

Wednesday, 29 April 2026

1  
 2 (2.05 pm)  
 3 MS LANGDALE: Ms Birtles, can you see and hear me still?  
 4 A. Yes, I can.  
 5 Q. Can I ask, please, that we look at NHFT0000168,  
 6 page 193. We were looking at VC's time at the Priory  
 7 and we have just looked at that entry about him having  
 8 a hammer. 14 October 2021, if we can enlarge this  
 9 single box, please, this is where you are attending  
 10 remotely via Teams?  
 11 A. Yes.  
 12 Q. We see halfway down:  
 13 "They do not feel that [VC] will need to stay on  
 14 a Section 3 and are actively planning discharge...  
 15 "Note: [VC] said that he has no problem working  
 16 with me following his discharge.  
 17 "The [Consultant] reflected to [VC] that he appears  
 18 reluctant to involve various support agencies. [VC]  
 19 disagreed and said everything was in hand."  
 20 You told us in your statement to the Inquiry, at  
 21 paragraph 362, that you felt this was premature and  
 22 a depot should have been considered; is that right?  
 23 A. Yes.  
 24 Q. Why did you think it was premature, this discussion of  
 25 discharge, and why did you think a depot should have

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1 consistency which I think it does make it -- it has its  
 2 challenges.  
 3 Q. In this ward round, did VC say that he has no problem  
 4 working with you following his discharge?  
 5 A. From what I've written on the notes, yeah, he will have  
 6 said that, yeah.  
 7 Q. Did you share that optimism, given his response to the  
 8 Social Circumstances Report?  
 9 A. Possibly not. I think I would have been sceptical  
 10 of it, but I'm obviously going on what he's saying at  
 11 that point, that he's saying he's okay to work with me.  
 12 Q. Did you say you obviously go with what he said?  
 13 A. Yeah, so -- well, I'm documenting what he said.  
 14 Q. Yes.  
 15 A. He may well have felt that at that point. I know he'd  
 16 previously said about the tribunal, but I suppose in the  
 17 back of my mind I would be bearing that previous  
 18 conversation we'd had in mind.  
 19 Q. Did anyone, any professional in this meeting, or any  
 20 psychiatrist, ask you separate from VC what you thought  
 21 about working with him following his discharge?  
 22 A. Not that I can remember. But I can't really remember  
 23 the ... I can't really remember the ward review. I've  
 24 got a very vague recollection of speaking.  
 25 Q. But it's not the sort of forum where you would have

3

1 been considered?  
 2 A. I thought this was probably the best opportunity,  
 3 I think because PICU had said they -- although I'd had  
 4 some conversations with the consultant on PICU -- they  
 5 felt it would be more appropriate to look at that once  
 6 VC had been stepped down to the acute ward, and then it  
 7 would be reviewed again.  
 8 Q. Just to be clear, he'd been in a Psychiatric Intensive  
 9 Care Unit --  
 10 A. Yes.  
 11 Q. -- and he needed to be stepped down where there needed  
 12 to be consideration of that?  
 13 A. Yeah, I guess I thought that -- not that it wouldn't  
 14 happen on a PICU, but I think that's what they  
 15 recommended, and then I thought we would --  
 16 *(overspeaking)* --  
 17 Q. Do you think the lack of continuity of care across  
 18 providers hampered the treatment considerations at this  
 19 point?  
 20 A. Well, it's different hospitals, different teams involved  
 21 in the PICU, and then the acute ward, and then obviously  
 22 that -- this admission was not -- obviously not at  
 23 Highbury, so there was different hospitals does make it  
 24 more difficult. They wouldn't know -- they wouldn't  
 25 have known him from previously, so there's a lack of

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1 flatly contradicted VC in that assertion?  
 2 A. I don't recall doing it at that point. Usually with  
 3 ward rounds, I've been in ward rounds before where you'd  
 4 have the opportunity to maybe meet with the consultant  
 5 before the patient might come in. But I can't remember  
 6 whether at that point I had that discussion. So to give  
 7 a bit more of a background.  
 8 Q. Well, you're on Teams, but sometimes that can still  
 9 happen in breakout rooms, can't it?  
 10 A. Yeah.  
 11 Q. Did that happen? You don't have any recollection of  
 12 that?  
 13 A. I can't remember if that happened, but I have done that  
 14 before.  
 15 Q. You had concerns, we know, throughout November about  
 16 VC's engagement. He was discharged 24 October. You  
 17 were concerned about his engagement, and we know no one  
 18 speaks to VC between 19 November and 16 December; is  
 19 that right?  
 20 A. Could you show me on the RiO, please?  
 21 Q. Let's take that down. If we look on the RiO, you next  
 22 speak to him at 197. NHFT0000168/197, and we see there:  
 23 "Attempted to call [VC] to discuss plans for an  
 24 appointment ... no answer. [VC] has indicated on [the]  
 25 text message he has 'plenty of tablets left' believes he

4

1 has two weeks left. According to the discharge summary  
2 [VC] was only given a 2 week supply ... which if taken  
3 correctly should be running out on Friday."

4 Was this, for you, evidence of non-concordance so  
5 soon after discharge?

6 **A.** Possibly, yes. I think that's what I was considering  
7 then.

8 **Q.** If we go, please, to 198, 5 November, if we can enlarge  
9 the top box, please. You visit VC:

10 "Felt the admission to hospital was awful and  
11 unnecessary. [VC] does not agree with medical  
12 professionals that he has been unwell. Said he was  
13 continuing to take his medication 'because he has to'  
14 although he doesn't feel it necessary. [VC] said he has  
15 realised he has been taking just one tablet (10 mg)  
16 rather than the two ... he is prescribed. This appears  
17 to have been an oversight and he did say he would take  
18 the increased dose. He should have a weeks supply ...  
19 if taken correctly."

20 Did you ask to see how many tablets he had left or  
21 if he had a week's supply at this meeting?

22 **A.** No, because as that was done at the Stonebridge Centre  
23 appointment, so he wouldn't have had --

24 **Q.** Sorry, done where?

25 **A.** At the Stonebridge Centre. So he came to meet me at the

5

1 engage with [mental health] ... services and is doing  
2 the minimum required. I believe it's unlikely [VC] will  
3 ever open up about his experiences given this has led to  
4 an admission previously and he doesn't trust [mental  
5 health] ... services."

6 Do you consider at this point he's becoming  
7 unmanageable in the community, relapse and repeat of  
8 violence is going to be inevitable?

9 **A.** I was definitely concerned about the engagement and the  
10 fact his outward presentation had shifted slightly, but  
11 it was more around his -- how he responded to questions  
12 and it was more likely -- I could appreciate that he was  
13 quite frustrated with mental health services at that  
14 time.

15 So although -- so I was concerned, but there was  
16 nothing to suggest that he was relapsing, as such, but  
17 there was a real shift in the -- the engagement and  
18 I think that's why I wrote my impression at that point,  
19 because I could see it was going to be difficult, to  
20 engage in the community.

21 **Q.** If we remove that box and go to the bottom half of the  
22 document from the 29 November to the bottom,  
23 14 December. As I suggested earlier, we see there he is  
24 not seen, is he, in that period? He is not home for his  
25 appointment on 6 December.

7

1 office. So I wouldn't, unless he'd carried them with me  
2 (sic), I wouldn't have had access to his medication at  
3 that point.

4 **Q.** To be clear, did you have meetings at the office at this  
5 point in time after the meeting you went to earlier  
6 where you were conscious of how it was to get out of the  
7 property, and you weren't happy visiting there?

8 **A.** Yeah, I think we agreed, as an MDT, that it would be  
9 better to have visits at the base.

10 **Q.** We see at the bottom of this page, 12 November:  
11 "[VC] has not collected his medication today."  
12 4 pm.

13 **A.** Yeah.

14 **Q.** So a failure to attend, not getting his medication.

15 **A.** Yes.

16 **Q.** 19 November, if we can have, please, 199, top box,  
17 please.

18 "Remains very guarded, wouldn't engage in any  
19 conversation ...

20 "Monosyllabic, responding to all questions with  
21 'fine' 'everything is fine' ... Manner was quite hostile  
22 and unfriendly."

23 "Provided a 28 day supply of medication  
24 (Aripiprazole 20mg).

25 "Impression: it appears [VC] remains reluctant to

8

1 **A.** No.

2 **Q.** 14 December.

3 **A.** No.

4 **Q.** "Attempted to call ... no answer."

5 **A.** Yeah.

6 **Q.** We see, 16 December, we see at 201, please.  
7 NHFT0000168, page 201, top box. This is a telephone  
8 call. If we can enlarge that, please, to the top.

9 "[VC] was very confrontational and quite angry  
10 throughout the call.

11 "He initially demanded whether I knew his phone  
12 number and if I did why had I tried to make contact with  
13 him via his mum. Went on to say that under no  
14 circumstances could I have any contact with his mum as  
15 it was 'stressing her out' and ... totally unnecessary  
16 ..."

17 "When asked about his medication", fifth paragraph:

18 "[VC] said he would pick them up at 'some point'. I  
19 pushed him for a date and time, he said tomorrow ..."

20 This, again, an indication of relapse, withdrawing  
21 consent in respect of his mother, is that right? He'd  
22 done that previously. He didn't want you to speak to  
23 her.

24 **A.** Yes, I think it's because I'd been trying to get in  
25 contact with him via Mum because I hadn't had any

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1 success with himself on his telephone number. So  
 2 I think he was frustrated about.  
 3 **Q.** When asked about medication said he'd pick them up, so  
 4 he wasn't on medication, was he? That was clear.  
 5 **A.** He was ambivalent about picking it up, I think I had to  
 6 push him for a decision about when he was going to  
 7 collect it.  
 8 **Q.** And the history, we spoke before about history being the  
 9 predictor of the future. After both discharges he'd  
 10 ceased taking medication, and after this one too.  
 11 **A.** Possibly, yeah. I mean I hadn't got any concrete  
 12 evidence that was happening but there was delays in  
 13 collecting and just his kind of reluctance to come.  
 14 I just had a sense that potentially it could be a risk,  
 15 yes.  
 16 **Q.** When he was in the community, again, was there a  
 17 discussion with Dr Lloyd at this point with whether he  
 18 could make -- he had the capacity, under the Mental  
 19 Capacity Act, to make a decision about his treatment and  
 20 whether he should be fetching it and taking it? Was  
 21 that ever something you discussed with her at this time?  
 22 **A.** Not that I can recall, no.  
 23 **Q.** If we go, please, to 203, so NHFT0000168/203.  
 24 17 January 2022. So towards the top third of the  
 25 document:

9

1 have disengaged, I have seen people being discharged.  
 2 If we don't know where somebody is or we're struggling  
 3 to locate somebody.  
 4 **Q.** Is that without any risk assessment about their risk in  
 5 the community? Discharged?  
 6 **A.** I think that the risk would always be considered, but it  
 7 wasn't -- it wasn't beyond the realms of it happening.  
 8 It was -- I have witnessed that, but hadn't --  
 9 **Q.** You hadn't discussed it about this case at that time, as  
 10 far as you're --  
 11 **A.** No, and I haven't -- in EIP it's -- I haven't personally  
 12 discharged one of our patients if they've disengaged,  
 13 but that's just my experience.  
 14 **Q.** At the bottom of the page the box, 18 January,  
 15 information. A telephone call from Ellie Turner to  
 16 Adele Pinder, and here setting out the assault on  
 17 a flatmate by VC, and the impact of that on the  
 18 flatmate, and what had happened. Did you see that at  
 19 the time?  
 20 **A.** Not on the day, because I think it was a non-working day  
 21 or I was on leave, but that's why Adele (*unclear*) the  
 22 information but I saw it after, yeah.  
 23 **Q.** And what did you or do you ascertain by the description  
 24 of events written here?  
 25 **A.** Um, so --

11

1 "[VC] did not attend his OPA at 12 noon. This is  
 2 his 5th missed appointment. We will discuss the plan at  
 3 MDT on Thursday. Consideration will need to be given to  
 4 discharge as [VC] has essentially disengaged and we have  
 5 not been able to monitor him. Perhaps a conversation  
 6 with his mum and course tutors to see if there are any  
 7 concerns currently will be prudent before considering  
 8 discharge."  
 9 That looks like it's an entry of Dr Lloyd; is that  
 10 right?  
 11 **A.** Yes.  
 12 **Q.** Did she discuss that with you at that time, this  
 13 consideration to discharge because of disengagement?  
 14 **A.** I can't remember that conversation but I think if  
 15 somebody didn't attend for an outpatient appointment,  
 16 generally I'd be ready for it, and Dr Lloyd would be  
 17 ready for it, and we'd be waiting for the patient. So  
 18 if they didn't attend it might be that we'd had a brief  
 19 discussion between the two of us. But I don't  
 20 remember -- I don't remember having a discussion about  
 21 discharge.  
 22 **Q.** What was your understanding about discharge as  
 23 a consequence of disengagement, whether that was  
 24 possible or not?  
 25 **A.** I was aware that it had -- it has happened, when people

10

1 **Q.** So if we start four lines down:  
 2 "The student who I was assaulted by and who trapped  
 3 me in the flat and physically wouldn't let me and my  
 4 flatmate [redacted], leave is called [VC]. ... I don't  
 5 know his last name ... know he studies a masters ... at  
 6 the University. ... police came to my accommodation and  
 7 dealt with the situation, but unfortunately, although he  
 8 had intent to hurt me, I stopped him by grabbing him and  
 9 holding him, stopping them from arresting him as  
 10 I didn't sustain any injuries. This has caused me a lot  
 11 of stress as he is still present in the flat and he  
 12 doesn't seem the most stable of people. Any support  
 13 would be extremely well received."  
 14 **A.** Yeah, when we -- obviously when we got the information  
 15 we were obviously concerned about that behaviour, and  
 16 the impact that might have had on the flatmates.  
 17 **Q.** Did you phone Ellie Turner or anyone to get further  
 18 details or account of that?  
 19 **A.** I didn't, but I wasn't on duty that day, so ...  
 20 **Q.** Do you know if anybody did?  
 21 **A.** Unless there's anything on the next entry, I can't  
 22 remember off the top of my head, following the 18th.  
 23 **Q.** If we go to the 18th, there's a gatekeeping discussion  
 24 on page 204, so NHFT0000168/204. That's not related to  
 25 you, of course, but there's reference there to:

12

1 "The incident last night where alleged he has  
2 assaulted a flatmate ...  
3 "Due to risks poses to others when unwell (police  
4 had to taser him last time, he has taken hostages in his  
5 flat, assault) ..."

6 So reference there to taking hostages in his flat  
7 assault. Do you know where that description had come  
8 from or how?

9 **A.** No, I don't know. I don't know where, which description  
10 that had come from. Whether that was a conversation  
11 with the Uni or whether that was something else; I don't  
12 know.

13 **Q.** If we go, please, to NHFT0000168/225, this is 3  
14 February 2022 and if we see the top third of the  
15 document, 0225:

16 "VC is guarded about the incident which happened  
17 prior to admission."

18 So this is the incident with the student.

19 **A.** Yeah.

20 **Q.** "Claudia has been his care coordinator since summer  
21 2020. He is very guarded and their relationship has  
22 deteriorated over the years as he feels persecuted by  
23 mental health services. The police [felt they] couldn't  
24 share any further information with Claudia."

25 Is that a contribution you have made to the meeting

13

1 **Q.** Over the page at 226, please, 6 paragraphs down:

2 "When asked how he was getting along with his  
3 medication VC said that its 'trivial to take the  
4 medication' and 'its easy' and 'it makes no difference'  
5 to him.

6 "He was then asked about having a depot form of the  
7 medication and he would prefer not to have a depot. It  
8 was explained that the community team thought it would  
9 be beneficial to have one however he said that he didn't  
10 like needles and would prefer to continue with tablets."

11 Were you sceptical of the suggestion that he didn't  
12 like needles, given that he'd had Covid vaccines, blood  
13 tests previously?

14 **A.** I think -- I don't remember feeling sceptical at the  
15 time, but I think he may well have not liked needles and  
16 having one every month, he may have felt that that was  
17 too much if he didn't like them. I don't know whether  
18 that was necessarily true or not, but I guess at that  
19 point we had to document what he said about the needles.

20 **Q.** Well, you had to look at what he said with the lens of  
21 experience about what he said about medication which  
22 entitled you to be fully sceptical of that as --

23 **A.** Yeah, it could have been an excuse.

24 **Q.** A bit like asking for medication-free trials.

25 **A.** Yeah.

15

1 and you've said they couldn't share further information?

2 **A.** Yeah, I think my colleague had tried to contact the  
3 police following the incident to get some more details,  
4 so I would have fed that back. It wasn't that I tried  
5 because I was off-duty that day. I think my colleague  
6 had tried, so that's why it was fed back, but it wasn't  
7 technically me.

8 **Q.** Further down the document about four paragraphs down:

9 "Claudia was asked about whether there were  
10 alternative plans for medications. She explained that  
11 she wasn't completely sure about whether he is  
12 concordant with medication and he hasn't been collecting  
13 medication [up] on time, and they felt that he would be  
14 better off on a depot."

15 So that was based on his extensive history of  
16 non-compliance, wasn't it, that you thought that?

17 **A.** Yes.

18 **Q.** "He has been evicted from his accommodation and VC has  
19 reported that he will find his own accommodation.

20 Claudia reports that he does move around a lot and is  
21 capable of sorting that out himself."

22 What did you mean, "moves around a lot"?

23 **A.** Well, I was aware that he'd moved between different  
24 student accommodation over the two years that I worked  
25 with him, which isn't uncommon. It does happen.

14

1 **Q.** He did not believe he needed medication, because he did  
2 not think he was mentally ill. That was loud and clear  
3 through the evidence, wasn't it? The evidence of his  
4 delusions, the evidence of what he was saying to  
5 different doctors.

6 **A.** Yes, when he shared it, yes, it was clear, yes.

7 **Q.** Well, a good look at the notes -- and you certainly  
8 looked at a number and heard him tell you that -- across  
9 time made that consistent point that he did not think he  
10 was ill and didn't think that the medication was  
11 worthwhile.

12 **A.** Yes.

13 **Q.** Can we have please NHFT0000168/0238, 10 February 2022,  
14 ward review. We see again at the top you're present and  
15 if we can have the top third highlighted, please:

16 "Dr Thangavelu asked Claudia about her wishes  
17 regarding the depot. She said that she wishes that he  
18 had the depot during his last admission due to risk of  
19 non compliance with medication. There was then a  
20 discussion around whether a CTO would beneficial and the  
21 long term consequences of [it]."

22 Did any of the others share your view about this  
23 depot at this point?

24 **A.** On the ward, the ward staff?

25 **Q.** Yes, on this ward review, yes, there's Dr Thangavelu,

16

1 there's a list of names there. What was the response to  
2 that; do you remember?

3 **A.** I can't remember but there was a lot of discussions  
4 around depots during the admission, so I do feel like it  
5 was considered. But I don't remember exactly what the  
6 thoughts were in regards to giving it at that point.

7 **Q.** When there was a discussion with the patient, we see  
8 that VC says his week has been "normal ... hasn't been  
9 doing much".

10 Second paragraph:

11 "... reports that he attended the gym (outside the  
12 hospital) and 'it was just fine'. He has been having  
13 short period of leave to go off the ward and he has been  
14 using this only to go to the gym."

15 I didn't take you to it on the previous record, but  
16 on the previous record he'd explained that he would like  
17 to go to the gym and he'd like to leave to go to the gym  
18 and the shop. His routine at the gym is 1.5 hours.

19 So at this point this is someone with a gym routine  
20 and he likes lifting weights, we've seen that. He is  
21 looking after himself physically, isn't he?

22 **A.** Yes.

23 **Q.** And building strength, on the face of it?

24 **A.** Yes, he's going to the gym, yeah.

25 **Q.** Yes, he's going to the gym and he's getting fit and he

17

1 **A.** Yes, I would have thought I would have said, "Well, how  
2 come you're getting it from Cripps when we're  
3 prescribing it?" But I don't remember whether I did  
4 that.

5 **Q.** "When asked whether he had forgotten to take a tablet,  
6 he said 'that's incorrect'.

7 "Claudia reported that when he came out of hospital  
8 last time, he was taking half the dose and coming to  
9 collect it every 5 weeks rather than every 4 weeks. She  
10 was concerned ... that he was missing medications. VC  
11 denies this and doesn't recall this."

12 So you do contradict that he's taking it all the  
13 time, and he says he doesn't recall it.

14 **A.** I am, yes.

15 **Q.** "Dr Thangavelu explained that the other option was  
16 a depot which would be an injectable medication once  
17 a month. It was explained ... he wouldn't have to think  
18 about [it] ..."

19 And we see:

20 "VC said 'no' to starting a depot ..."

21 "... expressed again wished to stay on the tablets  
22 rather than the depot."

23 Do you know if Dr Lloyd ever explained the benefits  
24 of a depot to VC?

25 **A.** I don't believe she'd seen him at this point.

19

1 is telling you in terms here, when we go over the page  
2 at 239, please, paragraph 2:

3 "It was explained [to him] that ... he may have  
4 stopped his medication. It was explained that it is a  
5 long term medication. When asked about his thoughts  
6 about taking medication in the long terms he said that  
7 he had already been taking it for a long time. He  
8 denies being non compliant ... prior to admission and  
9 reports that he was taking his 20mg. He said that he  
10 was getting his medication from Cripps Medical Centre  
11 weekly."

12 That would have been easy to check, wouldn't it, to  
13 fact check with the Cripps Medical Centre to see if he  
14 was getting his medication from them?

15 **A.** Yes, although I would have known that he was getting his  
16 medication from -- oh, I see, sorry, yes, we were  
17 providing it, and whether they were as well, yes.

18 **Q.** So he throws something into a ward review, the Cripps  
19 Medical Centre weekly, were they giving him any  
20 medication?

21 **A.** Not that I was aware of.

22 **Q.** No, so straight away, nobody contradicts that, do they,  
23 or says "That can't be right". Is that not the forum  
24 for contradicting a patient when they say something like  
25 that?

18

1 **Q.** No, she hadn't. But is that your understanding: that  
2 she hadn't seen him at all, let alone explained the  
3 benefits or otherwise of a depot to him?

4 **A.** Yeah, if she's not seen him, she wouldn't have been able  
5 to explain that, no.

6 **Q.** In this meeting, was the benefit of the depot explained  
7 to him, not just in terms of taking the tablet every day  
8 but the potential impact on his behaviour? That he was  
9 getting arrested, he was causing serious harm to people.  
10 This isn't addressed, is it, in this ward review, the  
11 effect he's having on other people?

12 **A.** Not according to the way the notes are written, no, and  
13 there's no mention of that.

14 **Q.** That's because risks to the public and others aren't  
15 discussed, are they? We've been through the ward  
16 reviews and it's not raised. There's discussion about  
17 VC as a patient, what he'd like to do, but nowhere do we  
18 see people in these ward reviews telling him the impact  
19 on others and where that's relevant to the issue of  
20 medication; is that fair?

21 **A.** From these ward rounds, yes, but I have seen other  
22 professionals challenge people about their behaviour.

23 **Q.** On one-to-ones, we've seen Dr Seedat do it, and no doubt  
24 there will be others. But the reality is when the issue  
25 of a depot is being discussed, he is able to deflect

20

1 that by saying he doesn't want to take it and he doesn't  
2 like needles and he'd prefer to have tablets -- when you  
3 know he's not taking those tablets.

4 **A.** Yes.

5 **Q.** How can that be?

6 **A.** I think at that point they're trying to -- well, if I'm  
7 talking to someone about a depot, I'd want to gauge how  
8 someone feels about it before -- obviously we can't  
9 enforce a depot. Gauge how they're feeling about it.  
10 Obviously they're restricted in what they can offer  
11 unless somebody is on a CTO.

12 So I think it's helpful to know what people are  
13 saying, and then obviously if it was felt necessary to  
14 look down a more formal treatment route, then that's  
15 kind of the next step. But I think I would want to know  
16 why -- on what basis someone would be refusing it on  
17 an informal basis in the community first.

18 **Q.** You were at that step, you were recommending and  
19 suggested he should be on a depot. Would you have  
20 supported there being a statutory basis for that,  
21 Section 3, a Community Treatment Order?

22 **A.** I did feel that would be sensible, yes, at the time, but  
23 obviously at this point he was on a Section 2 when he  
24 was discussing this. So there'd be other things we'd  
25 have to consider first.

21

1 "Claudia will organise medication after TTOs have  
2 finished.

3 "Claudia ... to do a ...follow-up 10:00 tomorrow  
4 morning at Stonebridge."

5 Did you raise with anyone at any point that you did  
6 not think this was feasible? I know you raised the  
7 point that you thought it should be a depot. But this  
8 being the discharge plan, did you say, "What do you  
9 expect me to do here?"

10 **A.** Not that I recall.

11 **Q.** Would you ever say that?

12 **A.** Yes, I'd like to think I would. But I can't recall what  
13 I said during this -- or in this meeting. I think, from  
14 their perspective, and they may say otherwise, I think  
15 it was difficult to elicit specific symptoms, and that  
16 kind of perhaps limited what they were able to do,  
17 legally -- (*overspeaking*) --

18 **Q.** And in terms of doctors, care coordinators, do you -- if  
19 the doctors have made this decision, do you find that  
20 difficult to say, "Well, I'm not sure how you got there"  
21 or "I'm not sure I agree" or are you respectful of how  
22 doctors make decisions? I guess it varies from case to  
23 case --

24 **A.** I think it varies from case to case and I think I would  
25 like to feel I was able to challenge a decision, because

23

1 **Q.** Could have been converted to a Section 3, couldn't it?

2 **A.** Yes.

3 **Q.** And established a therapeutic medication regime, and  
4 indeed it should have been.

5 **A.** Yes, if he'd met the threshold for the Section 3, yes.

6 **Q.** You say "if", do you have any doubt about that? Again,  
7 we can ask the doctors.

8 **A.** I think it's probably better to ask the doctors about  
9 that.

10 **Q.** Fair enough. Can we look at NHFT0000168/260, please.  
11 This is the discharge from this fourth admission. We  
12 see, where it says "Note":

13 "[VC] denied any thoughts that people were tinkering  
14 with his thoughts or influencing them over the past 4  
15 weeks ... When asked whether he had ever experienced  
16 this, he said ... he has researched a number of  
17 technologies which so exist, such as computer brain  
18 interface ... He said at [the] time he felt  
19 uncomfortable, and stressed. He did feel that someone  
20 outside him was influencing him and controlling him but  
21 it didn't frighten him. He denied ... [it] was still  
22 happening and doesn't see any reason for this to happen  
23 again. He was unsure as to who was doing this."

24 "Plan":

25 "Discharge with 14 days of medication.

22

1 I feel like I do know the patient best if I've been  
2 working with them in the community. So I do feel like  
3 I could do that.

4 But I think there's -- it's -- it doesn't -- it's  
5 a much bigger picture, service-wise, around admissions  
6 and discharges. It's not straightforward. I think --

7 **Q.** When you say service-wise, do you mean availability of  
8 resources, of beds?

9 **A.** Yeah, beds and things. I'm not saying that was the case  
10 in this --

11 **Q.** No, it doesn't look like it --

12 **A.** -- but we're aware that there are those difficulties and  
13 that we are managing, maybe we've become accustomed to  
14 managing more risk in the community than maybe  
15 historically when there wasn't quite the pressure on the  
16 beds.

17 **Q.** That can come down, please. Can we have NHFT0000190,  
18 page 1. Ms Birtles, this is the final risk assessment  
19 which you do update, 28 February 2022. If we go,  
20 please, to page 2, it's updated with the events  
21 surrounding Christopher, the top block, if we highlight  
22 that, please:

23 "[VC] was reported by the Police and University  
24 staff alerted due to an incident in his flat. Two  
25 flatmates claim that [VC] physically assaulted them in

24

1 the flat and refused to allow them to leave. They were  
 2 only able to escape after one of them grabbed [VC] and  
 3 held him back. According to the student report, the  
 4 Police did not arrest [VC] as he hadn't inflicted any  
 5 harm. Information obtained from flatmates indicated  
 6 that there had been some concerns about [VC's]  
 7 presentation for about a month. Short screams were  
 8 heard intermittently from his room, which were thought  
 9 to be him. He also reportedly entered another  
 10 flatmate's bedroom in the middle of the night and asked  
 11 'Can you hear that screaming' (referring to a different  
 12 scream, potentially hallucinatory).

13 "... flatmate also explained there had been in  
 14 running dispute about large amounts of hair being left  
 15 in the shower [et cetera, et cetera]."

16 Where did you get the information for this update?

17 **A.** I think there was a conversation between the flatmate  
 18 and one of the doctors on the ward who had spoke to them  
 19 to get some context around what had happened.

20 **Q.** So you were relying on information from others for that?

21 **A.** Yes (*unclear*).

22 **Q.** Then the second paragraph you update about the police  
 23 attendance when he was tasered twice to no avail?

24 **A.** Yes.

25 **Q.** Then 3 September appears to be an incorrect date.

25

1 **A.** Yes.

2 **Q.** You put some alerts on the system if we go to  
 3 NHFT0014976, we should be able to see what those alerts  
 4 are on page 2. We need to make them larger if we can.  
 5 So we see there there's one entered on  
 6 28th February 2022:

7 "Due to history of violence and aggression when  
 8 unwell, home visits to be undertaken in pairs. Most  
 9 appointments will be scheduled at the Stonebridge  
 10 Centre."

11 **A.** Yes.

12 **Q.** Yes? So that's a decision taken on 28 February. Was  
 13 the University ever told about that alert, that you, as  
 14 professionals, thought you needed to be in pairs?

15 **A.** No, I don't think I shared that alert with the other --

16 **Q.** Because that may well have applied for either their  
 17 students or their teachers, mightn't it, their academics  
 18 who were working with VC? Did you not consider the fact  
 19 that you had had to take that step was something that  
 20 needed to be shared as a piece of information?

21 **A.** I think I have seen the link between the healthcare  
 22 professionals and the police, which she'd shared as part  
 23 of his delusional beliefs, and they'd not mentioned the  
 24 University as being part of that. So I think I was  
 25 seeing it as the risk was greater, with maybe healthcare

27

1 That's referring to Brook Court incidents, isn't it, in  
 2 May 2020?

3 **A.** Oh, yes, yes.

4 **Q.** Then you record a period of:

5 "... appears ... suspicious/paranoid. Appears to be  
 6 relapsing."

7 31 August --

8 **A.** Yes.

9 **Q.** -- and 14 July. Again, events surrounding neighbours.  
 10 You didn't know about Sebastian in July 2021, did you?

11 **A.** No.

12 **Q.** But you had, even without that, a catalogue of events  
 13 here --

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

15 **Q.** -- that were indicative of violence and aggression that  
 16 needed to be taken really seriously when he was in the  
 17 community?

18 **A.** Yes.

19 **Q.** If we see page 3:

20 "[VC] has always been vague about his social  
 21 circumstances. He appears to have given a false address  
 22 to his care team following his last admission. [The]  
 23 University have since provided an accurate address."

24 Really significant, isn't it: false information, not  
 25 attending; do you agree?

26

1 professionals visiting at home.

2 **Q.** You knew, from the assault on the police officer,  
 3 clearly police, position of authority, but also, he had  
 4 reacted, hadn't he, when he was challenged for something  
 5 he didn't want to do?

6 **A.** Yes.

7 **Q.** The description, such as it was that you had about the  
 8 January events with his flatmate, surrounding --  
 9 described by VC as an "altercation" also related to  
 10 something that he was being asked to do that he didn't  
 11 want to do?

12 **A.** Yes.

13 **Q.** So was it safe to say that his risk of violence and  
 14 aggression related to his conspiratorial beliefs around  
 15 mental health professionals?

16 **A.** Not -- no, not definitely, no. That would --  
 17 (*overspeaking*) --

18 **Q.** -- should that have been shared for others to make their  
 19 own assessments about what it represented for them?

20 **A.** Yes, I think it should have been, yes.

21 **Q.** We can see the other alerts that are raised on the  
 22 system. What is the purpose of the alerts tab?

23 **A.** It's -- I think it's an easier format if there's  
 24 a specific risk or safeguarding issue. It's much easier  
 25 if you're not familiar with the person and you're

28

1 perhaps needing to find out some information, it's there  
2 in a very brief form, format for you to then perhaps  
3 look in more detail in the risk assessment. So it's  
4 generally for the most serious incidents.

5 **Q.** That can come down, thank you.

6 Can we have NHFT0000168/265, please. This is the  
7 discussion with the team leader, Emma Robinson. Make  
8 that larger, please. The fourth box.

9 "... agreed, given the historical risks of violence  
10 and aggression and hostage taking, home visits were not  
11 appropriate unless absolutely necessary and it would be  
12 better to continue with plan to offer appointments at  
13 the Stonebridge Centre."

14 If we go to page 266, please, information provided  
15 from the University, from Ellie to you.

16 "I've just learned that VC returned to Raleigh Park  
17 last Thursday 21/4. One of the Security officers  
18 approached him and VC said he was visiting a friend, but  
19 gave a false name when questioned who he was visiting.  
20 VC was escorted off site by Security at 19:45".

21 Deeply troubling, wasn't it, that?

22 **A.** Yes, I remember thinking that was concerning.

23 **Q.** Did you discuss that with Dr Lloyd?

24 **A.** The chances are it would have been something that I  
25 would have raised in MDT, yes, in our weekly meeting.

29

1 **Q.** Was it purely around that?

2 **A.** Yeah, at the risk assessment side of it, it was. I know  
3 there'd been a deterioration in our therapeutic  
4 relationship following the third admission, but that --  
5 it was because I was pregnant.

6 **Q.** And if we go to 267:

7 "[VC] will be transferred to a new [care  
8 coordinator] ... Gary Carter ..."

9 267, City South EIP at the bottom of the box.  
10 Transferred to Gary Carter, "Medication next due"  
11 13 May.

12 What handover was there between you and Gary Carter?

13 **A.** I can't recall a formal handover. I think it was --  
14 because we were -- we were working within the team, he  
15 would have been familiar. Well, everybody was fairly  
16 familiar with VC, based on his kind of presentation  
17 throughout the two years. So I don't remember a formal  
18 handover, but there would have been a discussion about  
19 what me handing over and then Gary taking it forward.

20 **Q.** Would he have known, for example, that you thought he  
21 should have had a depot and you didn't think he was  
22 concordant with his medication?

23 **A.** Yes, yes, we would have spoken about that.

24 **Q.** How would you have expressed that?

25 **A.** I think that was -- I don't even think I would have

31

1 **Q.** If we look at the bottom of that page on 28 April:

2 "Following a risk assessment and discussion in MDT,  
3 agreed it would be appropriate to transfer [VC] to a new  
4 CCO, preferably 2 CPNs."

5 So what risk assessment and discussion -- obviously  
6 it's not documented otherwise I'd been taking you to it,  
7 so what risk assessment was there leading to that?

8 **A.** I think that -- (*overspeaking*) -- in regard to the  
9 change of care coordinator, I -- I think I was referring  
10 to my risk assessment as in my personal risk assessment,  
11 with my manager. And then regarding my circumstances,  
12 and then we would have brought that to MDT to have  
13 a discussion within the team about a transfer.

14 So I don't think that was his risk assessment,

15 I think that was --

16 **Q.** For you, yes.

17 **A.** -- for me.

18 **Q.** Did you share with Ellie Turner that you'd had a risk  
19 assessment conducted and that was the conclusion, and  
20 that was how serious it was: that VC posed a risk to  
21 you, as far as you were concerned at this time?

22 **A.** It was purely around pregnancy. So she was aware that  
23 I was pregnant and she could appreciate why it wouldn't  
24 be suitable, and I think she knew that and we had  
25 a conversation in the email about that.

30

1 needed to do it at that point. I think that was common  
2 knowledge for the team. We'd all been through the  
3 admissions with -- we'd all been aware of the admissions  
4 and discussions around how he was presenting, and he  
5 would turn up at Stonebridge so other people would see  
6 him.

7 So people were very, very -- my opinion -- familiar  
8 with the case, and what our concerns were. Because it  
9 was something I would have spoke about.

10 **Q.** So there was nothing over and above what he'd gleaned or  
11 ascertained by virtue of working in the same place and  
12 being at MDTs?

13 **A.** I don't think so.

14 **Q.** Can we look at, please, at NHFT0000123, page 1. We see  
15 here, discharge:

16 "Following a discussion in our Multi-disciplinary  
17 Team on 22 September 2022, the decision has been made to  
18 discharge [VC] from our services due to non-engagement.

19 "No contact has been made for a period of time  
20 despite attempts to make contact and having carried out  
21 cold calls. ...

22 "Therefore at this time, we are closing his referral  
23 and transferring his care back to yourselves."

24 The Cripps Health Centre is the GP listed. Did you  
25 ever have any contact with any GP?

32

1 A. No, I don't think I did.  
 2 Q. So discharging in circumstances where there's  
 3 an unidentified GP, if that's the case, to any of the  
 4 professionals making the discharge, on its face seems  
 5 extraordinary, doesn't it?  
 6 A. As in like not one identified individual?  
 7 Q. Yes, not speaking to that GP or making clear that GP  
 8 knows the patient they're going to get in any referral.  
 9 A. Yes, yeah.  
 10 Q. Do you think they ought to be able to be in a position  
 11 to say whether they would agree with taking on a patient  
 12 and if it was right for them to do so?  
 13 A. Yeah, I think a discussion would be helpful.  
 14 Q. Helpful or vital?  
 15 A. Vital.  
 16 Q. Because they might have a different view of the risk and  
 17 everything else that's involved, mightn't they? They  
 18 might bring fresh eyes to this situation.  
 19 A. Yes.  
 20 Q. And it did need fresh eyes, didn't it, because it's  
 21 frankly absurd he was discharged in these circumstances,  
 22 unmedicated and into the community, isn't it?  
 23 A. I think it was -- I wasn't there for the decision, but  
 24 I can appreciate that that certainly seems that way,  
 25 yes.

33

1 told me the Beeston -- that he was going to the Beeston  
 2 address and confirmed it was the Beeston address shortly  
 3 after. So that's why I had left it on there, if that  
 4 makes sense.  
 5 Q. What, you thought he knew the pertinent address?  
 6 A. Yes. He -- sorry, I can't remember where the entry is,  
 7 but there was an entry about me asking about where he'd  
 8 gone back to and it was the one I believed he was at.  
 9 Subsequently, he said it was a miscommunication and  
 10 something had fallen through.  
 11 Q. Can we just have a look at witness statement  
 12 WITN0368001, page 64. And the last paragraph of  
 13 page 64, 275:  
 14 "On 9 August ... , Claudia noted:  
 15 "[VC] has requested access to his notes ...  
 16 "... documented a different address to the address  
 17 he had provided to the EIP team post discharge."  
 18 If we go to page 65, that's the address:  
 19 "CCO informed via email."  
 20 A. Yes.  
 21 Q. And Mr Carter says:  
 22 "I can't recall exactly ... I am sure I would have  
 23 received the email referred into Claudia's note. I also  
 24 recall discussing with Emma in her office that VC had  
 25 requested his notes, and I recall looking at the request

35

1 Q. Although you didn't have the benefit of hindsight, as we  
 2 walked through all the records today, it's very clear  
 3 early on you don't need that to see that there's  
 4 non-concordance and he's saying things that are clearly  
 5 not true.  
 6 A. No, I think it's clear.  
 7 Q. I've asked you a number of questions about the  
 8 University. Just one other one, please. Why were the  
 9 difficulties engaging with VC in the autumn and winter  
 10 of 2021, leading up to the incident with Christopher in  
 11 January 2022, not shared with the University?  
 12 A. I don't think there was any specific reason why it  
 13 wasn't. I don't -- I think after the admission he'd  
 14 said he didn't find it necessary to be involved with  
 15 mental health advisor service, but that wouldn't  
 16 necessarily stop that communication happening if we felt  
 17 there was a risk. So I'm not sure why those kind of  
 18 ongoing -- because we do have a very close relationship  
 19 with the team, and I don't know why those ongoing  
 20 discussions didn't happen in that particular point.  
 21 Q. As far as VC's addresses were concerned, we went to VC's  
 22 discharge summary from the Priory, which had his address  
 23 on it. Did you not input the new address on to the RiO  
 24 records?  
 25 A. I've tried to make sense of that and I think he'd also

34

1 and seeing that VC had provided [that] ... address ...  
 2 that I had not previously seen."  
 3 A. Yeah, I don't think -- um, sorry, was the question  
 4 whether I had -- if I had updated his address?  
 5 Q. Yes.  
 6 A. To that, seeing the request for notes?  
 7 Q. Yes.  
 8 A. Yeah, no, I wouldn't have -- no, I didn't update it then  
 9 because I don't think that -- we couldn't have --  
 10 I don't think -- we hadn't confirmed that that was his  
 11 address, so changing it on RiO, we'd need to confirm  
 12 that he was at that address before we could change it.  
 13 Q. Right, so you hadn't changed it because you didn't know  
 14 if it was right or not?  
 15 A. Yeah, no, I was just -- it was an acknowledgement that  
 16 it was a different address to what we thought and maybe  
 17 this was somewhere we could try, and then obviously if  
 18 we confirmed that we could update it, and then there's  
 19 not the information going to the wrong address, for  
 20 example.  
 21 Q. And finally for me, can I ask you about policies,  
 22 please. If we go to NHFT0000460. This is the  
 23 Nottinghamshire Healthcare NHS Foundation Trust Early  
 24 Intervention in Psychosis Service Operational Policy.  
 25 If we go, please, to page 3 at the bottom:

36

1 "EIP staff will demonstrate the 'Ten Essential  
2 Capabilities,' for Mental Health Workers ..."  
3 And we see them:  
4 "Working in partnership.  
5 "Respecting diversity.  
6 "Practising ethically.  
7 "Challenging inequality.  
8 "Promoting recovery.  
9 "Identifying people's needs and strengths.  
10 "Providing service user centred care.  
11 "Making a difference.  
12 "Promoting safety and positive risk taking".

13 And over the page:  
14 "Personal development and learning".

15 Can we have the list, is it possible to do the list  
16 together, all ten? Thank you.

17 There's no inclusion in that list, is there, with  
18 anything that refers to managing risk to the public or  
19 protecting the public, or thinking about the public,  
20 others, when --

21 **A.** No.

22 **Q.** -- you're working with patients with psychosis, thinking  
23 about their impact on the public?

24 **A.** Not there, no.

25 **Q.** Do you think it is an essential capability for mental

37

1 service is:  
2 "Culture, age and gender sensitive.  
3 "Family orientated.  
4 "Meaningful and sustained engagement based on  
5 assertive outreach principles.  
6 "Treatment provided in the least restrictive and  
7 stigmatising setting.  
8 "Separate, age appropriate facilities for young  
9 people.  
10 "Emphasis on normal social roles and service user's  
11 development needs, particularly involvement in education  
12 and achieving employment.  
13 "Emphasis on working with distressing experiences  
14 rather than diagnosis."  
15 Again, no reference to public harm.

16 **A.** No, not there, no.

17 **Q.** And the key features of the service:

18 "... oriented towards recovery.

19 "[Again] Promotes social inclusion ..."

20 "Minimises stigma. [And]

21 "Emphasises family interventions."

22 Doesn't say, "Addresses public protection" or  
23 anything like that?

24 **A.** No.

25 **Q.** And you described circumstances where you, in a risk

39

1 health workers to think about the public and risks to  
2 the public posed by their patients?  
3 **A.** Yes, absolutely. And family members and people around  
4 them, yeah, and other people.  
5 **Q.** Because we're hearing in the Inquiry, and no doubt it's  
6 a relevant principle applied correctly about least  
7 restrictive options, maximising independence, but all  
8 that is in the context of safety, isn't it, public  
9 safety, safety to the patient and safety to other  
10 people?

11 **A.** Yes.

12 **Q.** Do you think messaging around that for those who take  
13 roles as you have in the community, working with  
14 patients, are sufficiently understood?

15 **A.** I definitely think ... it's difficult to -- we do always  
16 consider that as part of our risk assessment and the  
17 risk to the wider public, and the risk to themselves.  
18 So it's not that it's not considered. But whether it's  
19 leaning heavily one way rather than the other way, it's  
20 difficult to say.

21 **Q.** Well, if we look at page 6, "Aims of the Service", we  
22 see at the top:

23 "The Early Intervention in Psychosis Service ...  
24 aims to deliver care in line with the following  
25 principles ... best practice ... to ensure that the

38

1 assessment, clearly felt unsafe and at risk.

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

3 **Q.** Where would you go, in the next of your professional  
4 body, for ethical guidance around difficult issues that  
5 all professions face? Doctors, lawyers, all sorts of  
6 professions face dilemmas about what should or should  
7 not be shared. Do you have access to support to make  
8 decisions about what is right or ethically right to  
9 share?

10 **A.** Information-wise?

11 **Q.** Yes.

12 **A.** Yes, I guess if we are weighing up whether it was  
13 appropriate to share information, then that's something  
14 I'd initially discuss with the team and then we could  
15 have got the information governance to kind of have  
16 those more detailed discussions about what is  
17 appropriate to share. And they might say "No, that  
18 isn't appropriate, but you can share this."

19 So there is advice we can seek, rather than me  
20 making that decision myself, about confidentiality and  
21 information sharing with others.

22 **Q.** Have you ever spoken to a Caldicott Guardian about that?

23 **A.** I haven't, no. I don't think I have. But I know  
24 colleagues have spoken with the information governance  
25 team if there is some information that we're not sure,

40

1 or even if it's, you know, using the safeguarding team  
 2 as well, and having that discussion about what's  
 3 appropriate to share. So there is avenues to do that.  
 4 I don't think I've done that myself.  
 5 **Q.** Royal College of Nursing, help me with that.  
 6 **A.** I'm not sure. I'm not aware. They may do. I've not  
 7 looked at that.  
 8 **Q.** Page 9, please, of this document. "Effective Care  
 9 Coordination". If you look at the bottom section,  
 10 please, if that can be enlarged:  
 11 "In accordance with [Care Programme Approach] ...  
 12 policy [the] ... reviews [this is for patients] ... :  
 13 "Comprehensive multi-disciplinary, multi-agency  
 14 assessment covering the full need range of needs and  
 15 risks.  
 16 "Assessment of social care needs ..."  
 17 And finally the one relevant to VC:  
 18 "Comprehensive formal written care plan (or in  
 19 accessible format): including risk and  
 20 safety/contingency/crisis plan."  
 21 That document didn't follow in this case, did it?  
 22 **A.** No, not at times, no.  
 23 **Q.** Well, not at all, really. The care plan doesn't assess,  
 24 does it, formally risk and safety contingency crisis  
 25 plan? We know how he was when an inpatient and forced

41

1 Sorry, I should wait until that's on the screen. At  
 2 the bottom of page 10:  
 3 "Keep in close contact with the service user and  
 4 coordinate their care.  
 5 "Advise the team of any changes in the circumstances  
 6 of the service user which may require changes to the  
 7 care plan.  
 8 "Update the care and crisis plan, and risk  
 9 assessment as needs change."  
 10 A dynamic process we've heard risk assessment is.  
 11 Again, that didn't happen, did it?  
 12 **A.** No, I think the risk assessment on the whole could have  
 13 explored things dynamically better, and that's something  
 14 I've reflected on -- (*overspeaking*) --  
 15 **Q.** If we see page 24, please. In terms of disengagement,  
 16 at the bottom of the page, penultimate paragraph:  
 17 "Reasons for disengagement should always be actively  
 18 explored including any associated risk. Where possible  
 19 the person's family or support network should be  
 20 involved and a plan put in place which covers risk,  
 21 actions (time frames, contacts method, telephone, cold  
 22 called etc ...) and ... clearly documented in the  
 23 assessment and progress notes."  
 24 So disengagement is not simply a thing to wipe away,  
 25 is it, and let someone be discharged? This sets out it

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1 or required to take medication, but not assessment of  
 2 risks in the community where he wasn't forced or  
 3 required to do so.  
 4 **A.** No, I think there's definitely things that I can improve  
 5 on in that respect.  
 6 **Q.** Well, you weren't alone there, were you? There was  
 7 a Multi-Disciplinary Team, and Dr Lloyd, no doubt you  
 8 say you had those meetings and were discussing them with  
 9 her.  
 10 **A.** Yes.  
 11 **Q.** So it's not just paperwork; this is about the real  
 12 decisions that were made, isn't it?  
 13 **A.** (*The witness nodded*).  
 14 **Q.** That's what matters most.  
 15 **A.** (*The witness nodded*).  
 16 **Q.** The real decisions were a number of you, presumably?  
 17 **A.** Yes, yeah. They were, yeah.  
 18 **Q.** The Responsible Clinician ultimately was Dr Lloyd; is  
 19 that right?  
 20 **A.** Yes.  
 21 **Q.** If we go to page 10, please:  
 22 "Role of the Care Coordinator:  
 23 "Keep in close contact with the service user and  
 24 coordinate their care.  
 25 "Advise the team of any changes ..."

42

1 needs to be actively explored in the context of the  
 2 risk?  
 3 **A.** Yes.  
 4 **Q.** That can go down, please. Finally, NHFT0004725, page 1.  
 5 Policy since September 2021 in respect of do not attends  
 6 and cancellations.  
 7 We see at 7.2.1, page 7, so the top of page 7:  
 8 "When it's clear a patient has not adhered to the  
 9 agreed level of contact the Multi-Disciplinary Team ...  
 10 should undertake an immediate assessment of the  
 11 patient's level of risk. In an outpatient's clinic  
 12 setting an assessment of the patient's level of risk may  
 13 not necessarily require the oversight of the full MDT  
 14 and instead may be conducted by a member of the medical  
 15 staff or another practitioner."  
 16 And:  
 17 "The level of response by the team will be  
 18 proportionate to the assessed level of risk of the  
 19 patient."  
 20 We see, if we go down, 7.2.3.3:  
 21 "If the patient is not at his/her address, the care  
 22 coordinator and service team should agree other agencies  
 23 to be contacted e.g. GP, housing departments, works and  
 24 pensions departments etc ..."  
 25 Were you aware of this policy at the time?

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1 A. I would have been aware there was a policy, but the  
 2 details of the policy, I don't recall at that point  
 3 thinking -- I don't know if I recall reading that  
 4 particular policy, if, for example, somebody wasn't  
 5 engaging.  
 6 But I guess we -- we take it to MDT and then we  
 7 would work through as a team what would be the  
 8 appropriate next step, and often it is like contacting  
 9 family and doing the things that are suggested there.  
 10 Q. Proper risk assessment, seeing what the available  
 11 support, is, what the position is, in reality?  
 12 A. Yeah, and I wouldn't leave it, you know, like I would  
 13 try and practically establish why someone might not have  
 14 engaged because there could be a perfectly plausible  
 15 reason why, but it wouldn't be a case of just leaving it  
 16 to the next schedule appointment, it's trying to follow  
 17 it up with the person, texting them, ringing them, and  
 18 seeing families and those things. So I think that part  
 19 of it was done.  
 20 MS LANGDALE: Thank you. Those are my questions,  
 21 Ms Birtles.  
 22 I wonder if that's time for the afternoon break.  
 23 There are some questions, I think, so a good time to --  
 24 THE CHAIR: Yes, so we'll take a break now and start again  
 25 at 3.20, thank you.

45

1 a serious concern with VC, wasn't it?  
 2 A. Yes, certainly at times, when I saw him, and he was very  
 3 unwell, he'd clearly lost insight into his condition,  
 4 yes.  
 5 Q. Can I ask you, did you feel that insight actually  
 6 decreased over the time so that by the time of the third  
 7 admission insight was a real problem compared to earlier  
 8 on?  
 9 A. I think it certainly fluctuated. When I've reflected on  
 10 it, I think there was at times when I was working with  
 11 him when he had some insight or partial insight and we  
 12 were able to have discussions about the service and what  
 13 we offered, and those kind of things suggested to me  
 14 that he -- there was more insight. But then there was  
 15 other times, yes, like you said, towards the latter end  
 16 of the care pathway where I, in my opinion, insight did  
 17 decline at times, yes.  
 18 Q. Yes, so, I mean, we've -- were you able to hear the  
 19 evidence of Dr Murphy this morning?  
 20 A. No, sorry, I didn't hear Dr Murphy this morning.  
 21 Q. Well, it doesn't matter, Ms Birtles, but would it be  
 22 fair to say that, essentially, after discharge from the  
 23 second admission, so we're talking 31 July 2020, at that  
 24 point, of course, VC had admitted that he'd failed to  
 25 take medication from about two weeks after discharge

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1 (3.06 pm)  
 2 (A short break)  
 3 (3.20 pm)  
 4 THE CHAIR: Yes, Mr Moloney, thank you.  
 5 Questioned by MR MOLONEY  
 6 MR MOLONEY: Thank you, Chair.  
 7 Ms Birtles, I've just four matters to ask you about,  
 8 please. Firstly, medication; secondly, insight; thirdly  
 9 depot; and fourthly, VC's relationship with the services  
 10 of which you were a part, okay?  
 11 A. Yeah.  
 12 Q. So first of all, medication. In the early days of his  
 13 contact with psychiatric services, so post the  
 14 24 May 2020 and on in those first few months, VC was  
 15 very concerned about medication because of the effect on  
 16 his studies; is that right?  
 17 A. Yes, that's what he said, yeah.  
 18 Q. Doing well in academic study was very important to him?  
 19 A. Yes, I'd say so, yes.  
 20 Q. He was under-achieving at that stage relative to his  
 21 siblings; did you understand that?  
 22 A. That was the feedback we'd had from family, yeah.  
 23 Q. And concern that medication was slowing him down?  
 24 A. Yes.  
 25 Q. Can I just ask about insight, now. Insight was

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1 from the first admission?  
 2 A. Yes.  
 3 Q. At that point, the discharge from the second admission,  
 4 then he was -- he had insight into his condition, and  
 5 insight for him to stay medicated, and why he needed to  
 6 have medication.  
 7 A. I can't be sure whether he had full insight at that  
 8 time. I was of the opinion there was some insight, but  
 9 I can't be sure whether there was full insight that he  
 10 knew the full ramifications of the psychotic illness and  
 11 taking medication.  
 12 Q. He knew he had a mental health problem and he needed to  
 13 take medication in relation to that mental health  
 14 problem?  
 15 A. Yes, although I don't think he necessarily agreed it was  
 16 psychosis.  
 17 Q. Well, that's an issue of nuance, isn't it? He knew he  
 18 had a mental health problem, he had insight that he had  
 19 a mental health problem and that medication assisted him  
 20 with that mental health problem?  
 21 A. Yes.  
 22 Q. Yes, and he knew that if he didn't take it, he got  
 23 unwell?  
 24 A. I certainly had those discussions with him, and I was  
 25 quite frank about what happens if people don't take the

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1 medication, what the likelihood of relapse is. I don't  
 2 know whether I fully grasped what he believed about  
 3 that. He said the right things but whether he believed  
 4 that, it's difficult for me to say.

5 **Q.** Right. But he failed to take -- just to -- essentially,  
 6 the words he said were equated to having insight into  
 7 the need to take medication, didn't they?

8 **A.** I guess it depends on -- sorry, which point that --

9 **Q.** If he said, "I need to take my medication. If I don't,  
 10 I'll become unwell". Those words, whether he means them  
 11 or not, are the words that reflect insight, aren't they?

12 **A.** On paper, yeah, I think it's a bit more complex than  
 13 (*unclear*) if that makes sense.

14 **Q.** All right, but he failed to take medication, didn't he,  
 15 over a long time?

16 **A.** I suspect that's the case, yes, and then we have got  
 17 evidence that he did this.

18 **Q.** He got worse and worse, he got sicker and sicker, and  
 19 that's how his insight declined and declined, isn't it?

20 **A.** That will impact on insight, yes.

21 **Q.** Depot would have been the right thing to do, wasn't it?

22 **A.** It certainly would have been an option, yes, but --

23 **Q.** "It would have been an option". You know, "it would  
 24 have been an option" is a rather blasé remark in the  
 25 context of what the evidence that Ms Langdale has just

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1 **A.** I guess it depends which admission it was, because  
 2 I think obviously he was -- he would have to consent to  
 3 it, for a start, unless he was subject to a CTO. And he  
 4 wouldn't be on a CTO unless he was on a Section 3.

5 So there was other things, I guess, that had to fall  
 6 in line before we get to that point. Obviously we could  
 7 offer it and he could accept it as an option informally,  
 8 and then we would offer it in the community, and I guess  
 9 that would be best-case scenario that someone would kind  
 10 of agree to it and we wouldn't need the legal framework  
 11 and then we could carry on in the community, offering it  
 12 monthly.

13 But obviously he didn't want that, so that kind of  
 14 stalled that --

15 **Q.** Why did you feel the inpatient clinicians didn't want to  
 16 follow your recommendation of depot?

17 **A.** Did I feel they didn't want to?

18 **Q.** Yes.

19 **A.** I don't see why they wouldn't want to, because I think  
 20 most clinicians recognise that it's a helpful way of  
 21 offering treatment if people are struggling with their  
 22 medication. So I don't -- I wouldn't say they didn't  
 23 want to but I don't know the reasons why they haven't  
 24 done that, other than perhaps the fact he'd declined and  
 25 he -- there would other things that need to be in place

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1 gone through with you so thoroughly, isn't it,  
 2 Ms Birtles? It was an option that you were pushing for,  
 3 wasn't it, Ms Birtles?

4 **A.** Yes.

5 **Q.** Because you felt it was the right thing to do,  
 6 Ms Birtles, didn't you?

7 **A.** Yes, but I do appreciate that it wouldn't necessarily  
 8 have solved all the issues, because people can be on  
 9 a depot and still be symptomatic. So we don't know that  
 10 because we didn't try it, unfortunately. But yes, it  
 11 was definitely the next cause of action after somebody  
 12 has been non-concordant several times and we still  
 13 suspect they're struggling with their symptoms, yes.

14 **Q.** You thought it was the right cause of action, but it  
 15 wasn't tried.

16 **A.** No.

17 **Q.** Now, why did you feel the inpatient clinicians didn't  
 18 want to follow your recommendation of depot?

19 **A.** I don't know. I'm not -- I'm not sure. I'd have to ask  
 20 them.

21 **Q.** Yeah, but can I ask you, you obviously were pushing for  
 22 depot. The inpatient clinicians didn't follow your  
 23 recommendation. How did you feel at the time as to why  
 24 that wasn't being followed, and what feelings did you  
 25 get about that situation?

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1 before they could do it down the formal route.

2 **Q.** Dr Lloyd was the responsible clinician, yes?

3 **A.** Yes.

4 **Q.** Did you ever seek Dr Lloyd's assistance in speaking to  
 5 the inpatient clinicians and trying to push harder for  
 6 depot?

7 **A.** I think she emailed the consultant in Highbury on the  
 8 fourth admission and reflected our concerns about the  
 9 concordance, yes.

10 **Q.** I just want to ask you about relations with the  
 11 services, finally. In the early part of his contact  
 12 with psychiatric services, relations between VC and the  
 13 services were good, weren't they?

14 **A.** Yes, I think there was -- I think in my statement  
 15 I always acknowledged that I felt it was fairly  
 16 superficial, the engagement, compared to my other  
 17 patients. But that's not unusual in itself. I'm quite  
 18 familiar with having to work really hard to build  
 19 a relationship with people who don't want to necessarily  
 20 be involved with mental health services. But I think,  
 21 especially during those first few months, he was  
 22 engaging enough, and was coming to appointments, and  
 23 there was a real shift towards the end when he was  
 24 clearly not meeting me as often as he would have  
 25 previously, and kind of all the pleasantries had gone

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1 and things like that. So to me, that was an indication  
 2 that he was perhaps not as well at that --  
 3 **Q.** That's following the third admission, isn't it?  
 4 **A.** Yes, but I think it was complicated by the fact he was  
 5 disappointed in how I'd --  
 6 **Q.** Sorry, I'm going to come on to that, but can I just ask  
 7 you, just whilst we are in terms of the third admission,  
 8 is it common for a patient of yours to be sectioned four  
 9 times in one year and nine months?  
 10 **A.** It varies. Yes, it has happened, yes.  
 11 **Q.** How often has it happened?  
 12 **A.** I couldn't say off the top of my head, but we work with  
 13 people who have multiple admissions. That isn't  
 14 uncommon in EIP.  
 15 **Q.** And six Mental Health Act Assessments in the same  
 16 period?  
 17 **A.** Yes, yeah. Yes, I've known numbers higher than that.  
 18 Very regular Mental Health Act Assessments for one  
 19 patient, yes.  
 20 **Q.** Just going back to that third admission, you -- because  
 21 you were about to, I believe, start to tell the Chair,  
 22 you played a part in connection with his third  
 23 admission, did you?  
 24 **A.** Sorry, say that again? I played a part?  
 25 **Q.** You played a part in connection with his third admission

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1 point.  
 2 "However, I think on reflection he was probably just  
 3 very suspicious of me ... as a whole."  
 4 Then if we go over to the bottom of page 11, please.  
 5 And we see there:  
 6 "But definitely the last few months leading up to me  
 7 handing [then over the page] him over things had got  
 8 increasingly difficult in our relationship. I just felt  
 9 at that point he'd lost... that that therapeutic side  
 10 had gone almost, he was finding it difficult to engage  
 11 with me after that tribunal."  
 12 Does that reflect your thoughts now as well?  
 13 **A.** Yes.  
 14 **Q.** Yeah. And in fact you met him the day after his release  
 15 from his third admission, didn't you?  
 16 **A.** That's right, yes.  
 17 **Q.** Can we go to RiO entry for that day which is at page 261  
 18 of NHFT0000168. Page 261. We see there, right at the  
 19 bottom, 25 February, 10.20 am. As often happens, it's  
 20 the very final entry on that page, but then over if we  
 21 can, please, to page 262, we see that this is the:  
 22 "3 day follow up.  
 23 "[VC] attended the Stonebridge Centre as arranged.  
 24 "Dressed in jeans, black boots and coat. Arrived  
 25 with hood up but did remove this during appointment.

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1 that VC was not happy about.  
 2 **A.** Regarding the tribunal report?  
 3 **Q.** The tribunal report --  
 4 **A.** Yes, I do, yes.  
 5 **Q.** And there was a significant deterioration in the  
 6 relationship following that.  
 7 Can I just take you to your interview with NHFT on  
 8 the -- and the document is TCLT0000748. It's page 9 of  
 9 that document, please, at the bottom of the page. You  
 10 say, right at the bottom:  
 11 "... and this a bit of a broad summary -- but  
 12 I think things deteriorated [and then over the page]  
 13 slightly after his third admission he had a tribunal.  
 14 "And obviously we did a Social Circumstances Report  
 15 and I think he found that hard to read what I'd said  
 16 about him being unwell. I remember him saying 'Look,  
 17 I'm not going to share anything with you now,' because  
 18 he didn't agree with what I'd said.  
 19 "And they're always a bit awkward when you have to  
 20 present how you feel someone is in front of them when  
 21 their insight isn't particularly good.  
 22 "And I think from that point onwards things got  
 23 a little bit more difficult because I think he felt I'd  
 24 betrayed him in a way and he was much less forthcoming  
 25 then with things, information about himself after that

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1 Hair was shaved. [VC] arrived without a mask however  
 2 did agree to wear one.  
 3 "[VC] continues to avoid usual greetings (hi/bye).  
 4 Minimal rapport established. [VC] remains quite abrupt  
 5 in his responses which are largely monosyllabic,  
 6 currently this seems to be more of a reluctance to share  
 7 information or build a rapport with services rather than  
 8 psychotically driven. No evidence of any overt symptoms  
 9 of psychosis symptoms observed today. [VC] denied  
 10 experiencing any current auditory hallucinations and  
 11 said that he hadn't experienced anything like this prior  
 12 to, or throughout the appointment. Despite numerous  
 13 attempts to try to build a little bit of rapport, [VC]  
 14 remained guarded and appeared reluctant to engage with  
 15 support."  
 16 And then may I just -- and that was your -- that's  
 17 consistent with your recollection today, is it --  
 18 **A.** Yes.  
 19 **Q.** -- Ms Birtles?  
 20 **A.** Yes.  
 21 **Q.** Indeed. And if we could just please go to -- well,  
 22 actually I don't need to go to another document. That  
 23 is the -- that's February 2022. It's after the third  
 24 admission. You can see the date again if you want.  
 25 It's after the third admission.

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1 A. Okay, yeah, yeah.  
 2 Q. And VC was mistrustful of services on that day, and  
 3 mistrustful of you, you felt.  
 4 A. Yes, I thought -- well, he didn't express any beliefs  
 5 about a mistrust in me, but I --  
 6 Q. "He was guarded and reluctant to engage".  
 7 A. Yeah, it was a sense, it wasn't -- he wasn't saying,  
 8 "I can't speak to you because you're feeding back to so  
 9 and so agency or this agency or that agency." But there  
 10 was definitely just in his presentation, it wasn't  
 11 a warm conversation. So that had -- although there'd  
 12 been a decline that was definitely a shift from when  
 13 I first met him.  
 14 Q. You say in that entry, there was a "reluctance to share  
 15 information or build a rapport with services".  
 16 A. Yes, yes.  
 17 Q. And that was a reluctance which was not, on that day,  
 18 psychotically driven, was what you concluded?  
 19 A. Not that I had elicited from the -- my attempts to  
 20 assess how his mental health was. He never said it --  
 21 like he never said anything delusional at that point  
 22 about services being involved. But I don't know whether  
 23 he felt that. I don't know.  
 24 Q. Well, you said he had no overt psychotic symptoms that  
 25 day as well, didn't you?

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1 But as to what he was experiencing at the time, it's  
 2 really difficult to say whether there was underlying  
 3 things.  
 4 I tried, I can see from the paragraph below I did  
 5 try and get his opinion about what had happened prior to  
 6 the admission, and where he felt or why he felt he'd  
 7 been in hospital, but I remember those conversations  
 8 didn't go far at all. It was -- (*overspeaking*) --  
 9 Q. We can see that in the next paragraph, can't we:  
 10 "Tried to explore events leading up to the  
 11 admission. Asked [VC] what we could try and do to avoid  
 12 this happening again, [VC] quite abruptly demanded what  
 13 I thought about this. I said that I appreciated that  
 14 [VC] had found the admission hugely inconvenient and  
 15 unnecessary but tried to explain how things had seemed  
 16 from our perspective. [VC] categorically denied missing  
 17 any medication prior to his admission, [(VC's)  
 18 medication had been due on the 14th but he had made no  
 19 attempts to collect this at the time). I explained that  
 20 although I know it feels like an inconvenience, it was  
 21 important [VC] remained in regular contact with us and  
 22 that he continued to take his medication. [VC] said  
 23 that he had already said that he had no issues with  
 24 this."

But this third admission was very much resisted,

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1 A. No, not on the face of it. Like I said previously, it  
 2 wouldn't look from my observations --  
 3 Q. You were the person who had probably met him more times  
 4 than anybody else?  
 5 A. Yes, but it's incredibly difficult, I've always said  
 6 it's been so difficult to assess those symptoms with VC,  
 7 harder than most, because I believe he was quite skilled  
 8 at hiding them. But again, this was my impression on  
 9 the day, and --  
 10 Q. Doing your best, you thought that that was reluctance to  
 11 share information or build a rapport with services  
 12 rather than psychotically driven, doing your best --  
 13 A. Yeah, and he had -- sorry --  
 14 Q. Doing your best that was it, yes?  
 15 A. Yes, and he had said that -- obviously I was aware that  
 16 he had said that to me about sharing information, and  
 17 I was aware he'd said that post tribunal, so that was  
 18 also in the back of my mind.  
 19 Q. Yeah. So after February 2022, we have a situation here,  
 20 this is the end of February, where he was reluctant to  
 21 share even though he didn't have any signs of overt  
 22 psychosis at that time?  
 23 A. He -- I got the sense he didn't want to be there and  
 24 there was a reluctance, but he did come, I did see him,  
 25 but he was definitely guarded and didn't want to share.

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1 wasn't it? There was no suggestion then that that --  
 2 from him, that that admission was justified?  
 3 A. No.  
 4 Q. Then if we look at the RiO, if we could again, please,  
 5 NHFT0000168 and go to page 224 if we may, just to  
 6 illustrate, and if we go down to the bottom, please.  
 7 This is essentially a review of his admission on 3  
 8 February 2022. He went in at the end of January, didn't  
 9 he, 28 January.  
 10 If we go over to the next page, we see in the second  
 11 paragraph:  
 12 "VC is guarded about the incident which happened  
 13 prior to admission."  
 14 You were present at this review, as we can see at  
 15 the top with Dr Thangavelu and Dr Gibson and this is  
 16 Dr Gibson's entry and we see in the first paragraph:  
 17 "Dr Gibson spoke to VC's mother yesterday and she  
 18 said that she didn't detect any ways that he was unwell  
 19 prior to this current admission which he has done  
 20 previously. VC's mother was very guarded on the phone  
 21 and didn't give much information. There seems to have  
 22 been regular [contact] between his mother and VC."  
 23 What did you feel about that, as a development in  
 24 the care around VC, if anything?

25 A. I don't recall being in the -- I was in the MDT, but I

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1 don't recall being in it, so I can't remember how I felt  
 2 at the time about it.  
 3 **Q.** All right, well, that's all I ask, then, Ms Birtles.  
 4 **A.** Sorry, yeah.  
 5 **THE CHAIR:** Yes, Ms Cartwright.  
 6 **Questioned by MS CARTWRIGHT**  
 7 **MS CARTWRIGHT:** Good afternoon, Ms Birtles, I ask questions  
 8 on behalf of the survivors.  
 9 You've already explained the role of the care  
 10 coordinator to Ms Langdale, but it's right, isn't it,  
 11 under the community mental health framework the care  
 12 coordinator's name has been rebranded to lead  
 13 professional to identify the very significant role  
 14 a care coordinator or lead professional has; would you  
 15 agree?  
 16 **A.** Yes.  
 17 **Q.** That the role of the lead professional or care  
 18 coordinator is to monitor, report and review the  
 19 aftercare plan and the working out of that aftercare  
 20 plan for a patient; would you agree?  
 21 **A.** Yes.  
 22 **Q.** So obviously if it's not working then to go and report  
 23 to the responsible clinician, but also ensure that the  
 24 amendments are made to the care plan; would you agree?  
 25 **A.** Yes, definitely.

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1 you?  
 2 **A.** No, I don't --  
 3 **Q.** Or check to see if it was appropriate and available  
 4 accommodation to VC?  
 5 **A.** Not -- no, not prior to discharge.  
 6 **Q.** Not just prior to discharge, but at any point did you  
 7 visit VC at that accommodation?  
 8 **A.** I visited it, but he wasn't there, yes.  
 9 **Q.** So you never actually saw VC in his accommodation to  
 10 check whether it was suitable and appropriate?  
 11 **A.** No.  
 12 **Q.** Then for the fourth admission we know that VC gave  
 13 a discharge address of 209 Ilkeston Road and, again, you  
 14 didn't check that accommodation as being appropriate or  
 15 even available for VC prior to discharge; would you  
 16 agree?  
 17 **A.** Yes. No, yes.  
 18 **Q.** At no point did you visit 209 Ilkeston Road?  
 19 **A.** No, I don't believe I did.  
 20 **Q.** Can you assist why you didn't, bearing in mind this was  
 21 then a fourth admission for VC, and it was absolutely  
 22 essential that VC, if the package of care was going to  
 23 work, had stable and appropriate accommodation?  
 24 **A.** I think largely the appointments were taking place at  
 25 the Stonebridge Centre, or were supposed to be taking

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1 **Q.** I think one of the things you perhaps would agree as  
 2 well, that as the lead professional when VC is having  
 3 revolving door admissions, detained, you as the lead  
 4 professional needed to ensure that there were safe  
 5 discharges back into the community; would you agree?  
 6 **A.** Yes, I was definitely -- I'd be part of those  
 7 discussions around the safe discharge, yes.  
 8 **Q.** That includes making sure that for a mental health  
 9 patient, that they've got appropriate accommodation;  
 10 would you agree?  
 11 **A.** Within the remit and what I can offer, I wouldn't be  
 12 able to find them accommodation, but I would want to  
 13 support them to be able to find accommodation --  
 14 **Q.** But, again, it would seem necessary, would it not, for  
 15 a safe discharge, someone should check that the  
 16 accommodation they're being discharged to, one, first of  
 17 all, is available, if that patient has given that  
 18 address, but secondly, that it is appropriate because  
 19 psychosocial stresses, again, are issues that can  
 20 deteriorate mental health; would you agree?  
 21 **A.** Yes, yes.  
 22 **Q.** Perhaps if we could just deal with it at this stage, we  
 23 know that following his discharge from his third  
 24 admission, VC gave an address of 278 Queens Road in  
 25 Beeston. You at no point saw VC at that address, did

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1 place at the Stonebridge Centre, and it wasn't a -- it  
 2 wasn't an awful long time before then I was handing him  
 3 over. So I don't believe I attempted a home visit on  
 4 the Ilkeston Road.  
 5 **Q.** Because, would you agree, you've said it's not for you  
 6 to sort out accommodation, but as a lead professional  
 7 and care coordinator, bearing in mind VC had had now  
 8 admissions pursuant to Section 3 of the Mental Health  
 9 Act, it entitled VC to a section 117, continuing  
 10 aftercare. So you would have had an ability to advise  
 11 VC about assistance he can have for accommodation  
 12 through the section 117 scheme; would you agree?  
 13 **A.** Yes, but he was always quite clear that he'd arranged  
 14 his accommodation, there was no issue with that. He  
 15 never wanted any support around the accommodation, and  
 16 that was always discussed as part of his discharge plan  
 17 with the ward.  
 18 **Q.** You --  
 19 **A.** -- (*overspeaking*) --  
 20 **Q.** -- say that, Ms Birtles, but every previous incident of  
 21 violence and aggression had occurred at VC's  
 22 accommodation and so would you not say even more so, as  
 23 a care coordinator, you needed to make sure (i) the  
 24 accommodation was appropriate, but also, secondly,  
 25 anyone living with VC was also safe?

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1 A. Yes, but I think I'd be limited in what I could do about  
 2 flatmates even if I turned up to somebody's house, how  
 3 I would ensure that indefinitely, unless I shared  
 4 everything about his care. So I think that is -- that's  
 5 difficult.

6 Q. I'm going to suggest, Ms Birtles, you should have done  
 7 more and the very least you should have done was check  
 8 after his third and fourth discharge that VC was living  
 9 at that accommodation and it was appropriate and that  
 10 was a responsibility you had for ensuring there was  
 11 a safe package of care in the community.

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

13 Q. Can I then briefly just deal with the social  
 14 circumstances report and then I want to take you to the  
 15 Mental Health Tribunal report, the decision. You've  
 16 already been taken to the Social Circumstances Report,  
 17 and you obviously, as the care coordinator, it was an  
 18 important report that you would provide to the tribunal  
 19 during that third admission.

20 If we can just display, please, NHFT0000275, and  
 21 you've been taken to aspects of the report, including  
 22 that you'd identified and recorded in the report that  
 23 you had believed that VC had been non-concordant with  
 24 his medication for some time.

25 Can we look at page 9, please, which is where  
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1 particular point in that report, yes. I think that  
 2 would always be a risk, and that would be what we would  
 3 have considered. Whether the risks around that had  
 4 increased or decreased, I think it was changeable  
 5 depending on how his mental health was at that  
 6 particular time.

7 Q. Well, perhaps --

8 A. But knowing that risk, that risk is a historical risk,  
 9 and it is something that we would take seriously.

10 Q. I hope to use that as a helpful summary because  
 11 Ms Langdale has been through with care what happened  
 12 after VC was discharged from the third admission, and  
 13 the very limited input and engagement at all VC had.  
 14 And then similarly, a very similar picture, after the  
 15 fourth admission, of VC just not engaging at all.

16 And so certainly from the notes there's no evidence  
 17 of insight, an appreciation of his mental disorder, and  
 18 I think you've accepted with Mr Moloney, essentially his  
 19 insight got worse.

20 A. Yeah, I think it's likely it did deteriorate, yes.

21 Q. Then if we can move down to page 11, please, which is  
 22 where you gave your recommendation, and again,  
 23 September 2021, where you'd arrived at, in box 29, is  
 24 you remained "concerned that [VC] does not think that an  
 25 anti-psychotic medication is necessary for his recovery  
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1 I think you address risk.

2 Thank you.

3 We can see at box 27, you provided the information  
 4 to the tribunal that:

5 "... [VC] remains unwell and has no insight into his  
 6 mental health there is a risk that he could act in  
 7 a manner dangerous to themselves or others."

8 You then deal with the two incidents involving  
 9 incidents in the accommodation and the attack on the  
 10 police officers. You say:

11 "He continues to experience conspiratorial  
 12 delusions, probable auditory hallucinations. He remains  
 13 suspicious and paranoid of others and presents a risk to  
 14 others when feeling under threat. [VC] does not agree  
 15 that he has ever experienced any mental health issues  
 16 and is adamant that the hospital/community team know the  
 17 truth that he doesn't have psychosis. [VC] hasn't  
 18 appeared to show any signs of remorse or insight into  
 19 how his actions have affected others in the past."

20 Now, this is September 2021.

21 But would you agree, those dangers, those risks,  
 22 essentially continued as you managed VC right up until  
 23 you handed over as care coordinator in April of 2022 to  
 24 Gary Carter?

25 A. I think that's a reflection of how things were at that  
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1 and there is a risk of non-concordance again."

2 Pausing there, we know that to be the case because  
 3 essentially that continued, would you agree, right  
 4 through the time when you were managing VC in the  
 5 community? That was the continuing issue.

6 A. That was my concern, yes.

7 Q. Then you essentially gave the hope that VC's "mental  
 8 health is stabilised on an effective medication regime  
 9 prior to his discharge", that you'd spoken to VC about  
 10 "long acting intramuscular anti-psychotic depot", and at  
 11 that stage, VC had "said he would be willing to explore  
 12 this further", and that was essentially your  
 13 recommendation.

14 Then can we briefly just look at the evidence you  
 15 gave to the tribunal, which is captured in the tribunal  
 16 decision, which is CYGN0000056. And whilst that's being  
 17 displayed, you said to Ms Langdale you didn't know  
 18 whether you'd seen the tribunal decision. Can that  
 19 possibly be correct? Was it not absolutely essential  
 20 that you, as a care coordinator, explored and looked at  
 21 what the tribunal had found? Because again, they make  
 22 observations about what was necessary for VC. So if you  
 23 did not consider tribunal decisions of your patients,  
 24 why not?

25 A. I don't think we had this information at the time.  
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1 Q. Well, let's move, then, to page 3 please, which I think  
2 captures the evidence you would have given to the  
3 tribunal. And I think we can see there you expressing  
4 at paragraph 3:  
5 "If discharged ... very concerned about [VC's] ...  
6 safety and that of others ..."  
7 Then giving a background, again addressing insight.  
8 Sorry, actually, you're further down. You're  
9 paragraph 6. Sorry, further down. Again, really you  
10 essentially giving a summary to the tribunal at that  
11 stage where you'd got to.  
12 A. Yes.  
13 Q. And really that you hadn't, in the time you'd been  
14 managing VC from June of 2020, actually managed to get  
15 a grip of the situation. It's my summary, but for time  
16 we can see paragraph 6 and 7.  
17 And again, would you agree that's really what you  
18 were saying to the tribunal: that notwithstanding the  
19 time you'd had with VC, you had still not really  
20 properly established a relationship where you were  
21 really making progress with addressing VC's issues and  
22 his mental disorder, and his psychosis?  
23 A. I would say that's fair, based on the fact it was very  
24 difficult to engage him, yes.  
25 Q. Then can we go to page 5, please. Thank you. We can

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1 "... no known history of self-harming behaviour [but  
2 that], his behaviour when unwell puts him at risk of  
3 retaliation from others."  
4 And again, the tribunal's view that if VC was to be  
5 discharged prematurely, then again his mental health  
6 would deteriorate, and it was effectively saying to VC:  
7 getting well trumps your desire to go back to  
8 university; would you agree?  
9 A. Yes, they needed to focus on getting better.  
10 Q. Now I'm not going to go back to the entry of 14 October  
11 where you've been taken to by Ms Langdale,  
12 14 October 2021.  
13 So bearing in mind VC was on a Section 3, why did  
14 you not make the very strong case for the need now for  
15 VC, within an established period of being  
16 non-concordance on medication, that the time had come  
17 that now VC had had a detention under Section 3, that  
18 what would reduce relapse and ensure compliance with  
19 medication was a need for a Community Treatment Order  
20 with a power of recall which makes it a requirement that  
21 VC has to receive depot medication?  
22 Because essentially, there's been over a year of  
23 trying and failing to get VC stable on his medication,  
24 and this really, in accordance with the tribunal's  
25 views, was what was needed to get a grip of at that

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1 see the tribunal have given lots of decisions, but as to  
2 (v) we can see:  
3 "Whilst [VC] had said he would take medication if  
4 discharged, his evidence was that he felt that it had  
5 'possibly' improved his symptoms which suggests  
6 uncertainty about its effectiveness and necessity.  
7 Given the rapidity and severity of relapses in his  
8 condition, it is essential that medication is maintained  
9 and optimised."  
10 So can I just check from your perspective, there'd  
11 been no dispute that it was absolutely essential for  
12 VC's package of care that that medication was maintained  
13 and optimised as indicated by the tribunal; would you  
14 agree?  
15 A. I would, yeah.  
16 Q. And then if we can see just further down at  
17 paragraph 13(i), thank you. We can see the view of the  
18 tribunal:  
19 "There is unequivocal evidence that the risks to  
20 others when [VC] is unwell are high and that relapse  
21 occurs rapidly and is difficult to manage. These risks  
22 eventuated very recently and it is important that they  
23 are minimised so far as is reasonable before [VC] is  
24 discharged into the community."  
25 The tribunal record that VC had:

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1 stage.  
2 A. I mean I was in agreement with that, and I considered  
3 that I had raised that, the importance of having  
4 potentially some legal framework to support his  
5 treatment, and I was of the opinion that I had shared  
6 that, at that point.  
7 Q. Then just finally for my purposes, in the second --  
8 sorry, the final period of detention between January and  
9 February of 2022. Now, Ms Langdale has taken you to  
10 ward reviews where you, your views have been captured.  
11 So you were taken to the 3 February ward review and the  
12 10 February ward review, but you made no notes of your  
13 own. Why were you not making notes at this point,  
14 Ms Birtles, bearing in mind the significance of now  
15 a fourth admission where medication has not been got  
16 a grip of, and VC has again been violent in the  
17 community?  
18 A. Well, we -- I will have handed over my concerns as part  
19 of the review process. So I wouldn't automatically then  
20 rewrite those notes if it was already captured in the  
21 RiO record from the ward round. Because that was part  
22 of it. So it would be a duplicate.  
23 Q. Can we then finally look at --  
24 **THE CHAIR:** Do you really have anything more to ask,  
25 Ms Cartwright, because we're well over time again?

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1 **MS CARTWRIGHT:** Well, I was going to go to the discharge  
 2 meeting that was attended and actually put it to the  
 3 witness that actually there is no clear evidence of any  
 4 robust advocating for depot or for a CTO, and bearing in  
 5 mind this was now the fourth admission, and --  
 6 **THE CHAIR:** Well, I think you've just said it. It's being  
 7 suggested that there wasn't any robust advocating at the  
 8 fourth discharge meeting.  
 9 Is there anything you want to say, Ms Birtles?  
 10 **A.** I think in that admission, I probably had more  
 11 discussions and more opportunities to discuss the depot  
 12 and the thought of a CTO than any of the previous  
 13 admissions, but it didn't happen at that point.  
 14 **MS CARTWRIGHT:** I won't go to the document but for your  
 15 reference, for you to make your own assessment, Chair,  
 16 in due course, it's page 260 of the NHFT0000168 records.  
 17 Thank you.  
 18 **THE CHAIR:** Thank you.  
 19 **MS CARTWRIGHT:** Thank you, Ms Birtles.  
 20 **THE CHAIR:** Yes.  
 21 Mr Straw.  
 22 **Questioned by MR STRAW**  
 23 **MR STRAW:** Ms Birtles, good afternoon. I represent VC's  
 24 family.  
 25 **A.** Hello.

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1 seen.  
 2 **Q.** Thank you. Could you go over to page 57, please.  
 3 Further down the page, please, there's an entry at  
 4 1 pm on 14 July. You've been referred to this already.  
 5 Second line down:  
 6 "[VC] ... expressed concern that his mum was at risk  
 7 despite reassurance from her that everything was okay."  
 8 Do you see that?  
 9 **A.** Yes, yeah.  
 10 **Q.** Did this echo 24 May 2020 when he'd been talking about  
 11 hearing his -- or hallucinating screams from his mum in  
 12 the flat next door, and also the evidence we saw from  
 13 the ward where he was kicking doors and he talked about  
 14 his mum screaming. Did that echo that for you?  
 15 **A.** Yes, it did, yes.  
 16 **Q.** Did it suggest he was experiencing delusions about his  
 17 mum being at risk?  
 18 **A.** Yes, potentially, yeah.  
 19 **Q.** You say in your statement at paragraph 483:  
 20 "I always felt ... that VC's behaviour was driven by  
 21 a strong belief that he needed to protect those close to  
 22 him; by a fear that the people he cared [for] ... most,  
 23 like his family, were at risk of harm."  
 24 Now going back to the withdrawal of consent, so late  
 25 2021 when he withdrew consent for you to contact his

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1 **Q.** You explained earlier that in late 2021, VC refused  
 2 consent for you to have any contact with his mum, and  
 3 you also explained in October 2020 VC stopped himself  
 4 having contact with his mum for a couple of months. But  
 5 before late 2021, as you indicate in your witness  
 6 statement, is it right you had frequent contact with  
 7 Celeste?  
 8 **A.** Yes, I did, yes.  
 9 **Q.** And she was heavily involved in his care, provided  
 10 valuable information about him, and was a positive  
 11 factor; would you agree?  
 12 **A.** Yeah. Yes, I would agree.  
 13 **Q.** Could we have the NHFT0000168 document on screen,  
 14 please, page 55. At the bottom of the page there's an  
 15 entry on 11 July that you've been taken to already.  
 16 It's Celeste raising concern that VC's "mental state may  
 17 be deteriorating", and "his conversation wasn't making  
 18 much sense".  
 19 Now, is it right that no -- there was no  
 20 face-to-face or any contact with VC between that concern  
 21 on 11 July by the mum, and the incident late on 13 July  
 22 where he again barged into a flat?  
 23 **A.** Yes, I believe that was the weekend. So that would be  
 24 -- the 11th July contact with Andrew Jackson was with  
 25 the Crisis Team, so it's my understanding that he wasn't

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1 mum, do you have any comment -- did you think that was  
 2 linked to his concerns about his family being at risk?  
 3 **A.** I guess it was a thought in my head, yeah. I think  
 4 I considered that. He didn't express that. And I know  
 5 I wanted to kind of know if it -- if this was driven by  
 6 a delusional belief that there was some risk somewhere.  
 7 But although I questioned it, that isn't what he told  
 8 me, and I couldn't elicit anything that would suggest  
 9 that was the case. However, it could have been, and  
 10 it's difficult to know.  
 11 **Q.** He was very guarded by that point.  
 12 **A.** Yes, yes.  
 13 **Q.** Could we go, please, to page 63. And the bottom of that  
 14 page. Right at the bottom there's an entry on 16 July  
 15 which then goes over the page, and could we go over the  
 16 page, please, again the bottom of the next page. Do you  
 17 see there's a paragraph "Discussed depot"?  
 18 **A.** Yes, I do, yeah.  
 19 **Q.** So:  
 20 "[VC] takes medication whilst on the ward but then  
 21 stops once discharged. Dr Seedat explained pros and  
 22 cons of depot. [VC] will think about it ..."  
 23 I think it was suggested earlier that the first time  
 24 depot was raised was on 21 July by VC's mum, Celeste.  
 25 In fact, would you agree, according to the notes, the

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1 first time it was raised was by Dr Seedat on 16 July?

2 **A.** Yes. I can see that, yes.

3 **Q.** Thank you. Can we go then on to page 162, please, of  
4 the RiOs.

5 This is the entry, again we've seen this, it's about  
6 31 August 2021. It's your entry. Halfway down the top  
7 paragraph:

8 "... [VC] went into a lengthily rant about why he  
9 was no longer taking medication (because he wasn't  
10 psychotic and never has been) and ... [VC] presented  
11 with a complex delusional system in which he believes we  
12 are working in collaboration with the judicial system  
13 and the hospital ... and we've created technology to  
14 cause his voice experiences/monitor him."

15 Next paragraph:

16 "[He was] ... paranoid/suspicious ... not trusting  
17 of services ... Refusal to engage ... knows we will have  
18 to 'feedback to the higher powers ...'"

19 Then the next paragraph:

20 "He appears to believe he is more at risk by  
21 engaging with us."

22 **A.** Yes.

23 **Q.** Would you agree that the features of his illness  
24 included, firstly, a delusion that there was  
25 a conspiracy against him by the medical staff and

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1 ward in Darlington. Celeste has tried numerous times to  
2 contact the team however they have never returned her  
3 calls."

4 What did you do, in the face of that, to try and  
5 encourage contact between the two of them?

6 **A.** I do remember speaking to the social worker just to pass  
7 on that family had been having trouble liaising with  
8 Darlington, but aside from that, I can't remember  
9 what -- I think she said, "Oh I'll speak to them" but  
10 I don't know, so I don't know what happened after that  
11 at that point.

12 **Q.** Now, going on from this point, so after September 2021,  
13 I think you agreed with Mr Moloney earlier that VC was  
14 becoming sicker and sicker, he was becoming less  
15 engaged, more guarded, and running late 2021 -- sorry,  
16 into 2022.

17 Now, are you aware of the NICE Guidelines, the NICE  
18 Quality Standards about psychosis which emphasise the  
19 importance of Early Intervention in Psychosis --

20 **A.** Yeah.

21 **Q.** -- and the need for a full package of treatment and  
22 care --

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

24 **Q.** -- within two weeks, really, of a referral to the early  
25 intervention psychosis system?

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1 others?

2 **A.** Yes.

3 **Q.** Secondly, a delusion that he wasn't ill?

4 **A.** Yes.

5 **Q.** Did those two factors lead him to disengage, to not take  
6 medication and so on?

7 **A.** Potentially, yes. Yes. Yeah, and I don't know, but  
8 people I've worked with often, auditory experiences,  
9 they might tell the person not to engage and that might  
10 kind of collude with it. So yes, it can be the case,  
11 yeah.

12 **Q.** And led him to be suspicious, guarded, mask his  
13 symptoms?

14 **A.** That was my suspicion, yes.

15 **Q.** Page 164, please. Actually, we have already been to  
16 that, so we can go on, sorry, to page 192, please.

17 This is an entry at the top of the page, that we've  
18 seen already. It was on 23 September 2021 that you made  
19 in the RiOs, and this is at a time when he's on the  
20 ward, so he's an inpatient.

21 **A.** Yes.

22 **Q.** He says there:

23 "Celeste does not object to an assessment however  
24 she doesn't feel she has a full understanding of Valdos  
25 current difficulties due to having no contact with the

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1 **A.** Yes, I --

2 **Q.** And that those guidelines emphasise the reason for that  
3 is that there are better outcomes if there is early  
4 intervention?

5 **A.** Yes, absolutely. Yeah.

6 **Q.** Would you agree that VC's case illustrates the need for  
7 early intervention, in that he was more receptive, more  
8 open, more engaged at an earlier stage?

9 **A.** Yes, absolutely, yes, yeah.

10 **Q.** I'd like to move on to relapse warning signs, please.  
11 So what were the signs of relapse in VC's case.  
12 Firstly, I'm going to suggest that there were at least  
13 five. Firstly, stopping taking medication. I think  
14 you'd agree with that, wouldn't you, that was a relapse  
15 warning sign?

16 Secondly, you say in your witness statement  
17 disengagement or avoidance was a potential sign of  
18 relapse.

19 **A.** Yes.

20 **Q.** Why was it that you thought disengagement was a sign of  
21 relapse?

22 **A.** I think it's -- it's different for every person,  
23 I think, but people disengage for various reasons. But  
24 for VC's case maybe it was around the suspicion  
25 potentially and the paranoia and not feeling comfortable

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1 engaging with the team based on what he was believing at  
2 the time. But people do -- it is different for every  
3 person and why they might choose to disengage. But it's  
4 something we're obviously very mindful of if it's  
5 a change.

6 **Q.** Okay, but in his case it would appear to reflect  
7 increasing persecutory delusions, paranoia and so on?

8 **A.** Potentially, yes, yes, yes.

9 **Q.** So by the same token, then, would you agree a similar or  
10 a third relapse warning sign is that he was especially  
11 guarded, suspicious, deceptive, and so on?

12 **A.** Yes, that is my impression, yes.

13 **Q.** A fourth sign, trespass and aggressive behaviour. We  
14 know that in May, July, there were the incidents of  
15 trespass, 2020 that was. In September 2021, we had the  
16 aggressive incident. Then on 15 January 2022, you  
17 indicated the alteration suggested he was relapsing.

18 Would you agree that those sort of -- trespass and  
19 aggressive behaviour are also signs of relapse?

20 **A.** It can be, but obviously people can be aggressive for  
21 a number of reasons. I guess it was trying to  
22 understand the context around the behaviour and the  
23 action of where that had come from and what was kind of  
24 leading to that behaviour. And if there was any other  
25 factors that potentially could explain it. But it would

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1 unusual thoughts; do you remember that?

2 **A.** That I did with VC in the early warning signs? Yes.

3 **Q.** We've seen a few entries, so 11 July, just before the  
4 barging into the flat on the 13th, Celeste saying VC  
5 wasn't making much sense, and then in January 2022, the  
6 screams where he goes into a -- another flat in the  
7 middle of the night and saying, "Can you hear that  
8 screaming?"

9 **A.** Yes.

10 **Q.** So fifth relapse warning sign, would you agree, strange  
11 or unusual behaviour, those sort of things?

12 **A.** Yes, and certainly like hearing things if other people  
13 can't hear them, and if you're asking "Have you just  
14 heard that?" then that would be a sign, yes.

15 **Q.** Thank you. Final issue, please, just your contact with  
16 VC in mid-2022. Could you have the RiOs back up on  
17 screen, please, the 168 document, page 264.

18 There's an entry right at the bottom of the page and  
19 can we go over the page, please, to see the entry  
20 itself.

21 In the middle of that entry:

22 "[VC] said he had been doing some research and

23 Wanted to discuss his treatment but didn't want to  
24 do this over the phone."

25 Strange, unusual behaviour, a sign of concern; would

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1 be something that I'd be concerned about if it was  
2 a change. It's a change in behaviour, isn't it, and  
3 I think that's the bit where we'd question whether  
4 somebody was struggling or -- (*overspeaking*) --

5 **Q.** Sure. Sorry, it was probably my fault for not being  
6 clear, but in his specific case, once you come to  
7 January 2022, you've got this whole history --

8 **A.** Yes, yes.

9 **Q.** -- where you have these incidents of trespass and  
10 aggression that are associated with periods of acute  
11 relapse?

12 **A.** Yes.

13 **Q.** So moments when he's known to be acutely relapsing.

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

15 **Q.** So for him specifically that was a sign of relapse?

16 **A.** Yes, I think it was demonstrate -- I wasn't at work when  
17 we received the information, but the team acted promptly  
18 and quickly to arrange an assessment based on what we  
19 knew had happened previously. It wasn't a case of:  
20 well, I'll go see him, he might be all right. It was  
21 very much: well, we need to have that assessment now to  
22 establish whether he's relapsing, and that did happen  
23 quite quickly, due to our concerns, yeah.

24 **Q.** Earlier on with Ms Langdale, you were taken to an entry  
25 in the RiOs which indicated early warning signs included

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1 you agree?

2 **A.** I definitely would have -- I would have wondered why he  
3 wouldn't want to do it over the phone. There is  
4 plausible reasons for that, but there could also be  
5 other reasons if someone is feeling paranoid or  
6 suspicious or worried that phones might be tapped. So  
7 that's something we're familiar with. The research bit,  
8 yeah, I don't know. He never actually shared what he'd  
9 been doing, so --

10 **Q.** Well --

11 **A.** I would have wanted to be able to discuss that and it's  
12 a shame that that opportunity didn't arise.

13 **Q.** Okay. Thank you.

14 Then the next page, please, 266. There's an entry  
15 at the bottom of the page which is by you on 29 April.

16 If we can go over the page at 267, please, there:

17 "Nil rapport established.

18 "Said he was spending time 'preparing', when asked  
19 what for? He said 'Whatever is next'."

20 A bit further down the page:

21 "[VC] has been asked ..."

22 Sorry:

23 "I explained that I was of the understanding that  
24 Valdo had been asked not to return to the accommodation  
25 after the incident earlier in the year. [VC] denied

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1 this and said he had no knowledge of this decision."  
 2 I think you thought that was untrue, didn't you?  
 3 **A.** Yes.  
 4 **Q.** You explain in your witness statement that was false.  
 5 Then at the bottom of the page "Guarded and  
 6 difficult to engage". So again, he's guarded, he's  
 7 deceptive; that was another sign of concern, wasn't it?  
 8 **A.** Yes, yes, it was, yeah.  
 9 **Q.** Then I think in mid-August you decided he'd provided  
 10 a false address to the team; is that right?  
 11 **A.** Yes.  
 12 **Q.** You found that strange?  
 13 **A.** Yes.  
 14 **Q.** Thank you. Then the last question, please, just about  
 15 Madison Court. On 9 August 2022, it's right, isn't it,  
 16 you emailed Gary Carter indicating that VC had got in  
 17 touch asking for his notes and he'd given Madison Court  
 18 as his address?  
 19 **A.** That's right, yes.  
 20 **Q.** Given that he'd given you his address for something he  
 21 wanted, so he wanted his notes, it appears that was his  
 22 correct address, didn't it?  
 23 **A.** Yes, yeah. Potentially, yeah. I don't know if he would  
 24 necessarily would have known that we'd seen the  
 25 photocopy of the request with the -- he may have done,

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1 Madison Court address, Derwent Way.  
 2 **A.** Yes.  
 3 **THE CHAIR:** If you had that address, was that not a way of  
 4 re-engaging with him at this time, in August?  
 5 **A.** Yes, but I guess -- I'd handed him over at that point so  
 6 it wouldn't have necessarily been me, but we would have  
 7 had a new address to try, yes. Certainly, yeah, the  
 8 care coordinator --  
 9 **THE CHAIR:** Because this is at a point when it's being  
 10 suggested that he's disengaged and in fact just a very  
 11 short time before in fact he's discharged in September.  
 12 **A.** Yes.  
 13 **THE CHAIR:** But he is actually asking, in August, for his  
 14 notes, isn't he?  
 15 **A.** Yes.  
 16 **THE CHAIR:** Do you think it would have been an opportunity  
 17 to re-engage with him at that time?  
 18 **A.** Yes, potentially, I guess. My hope is it would have  
 19 been carried out or attempted home visit to see if he  
 20 was there, yes.  
 21 **THE CHAIR:** Or even to suggest that he might come in and  
 22 pick up the notes.  
 23 **A.** Yes.  
 24 **THE CHAIR:** Because that was something he wanted, wasn't it?  
 25 **A.** Yes, I'm not sure process -- I wasn't familiar with how

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1 but I don't know, what he'd have known we would have  
 2 seen.  
 3 **MR STRAW:** Thank you very much.  
 4 Thank you, Chair.  
 5 **Questioned by THE CHAIR**  
 6 **THE CHAIR:** Yes. Can I just ask you about that. You've  
 7 said it was his right address, Madison Court; was that  
 8 what your understanding was at the time?  
 9 **A.** Well, I think it was an option. He'd written it down as  
 10 his current address, so I guess we would have to go on  
 11 what he said. But he obviously hadn't -- I don't  
 12 believe he'd intended to give us that because it came  
 13 inadvertently through his request for notes.  
 14 **THE CHAIR:** Yes. Can we just have two documents up  
 15 together, please. One is WITN0163002, and then the  
 16 email, which was sent, I think -- you sent to Gary  
 17 Carter, which was NHFT0018055.  
 18 So you have I think we can see on the right there,  
 19 that was the address he gave, wasn't it, when he made  
 20 the application for his medical records?  
 21 **A.** Yes.  
 22 **THE CHAIR:** And I think that that's the -- what you're  
 23 sending on to Gary Carter, isn't it?  
 24 **A.** Yes.  
 25 **THE CHAIR:** And you then give him the, I think it's the

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1 the process of requesting notes and how it works. So  
 2 I don't think it comes straight to us, I think it goes  
 3 somewhere and then they pass it to us, if that makes  
 4 sense. I'm not sure what happens after that so  
 5 I couldn't comment on whether it would be something we  
 6 hand over or whether it goes through information  
 7 governance.  
 8 **THE CHAIR:** But had you still been in post, and not handed  
 9 over, it would have been a way of suggesting to him that  
 10 he come in or you see him to discuss the notes.  
 11 **A.** Yes, and if I'd spoke to him I guess I would have  
 12 challenged on the -- I would say, "Well, why is your  
 13 address this? This seems to be different to the one we  
 14 have on the system, is this right?"  
 15 **THE CHAIR:** Thank you. Just one further matter.  
 16 Right at the very beginning, when Ms Langdale was  
 17 asking you some questions, you were talking about your  
 18 involvement in mental health services, in their  
 19 different incarnations, if I can put it that way, with  
 20 the Early Intervention Psychosis Team and so on. Were  
 21 you ever involved in the Assertive Outreach Team before  
 22 it was disbanded in 2015 as we've heard from Dr Lomas?  
 23 **A.** No, I wasn't, no.  
 24 **THE CHAIR:** Were you aware of it at the time or not?  
 25 **A.** Yes, yes, I was familiar with --

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1 **THE CHAIR:** Did you know how they were operating or not? 1  
 2 **A.** Never worked in the team and I've never heard 2  
 3 a placement as a student nurse, but I was aware of the 3  
 4 general principles of the Assertive Outreach Team. 4  
 5 **THE CHAIR:** I don't know whether you can help, then. Do you 5  
 6 think it would have been something which would have been 6  
 7 applicable to VC at that time, given his -- 7  
 8 **A.** I think we could have considered it, yes. 8  
 9 **THE CHAIR:** Thank you. 9  
 10 Yes, thank you. Well, we'll finish there for today 10  
 11 and we'll start again tomorrow at 10.00. Thank you. 11  
 12 **(4.20 pm)** 12  
 13 **(The hearing adjourned until 10.00 am the following day)** 13  
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<p><b>P</b></p> <p><b>please... 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<p><b>trials [1]</b> 15/24</p> <p><b>tribunal [21]</b> 3/16 54/2 54/3 54/13 55/11 58/17 65/15 65/18 66/4 68/15 68/15 68/18 68/21 68/23 69/3 69/10 69/18 70/1 70/13 70/18 70/25</p> <p><b>tribunal report [1]</b> 54/3</p> <p><b>tribunal's [2]</b> 71/4 71/24</p> <p><b>tried [10]</b> 8/12 14/2 14/4 14/6 34/25 50/15 59/4 59/10 59/15 79/1</p> <p><b>trouble [1]</b> 79/7</p> <p><b>troubling [1]</b> 29/21</p> <p><b>true [2]</b> 15/18 34/5</p> <p><b>trumps [1]</b> 71/7</p> <p><b>trust [2]</b> 7/4 36/23</p> <p><b>trusting [1]</b> 77/16</p> <p><b>truth [1]</b> 66/17</p> <p><b>try [8]</b> 36/17 45/13 50/10 56/13 59/5 59/11 79/4 87/7</p> <p><b>trying [6]</b> 8/24 21/6 45/16 52/5 71/23 81/21</p> <p><b>TTOs [1]</b> 23/1</p> <p><b>turn [1]</b> 32/5</p> <p><b>turned [1]</b> 65/2</p> <p><b>Turner [3]</b> 11/15 12/17 30/18</p> <p><b>tutors [1]</b> 10/6</p> <p><b>twice [1]</b> 25/23</p> <p><b>two [12]</b> 5/1 5/16 10/19 14/24 24/24 31/17 47/25 66/8 78/5 79/5 79/24 86/14</p> <p><b>two years [2]</b> 14/24 31/17</p>	<p>10/22 20/1 74/25 78/24 84/23 86/8</p> <p><b>understood [1]</b> 38/14</p> <p><b>undertake [1]</b> 44/10</p> <p><b>undertaken [1]</b> 27/8</p> <p><b>unequivocal [1]</b> 70/19</p> <p><b>unfortunately [2]</b> 12/7 50/10</p> <p><b>unfriendly [1]</b> 6/22</p> <p><b>Uni [1]</b> 13/11</p> <p><b>unidentified [1]</b> 33/3</p> <p><b>Unit [1]</b> 2/9</p> <p><b>university [9]</b> 12/6 24/23 26/23 27/13 27/24 29/15 34/8 34/11 71/8</p> <p><b>unless [7]</b> 6/1 12/21 21/11 29/11 51/3 51/4 65/3</p> <p><b>unlikely [1]</b> 7/2</p> <p><b>unmanageable [1]</b> 7/7</p> <p><b>unmedicated [1]</b> 33/22</p> <p><b>unnecessary [3]</b> 5/11 8/15 59/15</p> <p><b>unsafe [1]</b> 40/1</p> <p><b>unsure [1]</b> 22/23</p> <p><b>until [3]</b> 43/1 66/22 89/13</p> <p><b>untrue [1]</b> 85/2</p> <p><b>unusual [4]</b> 52/17 83/1 83/11 83/25</p> <p><b>unwell [11]</b> 5/12 13/3 27/8 47/3 48/23 49/10 54/16 60/18 66/5 70/20 71/2</p> <p><b>up [19]</b> 7/3 8/18 9/3 9/5 14/13 23/3 32/5 34/10 40/12 45/17 55/6 55/22 55/25 59/10 65/2 66/22 83/16 86/14 87/22</p> <p><b>update [6]</b> 24/19 25/16 25/22 36/8 36/18 43/8</p> <p><b>updated [2]</b> 24/20 36/4</p> <p><b>us [7]</b> 1/20 10/19 59/21 77/21 86/12 88/2 88/3</p> <p><b>use [1]</b> 67/10</p> <p><b>user [4]</b> 37/10 42/23 43/3 43/6</p> <p><b>user's [1]</b> 39/10</p> <p><b>using [2]</b> 17/14 41/1</p> <p><b>usual [1]</b> 56/3</p> <p><b>Usually [1]</b> 4/2</p>	<p><b>varies [3]</b> 23/22 23/24 53/10</p> <p><b>various [2]</b> 1/18 80/23</p> <p><b>VC [134]</b></p> <p><b>VC's [21]</b> 1/6 4/16 25/6 34/21 34/21 46/9 59/17 60/17 60/20 64/21 68/7 69/5 69/21 70/12 73/23 74/16 75/20 76/24 80/6 80/11 80/24</p> <p><b>very [31]</b> 3/24 6/18 8/9 13/21 29/2 32/7 32/7 34/2 34/18 46/15 46/18 47/2 53/18 55/3 55/20 59/25 60/20 61/13 65/7 67/13 67/14 69/5 69/23 70/22 71/14 76/11 81/4 82/21 86/3 87/10 88/16</p> <p><b>via [4]</b> 1/10 8/13 8/25 35/19</p> <p><b>view [4]</b> 16/22 33/16 70/17 71/4</p> <p><b>views [2]</b> 71/25 72/10</p> <p><b>violence [6]</b> 7/8 26/15 27/7 28/13 29/9 64/21</p> <p><b>violent [1]</b> 72/16</p> <p><b>virtue [1]</b> 32/11</p> <p><b>visit [5]</b> 5/9 63/7 63/18 64/3 87/19</p> <p><b>visited [1]</b> 63/8</p> <p><b>visiting [4]</b> 6/7 28/1 29/18 29/19</p> <p><b>visits [3]</b> 6/9 27/8 29/10</p> <p><b>vital [2]</b> 33/14 33/15</p> <p><b>voice [1]</b> 77/14</p>
<b>W</b>				
<p><b>wait [1]</b> 43/1</p> <p><b>waiting [1]</b> 10/17</p> <p><b>walked [1]</b> 34/2</p> <p><b>want [22]</b> 8/22 21/1 21/7 21/15 28/5 28/11 50/18 51/13 51/15 51/17 51/19 51/23 52/10 52/19 56/24 58/23 58/25 62/12 65/14 73/9 83/23 84/3</p> <p><b>wanted [7]</b> 64/15 76/5 83/23 84/11 85/21 85/21 87/24</p> <p><b>ward [26]</b> 2/6 2/21 3/3 3/23 4/3 4/3 16/14 16/24 16/24 16/25 17/13 18/18 20/10 20/15 20/18 20/21 25/18 64/17 72/10 72/11 72/12 72/21 75/13 76/20 78/20 79/1</p> <p><b>warm [1]</b> 57/11</p>				

<p><b>W</b></p> <p><b>warning [6]</b> 80/10 80/15 81/10 82/25 83/2 83/10</p> <p><b>was [343]</b></p> <p><b>wasn't [40]</b> 9/4 11/7 11/7 12/19 14/4 14/6 14/11 14/16 16/3 24/15 29/21 33/23 34/13 42/2 45/4 47/1 49/21 50/3 50/15 50/24 57/7 57/7 57/10 60/1 63/8 64/1 64/2 73/7 74/17 74/25 77/9 78/3 82/16 82/19 83/5 85/7 86/19 87/24 87/25 88/23</p> <p><b>way [10]</b> 20/12 33/24 38/19 38/19 51/20 54/24 87/1 87/3 88/9 88/19</p> <p><b>ways [1]</b> 60/18</p> <p><b>we [178]</b></p> <p><b>we'd [10]</b> 3/18 10/17 10/18 21/24 32/2 32/3 36/11 46/22 82/3 85/24</p> <p><b>we'll [3]</b> 45/24 89/10 89/11</p> <p><b>we're [9]</b> 11/2 19/2 24/12 38/5 40/25 47/23 72/25 81/4 84/7</p> <p><b>we've [11]</b> 17/20 20/15 20/23 24/13 43/10 47/18 77/5 77/13 78/17 83/3 88/22</p> <p><b>wear [1]</b> 56/2</p> <p><b>Wednesday [1]</b> 1/1</p> <p><b>week [2]</b> 5/2 17/8</p> <p><b>week's [1]</b> 5/21</p> <p><b>weekend [1]</b> 74/23</p> <p><b>weekly [3]</b> 18/11 18/19 29/25</p> <p><b>weeks [7]</b> 5/1 5/18 19/9 19/9 22/15 47/25 79/24</p> <p><b>weighing [1]</b> 40/12</p> <p><b>weights [1]</b> 17/20</p> <p><b>well [43]</b> 2/20 3/13 3/15 4/8 12/13 14/23 15/15 15/20 16/7 18/17 19/1 21/6 23/20 27/16 31/15 38/21 41/2 41/23 42/6 46/18 47/21 48/17 53/2 55/12 56/21 57/4 57/24 57/25 61/3 62/2 67/7 69/1 71/7 72/18 72/25 73/1 73/6 82/20 82/21 84/10 86/9 88/12 89/10</p> <p><b>went [5]</b> 6/5 8/13 34/21 60/8 77/8</p> <p><b>were [62]</b> 1/6 4/17</p>	<p>6/6 12/15 14/9 15/11 17/6 18/16 18/17 18/19 21/18 21/18 22/13 23/16 25/1 25/7 25/8 25/20 26/15 27/18 29/10 30/21 31/14 31/14 32/7 32/8 34/8 34/21 42/6 42/8 42/12 42/16 42/17 44/25 46/10 47/12 47/18 49/6 50/2 50/21 52/13 53/21 58/3 60/14 62/4 63/24 63/25 66/25 68/4 69/18 69/20 72/11 72/13 75/23 80/11 80/12 81/14 82/24 88/17 88/20 88/24 89/1</p> <p><b>weren't [3]</b> 6/7 42/6 52/13</p> <p><b>what [82]</b> 2/14 3/5 3/10 3/12 3/13 3/20 5/6 10/22 11/18 11/23 14/22 15/19 15/20 15/21 16/4 17/1 17/5 20/17 21/10 21/12 21/16 23/8 23/12 23/16 25/19 27/3 28/19 28/22 30/5 30/7 31/12 31/19 32/8 32/10 35/5 36/16 40/6 40/8 40/16 42/14 45/7 45/10 45/11 46/17 47/12 48/25 49/1 49/2 49/25 50/24 54/15 54/18 57/18 59/1 59/5 59/11 59/12 60/23 62/11 65/1 67/2 67/11 68/21 68/22 69/17 71/18 71/25 76/7 79/4 79/9 79/10 80/11 81/1 81/23 82/18 84/8 84/19 86/1 86/8 86/11 86/22 88/4</p> <p><b>what's [1]</b> 41/2</p> <p><b>when [53]</b> 8/17 9/3 9/6 9/16 10/25 12/14 12/14 13/3 15/2 16/6 17/7 18/1 18/5 18/24 19/2 19/5 19/7 20/24 21/2 21/23 22/15 24/7 24/15 25/23 26/16 27/7 28/4 29/19 37/20 41/25 44/8 47/2 47/9 47/10 47/11 52/23 54/19 54/20 57/12 62/2 66/14 68/4 70/20 71/2 75/10 75/25 78/19 82/13 82/16 84/18 86/19 87/9 88/16</p> <p><b>where [37]</b> 1/9 2/11 3/25 4/3 5/24 6/6 11/2 13/1 13/7 13/9 20/19 22/12 25/16 33/2 35/6</p>	<p>35/7 39/25 40/3 42/2 43/18 47/16 58/20 59/6 65/25 67/22 67/23 69/11 69/20 71/11 72/10 72/15 74/22 75/13 81/23 82/3 82/9 83/6</p> <p><b>whether [34]</b> 4/6 8/11 9/17 9/20 10/23 13/10 13/11 14/9 14/11 15/17 16/20 18/17 19/3 19/5 22/15 33/11 36/4 38/18 40/12 48/7 48/9 49/2 49/3 49/10 57/22 59/2 63/10 67/3 68/18 82/3 82/22 88/5 88/6 89/5</p> <p><b>which [37]</b> 3/1 5/2 13/9 13/16 14/25 15/21 19/16 22/17 24/19 25/8 27/22 34/22 43/6 43/20 46/10 49/8 51/1 55/17 56/5 57/17 60/12 60/19 65/25 67/21 68/15 68/16 69/1 70/5 71/20 76/15 77/11 79/18 82/25 84/15 86/16 86/17 89/6</p> <p><b>whilst [4]</b> 53/7 68/16 70/3 76/20</p> <p><b>who [10]</b> 12/2 12/2 22/23 25/18 27/18 29/19 38/12 52/19 53/13 58/3</p> <p><b>whole [3]</b> 43/12 55/3 82/7</p> <p><b>why [31]</b> 1/24 1/25 7/18 8/12 11/21 14/6 21/16 30/23 34/8 34/12 34/17 34/19 35/3 45/13 45/15 48/5 50/17 50/23 51/15 51/19 51/23 59/6 63/20 68/24 71/13 72/13 77/8 80/20 81/3 84/2 88/12</p> <p><b>wider [1]</b> 38/17</p> <p><b>will [17]</b> 1/13 3/5 7/2 10/2 10/3 10/7 14/19 20/24 23/1 27/9 31/7 37/1 44/17 49/20 72/18 76/22 77/17</p> <p><b>willing [1]</b> 68/11</p> <p><b>winter [1]</b> 34/9</p> <p><b>wipe [1]</b> 43/24</p> <p><b>wise [3]</b> 24/5 24/7 40/10</p> <p><b>wished [1]</b> 19/21</p> <p><b>wishes [2]</b> 16/16 16/17</p> <p><b>withdrawal [1]</b> 75/24</p> <p><b>withdrawing [1]</b> 8/20</p> <p><b>withdrew [1]</b> 75/25</p> <p><b>within [5]</b> 30/13 31/14 62/11 71/15</p>	<p>79/24</p> <p><b>without [3]</b> 11/4 26/12 56/1</p> <p><b>WITN0163002 [1]</b> 86/15</p> <p><b>WITN0368001 [1]</b> 35/12</p> <p><b>witness [12]</b> 26/14 35/11 40/2 42/13 42/15 65/12 73/3 74/5 79/23 80/16 82/14 85/4</p> <p><b>witnessed [1]</b> 11/8</p> <p><b>won't [1]</b> 73/14</p> <p><b>wonder [1]</b> 45/22</p> <p><b>wondered [1]</b> 84/2</p> <p><b>words [3]</b> 49/6 49/10 49/11</p> <p><b>work [6]</b> 3/11 45/7 52/18 53/12 63/23 82/16</p> <p><b>worked [3]</b> 14/24 78/8 89/2</p> <p><b>worker [1]</b> 79/6</p> <p><b>workers [2]</b> 37/2 38/1</p> <p><b>working [16]</b> 1/15 3/4 3/21 11/20 24/2 27/18 31/14 32/11 37/4 37/22 38/13 39/13 47/10 61/19 61/22 77/12</p> <p><b>works [2]</b> 44/23 88/1</p> <p><b>worried [1]</b> 84/6</p> <p><b>worse [3]</b> 49/18 49/18 67/19</p> <p><b>worthwhile [1]</b> 16/11</p> <p><b>would [129]</b></p> <p><b>wouldn't [27]</b> 2/13 2/24 2/24 5/23 6/1 6/2 6/18 12/3 18/12 19/17 20/4 30/23 34/15 36/8 45/12 45/15 50/7 51/4 51/10 51/19 51/22 58/2 62/11 72/19 80/14 84/3 87/6</p> <p><b>written [5]</b> 3/5 11/24 20/12 41/18 86/9</p> <p><b>wrong [1]</b> 36/19</p> <p><b>wrote [1]</b> 7/18</p> <hr/> <p><b>Y</b></p> <p><b>yeah [59]</b> 2/13 3/5 3/6 3/13 4/10 6/8 6/13 8/5 9/11 11/22 12/14 13/19 14/2 15/23 15/25 17/24 20/4 24/9 31/2 33/9 33/13 36/3 36/8 36/15 38/4 42/17 42/17 45/12 46/11 46/17 46/22 49/12 50/21 53/17 55/14 57/1 57/1 57/7 58/13 58/19 61/4 67/20 70/15 74/12 75/9 75/18 76/3 76/18 78/7 78/11 79/20 80/5 80/9</p>	<p>82/23 84/8 85/8 85/23 85/23 87/7</p> <p><b>year [3]</b> 53/9 71/22 84/25</p> <p><b>years [3]</b> 13/22 14/24 31/17</p> <p><b>yes [195]</b></p> <p><b>yesterday [1]</b> 60/17</p> <p><b>you [323]</b></p> <p><b>you'd [10]</b> 4/3 30/18 65/22 67/23 68/9 68/18 69/11 69/13 69/19 80/14</p> <p><b>you're [12]</b> 4/8 11/10 16/14 19/2 28/25 28/25 37/22 57/8 69/8 69/8 83/13 86/22</p> <p><b>you've [12]</b> 14/1 61/9 64/5 65/15 65/21 67/18 71/11 73/6 74/15 75/4 82/7 86/6</p> <p><b>young [1]</b> 39/8</p> <p><b>your [33]</b> 1/20 10/22 16/22 20/1 40/3 50/18 50/22 51/16 54/7 55/12 56/16 56/17 58/10 58/12 58/14 67/22 68/12 68/23 70/10 71/7 72/10 72/12 73/14 73/15 74/5 75/19 77/6 80/16 83/15 85/4 86/8 88/12 88/17</p> <p><b>yours [1]</b> 53/8</p> <p><b>yourselves [1]</b> 32/23</p>
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