Thursday, 30 April 2026

(2.00 PM)

MS LANGDALE: Mr Carter, we pick up in the chronology to 31 August 2021 which is NHFT0000168/162, please.

This is the home visit that you wished to refer to earlier this morning where you said there was a change. I think in your statement to the Inquiry you say you thought VC was on the verge of a major breakdown.

A. I don't think I used those words, "a major breakdown".

Q. What would you say about how it was?

A. He looked -- he looked very different to how I remember him. He looked quite agitated. He looked very preoccupied with his thoughts. He was quite paranoid, he felt that we were working with the police. I had to pull out my ID card just to reassure him that I was a nurse, because although I'd met him before it had been quite a while and he might not have recognised me. So I just wanted to reassure him that I was a genuine nurse.

We needed to reassure him that we weren't working with anybody, we worked for the health services. But I wasn't entirely convinced he was reassured by that. And he just unnerved me, to see him like that. And I'm perfectly frank with you, I'm glad when we both exited the room.

Q. Why?

A. Because in a situation like that, you know, you can kind of feel an atmosphere that I've experienced before, not just in my career, but in life generally. You -- you can just feel that things our not quite right, and it might be a good idea to just leave an environment.

Q. Because you were in fear of physical violence?

A. No, I wouldn't say that, to be perfectly frank with you. I was just fearful -- well, I weren't fearful, I was just concerned the way he was. I just felt that yes, he probably hasn't been taking his tablets, and really, you know, we might have to kind of initiate something in the near future.

Q. The record says, if we go to the fifth paragraph:

"We did not feel it was safe to continue to push the assessment".

Do you see at the bottom?

A. Yeah, yeah, fair enough, if that's Claudia's view, yeah I'll go with it.

Q. It sounds like it was your view, you wanted to get out of there.

A. No, no, I didn't feel unsafe, I just felt as though we'd tried to persuade him who we were and, you know, we weren't really making much progress, so it was probably a good idea to exit, and take things from there.

Q. The impression, the risk was:

"[He's] currently relapsing ... appears paranoid/suspicious ... is not trusting of services."

A. Yeah, yeah.

Q. You do say, if you want it on the screen it's paragraph 159, WITN0368001, page 36. Page 36 of your witness statement at paragraph 159:

"VC confirmed he was not taking his medication, which was obvious ... said he would not accept any further visits. His lack of insight was quite clear. My view was ... he appeared to be on the verge of a major breakdown."

So you said that in your statement to the Inquiry.

A. That's right, yeah.

Q. When you said a moment ago you don't think you said that, which is right? Did you think he was on the verge of a major breakdown or not?

A. I think he was on the verge of a breakdown, certainly.

Q. He confirmed that he was not taking his medication?

A. Yeah, which would have -- you know, reinforced that, reinforced that view.

Q. So you didn't feel safe to continue the assessment. You knew he wasn't taking the medication, and you knew he had been violent previously when he hadn't taken his medication.

A. Sorry, just repeat that again for me, please.

Q. You knew, at the time of the assessment -- can we have that NHFT0000168/162 back on the screen, please -- you knew that he wasn't taking his medication, you knew you didn't feel safe there yourselves and you knew that he had been violent to others when he hadn't taken medication?

A. I suppose this is an example of, you know, like, yes, Claudia probably didn't feel safe. I felt uncomfortable, and I think there's a difference.

Q. Why do you think she didn't feel safe?

A. Probably because she knew him better than I did. She was his CCO. She had a lot more experience with him and, you know, like I'm -- she probably just knew a lot more than I did about him.

Q. So if she felt unsafe, was it reasonable for you to think that others may well feel unsafe around him?

A. Well, other people might do, or might just feel uncomfortable around him.

Q. So in terms of the risk, the risk he posed, this assessment or visit was significant, wasn't it? You were both --

A. Yeah, yeah --

Q. -- recognising he posed a risk?

A. -- yes, definitely. Because I was comparing him with

how I once knew him when I saw him, you know, in 2020, or whatever. And yeah, he looked different. He sounded different.

Q. "Plan;

"Discussed with Dr Lloyd, plan to discuss with [the Crisis Team] however it is very unlikely that [VC] is going to engage with home treatment.

"May require Mental Health Act due to lack of insight ..."

We know, actually, on the same date, 31 August, Ms Birtles does refer him for a Mental Health Act Assessment.

A. Yes.

Q. But in terms of the language of this "may require Mental Health Act Assessment" it was obvious and vital, wasn't it, at this point?

A. May require --

Q. It sounds very casual that, doesn't it, "may require"; it was vital?

A. Yes, I would say, yes, certainly -- I hate to use this word, with the benefit of hindsight, yes, "may" is not a good word to use here. He needed a Mental Health Act Assessment.

Q. You were both commenting in this at the end about how it was quite difficult to get out of his flat. Do you see

that in that paragraph above the one highlighted, please?

A. Sorry, where's that sorry? Thank you.

Q. Have a look:

"I was also concerned it was potentially quite difficult to get out of the flat due to a long corridor/hallway to the exit should we have needed to leave promptly."

A. Yes, it was a narrow corridor, from a safety point of view -- and this is not just with regards to this case but with similar cases I've had with other people in the past throughout my career on occasions -- you always look for the exit. You always look for a safe exit. A quick exit, if necessary so that you don't, in effect, get trapped, as an example. So yes, it was a little bit -- it was narrow. For both of us to exit the room quickly, would have been problematic certainly.

Q. Did you think at this stage how it might be for others, not just you two, in that situation to be in the same room as him or the same space as him?

A. Did I think that? I wouldn't say so, no. I had my mind on this -- *(overspeaking)* --

Q. You had your mind on him.

A. Yeah.

Q. But did you have your mind at any time on others who

might have been impacted by him? Other students, neighbours, people who were around him at a time when you were stating you thought he was going to have a major breakdown?

A. No, I didn't, but I would imagine that people in a similar situation might have been -- might have felt very different to how I felt, and maybe different to how Claudia felt. But yes, some people would have probably been quite anxious, frightened even, maybe.

Q. Justifiably?

A. Yes.

Q. Not taking his medication, relapsing, major breakdown --

A. If they knew what we knew about him, his medical condition, two admissions to hospital, et cetera, you know, like people jumping out of windows, and if they'd had seen him in this state and been in close company with him, yes, they could have, yeah, feel very frightened, yeah.

Q. So what do you think, as a team visiting him, your responsibility was in that role to other people out there, the people that you don't know that are dealing with him? Not just VC, your responsibility to him as a patient, but your responsibility to members of the public that are going to come across him when you feel like this and you put safeguards around your own

dealings with him --

A. Yeah.

Q. -- do you think you should be sharing information so others can think about safeguards that should be around them?

A. Well, certainly, yes. If it's appropriate to share information like that to our colleagues, for instance, yes, I think they should be made aware of that.

Q. Do you mean colleagues in the team? Just the mental health services team, or do you mean colleagues out --

A. Whatever, the Crisis Team, because, you know, like our team, you know, anybody who has close contact with him, face-to-face contact with him.

Q. The University, should this information have been shared with the University that there was this -- *(overspeaking)* --

A. It wouldn't have done any harm, yeah.

Q. Well, it would have done some good, wouldn't it?

A. Yes, that's right, yes.

Q. It's important to share it.

A. Yes.

Q. So did you ask anyone: can we share this with the University? We've both had this experience. He's relapsing. He is at the University, he's around young people. There's a history of events. There's so many

reasons for sharing this information with the University, isn't there, at this time?
A. Yes, there's lots of reasons, definitely. I'm just thinking about the confidential nature of information about his condition. Like you're right, I think what he's suggesting would have been perfectly reasonable and that would have been a good idea.
Now why -- I don't know whether it was shared with the University, I don't know. But I think it would have been very good if it had have been.
Q. What's the barrier to sharing it? You've raised confidentiality. Did you think you couldn't share concerns about the risks that a patient posed to others, because of patient confidentiality?
A. Well, in this day and age, above all else -- well, it's been a trend for many years, we do not want to stigmatise the patient. We do not want the whole world to know that he's got a diagnosis of paranoid schizophrenia.
Q. He doesn't even know if it's not on the care plan, does he? It's not written anywhere.
A. Well, I didn't write that care plan.
Q. You should have done. You should have updated it.
A. Yeah, well, I think Claudia should have updated it. She was his CCO.

Q. You were later and could have added to it. But anyway, continue. You were saying, stigmatisation. So what's the impact of that?
A. Well, basically, you know, like -- you know, like we're trying to basically seek inclusion at every opportunity. All right, people suffer from various mental health problems but it doesn't -- not all of them are murderers or dangerous. You know, there are thousands, millions of people worldwide who have a mental health issue but basically they're trying to live with that, and we're trying to encourage them to be fully integrated in society.
Q. As far as it's safe to do so.
A. Yes, exactly, yes, I agree. I agree. And if it's not safe to do so, then we have to remove them from society, even if it's just on a temporary basis, if nothing else.
Q. But in terms of sharing information, where you felt it wasn't safe to be around him, that's information that should have been shared. Why would that have stigmatised in any way? It's information that needs to be shared, doesn't it, about risks?
A. Yes, I would agree with you. I would agree.
Q. But did you at any time in an MDT meeting with Dr Lloyd or any of your colleagues, discuss that? "What should we say to other people to stop other people getting

harmed?"
A. I do not recall discussing it.
Q. Do you think it was the fear of stigmatising someone who must be included in society and not known for their illness? Was that the driver for that?
A. One of them, yes, possibly.
Q. What's the others?
A. Well, his race, his colour. That would definitely have been an important issue.
Q. Why was that an important issue?
A. Why? Because black men are more likely to be diagnosed with schizophrenia or paranoid schizophrenia, et cetera, those kind of things, and I think this was pointed out earlier in this Inquiry about considering VC's colour as an issue.
Q. In your conversations with colleagues, was race ever raised as an issue, in the Community Team?
A. No, no, and it never would be. No, it wouldn't. No, because to us, it's not an issue. To us, it's not an issue. But to some people it is. For some people it is a significant issue.
Q. Why was that an issue at all, or are you saying it was not, in terms of information sharing with the University?
A. No, it wasn't in terms of sharing with the University.

Yes, what you're saying, I think, is on the whole very reasonable. Yes, this information --
Q. Should have been shared and it wasn't --
A. Yes, I would not disagree with that.
Q. The effect of that was you could ensure you and your mental health colleagues kept yourselves safe, but you weren't giving other people information to assess how they could keep themselves safe; do you agree?
A. I think that's a little bit harsh, to be honest with you, on the whole team.
Q. Well, who takes responsibility --
A. I understand why you're saying it. I understand why you're saying it, but it's more or less condemning the whole team.
Q. Okay, who should be -- your words -- condemned for that, then? That choice?
A. No, I don't think we should be condemning people. We should be more open with each other. And the team at that time, I like to think, that we could all at least talk about an issue like this and say: "Look, this is serious. Who can we tell about this? Do we need to talk to the University? Do we need to talk to whoever to ensure their safety as well?" Because we don't want them feeling the way we did, or I did.
Q. But no one raised that as far, as you're concerned, so

it is a whole team thing. If nobody asked that question at an MDT or generally, and we've seen emails, you share information.

A. Yeah.

Q. Wouldn't that have been an appropriate question for somebody to raise?

A. Whether or not to share it with the University?

Q. Yes. You hadn't felt safe, you say it to Ms Birtles.

A. Yeah, I think it's probably a reasonable question, yeah.

Q. And instead, we have:

"Risk to others; [VC] is usually a very personable, kind, polite and gentle man ..."

A. Sorry, where is this?

Q. It'll be highlighted for you now, it's on the screen in front of us:

"Risk to others: [VC] is usually a very personable, kind, polite and gentle man however when unwell he did break down a neighbours door because he believed he could hear voices of someone in trouble next door".

Doesn't mention somebody jumping out of a window and injuring themselves.

A. No, no.

Q. But by the by, despite minimising events at Brook Court, which this does, it continues to say:

"Lack of insight, [VC] doesn't appear to recognise

that he has ever been unwell, behaviour can be unpredictable when unwell."

So the description there, "usually a very personable, kind, polite and gentle man."

Can we please have on screen, please, NHFT0000168/163, also on 31 August. What we see in this discussion:

"Very accusing ... and confrontational in nature."

If we can underline that, please. So discussing his presentation at the same date:

"... currently presenting ... psychotic, delusional ... suspicious ... stopped his medication -- not clear when he last took it ... believes he has been deteriorating for several months."

That's Ms Birtles believes he's been deteriorating. Do you see it? It's the box number 3.

A. Yeah.

Q. If we can highlight it, "Gatekeeping discussion", that section.

A. Mm. Yeah, I see it.

Q. "Refusing to have ... contact with his [care coordinator] ... or [Crisis] ... Very accusing and confrontational in nature."

Yet we see time and again, VC usually very "personable, polite, kind and gentle man", almost a cut

and paste across documents.

A. I would say that when he is well, he is a very sociable, well behaved, polite man.

Q. Well, you haven't seen him that often, have you?

A. No, I haven't but --

Q. So how would you know that?

A. No, I don't know for certain.

Q. Quite.

A. But I'm willing to give him the benefit of -- in this one. I'm not going to be judgmental towards him.

Q. It's not being judgmental, it's being positive, isn't it, to describe someone as "usually personable, kind, polite, and gentle man --"

A. Yes, yeah.

Q. Given his involvement with the criminal justice system up to that time --

A. Yes, and --

Q. -- and evidence of aggression?

A. Yes, when he is unwell he's a different person completely. Yes, I agree.

Q. Well, that's the assumption, isn't it? Again, what information -- it may or may not be right -- but what information did you have about what he was like when he was well, from other people apart from VC?

A. Only general conversations with my colleagues, probably

with Claudia as well, with how I seen him in September 2020 or thereabouts. So I have a limited knowledge of the man. I acknowledge that. But the fact is people, you know, I think people give me the impression that yeah, when he's well, he's a nice guy. However, when he's unwell he's something totally different. And what I saw on that day was something a lot different to what I'd seen when I first met him.

Q. He's described as "guarded" on so many occasions --

A. Yes, yes, I agree.

Q. -- in the notes, so how is it possible to assert, in a positive way, how kind and polite and gentle someone is if you're concluding they're guarded, which I understand to mean they're not telling you -- a great deal.

A. With great difficulty. It's like when people are lying to you, misleading you, you can have a feeling that something's wrong. You can make a judgement. It might be a wrong one. It might be the right one, or it could be wrong. You know --

Q. These are wrong, aren't they? They're very superficial descriptions of personality in complex circumstances where you know, by then, what his conspiratorial beliefs are from 31 August and the impact they're having and you said you didn't read the text and the messages and what

they --
A. -- yeah.
Q. -- they made him feel about what he wanted to do to people. But this personable, kind, polite and gentle positively obfuscates what's going on here, doesn't it? In terms of other people understanding risk when they look at this document?
A. I'm sorry, you're saying --
Q. The description on the last one that we see repeatedly, personable kind, polite, gentle --
A. Right.
Q. -- obscures the risk. Anyone reading that doesn't get the picture.
A. Yes, yes, I would probably agree with that. You know, the wording is not terribly good.
Q. If we go to the box further down on the page we're looking at, 163, on 1 September you explain in a call:

"... did not have an absolute emergency on our hands but a MHA assessment was considered the way forward in the near future."

A. Yes.
Q. "Plan

"[to] discuss [it] ... with Dr Lloyd."

Again, "the near future" doesn't communicate the urgency of the situation that you didn't feel safe then.

A. Well, when we got back to the office, I remember this meeting ended, we had a very brief discussion after we both came out. We headed back to Stonebridge. As soon as Claudia walked through the door she was on the phone to Crisis.
Q. Well, we know if we look at NHFT0018141, page 1, she refers for the Mental Health Act Assessment, yes?
A. *(Reads to self)*.
Q. We know he is assessed on 3 September and we know that he violently attacks a police officer, doesn't he, during attempts to conduct that assessment?
A. Yeah, yeah. Well, I --
Q. 3 September that happens.
A. Yeah, yeah.
Q. When did you first learn of what had happened on 3 September?
A. I'll be perfectly frank with you, I don't know. That's a good question and I honestly don't know how I heard about that. I think it was probably the MDT, because I remember at the MDT, it might have been the next MDT on from this incident, that Claudia came into the office and she did mention to Dr Lloyd he'd been tasered, led away in handcuffs, leg restraints, et cetera. So, you know, a few days later, shall we say.
Q. That can come off the screen, please.

So what did you and Ms Birtles say about that when you spoke about it, given how you'd experienced visiting on 31 August, when you knew what had happened to the police officer, what did you discuss between yourselves about that?
A. About the --
Q. The assault on the officer.
A. Yeah. Well, needless to say we were very shocked. Very shocked indeed.
Q. Shocked?
A. Yes, because he'd used -- he was not only aggressive, he was very violent. He's assaulted a police officer, he'd been tasered twice, I believe, he'd had to be restrained by a number of police officers. They required assistance, and he was led away in ankle restraints which I didn't even think we used in this country.

Yes, I was very shocked by that particular description of what happened.

Q. Did you, in your mind, if you weren't aware of it before, think: he can be a very violent man?
A. Dead right I did, yeah, of course. Anybody would say that, yeah. Absolutely.
Q. Did you take that forwards with you in your dealings with him; that you knew that he could be very violent, in the circumstances you have just described?

A. I did take it with me, yes, yes.
Q. Can we have please NHFT0017897, page 1. This is an email from Ms Birtles to you and others and it was surrounding his discharge. We know he had a period of detention, you'll have known that, at The Priory and Cygnet --
A. Yeah.
Q. -- immediately after that Mental Health Act Assessment that you'd initiated.

Were you surprised that he was going to be discharged at the end of October, 24 October, so soon after admission, or did you not think about that?

A. This was his third admission, I believe --
Q. Yes.
A. -- yes. Well, my understanding is that he spent a month at the Cygnet facility in Darlington, he then transferred to Calverton Priory Arnold, and then he was just discharged.
Q. Just to say, while this is on the screen, so this, in context, we know Ms Birtles has attended a ward review over Teams and she says, "Is anyone else free to join? That would be amazing if so".

Did you see that at the time? Did you think about meeting over Teams for the ward review?

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

Q. We know -- and Inquiry has examined the evidence with Ms Birtles -- that she was suggestive and considered that a depot should have been prescribed at this time, that VC needed a depot?
A. Mm, yeah.
Q. You say, "Yeah"; do you agree with that?
A. Absolutely.
Q. You say "absolutely", is that because it was common knowledge in the team he wasn't taking his medication. There was no ifs and buts, he just was not taking it.
A. Yeah. I -- throughout his kind of time with EIP, I cannot understand how this man has avoided a depot. But this is what I'm saying about this man negotiated his care and for God knows what reason, the medical and nursing staff, the medical staff in particular, went with his kind of desires, his wishes.

You know, we -- you know, the medical staff, nurses, we're the healthcare professionals. In theory, we know what we're doing. We know what's best for this man. And in similar situations in history where somebody is having a lot of problems with tablets, can't take them, forget to take them, whatever, a depot could be a good solution for you.
Q. Can I just be clear, Mr Carter, because it's a matter for the Chair, but it may be your colleagues have been

less clear about the issue of whether you fully understood he wasn't concordant. We've heard would we know if he's taking it; we're not clear if he's not taking it; we don't ask to see him take the medication were you clear he was not taking medication over this time?
A. I was clear on that day.
Q. Over the period. I'm not just asking you about one day. You go in August 2021. We know in September 2021 that a whole stash of medication --
A. My understanding of his non-concordance came from discussions with colleagues. Because I wasn't his CCO at the time and because he was -- his name was brought up on a regular basis at MDTs for instance, people did mention that he was non-concordant, he was very elusive, you know, he didn't engage very well, et cetera. That's what I knew about him. His non-concordance was brought home to me in a major way when I found out how he'd been arrested, you know, like -- because I -- because when we did the visit, we both suspected he'd not been taking his tablets. And that would appear to be the case.

Then he was arrested in such circumstances that -- well, if there was any doubt, that obliterated it, basically.

So yeah, my understanding of his non-concordance is

not through reading through his notes from day one onwards., it was from discussions, informal discussions with my colleagues.
Q. Can we please, please, NHFT0018957, page 1. And this is an email from Ms Birtles, 17th December:

"Hi all ...

"... just to mention VC ... I don't know whether it's worth discussing him in MDT, I am concerned about him, he is very angry and told me not to contact his mum under any circumstances but is not fully engaging with us. He has collected his medication from Abi today and I've text him about the OPA on the 10th Jan but not sure what else I can do in the meantime.

"Thank you so much ..."

Et cetera.

So she informs the team that it's worth discussing at MDT, and if we go, please, to NHFT0018181, page 1, please. At the top:

"Hi Claudia yes please bring for discussion on Thursday we may need to consider discharge, we know he can become unwell and has had admissions but he is not engaging at all. I don't know what more you can do I know we discussed looking at a different CCO but I don't think that will change engagement with services, but happy to discuss."

Did you know that at this point there was consideration, or appeared to be a consideration of discharge of VC, given he's not engaging at all?
A. No.
Q. Five days after this email he assaulted Christopher, a flatmate, held his flatmate in a headlock, prevented two of them leaving the premises --
A. Yeah.
Q. -- in an intimidating manner.

When did you learn about the event with his flatmate? Can you remember?
A. Again, I do not know when I learnt of it. I don't know who told me about it. I'll be honest with you, I don't know.
Q. That can come down please and can we have NHFT0000168, page 264. It's in the last box or the last three boxes. So NHFT0000168/264.

This is a time where you are recorded making a phone call to VC. VC agreed to collect his medication at 10 am on Thursday, 14 April. We see that.
A. Yes.
Q. So by this time, this is when you're no longer going to the premises; is that right? You referred to it earlier. He's coming to Stonebridge instead to get his medication.

A. Well, no, I -- basically -- yes. I stand corrected. Yes, you're quite right. You're quite right.
Q. But you remember that now, that's why you're phoning him?
A. Yeah.
Q. You said it this morning. He's coming to you, as it were.
A. Yeah.
Q. So you don't get a chance, you say, to look at him in the same way as you would in his home.
A. Yeah.
Q. If we go please to NHFT0000168/265, 20 April:
"[VC] arrived ... collected [two] ... weeks of medication as agreed. Pleasant on approach, asked how I was doing then left promptly. Next due on 28th April."
So these exchanges are very surface, aren't they? Very brief and very surface. We don't see you doing any mental state examination or profound conversation with him.
A. He wasn't -- he wasn't easy to kind of engage with this man. I think you've got to bear in mind is that I've often said that all I wanted, or what would have helped me a great deal, would be if he'd have just given me 30 minutes of his time to sit down with him, have

a conversation, and then I could have kind of got to know him and assessed his mental state as an example.
He never did that with me. He never did that with me. You know, he was -- by this time, he was -- in the lead-up to me taking over as his care coordinator, I think he'd virtually disengaged from contact with Claudia completely.
Q. And it was 29 April, wasn't it, that you took over as lead?
A. Yeah, that's right, 29 April, early May. By which time he wasn't having nothing to do with Claudia. And I don't think -- again, I didn't have a handover on the 28th when this decision was made.
Q. We'll come to the decision.
A. Yes.
Q. But you were copied in emails, you all were.
A. Yeah.
Q. Everybody knew about him and his case --
A. Yeah.
Q. -- because we see Ms Birtles' emails. That's how the system seemed to work. Yes? You had information about him, you'd visited him, you'd had informal chats about him. So you knew about his case. The lack of a formal handover didn't prevent you knowing about him, did it?
A. I think it -- I think without a formal handover it was

necessary to make a number of assumptions, you know, like when you hand over a patient off your caseload to someone else, you give them all the information that you feel is necessary and required, and you allow that person to ask any questions they want of you, as an example. And you eventually come to the stage where I've given you as much as I can give, or I've asked you all the questions I need to ask, thank you, I'll take it from here.
Q. We don't see an email from you to her asking for that, or anything like that.
A. What, a formal --
Q. Yes, just "Talk to me more about this patient before I take him over". You could have done that -- *(overspeaking)* --
A. No, he didn't require an email from me. It's standard practice.
Q. Did you ever ask her and say "I need to know more"?
A. No, it's standard practice, I can assure you.
Q. So did you ask her and say, "I need to have more information about VC now I'm his lead", on 29 April?
A. No, I did not.
Q. What's the point then? You must have understood enough about him to feel you could take that on.
A. I was basically encouraged to take this man for a number

of reasons.
Q. We'll come to that when we come to the meeting. Can I just in the meantime, please, INQY0000024, page 1. And the Inquiry has put together, Mr Carter, I know you've seen it, a chronological order of phone calls and text messages between yourself and VC. If we start, please, on page 2. We've got yours obviously from the RiO records and we've had access to VC's phone records.
So if -- or those that can be analysed, I should say. So if we look at page 2, please, we see there exchanges. I'll give people time to scroll down, including obviously yourself, Mr Carter.
If we go to page 3 you see at the top, 27 May:
"... see you at 9 am", text to him.
"... what time are you picking up your meds?"
You're chasing.
He says, "Can't do it today".
He says, "I'll come around tomorrow".
A. Yeah.
Q. You say: "Can we do it today it's Saturday and no one will be here tomorrow. We can make it on Monday ...
"Monday then.
"Ok no problems.
"[VC] could not collect his medication today. He will collect his medication on Monday. I will ring him

Monday morning to confirm a time."
"When are you picking ... up?
"... come tomorrow.
"Are you coming for your meds ...
"Come around 3".
Over the page, 4.
"... contacted [him] asking him to collect his medication ... rang me back said he had enough ... until Friday 1st July.
"I will offer him the option of taking his medication out to him ...
"If you like I could drop your meds off ... no bother ...
"... meds are due tomorrow.
"... come around.
"Ok".
Obfuscation, obfuscation, isn't there?
And we see at 27:
"Phone call to [VC's mother] ..."
27. It's the one up, please, on page 4. Box 27:
"Phone call ... explaining VC may have gone to Africa? [His mother] ... knows nothing about this and has not heard of anything to suggest [VC] is abroad. "I phoned [VC] ... [he] did not answer. I left a voicemail asking him to call me."

What had been said that made you think he was abroad? He said he was abroad, didn't he'd?
A. Sorry?
Q. Did VC tell you he was abroad?
A. I don't -- I don't recall this. I don't think I was contacted directly with this, somebody else was, they were led to believe that he'd gone abroad, which was surprising, obviously. You know, like, if I contacted Celeste, yes, that appears to be the case. She knows nothing about it. As far as she's concerned, he's still in the UK.
Q. Yes, so she poured water on that idea, didn't she --
A. -- yes, yes.
Q. -- that he wasn't abroad, he was in Nottingham?
A. Yes.
Q. So it continues with attempts to find him. So what we see here is communication between you and VC who is ducking and diving and not doing what he's supposed to do?
A. Yeah, yeah, he is.
Q. An ongoing pattern of not getting his medication, not taking his medication. When a patient is refusing medication, and it's clearly in their best interests to take it, should you not be engaging in coercive practice to make sure that they do?

A. Sorry, coercive?
Q. Yeah, coercive. To make him do it.
A. To make him collect his medication?
Q. Yeah. Yeah. How can you not collect it, to make him collect and take his medication. Wasn't this the time to make sure that his treatment needs were met, and that whether he was sectioned, on Community Treatment Order, you knew he wasn't taking his treatment --
A. Yes.
Q. -- and he clearly had to?
A. Yes, yes. It's just the word "coercive", I just find it a little bit unusual, that's all.
Q. It's unusual, isn't it, in mental health services to talk about coercion, but it is coercing someone to take medication whichever way they will, whether it's in the community being watched taking it, whether it's with the Community Treatment Order, and having to be re-called to hospital for it. It's making them take medication.
A. Yes.
Q. Was there ever a discussion that firm within the team about "He has to take this medication and we've got to work out how it's done". It's not an if, he has to --
A. Was there discussion amongst the team?
Q. Yes.
A. Not that I'm aware of, no.

Q. Was there any consideration about his capacity to take medication? In other words, whether he legally understood, was able to weigh up the benefits of taking his medication, to him, never mind anyone else?
A. No, there was no discussion about his capacity, no. None that I recall.
Q. Don't you think there should have been?
A. Yes, there should have been a lot of things happening, yeah. It's like, it's like when you talk about coercion to take his medication, this had been tried with the Crisis Team I believe, who -- the Crisis Team are often involved, one, because they have an assertive outreach kind of attitude, mentality, plus they've got a big team, they've got a big team. We have -- at that time, we had what, five -- were it four or five -- five nurses, I believe. We're a small team.
So they tried this with him, and even they failed, miserably.
Q. Well, he didn't take it. They saw that he didn't take it, didn't they?
A. Yes, that's the point I'm making. Despite their best efforts, a whole team from Crisis could not ensure that this man was taking his medication.
Q. So was that the time to make the suggestion, as Claudia Birtles did after the third admission, he had to take

a depot because no one could get him to take his medication?
A. Yes, I'm not going to disagree with you about his depot. Yes, he should have been on a depot from, I would say, admission two onwards.
Q. Did you ever say that to anyone --
A. Yes.
Q. -- to any doctor? Which doctor did you say that to?
A. I do not know, but I said why doesn't this man be placed on a depot? Why don't we try depot with him? It's the obvious -- well, it's not a solution, no. But it's a better solution to what we've got at the moment.
Q. So when did you say that to anyone?
A. Numerous, numerous occasions. I'm sorry, I can't be specific.
Q. To your team, colleagues, or to a psychiatrist?
A. Team, colleagues --
Q. What about Dr Lloyd; did you say it to her?
A. I don't recall saying it to Dr Lloyd, no.
Q. She's the obvious person to say it to, isn't she?
A. She is, yeah, but she never mentioned it either, and it's something never came into her kind of mindset, I don't know why.
Q. Are you sure you mentioned it because you don't seem to know who you did say it to?

A. Well, I'm sorry, I did mention it to -- I did have this discussion with several of my colleagues. And I think I recall Dr Burri, I think, I mentioned I had a chat with him about it at one stage. But it were quite a while back.
Q. Can we have NHFT0000168/266, please, and this a record on RiO, information received from the University. Did you see this? You took over shortly afterwards on the 29th. This was 26 April., and we see to Claudia, an exchange between Claudia and Ellie, and reference there:

"I've just learned that VC returned to Raleigh Park last Thursday ... One of the Security officers approached him and VC said he was visiting a friend, but gave a false name when questioned [when] he was visiting."

You'll appreciate the significance of Raleigh Park was where he assaulted his flatmate and he wasn't allowed to go back there. He wasn't able to go back to that address after that.

Did you know, contrary to instructions to him, he'd gone back there and had to be escorted off site by security?
A. Yes, I was made aware of that, yeah. Yeah, I do recall that. By who, I don't know, but I was made aware of that.

Q. How did that fit into risk assessment, his risk to others, as far as you were concerned?
A. Well, again, it's indicating that this man is -- well, he's quite poorly. He's very poorly. You know, like he's got no understanding of any kind of instructions that he's receiving, he shouldn't have been there, but he was there anyway. You know, like he was -- it says here he was not aggressive or confrontational, although the incident was strange. Yes, it is strange.

"... flat and Raleigh Team have been advised to contact the Police ..."

And that's probably wise. It's very wise.
Q. If we go to the bottom of the document, 266, so still page 266, 28 April, this is a Multi-Disciplinary Team meeting, and it's noted:

"Following a risk assessment and discussion in MDT, agreed it would be appropriate to transfer [VC] to a new CCO, preferably two CPN's."

You were not at that meeting, you say.
A. No.
Q. It was after that meeting that you were asked to be his lead care coordinator.
A. I was -- well, yes, I suppose you could say I was asked to be his lead coordinator -- his care coordinator.
Q. Did you know that this discussion was taking place and

that you were going to be asked to be that?
A. I didn't know this discussion was going to take place then, no, I did not know, no.

I -- I find it unacceptable that I wasn't there, basically. You know, I -- because a risk assessment has been -- "following a risk assessment", now when I first read that, I thought this was a risk assessment on VC. Then it suddenly dawned on me, it was pointed out by somebody that it was actually done by Claudia and because of her, I believe, she was in the early stages of her pregnancy, a new CPN was required, and interestingly, preferably two CPNs. Yes. I agree with that, definitely.
Q. You agreed with two CPNs?
A. Well, one is quite obviously not enough.
Q. Why not?
A. Why? Because you can't -- one person -- this man is -- because he's negotiated everything, he's just permanently unwell. Even when he's reasonably well, he's not terribly well and basically, you know, like even to -- you know, one CCO is not enough to monitor him closely in the community. And I would say that, you know, like even two CPNs, that's not a guarantee, that is far from a guarantee, that he could have been monitored closely, in my opinion.

Q. Can we go, please, to NHFT0000168/267 and you see him twice in May, don't you?
A. Yes, that's right.
Q. When you are his care coordinator, two face-to-face visits --
A. Yeah.
Q. -- which we see on 267, and that's all, isn't it, that you see him face-to-face?
A. That's it, yeah. He collects his medication. I tried to engage with him, but he just takes the medication and promptly leaves. And I believe that's what occurred with two of my colleagues as well.
Q. So if we go to 13 May, you:
"Texted [VC] to let him know his medication was due. Later ... phoned ... to find out when he was coming."
A. Yeah.
Q. "We agreed on 1230hrs. ... arrived on time and accepted his medication then promptly left without any chance of me having a chat with him."
Did you ever ask to see him take the medication or did you think there was no point in that?
A. *(Reads to self)*.
Sorry, the question again?
Q. Did you ask to see him take a dose of medication? He'd come to collect it --

A. What, there and then?
Q. Yes.
A. No.
Q. Why not?
A. I can only assume, you know, like -- he may have taken the dose in the morning or whatever, when is this, 12.30? When was it? When was it? I'm just trying to look at the time.
Yeah. He's picking up his medication. I don't think I've ever asked a patient to take a dose of his medication there and then.
Q. But you knew, you say, he wasn't taking his medication; that was the concern, wasn't it?
A. So basically you feel that I should have asked him to take a dose right there in front of me?
Q. I'm just asking you, would you do that if you knew --
A. No, I --
Q. -- you knew he wasn't taking it.
A. Yes, I do. Yes, I wouldn't do that and, you know, because I would have rightly assumed that he might have taken some medication that morning, and he could well have confirmed that, maybe. I don't know.
Q. But you said earlier you had known he wasn't taking medication. That's something you had realised before this time, hadn't you, that he wasn't taking his

medication? You knew it from September 2021, there was seven months of it, and by this point you say you talked openly with colleagues about he was non-concordant.
A. Mm.
Q. Is the phrase you use.
A. Yeah.
Q. Non-concordant. That means not taking his medication, right?
A. Correct.
Q. So you had a conversation, he's not taking his medication?
A. Yeah.
Q. When he turned up, was this something of a tick box "Oh, we've given him his medication, now it's over to him? We've done our bit, he's got it, it's up to him" --
A. Well, he has his medication. At least he's turned up for his medication. That's an achievement in itself.
Q. Is it, if you're not taking it?
A. Well, no, the fact at least he's picking up his medication. Now, he may throw the medication in the bin outside, I don't know. But he has arrived in that building to pick up his medication.
Q. In circumstances where his engagement was limited to him simply collecting the medication, was there any realistic hope of properly monitoring whether he was

going to take it?
A. Not from our team point of view. Not from one person's point of view. You know, like I gave him his medication twice. I think Abi gave him his medication once. I think Kaisha gave him his medication once, and each time he picked up his medication and promptly left. You know, he didn't stay.
Q. If we go, please, to 268, over the page. That's the occasion, 15 June. Ms Parsonage --
A. Yeah, there we are, yeah.
Q. -- gave his medication.
"VC was well kempt but ... facial hair and head hair was overgrown. ... looked suspicious ... looking around."
We don't see any notes like that from you when you see him and give his medication.
A. No, and you don't see it recorded that she insisted on him taking his medication.
Q. No, I'm not suggesting it does say that, but in terms of commenting on being suspicious, looking around --
A. Yeah.
Q. -- the signs -- *(overspeaking)* --
A. Yes.
Q. We don't see you record anything like that.
A. Right, well basically if I'd have seen him in that state

I may well have noted that.
Q. We see on 24 June further down, you contacting him asking him to collect his medication:
"[He] rang back to say he had enough medication until Friday 1st July."
Did you challenge that and wonder how he had that? Or did you not just discuss medication with him?
A. Or did I what, sorry?
Q. Did you challenge him and say, "How come you've got enough since 1 July?" Or ...?
A. No, I don't think I did challenge him, no.
Q. Or discuss it with him?
A. No, I was basically offering him a choice of taking his medication now. That would have been desirable, certainly.
Q. 4 July, "Provided [him] with ... oral medications as prescribed". Two weeks. It had run out on 18 July. That's not you; it's someone else, isn't it? Below your entry. Yes?
A. Yeah, I was out on visits ... yeah, "declined wanting anything passing onto" me.
Q. 4 July, that's the last time he's seen, isn't it?
A. What's the --
Q. 4 July.
A. -- 18th July note? What's that?

Q. Ms Parsonage, "Text sent". Come in for meds. He says "Not in the UK at the moment". "Are you on holiday?" That's the conversation about being abroad.
A. Yeah, that would appear to be the last time he's seen, yes.
Q. And it's clear that he's going to run out of medication even if you thought he was taking it. But it sounds as though you knew he wasn't taking that medication over this period; is that right?
A. I think there were some very strong indications that he weren't taking his medication.
Q. Clear indications?
A. Well, certainly the comment made by Abi about him looking very dishevelled would certainly -- might indicate that he's not taking his medication.
Q. And if we look at the boxes from 25 July down to the 3 August, that's where the phone call was made to his mother.
A. Yeah.
Q. Who knows nothing about him being abroad.
A. Yeah.
Q. You telephone VC, no answer. He doesn't pick up his medication, 27 July. 29 July: attempt to make contact, no answer.
Doesn't attend 1 August with Dr Tuhina Lloyd.

3 August, again you make a telephone call and no answer.
A. Mm-hm.
Q. Why doesn't this trigger rapid escalation?
A. Probably because I was going to go out and see him with Paul Williams the following day, which I believe I did.
Q. And you went to an address that wasn't his. That's right, isn't it?
A. Well, it used to be his. You know, which address were we considering? Because when he was discharged after -- on discharge three, after his third admission, it was 268 Queens Road Beeston. But if you look at the RiO notes, ten days later, Dave Waldron provides an alternative address, flat 15, Derwent Way. And yet when I went to visit him, I --
Q. Where did you go?
A. I visited 209 Ilkeston Road.
Q. Yeah. That was an address you made a cold call to on 4 August --
A. Correct.
Q. -- and you were told he doesn't live there. That's right, isn't it?
A. That's correct, yes. Now --
Q. Just let me ask you my next question.
A. Right.

Q. The Derwent address, the flat 5 address, was where he'd assaulted his flatmate.
A. Right.
Q. And it was clear on the RiO records he wasn't allowed back there, was he, by February? So he was never going to be there, was he?
A. Well, that's the address Dave Waldron gave, flat 15 Derwent Way.
Q. Well, he may have done, but as his care coordinator, if you'd traced that issue through you would have seen he couldn't possibly have lived there, because he'd come to an agreement with the University that he was going to move out from there. Ellie Turner had told you that, there had been communication about that with the team.
So you went to an address he hadn't lived at for a long time. And it may have been you didn't know the right address, that's where you got to, you didn't know where he was living --
A. Yeah, yeah.
Q. -- he wasn't living at the Ilkeston Road one, he definitely wasn't going to be living -- and that should have been clear before visiting it -- to the address that the discharge letter was sent to, and it may have been necessary for you to try and find out where he was living then, wouldn't it? And how would you go about

that?
A. Yes, it would have been useful to know where he's living, definitely.
Q. Well, it's vital. You still had his telephone number, didn't you?
A. Yes, I had his telephone number. I tried ringing him and he weren't --
Q. You text him, if you couldn't do that; what else would you do to try and find out where someone was?
A. Well, we could go out and try and find him. Literally go out and try and find him. But the fact remains, you know, the reason why I probably didn't do that was because I had other people to see as well. I weren't -- I didn't just have a caseload of one.
Q. You might have suggested someone else found out where he lived for you. I'm not suggesting you had to do that, but you needed to say, "This man is dangerous, he's relapsing, we don't know where he lives. Can you find out?" You contact the police, you contact the local authority, housing, find out where he was. His mother didn't know.
A. -- ask one of my colleagues to go out to find a dangerous man?
Q. No, to find out where he lives. Someone from admin to contact the police to find that out, where he may be or

housing or the local authority. His family had told you he was in Coventry, they didn't know. That's what he had said to them. VC had told you he was abroad. He's not telling people the truth. You needed to know where he was.
A. Correct, yeah, I agree.
Q. So how would you go about that?
A. Well, ultimately it would -- I would -- after they the failed visit on the fourth, you know, like as I look at it, we just had one more card left and that was contact the police.

The alternative was discharge him and I don't think that was a good idea.
Q. Let's come on to that in a minute. So if we go, please, to NHFT0004909, page 3, and the top box, please. Page 3 top box. Just the top box. So this is a note of your supervision with Sharon Stone, so that's your supervisor, is it?
A. Yeah.
Q. You have monthly supervisions with her. What was her qualification? What was her role in relation to you?
A. She was -- well, she used to be the clinical lead, then, when Emma left for another position, she became the manager.
Q. So you have this on 27 July 2022, and it looks like you

raise in this supervision:

"[VC] - went missing ... believed he may have left the country ..."

That's what Abigail Parsonage's information was.

"Call from mum who informed ... he is in Nottingham, plan to try and visit with CSW — when previously unwell did need a taser when sectioned."

So you've raised it in your supervision. You told us earlier you could. So what are you sharing with Sharon Stone here? What are you discussing?
A. I'm just trying to update her on the situation with this man, basically. You know, there's been a question mark about him even being in the country. We seem to have, you know, basically found that that is not the case. He's still here. And we're going to possibly visit him in the near future at an address. You see, the address I went to, 209 Ilkeston Road, was the one on the RiO notes.
Q. Yes.
A. On the front of the --
Q. That's one of them. There's a number of addresses --
A. No, no, no, no. I would have gone to the address on the front page of his RiO notes. That is his latest address, 209 Ilkeston Road.
Q. Yes, he'd given that in February 2022. But when you

knocked on the door --
A. Yes --
Q. -- someone told you they weren't there?
A. -- yes, yes, I agree -- I agree --
Q. So it was the wrong one --
A. But the question I'm trying to raise here is why wasn't the address updated?
Q. Well, there wasn't an address to update. No one appears to have known it.
A. Well, what about 268 Queens Road?
Q. That's not where he was either, was it, at that time?
A. I don't know where he was. I don't think anybody knew where he was.
Q. That's the point. What did you do to find out? Did you discuss with Sharon Stone how you were going to find out where he was?
A. Well, I was -- well, we had one option, as I look at it, and that was to call the police.
Q. So why didn't you?
A. Because I was probably slow off the mark, yes, I was probably slow off the mark here.
Q. Did you discuss it with anyone else, with Sharon Stone, let's phone the police? Did she raise it?
A. I don't recall, I don't recall, to be honest with you.
Q. How can the police help you in those circumstances when

you're trying to locate --
A. Well, they've certainly helped me before with other clients.
Q. So they've found them for you, they can --
A. Yes, I can remember one client who went off the radar for ten days. We were both very worried, me and Dr Lloyd. I contacted the police and amazingly they found him within 24 hours and that was great, because I could work with the police, and just give them all the assistance that I could possibly give them.
With regards to VC, you know, like that was the last -- that was the last thing we could do, really.
Q. But you failed to do it.
A. Yeah.
Q. NHFT0000179, page 1, please. This is a mental health clustering tool, which I think you filled in on 10 August 2022; is that right? We see at page 1, the date, and if we go to page 4 we see "Updated by Gary Carter", yes?
If we go to page 2, please. You've only seen him twice, but you complete it at this point. Why do you complete it at this point in August 2022?
A. Because probably because I've been encouraged by Sharon to make sure that all the necessary paperwork concerned with all my clients, not just VC, is updated wherever

possible.
Q. Was that an issue for you, not updating paperwork?
A. Well, it was something that I had to get on top of. There's no two ways about it. And whenever I could, I did, and if I didn't, I would come to it as soon as I could.
Q. We see anyway, when you've completed this at the top:
"Overactive, aggressive, disruptive or agitated behaviour.
"0 = no problem ..."
"No problem" appears there. Do you agree? You've put "No problem" there.
A. No, I do not agree with that.
Q. So if you were going to complete it, was there a reason for not filling that in?
A. No.
Q. Number 3:
"Problem-drinking or drug taking ...
"1 -- Minor problem requiring no action."
Why did you put that there?
A. It had been suggested that he might have been using -- well, it were a question mark using cannabis as an example.
Q. Who had raised that, or when was that raised?
A. I think this was -- I'm pretty sure this was raised very

early in his care. I personally never really thought that was the case. I never got the impression that drug misuse was a major issue with this man. But I put that in basically just as a kind of: well, if it is, at least I've acknowledged it.
Q. You say at number 6:
"Problems associated with hallucinations and delusions
"Moderately severe problem."
A. No, that should have been high. That's a mistake on my part.
Q. That's just wrong, isn't it?
A. Well, it's a mistake on my part, so ...
Q. Mistake in what? In assessing the level of problem and risk and difficulty, or you just wrote the wrong thing down?
A. I'm pretty confident that I understood that, you know -- as I said, with the conversations I had with people, with what I knew about this man from reading through parts of his notes that, yes, there were issues around hallucinations, delusions, et cetera. It's probably a mistake that I've made there. They should have been higher than that, certainly.
Q. That can come off, please. Then NHFT0017920, page 1. 17 August, you send a letter to the admin team, City

South Admin:
"Hi everyone
"Could we just send this chap a quick letter asking him to call me. He's been off the radar for quite some time."
A. Yeah.
Q. Then if we have 122 -- so NHFT0000122, page 1 -- sent to the address that the hospital should be fully aware, from the RiO notes and Ellie Turner's communications, to an address he's not at.
A. "15 Madison Court." Now, I do not recall changing that. I don't know.
Q. What do you mean changing?
A. I just do not recall changing that. Because me and Paul went to 209 Ilkeston Road.
Q. Where he didn't live.
A. Well, yeah, apparently he didn't live.
Q. Well, when you spoke to the person --
A. Yeah, I spoke to --
Q. -- did you have any doubt that they were telling you -- *(overspeaking)* --
A. Yeah, I did have some doubts actually, yeah, because I think basically this man, I felt, was being assisted, and I think that somebody might have been helping him out here. So I had my doubts about that. However,

there's nothing I could do about it.
Q. Well, if you thought that, again, you could contact the police, couldn't you, and say, "We're trying to find this man, VC, can you help us with it?" If you actually thought --
A. Yeah.
Q. -- you knew where he was and you don't want to take that further?
A. *(The witness nodded)*.
Q. But instead we see -- and it may be admin. You're saying you didn't revert it to the Derwent Way address, but it's a fact that that wasn't --
A. Yeah.
Q. -- the right address. What address did you think the admin team were going to put on when you said, "Send a letter"?
A. They would put the latest address on the RiO notes.
Q. And he hadn't been engaging with services at all, had he?
A. No.
Q. This letter, if we read it, doesn't set out anything as to why he should engage, why you're concerned, why it's necessary to be in touch. Did you think this had any prospect of working in terms of engaging him or getting him on board with what you wanted him to do?

A. Well, it was an attempt to just kind of reach out to him and basically say, "Look, can we have a chat? Can we at least meet up and just have a chat about things and see where we go from here."
Q. Did you know anything about the "Did Not Attend" policy and what should be done if someone did not attend and weren't doing as they should be?
A. I was made aware of it, yeah.
Q. If we have a look, please, at NHFT0004725, page 7. So 7.2.3.3 highlighted, please:

"If the patient is not at his/her address, the care co-ordinator and service team should agree other agencies to be contacted eg GP, housing departments, works and pensions departments ... including a discussion regarding contact with family members even if the patient has requested no contact with their family. This requires to be judged on a case-by-case basis determined by the level of risk, whilst at the same time, must respect patient confidentiality in not discussing or passing on clinical information."

In terms of risk at the moment, without a doubt he was a serious risk, wasn't he, relapsed and unmedicated in the community?
A. *(The witness nodded)*.
Q. Despite that, there weren't further attempts, were

there, to find out where he lived and to visit him at home beyond the ones you've told us about.
A. Mm *(The witness nodded)*.
Q. Do you agree?
A. Again, I would -- I would say, you know, I had other people to see, and yeah, I wanted to make some progress here. But I also needed to make progress with other people as well.
Q. Did you get anyone else to do the attempts to find and visit him, then, either through Crisis?
A. Well, I certainly didn't approach Crisis at that time, not yet, no.
Q. Why not?
A. I was -- I was still hoping that we could find him, and engage with him. And again, I probably -- I was probably slow off the mark on this. I could have contacted him earlier, I suppose.
Q. Could have contacted the police?
A. Could have contacted the police.
Q. Request a multi-agency meeting?
A. I'm not really sure how the police might have reacted to this because, you know, like from my experience of the police is that you've got to give them an incredibly good reason to do -- shall we say for them to search for people.

Q. Well, he was wanted, wasn't he, and the irony, grave irony --
A. I'm sorry, was what?
Q. He was wanted by September 2022 on a warrant for seriously assaulting a police officer --
A. Yes, that was issued on September the 22, yeah.
Q. So when you say the police needed a serious reason --
A. Yes --
Q. They --
A. At that time, yes.
Q. Yes. So if you had contacted them at 2022, and said, "We have lost this man", they were looking for the same person on a warrant, weren't they?
A. They could have done, they could have done.
Q. So are you suggesting that they wouldn't have tried to find him if you had alerted them to the fact that he was unmedicated and in the community? -- *(overspeaking)* --
A. No, no, the bench warrant was issued on 22nd September. That's the day he was discharged.
Q. Yes, of course. So I'm saying around this time they know he's been arrested --
A. Yeah.
Q. -- for the offence on PC Pritchard. Yes? So when you say would the police be interested in helping you and finding him, they would, wouldn't they, on the evidence?

A. I'm not convinced. I'm not convinced of that. If he had not been discharged on the 22nd September. In fact if say -- imagine that he was still on my caseload on the 22nd and we found out on that day there was a bench warrant out for him, that would have been fantastic. Then I could have contacted the police and said, "Right I too am looking for this man. Perhaps we can work together. I have a number of addresses that you could check and if necessary you could gain access to, because I cannot." But by then it was -- he was discharged. Ironically.

Q. You could contact the police --

A. Sorry?

Q. You could contact the police on the information you already had. You didn't need to know about the warrant not backed for bail.

A. I could have done, yes.

Q. You knew he had seriously assaulted --

A. Yes.

Q. -- a police officer. They knew he had seriously assaulted a police officer. So irrespective of the warrant, if you contacted them, they would have done something.

A. Well, hang on, yeah, he seriously assaulted a police officer the previous year.

Q. Yes, yes.

A. That's correct.

Q. Yes.

A. I didn't imagine for a moment that he was -- he wasn't even going to be arrested until the following year. You know, like that was what, a year apart?

Q. Mm-hm.

A. Correct me if I'm wrong? More or less a year apart. So he assaulted a police officer and a year later a warrant is issued for his arrest? Is that what you're saying?

Q. I'm saying what did you do? Let's not talk about what the police did and didn't do. What did you do?

A. No, I didn't contact the police.

Q. And you should have done.

A. Yes, on the 22nd. -- *(overspeaking)* --

Q. And there was a really good chance they would have found him.

A. On the 22nd, definitely.

Q. Yeah, and they would have found him, good chance they would have found him.

A. Possibly.

Q. You said in another case they did it in ten days.

A. Yes.

Q. Good chance they would have found him.

A. Possibly.

Q. He would have had a Mental Health Act Assessment, as happened previously.

A. Yes.

Q. And he'd have had medication.

A. Yeah.

Q. That seemed to take a long time, Mr Carter. It is how the events followed or should have followed, isn't it?

A. Mm, yeah. I will acknowledge that yes, I probably could have contacted the police a bit -- at some --

Q. Not probably. You should have done.

A. Yeah.

Q. The team throughout this time did not escalate what was an extremely serious and dangerous situation: an unmedicated man in the community --

A. Sorry, the team? What --

Q. Your team, the Community Team. He's discharged in September '22, and it's astonishing that he's discharged; do you agree with me?

A. Well, I didn't discharge him. I did not discharge -- I was not involved in his discharge.

Q. You may not have been involved in that discussion or these -- *(overspeaking)* --

A. Yes, and I think -- and, you know, and I think it's very significant that I wasn't there, when he was discharged.

Q. What's the significance?

A. I think the significance is basically that the team, if you want to call it that, had done everything they could to try and deal with this man, manage him in the community, and had failed. The inpatient services had failed. And basically, people had run out of ideas. People had just run out of ideas as to how to manage this man, when it was blatantly obvious what needed to happen to him.

Q. Which was what?

A. He needed to be admitted to hospital for a lengthy period of time and treated. It really is that simple.

Q. And when you started at the beginning today, reflecting on your evidence, you didn't seem to take much responsibility for that. Do you take responsibility for your own part in that, that that did not happen?

A. I'm sure I played my part. I'm sure I played my part. I am not avoiding nothing.

Q. So what --

A. Everybody who has attended this Inquiry over the last two months has come out bruised. Some people have come out looking broken. And yet I have played my part. There's no two ways about it.

Q. You say, if we go, please, to NHFT0004916, page 1, this is an email you sent subsequent to events, August 2024, emailed to Sharon Stone. You say in the last paragraph,

please, penultimate paragraph:

"It was my intention to go out to the latest address noted and see if I can make contact with [VC]. At this time I considered calling the Police and reporting [him] as a missing person. ... due to my other caseload issues and my experience... this did not happen."

A. Yeah, okay.

Q. That's what you've said and you repeated that today.

A. Yes, yes, that's right.

Q. Did you think about suggesting somebody else, either took on some of your cases or made the call to the police, and took some of the burden away from you?

A. No, I -- I think you've got to look at what was really happening in this team. Asking my colleagues to take over some of my caseload was not really an option.

Like my colleague this morning, Abi Parsonage, she, too, was a lady who had a caseload of plus 20 at the worst. And at my worst it was 24, and I think she had something similar at one stage.

And asking other members of the team to kind of take on parts of my caseload and -- I think, I think there would have been an objection to that. I think there would have been an objection to that.

MS LANGDALE: Chair, those are my questions. I think it might be a good time for the break, the afternoon break.

THE CHAIR: Yes, shall we have a break now? Let's start again at 3.30.

(3.18 pm)

(A short break)

(3.30 pm)

THE CHAIR: Yes, Mr Moloney.

Questioned by MR MOLONEY

MR MOLONEY: Good afternoon, Mr Carter. I ask questions on behalf of the bereaved families.

A. Okay.

Q. I've only got two short matters to ask you about, please.

A. Sorry?

Q. I've only got two short matters to ask you about and the first of them is 209 Ilkeston Road, and you and a colleague went round to 209 Ilkeston Road, didn't you?

A. That's correct.

Q. You said you weren't completely convinced by the person you spoke to who said that VC did not live there --

A. Yeah.

Q. -- and you thought that somebody probably was assisting him at this time in any event?

A. Yeah, might have been.

Q. Might have been, yeah. Can I just ask you what sort of impression you got of 209 Ilkeston Road?

A. Well, from the door, I didn't actually go in, it -- well, 209 Ilkeston Road is on the main road in an area frequented a lot by students. It tends to be a little rundown, shall we say. The house --

Q. Can I try and help with a question?

A. Yes.

Q. Did it look like a settled address?

A. Again, I didn't see inside. So I didn't see whether or not there were any furniture in there, or all the kind of usual things that someone might have, and say in a comfortable, settled home.

Q. Okay. Can I then just ask you about, and it's just a brief point, about how in the session before lunch -- and it was from 12.25 onwards -- you told the Chair, in answer to questions from Ms Langdale King's Counsel, that you'd not looked back through all the records on the RiO, for example, when you came to take over?

A. Yeah.

Q. You said you'd probably look back as far as the third admission and, really, you start as CCO, as you said, at page 267 out of --

A. Yeah.

Q. As a result, you weren't aware, you said, of the -- that he'd gone to premises at Brook Court on three occasions requiring arrest on the second occasion, a woman jumping

from a first-floor window requiring back surgery as a consequence. And on the third occasion, in July, requiring a number of people to restrain him, a number of men to restrain him. And you said you didn't know all about that and it would have been useful to know about it.

A. Well, I knew about the third admission, the nature of his arrest. Because me and Claudia, we'd met up with him the day before, or whatever, he was arrested, and I'd found out very quickly the nature of the arrest.

Q. So did you think that was an arrest for something to do with Brook Court or did you think it was a -- the execution of a warrant?

A. Well, my understanding was the Crisis Team were in the process of attempting to conduct a Mental Health Act Assessment. Unfortunately, in some cases such as this one, the patient or prospective patient is not very keen on that to happen, and has no insight, as an example, to cooperate or --

Q. Because we know all about the circumstances of the 3 September, Mr Carter, so I won't -- if you'll forgive me, I don't mean to be rude --

A. Yeah, that's all right.

Q. -- I'll just move on.

A. Sure.

Q. You knew about that because you'd seen, you'd been there the day before with Claudia?
A. Mm.
Q. But in terms of knowing about the previous incidents, had you -- and getting to know VC's case -- can we assume that you read the risk assessment that was current at that time?
A. I probably did. Because taking over as a CCO, I would have -- well, I'd have said: is the risk assessment and care plan up to date, as an example?
Q. Can I ask you this, then, just again to save time. If I could just take you to that risk assessment, which is NHFT0000190. You see this is Claudia Birtles and it is 28 February 2022.
A. Yeah.
Q. If we go to page 2 of this, and we look down at the bottom of this page, we see 14 July 2020, and we see:

"Arrested for attempting to gain entry into a random neighbour's flat as he felt that someone is in trouble. [VC] did not gain entry or harm anyone but he was kicking the door.

"Prior to previous admission [VC] was involved in a similar incident whereby he entered into another resident's flat whilst experiencing distressing auditory hallucinations. The woman that resided in the flat

jumped out of the window due to being frightened, she injured herself severely and needed surgery on her back."

Then if we go up to 3 September 2021 on that page in this risk assessment that was current when you took over, and the date is wrong in terms of the incident because 3 September was when the Mental Health Act Assessment took place, but we see:

"[VC] had gone to a neighbour's flat who was staying above him, knocked at his door to confront him as to why he was discussing him as he heard voices to that effect and he was certain that it was this person living above his flat responsible. He barged into the person's flat and wanted the person to admit what he was doing, and other neighbours came to the rescue and called the police."

Those are the three incidents that Ms Langdale asked you about, aren't they?
A. Right, okay. 3 September. This is after we'd visited him at home.
Q. That's the wrong date, isn't it? Because you know on 3 September that that's when there was the assault on the police officer you were describing to us --
A. Yeah, yeah.
Q. -- the arrest on that date, yeah?

A. Right.
Q. So that date's wrong. There's something before. And in fact, 14/7/20 is wrong as well, for the -- those two, but those three incidents are there in the risk assessment for VC that was current when you took over as CCO, aren't they?
A. Well, yeah, and I don't know why they're wrong. You know, like Claudia wrote this risk assessment which she's got -- you're saying that basically she's got her dates wrong.
Q. I'm not bothered about the dates, Mr Carter. But essentially you can see that those three incidents, irrespective of the dates, the incidents that Ms Langdale asked you about at Brook Court, those are contained, described in the risk assessment, dates wrong or right?
A. Yes, yeah. The dates are wrong, but, yeah, yeah, I agree.
MR MOLONEY: Thank you very much, Mr Carter.
THE WITNESS: You're welcome.
THE CHAIR: Yes, Ms Cartwright.

Questioned by MS CARTWRIGHT

MS CARTWRIGHT: Good afternoon, Mr Carter. I ask questions on behalf of the survivors.

Can I start, please, with one of your paragraphs in

your witness statement, please. It's paragraph 353, which is WITN0358001, at page 86, please. Sorry, I've given a rogue reference there, sorry. WITN0368001. So WITN0368001. Thank you.

If we could move to page 86. Thank you. I'm just going to take you through paragraph 353, please. But essentially you've given frank evidence this afternoon that it was blatantly obvious what was needed for VC, namely a lengthy admission in hospital and treatment.
A. Definitely, in my opinion.
Q. Now, obviously completely contextualising, we know you don't become the care coordinator until the end of April 2022, so I know this isn't the time when you are the care coordinator, but you say this:

"After the violence shown by VC before his third admission, I don't understand why inpatient services didn't keep VC in hospital for longer. With the benefit of hindsight, I also think inpatient services should have referred him to forensic services after the third admission as there was clear proof of how dangerous he was."
A. Yes, yes, I would agree with that.
Q. Now, one of the things I want to ask you about, because we know you became the care coordinator, and obviously Ms Langdale has asked you questions about reviewing of

the records, and you sought to indicate, I think earlier on today, that you really wouldn't have had the time to read what I think you've said 263 pages of VC's records?

A. Yeah.

Q. That's what I really want to cover with you.

Obviously, when you became the care coordinator, do you accept that you should have reviewed all of those RiO records and they were only about 266 pages at that point?

A. 266 pages is a lot of reading. A lot of reading. 266 pages of RiO notes.

Q. I'm going to suggest it's not that much, actually, and it was within your responsibility as a care coordinator --

A. Well, I'm sorry, I disagree with that. Because it's not as if I'd just got this gentleman on my caseload, I've got other people on my caseload. You know, I come to work on a Monday morning, and I may have two or three, four appointments during that day, as an example, typical day. No, I don't agree with that, I'm sorry.

Q. Because what I'm going to suggest is --

A. It would --

Q. All of that information was there as to just how dangerous VC was, that was for you as a care coordinator, after the fourth admission, to be proactive

in advocating for -- *(overspeaking)* --

A. What should have happened is that my predecessor, Claudia, should have said, "Right, Gary, I will bring your attention to page 25. I think that's worth reading. That is a very important part. Page 52, that is another important part. Page whatever, that is incredibly important make sure you read it."

But, you know, to just expect me to start at page zero, one example, and start reading, I'm sorry, that -- I would not have had the time to do that. You know, I have been criticised by my boss for taking work home with me, and on many occasions I've thought: well, I'm glad I have taken it home with me because at least I've recorded certain things and made sure that certain things are done. I would have had to take this home and started reading.

Q. So you effectively say it was for Claudia Birtles to flag the relevant pages you needed to read -- *(overspeaking)* --

A. The relevant pages --

Q. -- and that's how you say essentially you approached all the time when you were in EIP, when you were the care coordinator you wouldn't have read the records.

A. Not from the beginning. Not when there's 266 pages. You know, that's a lot of care records.

Q. So can we then just deal with culture, then, because you've helpfully clarified your approach to care coordination and your approach to records. Can we look, please, at paragraph 140 of your statement, please, at page 33.

Perhaps to give a context to evidence you've already given about the time when VC was discharged from EIP in September, and I think you've told us in your witness statement in any event you had a period of carers leave from 25 August to 2 September, and then you were on a period of sick leave from 6 to 25 September, so essentially almost not available for a full month; would you agree?

A. Yes, yeah, that's right.

Q. So what I also want to look at with 140 is just really the culture in this team during the period of time you were working there.

Now, you tell us at page -- sorry, paragraph 140, that when you first joined the team, your memory of the first couple of months was of wondering where everybody was a lot of the time. The team was very reduced, you felt isolated and you had a huge number of your own patients to be concerned about.

So can you just give us an impression, and certainly there's lots of references to leave within records, but

what was it like in the team?

A. What, when I joined the team?

Q. Yes.

A. In September 20 -- 2020?

Q. Yes.

A. Right. Basically it was a -- you see I was approached by an agency who rang me up out of the blue and said, "Look, do you fancy working with EIP services in Nottingham?" And I asked them about details about it, they couldn't really give me much, but they said, "Look why don't you go and have an informal chat with the manager," Emma Robinson, at the time. I said, "Fine, yeah, okay, I'll do that."

So I turned up at Stonebridge and had a chat with Emma to find out more about EIP services and what she -- what it was all about, and what she felt was the future of the service. And I was very impressed by her enthusiasm, the fact that she felt that it was a great service, and it was definitely needed. And I thought yes, this sounds quite interesting. I must admit, I'm quite interested in this.

However, she did point out that the team at the moment was -- had not been developed fully, insomuch that from a staffing point of view, we had a member of staff who was leaving for another team as an example.

I think, shortly after joining, Claudia had to take couple of weeks off sick because one of her clients had killed themselves, so she was off. So we lost Sabrina to another team. Then Claudia had to go off sick because she was so upset by the death of one of her clients. And it really left basically just me and Abi in the team, the two of us. And some -- I don't know -- basically, I don't know what happened but I ended up in a situation where I was the only EIP nurse there.

Q. Right. Well, I think --

A. The only one. Because they used to -- the admins used to call me "Mr EIP".

Q. Okay, well then can I just pick up on some things, because one of the things you've raised in the various interviews is no one in supervision in any other way picked up your record-keeping; is that correct?

A. No, no.

Q. And you've described in evidence you kept it short and sweet.

A. Yes.

Q. But would you agree there are many occasions, Mr Carter, where the notes shouldn't be short and sweet; they should give a comprehensive assessment --

A. Yes, yes, I would agree with that, yeah.

Q. You have been taken to, I think, the Health of the

Nation cluster tool that they updated in August of 2022, but you didn't update the risk assessment or the care plan at a time when you were care coordinator, and would you agree there was clear risk information that you should have been updating? Fundamentally you didn't know where VC was.

A. The care plan and risk assessment should have been fully updated before it was handed to me, simple as ... that is standard practice .

Q. But it hadn't been done -- *(overspeaking)* --

A. Yes, it hadn't been --

Q. You were the care coordinator --

A. -- it hadn't been done --

Q. -- and you should have done -- *(overspeaking)* --

A. Yes.

Q. -- particularly when you've giving evidence --

A. And when I would have got chance I would have updated it.

Q. Because you have given evidence, effectively, that VC was so dangerous you wouldn't have asked any other members of the team to go out and look for him at addresses. So this was essential that this was the appropriate risk assessment and care plan.

A. Yes, yes, I agree, yeah.

Q. And in particular they would have been highly relevant

because they would have hopefully been considered by the MDT when they made the decision in your absence to discharge VC?

A. Well, I'm not sure about that. I don't know.

Q. Now you've said in one of your interviews that at the time when you inherited VC as care coordinator, essentially the team was getting desperate about what to do with VC; is that correct?

A. I think, yes, I think -- yes, yeah, we were desperate. Yeah, I think it was fair to say that.

Q. You also detail at paragraph 180 of your witness statement that Ms Birtles was frightened, when she handed over, about what VC could do, and she was unnerved by VC's behaviour; is that correct?

A. She was what, sorry?

Q. She was unnerved by VC's behaviour.

A. Yes, I believe that. Yeah, I believe that.

Q. So can I ask you, with that being the case and risk of harm to others being one of the categories that requires Mental Health Act Assessment for consideration of detention, if that was the held view of the team, why you weren't urgently requesting a Mental Health Act Assessment in April of 2022?

A. So yes, it would have been desirable to do that, definitely. Definitely. It could have been done before

he was handed over to me that's what -- that's my argument, basically. You know, like it's all right leaving it to someone else to clean up, you know, it's not good enough. You know, it could have been done before that time.

Q. Can we then look at something then you express in paragraph 303 of your statement at page 71. Thank you.

This is in one of the interviews you gave, you effectively say that it felt like that the team had given up on VC. I'm just trying to find that now as I look at it.

A. [reads to self].

Q. Yeah. "[They'd be] kind of, giving up on this man." And that's what you were expressing, and certainly the Inquiry has looked at with Ms Birtles, what happened between the third and fourth admission and then what happened after the fourth admission before you took over.

Would you agree that that essentially is what the EIP team did? You essentially gave up on VC.

A. Yes, I'll stick with it. Yes, I still agree with that.

Q. Would you agree that by giving up on VC, when it had been identified that he was dangerous, essentially the EIP team gave up on public safety?

A. Well, yes, yes.

Q. Then finally, for my purposes, please, you give an interesting observation about the senior leadership team's response. Can we move, please, to paragraph 345, please, at page 85. Thank you. You describe essentially what was the catalyst for your resignation. You say:

"I went to one of these [meetings] and said something along the lines of 'Do you think we missed something? Do you think we could have prevented this?'"

You remember Diane Hull, Dr Lloyd, and Dr Thangavelu all rounded up on you and said:

"'No. There's no way we could have predicted this and no way we could have prevented it'. After that meeting, I felt like, if I didn't resign from [the Trust], I would be forced to just toe [the] line about what happened and wouldn't be able to express my own feelings about the tragedy."

A. Yes, I agree entirely with that. I'm still of that opinion.

Q. Can you just be clear. What are you saying about the reaction from those senior members of the Trust?

A. I remember, yes, on top of that meeting, I remember it vividly, and I did ask for the date of that meeting which I never received, I might add.

On top of that, in conversation with Dr Lloyd and

Claudia, I think it was in the car park, Dr Lloyd turned to us both and said, "Look, we've got to get together and have a meeting because we've got to be singing from the same hymn sheet here."

Now, you know, on top of what I've said there, and that conversation, I felt that my position really -- if I wanted to say what I really felt was the truth, in my opinion, that I could not do it by working with -- continuing to work within the Trust.

Q. All right.

A. I just felt as though ... I think either I felt that the Trust lawyers would have pressed me into giving a different kind of statement.

Q. All right. Then, finally, can I ask this: you obviously tell us within the statement that you've retired. I think you still retain your PIN within the NMC; is that correct?

A. Well, I haven't paid for it. I haven't paid for it. I had a call from the NMC about a week ago, funnily enough, and said, you know, like "We've still got you on the register". I said, "Why? I haven't paid my annual fee, so, you know, I'm not a nurse and I've got no intention of practising again."

And I haven't, and that's it.

MS CARTWRIGHT: Thank you. Thank you for answering my

questions, Mr Carter.

THE WITNESS: Thank you.

THE CHAIR: Yes, Mr Straw.

Questioned by MR STRAW

MR STRAW: Good afternoon, Mr Carter, I represent VC's family.

A. Okay.

Q. Just that last point about Dr Lloyd in the car park saying everyone should be singing from the same hymn sheet. Just to clarify that, then, it was Dr Lloyd -- what Dr Lloyd was trying to do was to ensure everyone put forward an account which indicated this wasn't preventable; is that right?

A. She didn't go into details, I'll be honest with you. It was just a statement she made. She didn't say, "Right we've got to be singing from the same hymn sheet by doing this, this, this and this." She didn't go into details.

Q. But essentially she wanted a cover-up.

A. I think that's not a word I'd use. I think -- I understand why you're using it but it's not a word I'd use.

Q. Okay. I'd first like to ask you about training, please. You mentioned earlier you didn't have training in conducting mental state examinations. Does that mean

that you didn't have training in spotting signs that a schizophrenic patient, who masks his symptoms, was unwell?

A. Not specific training around that issue, no, no I wouldn't say so.

Q. We've heard some people talking about subtle signs of someone like that being unwell.

A. Yeah.

Q. So long pauses, a stare, a sort of fixed stare.

A. Yeah.

Q. Being suspicious, looking around.

A. Yeah.

Q. At the time, were you aware that those sort of things could be signs that someone --

A. Yes, yes. A new assessment tool was introduced into EIP not long after I started. It was the CAARMS assessment tool. I think it stands for Clinical Assessment of At Risk Mental States. And this was quite a good tool. It was a little bit different, and it took some getting used to, but it looked at like speech as an example: is the speech pressured? Is it confusing? Are there examples of what we call neologisms? Is it pressured? And various other aspects of speech. And also other things as well, like hallucinations, passivity feelings, and things like that. It took a bit of getting used to

but it was a good assessment tool.
Q. Okay, and that was before or during the time that you were dealing with VC.
A. Oh yeah, that was -- I think it was beginning at 2021. I'd only been there a few months.
Q. What about paranoid schizophrenia itself? Did you understand that paranoid schizophrenia can lead a person to believe that there's a conspiracy against them?
A. Yes, yes.
Q. Including a conspiracy by the medical services?
A. Yeah, yeah.
Q. That it can lead them to mask their symptoms?
A. Well, yes, yeah, they can mask their symptoms in various ways. You know, like -- yes, I understand that. Yes, yes, certainly.
Q. I'd just like to look at one entry in the RiO notes, please, just to ask you about that topic particularly. It's the NHFT0000168 document, please, and could that be brought up on screen. Page 162.
So this is a note of Claudia in your visit on 31 August 2021 --
A. Right.
Q. -- to VC. And halfway down the first paragraph it's noted:
"[VC] presented with complex delusional system in

which he believes we are working in collaboration with the judicial system and the hospital (highbury) and we've created a technology to cause his voice experiences/[or] monitor him."
The next paragraph:
"[He's] ...paranoid/[or] suspicious and is not trusting of the services."
"Refusal to engage ... [he] knows we will have to 'feedback to the higher powers ...'"
Then a little bit further down:
"[He] Appears to believe he is more at risk by engaging with us ... it was clear he didnt trust our intentions so remained very guarded ..."
Would you agree this is a man whose illness led him to mask his symptoms?
A. Well, his symptoms were very obvious on that day. He weren't trying to mask anything.
Q. No, sure, but his illness led him to this delusion of a conspiracy against him; you'd accept that?
A. I'm sorry, could you just repeat that question?
Q. His illness led him to this delusion that there was a conspiracy against him.
A. Yes, yes.
Q. And it led him to believe he was more at risk in engaging with you. That's what's said here.

A. Mm.
Q. And that led him to be very guarded with you.
A. Yes.
Q. That's right, isn't it? Did you bear that in mind going forward? So coming into 2022 when you're assessing him, did you bear in mind that this was someone who was very guarded because of his illness?
A. I think it was well understood by then. When you say 2022, at what time in 2022? You say I assessed him.
Q. Whenever you had contact with him in 2022.
A. Well, the only contact I had with him was when he came for his medication. Twice. And that was literally for minutes.
Q. Okay. So you didn't have any sort of assessment of him --
A. Well, this is -- no, sadly I did not. This is why it would have been fantastic if I could have persuaded him just to sit with me for, say, 30 minutes so we could have that assessment, so I could get to kind of understand his mental state better than what I did. Yes.
Q. Then you've been asked a lot of detail about your thinking in 2022. I'd just like to try and understand it in summary, please.
You indicate in your witness statement that you

considered medication was key or vital to avoiding relapse; is that right?
A. Yes, I would say so.
Q. Okay. You accepted earlier, in response to questions, that if he didn't take it he would get unwell; correct?
A. If he didn't take ...
Q. If he didn't take his medication, he would get unwell?
A. Yes, yes.
Q. When unwell, he was at high risk?
A. Yes.
Q. By the middle of 2022, it was clear he wasn't taking his medication?
A. Mm-hm. *(The witness nodded)*.
Q. I think you say in your witness statement it was clear he'd run out by mid-July; that's right, isn't it?
A. Yes, I believe so, yeah.
Q. At this point, there's a -- you accepted there's a serious risk, and I think, is it right, that you were very concerned?
A. Yes, and this is one of the reasons why I sought to make contact with him, with Paul Williams, why I wrote him a letter, you know, just trying desperately to get in contact with this man and engage with him.
Q. You say in your witness statement finding him was of paramount importance; you'd agree with that?

A. Yeah, I think finding him was very important, yeah.
Q. Did you tell anyone in your team about all of this?
A. Well, yes, yeah. Because this was discussed on a regular basis. VC was discussed in MDT on a very regular basis, not just during the time I was his CCO, but for the previous best part of two years that he'd been in contact with the service. You know, it's -- his name was kind of coming up, flashing up on a regular basis.
Q. But at this point in particular, so it was July, August, 2022, you think he's at serious risk, it's of paramount importance to find him; did you say that to the MDT?
A. Well, I told them exactly what I was doing and writing letters, going out with Paul to see him.
Q. But it's quite important, because we're going to hear from them later, did you tell the MDT that you considered he was of serious risk and that it was of paramount importance that he be found?
A. I would have said to MDT I'm very worried about him, there's a good chance he's not concordant, he's disengaged, I cannot find him and, you know, we need to look at other approaches, basically.
Q. On those other approaches, you candidly accepted earlier that you should have done more to try to find him, for example contact the police?

A. Yeah.
Q. The aim of all of that was to try and bring about a Mental Health Act Assessment?
A. I think really, yeah, I think -- you see, he'd had four admissions by the time I took over, and I think we were heading towards a fifth. And I think that would have been desirable, very desirable, because basically this man needed treating consistently over a period of time, and if you look at his previous admissions, well, second one was 16 days, and the fourth one, I think, was a month. They weren't very long admissions.
Q. Sure. Just a point of detail, you were asked about the steps you could have taken -- should have taken. Madison Court; did you try him there?
A. I didn't get chance to go to Madison Court, and that was basically because I was probably dealing with other people, other issues, other people on my caseload as an example.
Q. You'd agree, I think, that someone should have tried Madison Court?
A. It would have been desirable, yes, if somebody could have done that, yeah.
Q. Did you ask anyone else to do that?
A. I personally didn't, no.
Q. So instead he was discharged to his GP. Were you aware

that that basically meant that there was no -- there would be no proactive management or treatment of his mental health problems at all?
A. I cannot understand why he was discharged, for the life of me. I just cannot get my head round it.
Q. It was disastrous, wasn't it?
A. Well, you said it. I think you've summed it up perfectly: you know, like, I have read through these notes over the last year or whatever, or 18 months, and, you know, like, I can't work out what happened in that meeting on the 22nd to allow the team to discharge this man. And, you know, I wasn't there, as you know, I wasn't there. Claudia wasn't there. So the two people who probably knew him better than most just weren't there.

And even Abi, my colleague, my ex-former colleague, she knew a lot about, she'd had quite a few dealings with him, and I don't think she has kind of indicated that she could remember the conversation that took place there. So, you know, I just cannot work out who actually made that decision.

Ultimately, Dr Lloyd has the final say. But obviously she will probably seek the advice of other people, and I'd like to know who advised her.
Q. But from your perspective it's an inexplicable

dereliction of duty by the team?
A. It was definitely a failure on the team, definitely. What, just the discharge, or ...?
Q. Yeah, discharge to the GP I'm talking about now.
A. Yeah, dereliction, well okay, I wouldn't disagree with you. I wouldn't use that word, but yes, many people would use it, and I'm not going to disagree with that.
Q. You then talked earlier about resourcing problems that you had on your team and in your witness statement you talk about severe staffing issues; so not enough resources to do your job, basically.

Did you tell management about that?
A. Yes, yeah. You know, I remember speaking to Sharon Heath about my caseload size, and at its worst, I had 24 people. The national recommendation is 15.
Q. You made that clear to her that that was a problem --
A. Now, if I might just raise this one issue. When I came to them for that informal chat/interview with Emma in late August 2020, before I took up the position with EIP, she did warn me that I'd probably have more than the 15 recommended national level. And I thought: right okay. I'll bear that in mind. But, you know, I imagine it would be around maybe 20, maybe a few more than 15. But certainly 24 was far too much, and then I started making headway into discharging people, transferring

people, and I think when I resigned I think I had a caseload of, I don't know, maybe 12, 13.
Q. But you made that clear to Sharon Heath, that you didn't have enough -- that you had too big a caseload, there wasn't enough resources to deal with your caseload?
A. I would have made her aware of the size of my caseload and said, "Look, I've got a lot on here. I've got a lot on." I'm sorry, I don't know what you're implying.
Q. That's fine. I think you've covered the issue. Thank you very much.
The last question I have about all of this is before the time that VC was discharged in 22 September 2022, did you have any sort of competency assessments? So assessments as to whether you were -- you had sufficient training or you were up to the job of a CCO?
A. Well, I'd kind of done all the training that every CPN, every nurse, has to do, and I think my training was pretty well up to date.
Q. What about the assessments; was there any assessment of your competency?
A. Just me personally, or ...?
Q. Yes, but also others.
A. Not that I'm aware of, no.
MR STRAW: All right, thank you very much.
THE CHAIR: Thank you.

Mr Beer, do you want to raise anything?
MR BEER: No, Chair.
THE CHAIR: Ms Milligan.

Questioned by MS MILLIGAN

MS MILLIGAN: Mr Carter, I'm going to start by asking you some questions about your knowledge of VC prior to becoming his CCO in April 2022.
You were taken to the care plan that VC was given in September 2020 when you visited him with Ms Birtles.
A. Mm.
Q. You said, when you were asked, that you would have had a basic knowledge based on discussions in MDT and informal conversations with the team. So a basic knowledge of VC.
A. Yeah.
Q. Would you have looked at that care plan in detail at that point?
A. I might have done. I can't remember looking at it. I may well have done. I can't imagine me not looking at it.
Q. You referenced informal conversations with the team. We don't see those informal conversations noted in RiO --
A. No, no.
Q. They're informal, so perhaps that's not unusual.
A. Yeah.

Q. What sort of things, in outline -- we don't have a lot of time -- would you have discussed? Would it be risk? Would it be updates? What sort of things?
A. It could have been anything, really. Like medication, for instance. Why is he not on a depot? Why are we still going with tablets? He doesn't take his tablets. He's proven this on many occasions. Why is a depot not even been considered? To the best of my knowledge, no one wrote this man up for a depot.
Q. When you say informal conversations, are we talking in the corridors of Stonebridge or going into someone's office; is that what you mean?
A. It could be anywhere, yeah, it could be in the kitchen, it could be anywhere. Car park. You know, like, it's just basically people passing by:
"How's your day going?"
"Oh, I've just been to see VC".
"Oh, how's he getting on?"
You know, et cetera, et cetera.
Q. As I say, we don't see all of that in RiO.
A. No.
Q. So would it be fair to say that just because we don't see something in RiO, it doesn't mean you've not had a conversation with somebody, or --
A. Yeah, I think it would be fair to say, yeah, because

there was a lot of conversations around this man going back.
You know, like Claudia was his CCO for 22 months, I was his CCO for about five, and there were a lot of conversations about this man over that period of time, over two years. So yes, I think that's a fair statement.
Q. Now, Ms Langdale put to you that as of 2021, before you became VC's CCO, you could have known about the content of his RiO records either by sitting down and reading them, or by there being a discussion in MDT where somebody reads the entries out. We heard evidence from Ms Parsonage this morning that MDTs were about an hour long; is that right?
A. Mm.
Q. Is it right that at the relevant time there were around five CCOs?
A. Yeah, yes.
Q. There or thereabouts.
A. Yes, five. Yes, I believe there were five.
Q. So we're talking 15 patients each, something like 75 patients.
A. *(The witness nodded)*.
Q. Is it right, was there ever an occasion where, in MDTs, people did just sit and read out all of the RiO entries

since last Thursday?
A. No.
Q. So what was it, was it ...
A. No, everybody -- all the CCOs had a different way of doing MDTs. Like me, for example. I had a list of my clients on my caseload, and I'd a habit of literally starting at the top and working my way down, right down to the bottom, stopping off at individuals who I felt really needed to be talked about. Like, so I could start at the top: Mrs Smith, no developments last week, everything's cool.
Mr Jones, no issues.
VC, now we've got a bit of a problem here.
Q. All right.
A. And work my way down.
If you look at it, there weren't a great deal of time for people to discuss in great depth any one of their clients, and if it did occur, then some clients might not get mentioned at all.
Q. Yes, okay. So you were asked by Ms Langdale about your knowledge of VC's first three arrests, this is in 2020 and it's the three incidents at Brook Court. Mr Moloney picked up on those with you.
A. Yeah.
Q. I'm not going to into dates, et cetera.

You gave evidence to Ms Langdale that at the time of you visiting VC with Ms Birtles for the first time, so 15 September 2020, you weren't aware of those incidents.
I don't want to confuse you, but you said earlier: 14, 15 days after joining the EIP, "I wasn't aware of the three incidents at Brook Court."
A. No, no.
Q. It was then put to you by Ms Langdale that there's the email to Dr Lloyd on 9 November 2020, and that's when you say: "I've taken this gentleman a month of tablets but he told me he had about 10 left."
Do you remember that email?
A. Yes, vaguely, yeah.
Q. It was put to you that at that point, 9 November 2020, that you knew VC was non-concordant and that he had been violent prior to his admissions as an inpatient, and you agreed; you said "yes".
A. Mm.
Q. Now, I just want to clarify: when and how did you become aware of those three incidents at Brook Court?
A. Well, put it this way: it was after the sad events of June the 13th, and I don't know who told me, I don't know where I found out, or in what way. But it came out somewhere. I was made aware of it. And even then, I wasn't made aware of the finer detail of it. You

know, there'd been incidents. The exact nature of it, you know, like, I wasn't quite savvy to at that time.
Q. I'm going to ask you about the handover or the transition between Ms Birtles to you as CCO.
Ms Birtles gave evidence yesterday that there was no formal handover as such, and when asked about that, she said that you would have had knowledge, an awareness of VC because you'd been present at MDTs and you were familiar with VC, and she said this:
"Question: ... there was nothing over and above what he'd gleaned or ascertained by virtue of working in the same place and being at MDTs?"
That was the question put to her, and she agreed. So nothing to be gained by sitting down and having a conversation, a formal handover.
A. Mm.
Q. Knowing what you know now about VC's history, do you agree that there was nothing to be gained from a formal handover between you -- *(overspeaking)* --
A. Well, I think there was a lot to be gained because I think it's just protocol, really. It's common courtesy. You know, like at the end of the day I could have at least said, "Right have you updated the care plan and risk assessment as a start off? Is it fully up to date?" And then taken it from there.

It was just the way it was done. You would sit down with your colleague who you were handing over to and you would give them -- you would answer all their questions, give them all the information that they felt they required, and perhaps make themselves available in the future if you wanted to seek their advice.
I think it -- to say there's nothing to be gained, I don't agree with that, no, I'm sorry.
Q. Right. I'm going to ask you to turn to the RiO records now, this is the NHFT0000168 document. Page 26 -- start with 266, and at the bottom, date 28 April, we see the decision there:
"Following a risk assessment ... agreed it would be appropriate to transfer [VC] to a new CCO, [or] preferably 2 CPNs."
Then over the page, please. This is another entry by Ms Birtles, and we can see from the third paragraph down that in fact it's a meeting with VC. Were you aware of this meeting?
A. No, no, I wasn't aware of this meeting to be perfectly frank with you. It's like just adding to what I've already said about just common courtesy and protocol about handing over people. It's usually the case that a CPN handing over someone will actually seek to have a joint meeting with the client and say: "Right this is

Gary, I think you know him from before. He's agreed to become your next CCO, with your permission, of course, and with your agreement".

And if that was the case, that's fine.

This meeting, no, I didn't know about this meeting. No, I didn't.

Q. All right, if I can take you now to another document, INQY0000007, please. Page 2. This is a document created by the Inquiry setting out some text messages. I'd just like you to look at paragraph 3 with me, please:

"[Ms] Birtles exchanged text messages with VC on the morning of 29 April ..."

That's surrounding the visit we've just seen:

"Otherwise, on 3 May ... she exchanged the following texts with VC:

"... texted to say ... 'Gary Carter (the other nurse in our team) will be taking over as your care coordinator'."

At "b" we see:

"VC replied ... 'What does that mean?' Claudia replied ... to say ... 'Rather than me, Gary will be your CPN' as she was having to 'reduce my caseload'."

Then:

"VC [replies] ... as follows...

"... You should move someone else. Since you've been looking at my case since the beginning, it's not really convenient having to build a rapport all over again'.

"... Claudia replied ... to say she did 'appreciate [it could be] ... frustrating but unfortunately I won't be able to do that' ... 'really sorry' ... 'Gary has met you a few times and we do work as a team so that he has [a] ... good understanding of your [case] ...' and that 'everything should just remain the same'."

Were you aware of those text messages?

A. No, I wasn't. No, no.

Q. Do you think it would have been helpful to be aware of them?

A. Well, VC doesn't sound very keen on the idea of changing his CCO and I think I would have taken that up with Claudia and said, "Look, you know, is there a way round this? Can we perhaps meet him together face-to-face? Would that be possible so that we can explain to him the situation?"

I'd have been very happy to do that. But no, he doesn't sound very keen on the idea at all. So no, I wasn't aware of that, no.

THE CHAIR: Ms Milligan, do you have much more?

MS MILLIGAN: I have probably about five minutes, your

Honour.

THE CHAIR: Yes.

MS MILLIGAN: I'll be as quick as I can.

THE CHAIR: Yes, thank you.

MS MILLIGAN: I'm going to ask about your caseload very briefly. You said your caseload was high, and there's a passage in your witness statement, but to save time I'll read it to you:

"Emma, in her interview for my conduct investigation, explained that I tended to work primarily with young males who had lots of challenging behaviours/risk histories or who were 'a bit higher profile' as I worked well with that particular group. She went on to explain:

'I can always remember him having a caseload of quite challenging younger patients. There were various reasons for this. He had those good relationships, but there were also times when the other CPNs didn't feel comfortable working with those patients - so GC would pick those patients up."

You were asked by Ms Langdale about whether you had ever suggested to anyone that could someone else pick up some of your cases to help you out, to reduce your caseload?

A. No, because, you know, like I didn't ask anybody to do

my job, you know. I had a caseload, I tried every opportunity to develop good working relationships with my clients. And I don't -- you see, I took on some very -- well, not so much challenging, but interesting characters, who made people feel very uncomfortable. Can I give you an example, perhaps?

THE CHAIR: I don't think it's necessary.

A. No?

THE CHAIR: No.

A. Okay, thank you.

MS MILLIGAN: New topic, Crisis and referring to the Crisis Team. The Inquiry has heard evidence from other witnesses about their opinion on the threshold that was required to be reached before one could refer to Crisis and seek a Mental Health Act Assessment.

What is your view on that? Where is the threshold? What is required before Crisis will take on a patient?

A. I think basically when a patient is well, just not engaging any more, just not taking any of the medication, where you can't come in contact with the patient and, yeah, you know, like what -- it was mentioned earlier on that I were a bit slow off the mark referring this guy to Crisis as an example. But one thing that was interesting during this period was his parents, specifically his mother, never rang me and

said, "I'm very worried about this man, Gary. I think you need to look at him. I think someone needs to look at him."

That was never the case and perhaps I put perhaps a little bit too much emphasis on that. Whilst Mum was happy, maybe he was getting by, maybe he was not -- whilst not fully concordant, he might have been partially concordant. But that aside, yes, I should have probably contacted the police earlier, or I should have contact Crisis.

Q. VC's discharge. You were not at the MDT meeting on 22 --

A. No.

Q. -- September. It was said by Ms Parsonage this morning that in fact VC's discharge had been discussed at MDTs prior to that. What is your recollection of that?

A. I never recalled that being mentioned, to be honest with you.

Q. Then finally, you were asked questions about the steps that you took, or ought to have taken, following your visit to VC, or your attempt to visit VC on 4 August '22, and you said you didn't get a chance to visit Madison Court.

You've given some candid evidence about what you could and should have done. I'm not going to explore

that with you, but is it right that in respect of late August and September, in fact from 25 August, you were off on carer's leave dealing with someone who was terminally ill.

A. Yeah.

Q. And so you were not around for that period, not around until after the discharge had taken place?

A. Yes, yeah, that's right, yeah. He was discharged before I came back to work.

MS MILLIGAN: Right, those are my questions. Thank you, Chair.

Questioned by THE CHAIR

THE CHAIR: There's just one question about one thing you told us. You've told us, I think, that you had up to 24 for your caseload.

A. That was the worst, yeah.

THE CHAIR: Yes, and then that you transferred and discharged people, so that you reduced that to around 12 or 13, so you halved that.

A. Yes, that's right, yeah.

THE CHAIR: How did that take place? How did you and who did you discharge -- who did you transfer them to?

A. Back to their GPs, mainly, or to the LMHT. So those are the two main places I discharged to.

THE CHAIR: So they were simply out of the EIP system?

A. Yes, and they were on a different pathway, then, yeah.

THE CHAIR: Yes. Did you have any sort of handover with any of those people, the 12 who you transferred them to?

A. Yes, oh yeah, I look, like, I took members of the LMHT to meet my clients, and that, I thought that was good practice. And introduced them. I gave them all the information I could about the client, and answered any of their questions. And yeah, and so that was the way I kind of did that. Yeah.

THE CHAIR: Yes, thank you.

Right, well, we'll finish there for today. Thank you. We'll start again on Monday -- Tuesday, in fact. So it's Bank Holiday, isn't it? Thank you.

(4.28 pm)

(The hearing adjourned until 10.00 am on Tuesday, 6 May 2026)

I N D E X