made  
24 it clear he was feeling under threat most of the time,  
25 didn't it? What he had told you about the  
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1 hallucinations?  
 2 **A.** Yeah.  
 3 **Q.** So when feeling under threat, did that adequately convey  
 4 the extent of how long he'd told you he was hearing  
 5 voices, and the conspiracy beliefs?  
 6 **A.** Sorry, say that again.  
 7 **Q.** Did that adequately cover what he had told you about the  
 8 extent of his delusional beliefs and voices into his  
 9 head and what they were telling him?  
 10 **A.** I mean, there's not an awful lot of information there  
 11 that would explain that in great detail, but it's --  
 12 I probably spoke about that during the -- it's likely  
 13 I would have spoke about that during the tribunal.  
 14 **Q.** Yes, and you say later you think this was a complete  
 15 breakdown in your relationship with VC after this,  
 16 because of what you were saying; is that right?  
 17 **A.** Yes.  
 18 **Q.** If we go to the tribunal's findings, CYGN0000056,  
 19 page 5, paragraph 13.  
 20 "There is unequivocal evidence that the risks to  
 21 others when [VC] is unwell are high and that relapse  
 22 occurs rapidly and is difficult to manage."  
 23 "These risks eventuated very recently and it is  
 24 important that they are minimised so far as is  
 25 reasonable until [VC] is discharged into the community."  
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1 option ..."  
 2 We see further down.  
 3 So did you raise that with him?  
 4 **A.** Yes, that will have been in that call, yes.  
 5 **Q.** He:  
 6 "... said ... [it] would depend on the side effects  
 7 ... it might be easier than taking medication everyday".  
 8 So you've recorded that. Is that what he said at  
 9 the time?  
 10 **A.** Yeah, I think that's what he said.  
 11 **Q.** So your view about depot was one that you were telling  
 12 him about?  
 13 **A.** Yes.  
 14 **Q.** Next box further down, 21 September, 3.45, you record:  
 15 "[VC] said he had read through the information in  
 16 the social circumstances report and expressed  
 17 disappointment in the way he was presented. [VC] also  
 18 questioned the boundaries of confidentiality and said he  
 19 was likely to be more guarded with me going forward  
 20 given that [the] information had been shared."  
 21 **A.** Yes.  
 22 **Q.** So can you unpack that a bit, please, and say what he  
 23 was saying to you there?  
 24 **A.** I mean, he would have known that I was sharing  
 25 information about -- or my impression of him at the  
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1 Did you get a copy of the tribunal decision?  
 2 **A.** I can't remember what was shared with us. I don't know,  
 3 to be honest, what we had. I can't remember what we had  
 4 at the time. I think it's likely that we'd get the  
 5 reports uploaded onto RiO by the Mental Health Tribunal  
 6 team, but I can't remember --  
 7 **Q.** You don't remember that, reading it. But it should be  
 8 accessible, should it, for clinicians on a --  
 9 **A.** Yeah, the decision, yeah, I guess, yeah. We wouldn't  
 10 necessarily see maybe the other reports, but generally  
 11 the decision, yes. So other reports from different  
 12 health professionals who did it as part of the tribunal.  
 13 **Q.** Can we have NHFT0000168, page 191, please, and this  
 14 a note, Ms Birtles, 17 September 2021 when you discussed  
 15 the Section 2 tribunal with VC and we see in the top  
 16 box:  
 17 "[VC] said there are no issues with his mental  
 18 health and maintains ... he does not have a psychotic  
 19 illness and he 'knows so' because he is 'most familiar  
 20 with his own situation' and knows that it is not and  
 21 never has been psychosis. ... this admission has been  
 22 unnecessary much like the previous two because he is not  
 23 mentally unwell. [He said he] ... also 'know that' it  
 24 is not psychotic."  
 25 "Discussed possibility of depot medication as one  
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1 moment as part of the tribunal, because I would have  
 2 made that clear on the call that I'd have to discuss  
 3 what my recommendations might be based on what I know.  
 4 But I think, after he'd read it, he felt that that  
 5 wasn't the true reflection of how he was and he was  
 6 disappointed that I'd shared it.  
 7 And I don't know whether he fully grasped why  
 8 I would share it, and why I would have to share it, and  
 9 that confidentiality doesn't -- that doesn't apply in  
 10 this situation. So I don't know whether he fully  
 11 understood that, and I think he felt let down by my  
 12 interpretation of his events, and the risks, and the  
 13 things I've stated in that report.  
 14 **Q.** Can we have, please, PAGR0000025, page 6, and this is  
 15 a record from Priory Arnold. We know you thought to  
 16 upload the notes from Priory to VC's RiO. We see an  
 17 email, I think around 28 October where you're attempting  
 18 to do that and get them uploaded.  
 19 **A.** Yeah.  
 20 **Q.** We also know notes in Cygnet, he says a lot about his  
 21 delusory beliefs. They were not uploaded in any risk  
 22 assessment format, were they? You've conceded earlier  
 23 on there was no careful collation of risk assessment  
 24 information, but evidence during this admission about  
 25 delusional beliefs and their impact would have been  
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1 relevant to risk, wouldn't they?  
 2 **A.** Yes.  
 3 **Q.** If we see "Keeping Safe", the second box, we'll hear  
 4 some primary evidence about this, and it's recorded  
 5 10 October:  
 6 "There have been no issues regarding his safety.  
 7 ... remains on level 2 x 2 checks per minute. [VC] had  
 8 brought some belongings brought in when he went on  
 9 community leave. [VC] had brought a hammer in his  
 10 rucksack, it is unclear as to whether he picked this up  
 11 by accident or whether it was intentional."  
 12 Did you see that note at any point?  
 13 **A.** I can't remember. I will have done ... I'm always  
 14 interested to read inpatient notes, so I would have  
 15 tried my best to read it. But I can't remember -- the  
 16 fact that I hadn't put it in the risk assessment, I mean  
 17 I think that's something I would probably document.  
 18 **Q.** But you don't remember now?  
 19 **A.** I can't remember. We do get quite -- I mean sometimes  
 20 they can be quite lengthy documents that we get from  
 21 someone's stay at a private hospital, because obviously  
 22 there's -- it's not -- it's paper -- it's almost like  
 23 scanned in and uploaded so it can be quite lengthy.  
 24 **THE CHAIR:** Is this a good moment to have a break?  
 25 **MS LANGDALE:** It is.

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1 **THE CHAIR:** Yes.  
 2 Ms Birtles, we'll start again at 2.05, thank you.  
 3 **(1.06 pm)**  
 4 **(The short adjournment)**  
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