Wednesday, 29 April 2026

(10.00 am)

MR CARR: Good morning. May I call Dr Craig Murphy?

THE CHAIR: Yes.

DR CRAIG MURPHY (affirmed)

Questioned by MR CARR

THE CHAIR: Yes, Mr Carr.

MR CARR: Thank you, Chair.

Dr Murphy, you have prepared a statement for the Inquiry, haven't you, dated 17 October 2025?

A. That is correct.

Q. There's a correction you wish to make at paragraph 44 of that statement.

A. Yes, that is correct.

Q. What is the correction? It's page 12.

A. The first sentence of that paragraph explains that I sought to arrange blood tests for VC at six months and also a cardiovascular risk assessment at 12 months. What that sentence is inferring that I sought to arrange a cardiovascular assessment at 12 months; I did not formally put it into the diary as such.

Q. So the correction, the change you would make is what?

A. Is "I sought to arrange a cardiovascular risk assessment at 12 months".

Q. Subject to that correction, is the statement true to your best knowledge and belief?

A. It is, yes.

Q. By way of professional background, you are a GP, aren't you, a general practitioner?

A. That is correct.

Q. In August 2020, you were a trainee GP on placement at the Cripps Health Centre in Nottingham.

A. Yes.

Q. That's the GP practice where VC was registered at the time.

A. Yes.

Q. For your training you were supervised by Dr Sarah Hamlyn.

A. Yes.

Q. You had a single consultation with VC which was on 17 August 2020.

A. That's correct.

Q. And it was by telephone?

A. By telephone, yes.

Q. That followed, didn't it, his discharge from his second admission?

A. That's right.

Q. You were not VC's named GP. Did he have a named GP?

A. My understanding of the process of having a named GP is that when patients are newly registered to the practice they are allocated a GP, one of the GP partners is allocated as their named GP. However, unless there is a specific role or task of that individual GP, then care in the primary care setting is shared between all GP members of the Cripps Medical Centre team. So although yes, there is in primacy(?) a named GP, the function of that is only used in specific circumstances.

Q. So what was the system that was in place for acting on correspondence that was received at the practice in respect of one of its patients?

A. My understanding is that when correspondence was received, it was reviewed by the duty doctor on that day. This would be a role shared amongst all qualified GPs at the practice. All letters coming into the practice would be reviewed, and if there were any action points, such as inviting the patient for an appointment to discuss the contents of the letter or discharge summary, then a task on the electronic case management system, EMIS, would be sent to the admin team who would then contact the patient and invite them in.

Q. So it was actioned, essentially, by the duty doctor?

A. Yes.

Q. Right. If we can turn to your consultation on 17 August. In your statement, you've explained that, ahead of that consultation or as part of the consultation, you considered the discharge summaries from the two recent admissions?

A. Yes.

Q. Was that, in fact, all of the documentation that had been received at the practice in respect of VC's mental health up until that point?

A. Pertaining to the mental health complaint, yes, this was all which was received at that time.

Q. Did the practice have access to RiO records in respect of its patients?

A. I certainly don't have access to RiO and my understanding is that the practice did not have access to that electronic record system.

Q. So the extent of the available information was what was contained in those two discharge summaries?

A. Entirely.

Q. If we can look at those, please. The first one, it's CHCA0000027 and this was a discharge summary following the first admission. We can see on page 1 there are background details, Dr Murphy.

A. Yes.

Q. Then if we go forward, please, to page 3, we have, in that main box, background leading to the first admission, don't we?

A. Yes.

Q. In the first paragraph about halfway down, it sets out that VC had been "hearing voices and responding to unseen stimuli"?
A. Yes.
Q. So that's a reference to psychotic symptoms or symptoms of psychosis?
A. I believe so, as per this discharge summary, yes.
Q. Then, towards the end of the paragraph, the final two lines, it sets out that a neighbour whose flat he had broken into had jumped out of the first floor window?
A. Yes.
Q. Then on the third paragraph on that page, it notes, final sentence, that VC had been started on aripiprazole, 5 mg.
A. Yes.
Q. If we can turn to page 4, please. This sets out, doesn't it, the post-discharge planning?
A. Yes.
Q. We can see in the middle of the page under "Physical Health Plan" there are a couple of entries for which the GP would be responsible, annual health check, and investigations following bloods and ECG?
A. Yes.
Q. Then further down, the penultimate box is titled "Action for GP" and it states:

"Please ensure he receives an annual health check, and please ensure that his medications are prescribed on his repeat prescriptions."
A. Yes.
Q. That would be a reference to the aripiprazole?
A. Yes, in addition to the vitamin D.
Q. Then if we'd look at the second discharge summary following the second admission, CHCA0000028. Again, on page 1, we have the background details. If we go to page 3 of this document, that provides a summary leading to the second admission?
A. Yes.
Q. You will have seen in that first box, fourth line again:
"[VC] had gone to a neighbour's flat ... [and] barged in ..."
A. Yes.
Q. The following paragraph sets out that VC had decided to stop taking his medication two weeks after discharge?
A. Yes.
Q. He was started on aripiprazole again?
A. Yes.
Q. Then, finally in this document, if we go to page 4 and look at the action plans, it's similar to before, not identical, but again, physical health plan, GP to be responsible for the annual health check?

A. Yes.
Q. Then actions for GP includes:
"... please ensure that his medications are prescribed on his repeat prescriptions."
A. Yes.
Q. So if we just pause there and consider the information that was available to you ahead of 17 August consultation, you were aware that on two occasions VC had been admitted following psychotic episodes in which he'd accessed neighbours' flats?
A. Yes.
Q. On one occasion a neighbour had jumped out of a window in fear?
A. Yes.
Q. Between his first and second admission he stopped taking his medication?
A. Yes.
Q. When he stopped taking his medication following the first admission, his symptoms returned leading to the second admission?
A. Yes, that's right.
Q. Both discharge summaries required the GP practice to ensure his medication was prescribed?
A. Yes.
Q. Now in fact, following both admissions, the Local Mental

Health Team ultimately took over prescribing VC's aripiprazole. Was that communicated to the GP practice?
A. No, that wasn't clear to us at this time. All the information regarding what the Local Mental Health Team or the Community Mental Health Team would do was articulated within the discharge summaries and that included a three-day follow-up prior to being handed over to the Local Mental Health Team. There was some additional information which I gained from VC during my consultation.
Q. If we look at the practice's medical records it's CHCA0000030. If we start at page 10. Thank you. So we can see entries, can't we. 17 June and 31 July is when the discharge summaries have been received by the practice.
A. Yes.
Q. But between those two dates, nothing seems to have been done by the practice, does it?
A. No.
Q. Following the first discharge, the next entry is the second discharge.
A. Yes.
Q. In light of your answer earlier as to the system that was in place, is the position that on receipt of that first discharge, the duty doctor, whichever duty doctor

was on, had the responsibility for acting on the first discharge?
A. That would be my understanding of the process at the practice, yes.
Q. Then if we go up above 31 July we can see the next three entries all describe text messages sent to VC asking him to make an appointment for a review and to discuss medication.
A. Yes.
Q. Does it follow that, following receipt of the second discharge summary, a duty doctor has, prompted by that discharge summary, arranged for those text messages or the first text message to be sent?
A. That is my understanding, yes. It may also have been the admin team who interpreted the discharge summary as well, and noted the need for GP follow-up.
Q. VC ultimately responded -- responds to the texts, and that is what leads to your appointment.
A. Yes.
Q. Where a patient does not respond, what happens?
A. My understanding of the process at the practice would be numerous attempts would be made via text message initially, and that this could be escalated ultimately to a printed out letter sent to their home address.
Q. If we look at the note of your appointment it starts at

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

aripiprazole and he's currently receiving it from the CMHT. That's a reference to the Crisis Team, isn't?
A. I would say in my records that's a mention to the Community Mental Health Team.
Q. You've noted your impression was that VC was stable --
A. Yes.
Q. -- and that he demonstrated understanding and insight of medication and need for monitoring. How did he demonstrate that understanding and insight?
A. I can't recall the entire contents of the conversation on the day but, given that I've documented it, the inference would be that we discussed his condition as paranoid schizophrenia, as per the discharge summary, we would have discussed his medication which the -- the aim of which is to control symptoms, that he needs to take it once a day. We may have touched on, as noted in the discharge summary, that when he stopped taking his medications, he experienced the auditory hallucinations again. And from this documentation, I can only assume that he would have confirmed what we were speaking about and was able to follow that in a real, genuine conversation.
Q. As for the plan that you have documented at the bottom, four numbered points, point 1:
"Has adequate supply of aripiprazole. I have

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

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

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

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

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

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

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

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

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

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

MR MOLONEY: Thank you very much, Dr Murphy.

THE WITNESS: Thank you.

THE CHAIR: Thank you, yes.

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

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

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

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

(10.29 am)

(A short break)

(10.40 am)

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

THE CHAIR: Yes.

CLAUDIA BIRTLES (affirmed)

Questioned by MS LANGDALE

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

A. Yeah.

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

A. Yes, I am.

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

A. Yes.

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

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

A. Yes, that's right.

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

A. Yes, that's right.

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

A. Yes.

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

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

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

A. Yes.

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

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

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

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

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

found any, but you may tell us --
A. No, not that I'm aware of. I haven't seen anything, not particularly for nurses, no.
Q. So where would you look to, if anywhere, for professional guidance around tips for monitoring or assessing?
A. I guess within the team, you know, within members of the MDT team. So colleagues who have different experiences working with risk, medical staff, psychology, if we had access at the time to psychology. So kind of leaning on other people's experiences, really.
Q. The consultant in the time we're going to be examining later that you were working with in respect of VC, was Dr Lloyd; is that right?
A. That is right.
Q. So what's her role in respect of yourself?
A. I guess ultimately she's the responsible clinician, ultimately is responsible for that person's care. I kind of feed into that as the care coordinator doing the more day-to-day regular work with somebody and then feeding back to her. So they've got a good understanding of what's happening day-to-day, but I think ultimately she's the highest level of clinical --
Q. She's responsible clinician?

A. Yeah.
Q. She's the psychiatrist?
A. Yeah.
Q. In terms of how often you saw her, we've obviously seen the RiO records, we've seen when there's Multi-Disciplinary Team meetings and we're going to go to a number of those later, but how often, roughly, did you see Dr Lloyd in a formal meeting session to discuss VC, do you think?
A. We would have MDT weekly, so the opportunity was there to discuss face-to-face weekly. If there was any other concerns or I might be worried, then there'd still be ways to access the consultant, either by email or in the office, depending on working days. So I guess formally weekly but there is other opportunities.
Q. That weekly MDT meeting, does it have an agenda, is it specific patients that you're talking about, or ...?
A. Back then, largely from what I recall, we would have a board with our patients' names, initials, and generally we would go through our caseload and if there was anything significant or anything we needed to bring up, the care coordinator would do that.
I think there's changes now in how the MDTs were, but back at that point there wasn't a particular agenda, we tended perhaps to talk about new referrals initially,

if there was any new referrals, allocate who would be assessing them, then any feedbacks from referral -- assessments the previous week, and then we'd look at our caseload and whether there's any cover needed or people are off or any concerns about any risk or any changes. So that was generally the kind of pattern that we followed.
Q. How long were the meetings, roughly, those weekly meetings?
A. I think in 2020 we probably would have had about an hour, an hour and a half. Sometimes it might go over.
Q. How many professionals present for that, apart from Dr Lloyd and yourself?
A. Depending on how many -- it would be the care coordinators in the team, and then if there was support worker, but obviously that -- over the period of time that I worked with VC, that there was obviously changes within the team and he was there and how many, so it did vary -- *(overspeaking)* --
Q. Four or five?
A. No, it could be more, depending on the number of care coordinators.
Q. There's no action plans recorded at the end of an MDT. Is there a reason for that? Do you have action plans and they're just not recorded, or ...?

A. Following a discussion that we've had about a patient, for example?
Q. Yes, when we see your notes of MDTs, we see entries but nothing that says, "Action plan" or who's doing what afterwards. Is there a reason for that?
A. I think at that point we didn't have an agenda and we didn't have a system whereby it was documented, for example, like with a template. So it was -- I guess at that point it wasn't done that way. So we didn't -- it wasn't something that was in our practice that we were regularly doing.
Q. So it was more like an informal discussion between healthcare professionals about caseload and what was going on; is that a fair summary of how it was?
A. It was a formal meeting in the sense that it had to be every week and we had to all attend and there was an expectation to attend, but I think it was just the documentation afterwards. So the discussions were there, but the documentation obviously didn't end -- you know, it wasn't there on RiO. So it was formal, I would say.
Q. So you say it's changed now. What happens now, in terms of MDT meetings?
A. I mean I'm not currently on work, so I'll just go from what I knew this time last year, but there's an agenda,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. *(The witness nodded).*

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

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

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

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

A. Yes.

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

A. Within the three years?

Q. Yes.

A. Yes.

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

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

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

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

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

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

Q. Do you do Mental State Examinations?

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

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

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

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

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

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

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

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

Q. Have you done that frequently?

A. *(The witness nodded)*.

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

A. Yeah.

Q. Do you do that?

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

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

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

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

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

A. Yes.

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

A. Yes, yeah.

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

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

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

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

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

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

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

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

A. Yes.

Q. You read that at the time?

A. Yes.

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

A. Yes.

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

A. No.

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

A. I have seen them, yes, yeah.

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

A. Yes.

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

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

Q. Mm, exchange.

A. -- format, yeah, it was -- it's -- I think it gives a good insight into what that person's experiencing. Because obviously we can summarise ourselves, as healthcare professionals, what that is, medically, I guess, symptom-wise, but I think seeing it it just gives you a little bit more -- a little bit more context about it, and the nuances in the messages and where it was kind of going. I think that's quite useful to see.

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

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

Q. That can come down, please.

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

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

A. Yes.

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

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

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

A. Yes, Yes.

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

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

A. Yes.

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

Dr Seedat clarifying the discharge plan.

Page 45, if we can highlight:

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

Did you see that, and did you understand that?

A. Yes, I think so, yeah.

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

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

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

A. Yes.

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

A. *(Witness nodded)*.

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

A. Yes, from the records, yes.

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

A. Yes.

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

perspective --
A. Yes.
Q. -- and the family?
A. Yes.
Q. Just so we're clear, why is it so significant that that's what he was identifying, as opposed to an early episode of psychosis?
A. He was -- I guess he was suggesting this is potentially more longer term or, like with schizophrenia, that the level of symptoms and things, it wouldn't be one episode, he's recovered. This is where we're at, this is thinking about this as a longer picture.
Q. Did you take that understanding on as the care coordinator? This wasn't going to be one of those cases that we've heard about where he could have an early episode, it resolves and it doesn't return. That wasn't the situation you were being presented with, looking at this, was it?
A. No, not -- no.
Q. If we go to NHFT0000168, page 53, please. This is your first meeting, 30 June. You do a joint meeting. I think you've introduced yourself, if we see at 26 June over telephone to introduce yourself earlier, and on 30 June you go, in attendance, I think, with Daisy Coleman?

A. Yeah.
Q. If we see the notes on page 54 at the top:
"[VC] stated ... everything was okay ... felt okay being back at the flat after his admission."
And if we go towards the end of that next larger paragraph:
"... doesn't feel he has experienced any side effects from the Aripiprazole.
"He believes he has couple of doses left but didn't appear clear on how he was going to ensure he gets a further supply."
That's already suggesting, isn't it, a lack of insight and potential problem with medication concordance, isn't it?
A. Yes, and I think I thought that at the time as well.
Q. Did you? So you assessed the fact that he didn't seem to have arrangements for medication in such a serious situation, you've been discharged, you're supposed to be on medication. Right from the off, this was a red flag; do you agree?
A. Yes, because I think if I compare it to somebody else I might be working with, some people might be more anxious about how they're going to get their medication. Other people might not, but some people might be "Can you let me know how I get it?" You know, and "I've

contacted the GP and they haven't got back to me yet". So I suppose in that sense he didn't come across like he was worried about how he'd get hold of that medication. But with some people that wouldn't worry them, so, yeah, it's difficult to know what was driving it at the time, but I did notice.
Q. You say there:
"There are some concerns that [VC] may play down some of his symptoms."
Was that from your reading of the notes or that meeting that made you say that?
A. I think that's from reading of the notes, because I know people had said it previously in the admissions and when he was seen by Street Triage.
Q. So if we go to page 55, that's NHFT0000168, 55, we see 9 July, second box, VC is telling you everything was good:
"... going through his studies and had been out for a run. ... usually likes to go to the gym and looking forward to these reopening."
Just on that point, were you aware whether he had an interest in physical fitness, in particular lifting weights and staying fit?
A. No, I think at that -- no, I think that was just what he told me about the gym, he just liked to go to the gym.
Q. Over your time of seeing him, did he get stronger and

fitter in the way people do when they embark on fitness programmes?
A. Not that I would have noticed.
Q. So no different from the beginning, from your perspective?
A. Not from my perspective, no.
Q. 11 July, we see the next box below:
"[VC's] mother ... called and asked to speak to someone."
Halfway down the first paragraph:
"... she thinks [VC] may not be taking his medication as prescribed, she was asking for an update on [VC's] care."
This is really significant, isn't it, when you get that kind of information from a concerned family member; do you agree?
A. Yeah.
Q. You say, this not actually you, it's Mr Jackson, isn't it, who's recording:
"... I could not discuss [VC's] care without his consent"?
A. Yes.
Q. It's your colleague who takes that call?
A. I think that's the Crisis Team.
Q. Yeah.

A. Yeah.
Q. So you see that record. Did you speak to VC's mother? Well, we know you did. So when did you first speak to her to get consent around discussing issues about VC?
A. I would have spoken to VC at some point around -- at this point, I would have explained the situation with carer contact. It's usually when I first meet people, I'll explain around confidentiality, just as part of the initial appointments, really. So -- and he was okay with that at that point.
Q. He was okay with you speaking with his mother?
A. Yeah, it was only later he withdrew that.
Q. We'll come to that. This is the call that the Crisis Team takes and you say this, you didn't pick that up until over the weekend.
We know if we go to page 56, NHFT0000168/56, 14 July, there's another episode, isn't there, where VC is breaking or attempting to break into a property at Brook Court and has to be restrained by three residents. Do we see 14 July?
A. Yeah.
Q. "The Police were contacted [top paragraph] by residents ... [he's] been banging on the door and when someone opened it, he immediately forced his way in, attempting to push past the resident. [Happens to have been]

restrained ... by a number of residents ..."
But from your perspective when looking at that, that is very serious conduct, isn't it, because he doesn't know who is behind the door, they don't know who he is. This is really serious behaviour, isn't it?
A. Yes.
Q. With consequences that we already know: somebody has jumped out of a first-floor window injuring their back?
A. Yes.
Q. So when you read that record, were you concerned that he had been back there again and done that?
A. Yes, I think obviously it was similar to the previous incident, so I suppose it fits that he was perhaps still unwell.
Q. We see:
"A box of his Aripiprazole had been obtained by Police and there was one 14 tablet strip left."
So your concerns on that first meeting, immediately borne out, confirmation of non-concordance, wasn't there?
A. Yeah.
Q. Straight from the off.
A. Yeah.
Q. On a number of visits to VC you note that you don't document whether you asked about medication, so you

can't always recall if it was raised; is that right?
A. Yeah, I generally -- I discuss medication at every visit, really. So I suppose it's -- it is routine. I'll be asking how people are getting on with it, to see if there's any change in what they're feeling around it.
Q. So you do check in with them about it, but you don't always necessarily note anything about it?
A. Yeah.
MS LANGDALE: Chair, that's probably a good time for the morning 15-minute break, I think.
THE CHAIR: Yes.
All right. Well, we'll break there, Ms Birtles, and come back at 11.35. Thank you.
(11.21 am)
(A short break)
(11.35 am)
MS LANGDALE: Ms Birtles, we were at 14 July and if we can have NHFT0000168, page 57, please. We've already looked at the document that showed what happened on that evening, and we know that VC was arrested and subsequently detained, and you make a telephone call to VC's mum, halfway down the page, and she's upset:
"... [VC] had become unwell again and she had noticed some 'red flags' [at] ... the weekend during a call ... [she's] unsure whether [VC] has been taking

his medication despite calling him everyday to prompt him. She believes he may mask some of his symptoms and has denied that he is experiencing any auditory hallucinations."
So she's pointing out two things very early on, isn't she: ability to mask. What it did you understand by that? Masking or denying symptoms?
A. Whether he had been -- *(overspeaking)* -- at that point he's denied things to Mum and maybe not been on -- I think she was worried he wasn't honest with us about his experiences still.
Q. Did she use that word: not "honest" with her, probably not honest with you?
Because we see all of these masking symptoms but to a layperson it's not telling you what's going on, it's not being honest, not being frank.
A. I don't remember using that particular word as such, but I think from what I've written there, I think that's what she was implying around that.
Q. So in terms of your approach as his care coordinator, did that influence you about how you might approach VC?
A. Yeah, I guess the fact that this could be happening would always be in the back of my mind and was always in the back of my mind that potentially he wasn't sharing ongoing symptoms, and feeling comfortable sharing them,

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

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

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

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

Q. Sorry --

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

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

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

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

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

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

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

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

A. No --

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

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

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

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

A. Mm.

Q. Yes?

A. Yes.

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

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

Q. When they're on treatment?

A. Yeah.

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

A. *(The witness nodded)*.

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

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

implications of that might be if they're still hearing voices. It's much easier to assess that, I guess, if they're really open about what they're experiencing.

Q. Can we go to NHFT0000168, 79, please. This is the ward review on 21 July, and you're there via Teams, and we see top box "Family/Carers involvement", second paragraph:

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

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

A. I can't remember whether I spoke to her before. But I know she's a health professional, so I know potentially she might know about those things.

Q. Yes, so she's raised it and in the discussion you say in the middle you're "happy with the plan to go for oral tablets for now. We are going to focus on accommodation

..."

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

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

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

A. No.

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

A. Yes.

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

have factored into your reasoning?

A. I think I would have considered it, but I think just explaining how I would have seen it at that point is that this would have felt quite early in the pathway and that's not something we're used to within EIP. Not to say that doesn't happen, it does, but I think I wrote for now, and I guess I must have thought that this, there must have been some kind of scepticism, but not enough for me to think a depot is the only answer now at that point.

Q. The past is a pretty good indicator of the future, isn't it, in terms of assessing risk? It's a good place to start?

A. Yeah, I think I saw the two episodes as one part of one episode, if that makes sense, although he'd come home in between, he'd almost, maybe he hadn't got as well as we thought he had, and this was kind of now we were seeing it was almost like we needed to see how it went going forward, whether he has one more chance to show that he can take his medication and be concordant.

Q. Well, you knew from his last admission he'd stopped taking his medication two weeks after it --

A. Yeah.

Q. -- so you had the history of his previous admission. Here he is on the second admission, and Dr Seedat is

saying in the last paragraph:

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

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

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

A. Um --

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

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

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

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

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

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

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

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

Psychiatrist whether you should?
A. Yes, Yes.
Q. Did you discuss that with Dr Lloyd at any point?
A. Not that I remember, no.
Q. Why was that?
A. Um, I honestly don't know why that wasn't discussed as a potential option, even if he hadn't met the threshold for forensic input from the service, I guess we could have had a conversation with them. But I'm not -- I don't know why, at that point, that wasn't considered.
Q. That admission was only 14-31 July, wasn't it? Were you concerned at the length of that admission?
A. I think I remember -- I think I wrote in my statement, I remember thinking: goodness, this is fairly short. But again, it's not unusual for people to have a fairly short admission if they're improving, and they're no longer experiencing any symptoms.

So it's not uncommon but I probably do remember thinking: oh, he's home already.
Q. Can we go, please, to NHFT0000168, page 126. And this is you returning a call to his mother on 6 August. And if we can mark up the second box, please, at the end.

"During the admission [VC] spoke of his concern ..."

We don't need the date of that, thanks, just the box itself.

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

Again, a significant contribution to your understanding of this patient, wasn't it?
A. Yeah, that's quite useful. I think family members know their loved ones best. So I think that's important, to acknowledge that that's their impression of maybe how, you know, their loved one would feel about us being in hospital and how that would affect their identity going forward. So that's really -- it is really useful.
Q. It means they're in denial, they don't want to take their medication as well, doesn't it? So in practice, that is informing your understanding of the likelihood of him taking medication, isn't it?
A. Yes, but I think -- I mean I wouldn't necessarily say he was -- I know there was issues with him not agreeing with the diagnosis, but again, lots of people might just come out of hospital and think that was just a blip, for example, albeit we might view it slightly differently,

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

So I think it's -- it's not necessarily around the denial; it's potentially he wants to come off and live a normal life not on medication, which again, lots of people will say that after their first admission. That's quite -- something we often expect.
Q. So even if a patient has insight you still have to be concerned about whether they're going to take medication.
A. Yes, yeah.
Q. In this case there was no insight and he wasn't taking medication.
A. Well, I didn't have -- I had concrete evidence with the medication that was found between the two admissions but I think obviously, coming back out the second time, I don't have at that point have confirmation that he wasn't taking it. But obviously I was aware that this was Mum's impression and we needed to be mindful of it.

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

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

Underneath "Diagnosis" it didn't include, did it, paranoid schizophrenia? Why not? Because that was the diagnosis by then, wasn't it: functional and most likely paranoid schizophrenia?
A. Yes, that could have been in there -- yes, it wasn't.
Q. If it should have been, shouldn't it?
A. Yes.
Q. Are you aware, we've heard expert evidence from Professor Fazel, of the association, greater association with risks of violence for those with paranoid schizophrenia?
A. Yeah, I was aware there was a risk, but yeah, I guess it was interesting to hear the experts' view on that as well.
Q. Greater for men --
A. *(The witness nodded)*.
Q. -- and particularly younger men.
A. Yeah.
Q. So seeing that diagnoses, understanding association of risks, and knowing it was interactions with the police leading to the Mental Health Act Assessments, it's important in the care plan for that to be right up at

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

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

paragraph under "Care Plan Details":

"Ongoing monitoring of mood and mental state.

"For mental health services to remain an assertive approach in continuing to work with [VC]."

What do you mean by "assertive approach"?

A. I guess it's one of the principles of EIP that we'll try and, if there's some difficulties around engagement, be flexible and creative in how we might work with somebody who might be having difficulties identifying that there might be issues, for example. And it's knowing your patient, knowing what -- why they might be behaving a certain way and then knowing how you can assertively engage them without pushing them away too far; that balance between engagement and building that relationship.

So it's generally how -- it's not a case of "Oh we'll pick somebody up" and then we'll not see them for a while. It's an assertive approach -- *(overspeaking)* --
Q. It's about meeting them.
A. -- contact and seeing them regularly, and keeping an eye on how things are.
Q. The Inquiry has heard evidence about something called Assertive Outreach, which is different from what you're describing, which involves seeing patients flexibly

around the clock, across a whole team, a whole-team approach, and effectively where there are difficulties with medication, hitting them head on, and if needs be, applying for detention and treatment, if that's the right thing to do.

You didn't do that at any stage, did you, as the EIP team? You didn't apply or suggest there should be a Mental Health Act Assessment to ensure treatment via depot, for example. You didn't take that approach to the medication issues.
A. Well, on occasions we had to, because although we might not have had evidence he wasn't taking his medication it was clear he was unwell, so at that point it would have been escalated. But generally, just suspecting somebody might not be taking their medication wouldn't -- *(overspeaking)* --
Q. Wouldn't trigger that?
A. *(The witness nodded)*.
Q. So if you suspected it, that wouldn't be something you would do.
A. I guess it would depend on a lot of other things around that. If there was kind of safeguarding or risks then obviously that would inform what the action would be, but just, just a suspected or a prediction that someone might not adhere with the treatment wouldn't be enough.

Q. You'd need to look at the safety, the safety of the person --
A. Yeah.
Q. -- the safety of others around them.
A. Yeah.
Q. Here there's a reference to rapid response as well, a "Rapid response if [VC] or family report sudden changes", in that same paragraph in the middle.
A. Yeah.
Q. What is a rapid response? What did that mean in the context of the care plan?
A. I think for me personally as the CCO it would be having contact with the person on the same day or the following day, if that allowed, with the patient, and within the restraints of the service.

So having the ability to see somebody fairly quickly, although we're not a crisis service, if there was concerns from family, or from them, it would be following it up. And I guess that's the idea of having slightly lower case loads than other Community Mental Health Teams that allows you to have that flexibility.
Q. On the next page, page 4, "Actions":

"On-going monitoring of concordance due to increased risk of relapse."
A. Yes.

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

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

plan, yeah.
Q. You mentioned the University on the care plan too, under "Actions":

"Liaise with University support services with [VC's] consent to do so."

We see later, interactions that you have with Ellie Turner. What was the role of the University's mental health advisory team, as far as you were concerned, in his case.
A. In his case?
Q. Yes.
A. I can't recall when he first liaised with the University support team. Sorry, that's difficult to know.
Q. Well, generally, then. More generally, have you dealt with the Nottingham University Mental Health Advisory Team?
A. Yes, frequently. They -- it's useful for students who are kind of suffering with mental health issues, and expected in their university experience. They're there to support them and put things in place around the education side of it. But we'll often say if we meet people and they're a university student, that we can liaise with the team if they like. Sometimes they might ask for some evidence about their mental health, and if they consent, we can pass that to the team so they're

aware of what's happening.
Q. Only with consent? Do you only pass that with consent?
A. If it's not something that's related to kind of a significant risk, yes. If it's just related to maybe their diagnosis or details about their health, then that would -- we'd want to get their consent to do that.
Q. In terms of VC, we see as matters progress, and even from the point when you've been involved, that he's been a risk to neighbours, a risk of causing them harm.
Would you, or did you, in those circumstances share information with the University about the risk he posed to those around him?
A. I don't think I -- I don't recall at that point I did, no.
Q. Because it seems pretty astonishing that, in September 2021, the University did not know about him assaulting the police officer or the detention?
A. Yes.
Q. Do you find that astonishing, that they wouldn't be aware of that?
A. I probably didn't realise they weren't aware of it at that point. I only found out about that through the Inquiry process. I don't think that had occurred to me at the time.
Q. Whose job would it have been to let them know about

that? Obviously the police know about it, you know about it as mental health. Who should have told them?
A. Well, obviously at that point he was just an inpatient in hospital, so I don't know whose responsibility that would have been. I'm sorry.
Q. You then say in the care plan, page 5:
"Actions:
"Mental health services to build non-judgmental, therapeutic relationship with [VC] allowing him a safe space to discuss any possible past experiences."
What do you mean "non-judgmental"? Because some behaviours need to be judged, don't they, discussed and judged candidly, even if they're driven by mental illness?
A. I guess we're aware of the stigma around mental health conditions and how that can affect people, and it's being aware of that in order to build that therapeutic relationship.
Q. Part of trusting relationships is that people are able to tell you the unpalatable truths and discuss them openly with you?
A. *(Witness nodded)*?
Q. So there were two things here, his diagnosis and also his behaviour towards others, and we've seen Dr Seedat address behaviour towards others and what he says to VC.

On that subject, did you ever approach that with him; what he did and the impact on others?
A. I couldn't recall -- again, that's something I've thought about a lot since. I can't recall what I spoke about regarding those incidents. And because there was nothing in the records to say that happened, I just can't remember whether -- it's unusual. We would -- it's unusual if I didn't, because we would normally go back, with anybody, kind of go back to what was happening before, how, you know, the triggers and potentially what might be some of the difficulties might have been, and what happened in an incident.
So it's unusual that I wouldn't have. But I can't remember the difficulties -- I can't remember that conversation or how that -- *(overspeaking)* --
Q. When we come to the social circumstances report, it's clear that you're communicating to the police around whether or not he has a caution that you're concerned it's triggering for him to discuss those issues because they're related to the time of admission. Does that ring a bell for you, or shall we look at that later?
A. I think that was obviously later, as in later down the pathway, so I can't remember after the first or second admission what I spoke about with him, about what happened in that -- *(overspeaking)* --

Q. Might you have been deflected because you thought it would be triggering? Because you don't record anywhere about those neighbours, what happened in the flat, the woman who was injured, what he thought about that.
A. I think it was -- I don't -- I wouldn't say I would be worried about raising things with people. It's not something that -- I'd be mindful that it's sometimes difficult for people to talk about things. And he was -- I know he -- I knew he was keen on moving forward, and perhaps not -- I could appreciate he didn't want to talk -- not that he said he didn't want to specifically talk about it, because I don't recall that, but he didn't engage particularly well during appointments, and offer much information, despite me trying. But that -- I can't say that I didn't ask or I did ask, and this is what he said because there's nothing documented about that.
Q. In the end, do you agree that this care plan failed to include any violence and risk management as part of his ongoing treatment plan?
A. Yes, but I think a lot of it would have been -- well, it should have been captured in the risk assessment.
Q. And the care plan. The summary in the care plan is the plan; what are you going to do. Addressing issues of insight and danger associated with his lack of insight.

A. Yeah, I think, I guess the plan was focusing on the medication and the concordance and potentially thinking about some CBTp, and maybe that was the things that would, you know, keep risks low and have -- and in order to have those more frank discussions about what had happened.

Q. It didn't have a plan for testing for non-concordance, given the risks that arose from it, did it? It didn't have how you were going to do it, what the programme was going to be?

A. No, although I guess -- I mean, we are fairly limited in that respect. It's difficult. We're monitoring concordance, but we're not there with them every day taking the medication. I guess the plan for everybody would always be if we were told they'd stop medication or they were flatly refusing it, then we would be having discussions about what the next step would be, or whether we'd be involved with the Crisis Team or Home Treatment Team.

Q. Well, you could have, as in fact occurred later, even at this stage, suggested that the Crisis Team went out every day and watched that he took the medication, and if he didn't, there would be consequences of that. That's one way, isn't it, of in the community monitoring, close monitoring, as to medication?

A. Yes, but that can't be done indefinitely, and the risks -- that is about -- more about preventing admission and using the concordance to get somebody well in order to, you know, not rely on an inpatient admission. So we couldn't indefinitely offer the Crisis Team. They'd have to be -- the threshold is fairly high for that involvement.

If I thought he was unwell and, you know, he was demonstrating that he was unwell and he was demonstrating risky behaviour, that is when we'd come together and have that discussion about whether we'd either do a Mental Health Act Assessment or we'd do some home treatment.

So yeah, it depends when -- there couldn't be a blanket "this is how you deal with non-concordance or suspected non-concordance".

Q. Can we have NHFT0000168/133, please, and this is 7 September 2020, Dr Burri's note. We see in the sixth paragraph reference to:

"There is no genetic loading for mental illness as such that he can think of."

Did you know about reported mental health concerns about VC's grandfather? He had mental health --

A. I don't know, I don't know when I knew that, whether that was before or after. I don't know what I knew at

the time.

Q. Two paragraphs along:

"... compliant with his medication with no reported side effects. He mentioned ... he would like to try to have a medication free trial but I reflected ... he had tried it in the past ..."

Did that request raise any red flags to you?

A. I think ... yeah, um, ... again it's something that lots of people will say. So it's not that I wouldn't take that seriously. I would -- that's an indication that somebody's perhaps thinking they might not need it or they don't want it or they're wanting to be off it sooner than we think. Because often when you say to somebody "We think you need to be on this 12 months to two years," for example, lots of -- most people are shocked by the length of time. It's not what they perhaps would have anticipated.

But I thought -- in a way, I think I thought during that appointment it was positive that he was at least letting us know what his thoughts were around medication, rather than, you know, I'll just keep continuing to take it, and then me thinking: you probably don't feel that.

So I thought, in a way it's a helpful thing because at least it opens up that discussion about well no,

because we know what happened last time, and this is what our recommendation is, for you to continue for this length of time.

Q. The following month, if we go to 135, NHFT0000168, 135, top of the page. This is 9 October. Ms Parsonage takes this call.

VC's mother has spoken to VC:

"... he ... stated 'Don't speak to me for 2 months'.

"She has ... been unable to contact him."

That's a significant red flag, isn't it?

A. Yeah, that's unusual I'd say, yeah.

Q. Why not elevate the situation at this stage to the consultant and say: "We need to have a look at this. He's been asking for medication-free trials. He's asked his mother not to speak to him. She hasn't spoken to him."

You knew she was a prompt in the past around medication; was that a time to get consultant input?

A. I wasn't at work at that point so I don't know whether that was discussed with Dr Lloyd at that point.

Q. You didn't --

A. Obviously I was off work, so I don't know what was discussed or with who at that point. -- *(overspeaking)* --

Q. Looking at it now, do you think that would be a really

concerning call?
A. Yeah, without knowing the context it's difficult. Obviously he's just said don't -- obviously we've only heard that he said, "Don't speak to me for 2 months." We don't know why. But that would be something that we would then ask him and then have a discussion about, just because it, I suppose it's out of -- from knowing the family, that would be out of character for that family.
Q. And you could receive that information from his mother. You don't just have to ask him, do you? You can ask her why he's said that.
A. Yes.
Q. Do you receive information from extended family? Even if you haven't got consent to share information about a patient, are you happy and willing to receive what people tell you about a patient?
A. Yes, always, yeah, it's really helpful. Even if we're unable to share specific details around someone's care, I'll always let people know that if they're wanting to share things with us --
Q. The following month, in November, we see NHFT0018155, page 1. 1 and 2 can probably fit on one page. It's an email that you send to Dr Burri. This is the request to speak to Dr Burri. You say in the email:

"He has told his mum not to call for 2 months which is out of character ... spoken to his brother ... told him he has something to share, but hasn't said what."
We know if we go to page 137, NHFT0000168, 137, that's your note of the conversation.
"[VC] politely requested a face to face appointment ... When I enquired as to why he may need a sooner appointment he said he had something very important to discuss."
Why not involve the Crisis Team, who could monitor this daily for a period at this point?
A. I think at this point we didn't really know, I didn't really know what -- what it kind of was indicating, because it was quite a brief phone call.
So my first step was to get him reviewed by one of our medics, to see -- that was going on kind of, I suppose, a gut instinct that lots of people might ring up and say, "I need to see the doctor today." It's not always possible. So that -- I suppose for me that was like I think this would be useful that we do facilitate this appointment at this time --
Q. Sure -- *(overspeaking)* --
A. -- because he's asked for it.
Q. It's what you do next, isn't it?
A. *(The witness nodded)*.

Q. Because if we look at NHFT0000168/138, paragraph 2. He tells you, at paragraph 2, that:
"He told [the] ward doctor [that's on his admission] that he no longer hears voices but he said that is not the case and he only said that because he was tired for being in the hospital."
Significant, isn't it? He's telling you he simply said that for secondary gain to get out the hospital.
A. *(The witness nodded)*.
Q. So you learnt at that appointment, didn't you, that he was hearing voices and, furthermore, he had said he didn't hear them just to get out of hospital?
A. Yes, yes --
Q. So you knew this was somebody who knew where he wanted to be and would say what suited that purpose.
A. Yes.
Q. So at that point, didn't that need serious escalation? You had all the proof you needed about what he was going to tell you.
A. I think we -- Dr Burri and I, from our impression, was that yes, he was still experiencing symptoms with the partial insight. But we -- you know, at his assessment at that point was that the risks were fairly contained -- well, were contained, and nothing had changed in that respect. So it was a case of

monitoring, and if anything changes then we would have to consider what the next step would be.
Q. It almost appears, doesn't it, that there needs to be an episode of violence to a member of the public before it's escalated? That seeing these risks as they develop, the flags, the emphasis where it lands here, that he's going to say what he needs to say, and it's a 'wait and see', see if anything happens.
A. Well, I think the hope for us is that we would -- it wouldn't get to that point and we would notice a real change in someone's presentation in that kind of crisis point. We would get to that point and know him well enough in order to put the next step in place, like you said putting the Crisis Team in place at that point. And it wouldn't be a case of just waiting for something terrible to happen; it would be trying to manage it in order to intervene when was -- when we felt it was appropriate and legally we could do that, if we're looking at the Mental Health Act.
So I, actually -- I actually felt the discussions we had in that session, or the discussions he had with Dr Burri, I remember feeling quite optimistic that he'd been honest with us and he'd felt like he could have been honest with us. So I thought that was -- I actually left thinking this is positive, because it's

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

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

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

A. *(The witness nodded)*.

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

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

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

of it throughout.

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

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

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

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

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

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

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

A. Yes.

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

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

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

A. Yes.

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

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

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

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

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

You offer VC:

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

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

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

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

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

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

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

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

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

A. Yes.

Q. You record here:

"[VC] was unable to identify anything specific that had triggered the episode but does feel stress, especially University workload/exams may have contributed."

Yes?

A. Yes.

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

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

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

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

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

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

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

Q. If we look at the relapse signature box, then:

"Feeling depressed and low

"Feeling violent, angry, aggressive or pushy (although never acted on these feelings."

You knew he'd acted on feelings leading to his

admissions to hospital, didn't you?

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

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

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

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

A. Um --

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

A. Yeah.

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

A. Yeah.

Q. He's been "reassured", paragraph 3:

"There['s] ...no obvious issues with his memory

following ... memory assessment".

The next paragraph, you'd received an email, hadn't you, from PC Gail Collins regarding an incident at Brook Court and he had been, VC, taken aback at the expected cost of £600 for the damage caused to a door; is that right?

A. Yeah.

Q. What was VC's reaction to that?

A. I think he was shocked -- I think he was shocked at the cost, and I think he said he was surprised that it was just a bit of damage to the door and how much it would cost, and I think I queried that, but I can't remember. They described -- it was one of the -- like a fire door or it had regulatory things that would have meant it cost so much money to replace and fix.

Q. And you queried that with the police, the cost of the door, yes?

A. Yes.

Q. And you also said, it could be very difficult to be discussing that issue with him because it precipitated his detention; is that right?

A. Yes, I wrote that, yeah.

Q. VC didn't accept that caution, "he wanted his day in court". Do you know anything about why he wanted his day in court or didn't accept that caution? What did he

say?

A. I think I wrote it in another entry but I can't remember what he said. I think I asked him about it, and I think he said one line, like I said, "he wanted his day in court". And I remember thinking: does he know what that means? And I queried a bit more about what that might entail, and he did. Because I was -- I did wonder myself why he might have said that. But --

Q. He did know it meant going to court and what it entailed --

A. *(The witness nodded).*

Q. -- and he was content for that.

A. Yeah.

Q. He didn't want the caution --

A. Yeah.

Q. -- and he didn't agree with the amount of money of the door, the damage was.

A. Yeah.

Q. So he was able to clearly set out his position and perspective on that criminal process.

A. Yes, yeah.

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

"T[elephone]/C[all] from Mum to advise she believes her son is becoming unwell ... over the last few days she sensed he is not doing well and ... wasn't making

sense. She felt he had not [been] ... taking his medication, she hadn't called his CPN ... [VC] has [since]... been talking to his brother and ... has reportedly told his brother he hasn't been taking his medications ..."

"Asked if he had any concerns ... reported no ... reports no difference to ... [himself]."

This is VC. So he gets a telephone call after this report from his mother, doesn't he?

A. Yes.

Q. A telephone call. Do you think, and I know this is Juliet Lopez, not you, do you think there should have been a face-to-face meeting after this?

A. Well, in light of the situation, yes, but I don't know what, in regards to the Crisis Team, what their capacity would be to do that, and whether that would be something they would offer.

Q. And we see at the bottom:

"[He] ... is polite and cooperative throughout the telephone assessment."

This is far too complex to assess down a telephone, isn't it?

A. It is difficult, yeah.

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

A. Yes.

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

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

Q. Okay. We know that VC went to Thames House on 31 May. So immediately following this telephone call. Do you know about that at all? When did you learn that he'd gone down to London and spoke to police outside MI5?

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

Q. Would it have been important to have information from the police about that, what he'd said to police officers, why he was there? Would you have wanted to know about that at this time?

A. Yes, definitely.

Q. Why would you want to know that?

A. I think he -- well, he'd mentioned before about MI5 in a previous appointment, so to me that seemed significant. I know people are interested in MI5 and might want to go and take pictures of the building or have a genuine interest. But I think because we'd known some of his beliefs -- well, we'd known he'd mentioned their involvement elsewhere. I would -- I'd want to know if he'd taken steps to go down there.

Q. Do you ever ask patients that you're visiting, or individuals in the community, about what they're looking

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

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

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

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

August 2021.
A. He was -- at that point our impression that he was clearly unwell, and quite obviously unwell. I know he'd continued to have symptoms, and he'd admitted to still hearing voices. But at this point I felt like it had kind of tipped over slightly. He was quite confrontational, agitated. He was talking about our involvement with other agencies, and at that point I didn't think he obviously he appreciated his presentation, how he was coming across. I don't think he recognised there was an issue. He said he wasn't going to engage, he wasn't going to take his tablets, and that was the first time those kind of things -- those things -- those are things he'd said.
So there was just a real shift in how he was presenting, and I hadn't seen that before.
Q. "Discussed with Dr Lloyd", that was the plan. What did she say?
A. Just -- obviously, she -- I think she agreed that this was an indication that the risks had escalated slightly, he wasn't going to engage with us in the community. He said he wasn't going to work with us, so obviously wanted to speak to the Crisis Team regarding options, Mental Health Act-wise if necessary, or whether we do home treatment. Having those discussions, basically.

Q. What was the plan? Never mind discussions, what was the plan? This was an occasion where you had felt unsafe.
A. Yeah.
Q. You've discussed it with Dr Lloyd. If you felt unsafe, isn't it likely other people are going to feel unsafe, even if you don't know about what had happened to Sebastian a month before?
A. Yes, so it wouldn't -- when I say discussions, they have to look at all the options. So as soon as -- the Crisis Team would gatekeep kind of a Mental Health Act Assessments as such, and you'd have to liaise with them first, and you'd have the discussion with the practitioner there. Then they would either agree it was necessary and it was unlikely that home treatment was going to work, and then he would refer for a Mental Health Act Assessment. So in my eyes, from that perspective, from seeing him, it was highly likely that we're not even going to consider home treatment at that point because it wouldn't work. So we would be going the next step to a Mental Health Act Assessment.
Q. Which is what subsequently happens?
A. Yeah.
Q. If we go to the risk assessment, risk and safety assessment, NHFT0000194, page 2, that has been updated on this occasion, and we see at page 2, second

paragraph:
"[VC] appears to be relapsing. Appears quite suspicious/paranoid, little bit confrontational although no evidence of any aggression. ... has stopped treatment ..."
No evidence of any aggression? Was there evidence of intimidation? What was there?
A. He wasn't making threats to harm us or ... I guess I felt intimidated by the fact he was unwell and we were in his house, and at that point you're quite vulnerable, but he wasn't saying, "I'm going to hurt you", or "This is what I'm going to do". So it feels intimidating in that environment when you're with somebody who is unwell in their home, but no specific threats to hurt us at that point.
Q. We know the assault, a violent assault on the police officer; would you agree?
A. Yes.
Q. Who did you get information about that assault from?
A. Just the notes from the assessing team, so the doctors that had done the Mental Health Act Assessment, from their impression of what had happened on RiO.
Q. What did you consider about that, in terms of risk?
A. Well, I thought that was a really significant assault. I was quite shocked to read about it.

Q. If we go, please, to WITN0348003, page 2, you sent an email to John Laverick, who is a senior nurse, where VC is detained, and you're asked to do a social circumstances report, aren't you, because he's seeking release from the detention?
A. Yes.
Q. You say here:
"How is VC doing? Is a depot being considered? This was discussed following his second admission however he declined it at the time. This is obviously his third admission and concordance remains an issue. Reflecting on things now I don't think VC has ever truly acknowledged he has a mental health issue and insight has remained poor."
If it's not obvious, why are you raising a depot now?
A. For that reason, really, that we were still in the same position that we had been back after the first admission, that he was potentially -- not taking his medication -- well, he told me at that appointment he wasn't taking it, so that was the first time he'd actually said, "I'm not taking my tablets, I'm not going to, I've got no intention of doing that". So, you know, it was going on that, really, that this clearly wasn't going to work with oral, unlikely to anyway.

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

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

Had you discussed that with Dr Lloyd before then?

A. The depot?

Q. Yeah.

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

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

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

A. Yeah.

Q. You then did the Social Circumstances Report and if we

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

A. Yes.

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

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

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

A. Yes.

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

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

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

A. No, no, possibly, but that's an oversight. There's no reason why I wouldn't have. Because that was a really

honest, open discussion between the three of us in that appointment. So it's not like I found it out secondhand or anything. He was aware that he'd said it, but it's probably unfortunate, but it's just a bit of an oversight.

Q. You have expressed at box 15:

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

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

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

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

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

Q. So that was wrong?

A. Yeah.

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

of medication, unused medication, dated back to February 2021? So when you're speaking about being non-concordant for a while, this was several months, isn't it?

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

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

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

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

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

A. Yes.

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

His description of his auditory hallucinations made it clear he was feeling under threat most of the time, didn't it? What he had told you about the

hallucinations?
A. Yeah.
Q. So when feeling under threat, did that adequately convey the extent of how long he'd told you he was hearing voices, and the conspiracy beliefs?
A. Sorry, say that again.
Q. Did that adequately cover what he had told you about the extent of his delusional beliefs and voices into his head and what they were telling him?
A. I mean, there's not an awful lot of information there that would explain that in great detail, but it's -- I probably spoke about that during the -- it's likely I would have spoke about that during the tribunal.
Q. Yes, and you say later you think this was a complete breakdown in your relationship with VC after this, because of what you were saying; is that right?
A. Yes.
Q. If we go to the tribunal's findings, CYGN0000056, page 5, paragraph 13.
"There is unequivocal evidence that the risks to others when [VC] is unwell are high and that relapse occurs rapidly and is difficult to manage."
"These risks eventuated very recently and it is important that they are minimised so far as is reasonable until [VC] is discharged into the community."

Did you get a copy of the tribunal decision?
A. I can't remember what was shared with us. I don't know, to be honest, what we had. I can't remember what we had at the time. I think it's likely that we'd get the reports uploaded onto RiO by the Mental Health Tribunal team, but I can't remember --
Q. You don't remember that, reading it. But it should be accessible, should it, for clinicians on a --
A. Yeah, the decision, yeah, I guess, yeah. We wouldn't necessarily see maybe the other reports, but generally the decision, yes. So other reports from different health professionals who did it as part of the tribunal.
Q. Can we have NHFT0000168, page 191, please, and this a note, Ms Birtles, 17 September 2021 when you discussed the Section 2 tribunal with VC and we see in the top box:
"[VC] said there are no issues with his mental health and maintains ... he does not have a psychotic illness and he 'knows so' because he is 'most familiar with his own situation' and knows that it is not and never has been psychosis. ... this admission has been unnecessary much like the previous two because he is not mentally unwell. [He said he] ... also 'know that' it is not psychotic."
"Discussed possibility of depot medication as one

option ..."
We see further down.
So did you raise that with him?
A. Yes, that will have been in that call, yes.
Q. He:
"... said ... [it] would depend on the side effects ... it might be easier than taking medication everyday".
So you've recorded that. Is that what he said at the time?
A. Yeah, I think that's what he said.
Q. So your view about depot was one that you were telling him about?
A. Yes.
Q. Next box further down, 21 September, 3.45, you record:
"[VC] said he had read through the information in the social circumstances report and expressed disappointment in the way he was presented. [VC] also questioned the boundaries of confidentiality and said he was likely to be more guarded with me going forward given that [the] information had been shared."
A. Yes.
Q. So can you unpack that a bit, please, and say what he was saying to you there?
A. I mean, he would have known that I was sharing information about -- or my impression of him at the

moment as part of the tribunal, because I would have made that clear on the call that I'd have to discuss what my recommendations might be based on what I know. But I think, after he'd read it, he felt that that wasn't the true reflection of how he was and he was disappointed that I'd shared it.
And I don't know whether he fully grasped why I would share it, and why I would have to share it, and that confidentiality doesn't -- that doesn't apply in this situation. So I don't know whether he fully understood that, and I think he felt let down by my interpretation of his events, and the risks, and the things I've stated in that report.
Q. Can we have, please, PAGR0000025, page 6, and this is a record from Priory Arnold. We know you thought to upload the notes from Priory to VC's RiO. We see an email, I think around 28 October where you're attempting to do that and get them uploaded.
A. Yeah.
Q. We also know notes in Cygnet, he says a lot about his delusionary beliefs. They were not uploaded in any risk assessment format, were they? You've conceded earlier on there was no careful collation of risk assessment information, but evidence during this admission about delusional beliefs and their impact would have been

relevant to risk, wouldn't they?
A. Yes.
Q. If we see "Keeping Safe", the second box, we'll hear some primary evidence about this, and it's recorded 10 October:
"There have been no issues regarding his safety. ... remains on level 2 x 2 checks per minute. [VC] had brought some belongings brought in when he went on community leave. [VC] had brought a hammer in his rucksack, it is unclear as to whether he picked this up by accident or whether it was intentional."
Did you see that note at any point?
A. I can't remember. I will have done ... I'm always interested to read inpatient notes, so I would have tried my best to read it. But I can't remember -- the fact that I hadn't put it in the risk assessment, I mean I think that's something I would probably document.
Q. But you don't remember now?
A. I can't remember. We do get quite -- I mean sometimes they can be quite lengthy documents that we get from someone's stay at a private hospital, because obviously there's -- it's not -- it's paper -- it's almost like scanned in and uploaded so it can be quite lengthy.
THE CHAIR: Is this a good moment to have a break?
MS LANGDALE: It is.

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

I N D E X