

Thursday, 30 April 2026

1
2 (2.00 PM)
3 **MS LANGDALE:** Mr Carter, we pick up in the chronology to
4 31 August 2021 which is NHFT0000168/162, please.
5 This is the home visit that you wished to refer to
6 earlier this morning where you said there was a change.
7 I think in your statement to the Inquiry you say you
8 thought VC was on the verge of a major breakdown.
9 **A.** I don't think I used those words, "a major breakdown".
10 **Q.** What would you say about how it was?
11 **A.** He looked -- he looked very different to how I remember
12 him. He looked quite agitated. He looked very
13 preoccupied with his thoughts. He was quite paranoid,
14 he felt that we were working with the police. I had to
15 pull out my ID card just to reassure him that I was
16 a nurse, because although I'd met him before it had been
17 quite a while and he might not have recognised me. So
18 I just wanted to reassure him that I was a genuine
19 nurse.
20 We needed to reassure him that we weren't working
21 with anybody, we worked for the health services. But
22 I wasn't entirely convinced he was reassured by that.
23 And he just unnerved me, to see him like that. And I'm
24 perfectly frank with you, I'm glad when we both exited
25 the room.

1

1 **Q.** The impression, the risk was:
2 "[He's] currently relapsing ... appears
3 paranoid/suspicious ... is not trusting of services."
4 **A.** Yeah, yeah.
5 **Q.** You do say, if you want it on the screen it's paragraph
6 159, WITN0368001, page 36. Page 36 of your witness
7 statement at paragraph 159:
8 "VC confirmed he was not taking his medication,
9 which was obvious ... said he would not accept any
10 further visits. His lack of insight was quite clear.
11 My view was ... he appeared to be on the verge of
12 a major breakdown."
13 So you said that in your statement to the Inquiry.
14 **A.** That's right, yeah.
15 **Q.** When you said a moment ago you don't think you said
16 that, which is right? Did you think he was on the verge
17 of a major breakdown or not?
18 **A.** I think he was on the verge of a breakdown, certainly.
19 **Q.** He confirmed that he was not taking his medication?
20 **A.** Yeah, which would have -- you know, reinforced that,
21 reinforced that view.
22 **Q.** So you didn't feel safe to continue the assessment. You
23 knew he wasn't taking the medication, and you knew he
24 had been violent previously when he hadn't taken his
25 medication.

3

1 **Q.** Why?
2 **A.** Because in a situation like that, you know, you can kind
3 of feel an atmosphere that I've experienced before, not
4 just in my career, but in life generally. You -- you
5 can just feel that things our not quite right, and it
6 might be a good idea to just leave an environment.
7 **Q.** Because you were in fear of physical violence?
8 **A.** No, I wouldn't say that, to be perfectly frank with you.
9 I was just fearful -- well, I weren't fearful, I was
10 just concerned the way he was. I just felt that yes, he
11 probably hasn't been taking his tablets, and really, you
12 know, we might have to kind of initiate something in the
13 near future.
14 **Q.** The record says, if we go to the fifth paragraph:
15 "We did not feel it was safe to continue to push the
16 assessment".
17 Do you see at the bottom?
18 **A.** Yeah, yeah, fair enough, if that's Claudia's view, yeah
19 I'll go with it.
20 **Q.** It sounds like it was your view, you wanted to get out
21 of there.
22 **A.** No, no, I didn't feel unsafe, I just felt as though we'd
23 tried to persuade him who we were and, you know, we
24 weren't really making much progress, so it was probably
25 a good idea to exit, and take things from there.

2

1 **A.** Sorry, just repeat that again for me, please.
2 **Q.** You knew, at the time of the assessment -- can we have
3 that NHFT0000168/162 back on the screen, please -- you
4 knew that he wasn't taking his medication, you knew you
5 didn't feel safe there yourselves and you knew that he
6 had been violent to others when he hadn't taken
7 medication?
8 **A.** I suppose this is an example of, you know, like, yes,
9 Claudia probably didn't feel safe. I felt
10 uncomfortable, and I think there's a difference.
11 **Q.** Why do you think she didn't feel safe?
12 **A.** Probably because she knew him better than I did. She
13 was his CCO. She had a lot more experience with him
14 and, you know, like I'm -- she probably just knew a lot
15 more than I did about him.
16 **Q.** So if she felt unsafe, was it reasonable for you to
17 think that others may well feel unsafe around him?
18 **A.** Well, other people might do, or might just feel
19 uncomfortable around him.
20 **Q.** So in terms of the risk, the risk he posed, this
21 assessment or visit was significant, wasn't it? You
22 were both --
23 **A.** Yeah, yeah --
24 **Q.** -- recognising he posed a risk?
25 **A.** -- yes, definitely. Because I was comparing him with

4

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

4 **Q.** "Plan;
5 "Discussed with Dr Lloyd, plan to discuss with [the
6 Crisis Team] however it is very unlikely that [VC] is
7 going to engage with home treatment.

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

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

13 **A.** Yes.

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

17 **A.** May require --

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

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

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

5

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

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

10 **Q.** Justifiably?

11 **A.** Yes.

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

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

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

7

1 that in that paragraph above the one highlighted,
2 please?

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

4 **Q.** Have a look:

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

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

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

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

23 **Q.** You had your mind on him.

24 **A.** Yeah.

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

6

1 dealings with him --

2 **A.** Yeah.

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

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

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

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

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

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

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

19 **A.** Yes, that's right, yes.

20 **Q.** It's important to share it.

21 **A.** Yes.

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

8

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

9

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

11

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

10

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

12

1 it is a whole team thing. If nobody asked that question
 2 at an MDT or generally, and we've seen emails, you share
 3 information.
 4 **A.** Yeah.
 5 **Q.** Wouldn't that have been an appropriate question for
 6 somebody to raise?
 7 **A.** Whether or not to share it with the University?
 8 **Q.** Yes. You hadn't felt safe, you say it to Ms Birtles.
 9 **A.** Yeah, I think it's probably a reasonable question, yeah.
 10 **Q.** And instead, we have:
 11 "Risk to others; [VC] is usually a very personable,
 12 kind, polite and gentle man ..."
 13 **A.** Sorry, where is this?
 14 **Q.** It'll be highlighted for you now, it's on the screen in
 15 front of us:
 16 "Risk to others: [VC] is usually a very personable,
 17 kind, polite and gentle man however when unwell he did
 18 break down a neighbours door because he believed he
 19 could hear voices of someone in trouble next door".
 20 Doesn't mention somebody jumping out of a window and
 21 injuring themselves.
 22 **A.** No, no.
 23 **Q.** But by the by, despite minimising events at Brook Court,
 24 which this does, it continues to say:
 25 "Lack of insight, [VC] doesn't appear to recognise
 13

1 and paste across documents.
 2 **A.** I would say that when he is well, he is a very sociable,
 3 well behaved, polite man.
 4 **Q.** Well, you haven't seen him that often, have you?
 5 **A.** No, I haven't but --
 6 **Q.** So how would you know that?
 7 **A.** No, I don't know for certain.
 8 **Q.** Quite.
 9 **A.** But I'm willing to give him the benefit of -- in this
 10 one. I'm not going to be judgmental towards him.
 11 **Q.** It's not being judgmental, it's being positive, isn't
 12 it, to describe someone as "usually personable, kind,
 13 polite, and gentle man --"
 14 **A.** Yes, yeah.
 15 **Q.** Given his involvement with the criminal justice system
 16 up to that time --
 17 **A.** Yes, and --
 18 **Q.** -- and evidence of aggression?
 19 **A.** Yes, when he is unwell he's a different person
 20 completely. Yes, I agree.
 21 **Q.** Well, that's the assumption, isn't it? Again, what
 22 information -- it may or may not be right -- but what
 23 information did you have about what he was like when he
 24 was well, from other people apart from VC?
 25 **A.** Only general conversations with my colleagues, probably
 15

1 that he has ever been unwell, behaviour can be
 2 unpredictable when unwell."
 3 So the description there, "usually a very
 4 personable, kind, polite and gentle man."
 5 Can we please have on screen, please,
 6 NHFT0000168/163, also on 31 August. What we see in this
 7 discussion:
 8 "Very accusing ... and confrontational in nature."
 9 If we can underline that, please. So discussing his
 10 presentation at the same date:
 11 "... currently presenting ... psychotic, delusional
 12 ... suspicious ... stopped his medication -- not clear
 13 when he last took it ... believes he has been
 14 deteriorating for several months."
 15 That's Ms Birtles believes he's been deteriorating.
 16 Do you see it? It's the box number 3.
 17 **A.** Yeah.
 18 **Q.** If we can highlight it, "Gatekeeping discussion", that
 19 section.
 20 **A.** Mm. Yeah, I see it.
 21 **Q.** "Refusing to have ... contact with his [care
 22 coordinator] ... or [Crisis] ... Very accusing and
 23 confrontational in nature."
 24 Yet we see time and again, VC usually very
 25 "personable, polite, kind and gentle man", almost a cut
 14

1 with Claudia as well, with how I seen him in
 2 September 2020 or thereabouts. So I have a limited
 3 knowledge of the man. I acknowledge that. But the fact
 4 is people, you know, I think people give me the
 5 impression that yeah, when he's well, he's a nice guy.
 6 However, when he's unwell he's something totally
 7 different. And what I saw on that day was something
 8 a lot different to what I'd seen when I first met him.
 9 **Q.** He's described as "guarded" on so many occasions --
 10 **A.** Yes, yes, I agree.
 11 **Q.** -- in the notes, so how is it possible to assert, in
 12 a positive way, how kind and polite and gentle someone
 13 is if you're concluding they're guarded, which
 14 I understand to mean they're not telling you -- a great
 15 deal.
 16 **A.** With great difficulty. It's like when people are lying
 17 to you, misleading you, you can have a feeling that
 18 something's wrong. You can make a judgement. It might
 19 be a wrong one. It might be the right one, or it could
 20 be wrong. You know --
 21 **Q.** These are wrong, aren't they? They're very superficial
 22 descriptions of personality in complex circumstances
 23 where you know, by then, what his conspiratorial beliefs
 24 are from 31 August and the impact they're having and you
 25 said you didn't read the text and the messages and what
 16

1 they --

2 A. -- yeah.

3 Q. -- they made him feel about what he wanted to do to

4 people. But this personable, kind, polite and gentle

5 positively obfuscates what's going on here, doesn't it?

6 In terms of other people understanding risk when they

7 look at this document?

8 A. I'm sorry, you're saying --

9 Q. The description on the last one that we see repeatedly,

10 personable kind, polite, gentle --

11 A. Right.

12 Q. -- obscures the risk. Anyone reading that doesn't get

13 the picture.

14 A. Yes, yes, I would probably agree with that. You know,

15 the wording is not terribly good.

16 Q. If we go to the box further down on the page we're

17 looking at, 163, on 1 September you explain in a call:

18 "... did not have an absolute emergency on our hands

19 but a MHA assessment was considered the way forward in

20 the near future."

21 A. Yes.

22 Q. "Plan

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

24 Again, "the near future" doesn't communicate the

25 urgency of the situation that you didn't feel safe then.

17

1 So what did you and Ms Birtles say about that when

2 you spoke about it, given how you'd experienced visiting

3 on 31 August, when you knew what had happened to the

4 police officer, what did you discuss between yourselves

5 about that?

6 A. About the --

7 Q. The assault on the officer.

8 A. Yeah. Well, needless to say we were very shocked. Very

9 shocked indeed.

10 Q. Shocked?

11 A. Yes, because he'd used -- he was not only aggressive, he

12 was very violent. He's assaulted a police officer, he'd

13 been tasered twice, I believe, he'd had to be restrained

14 by a number of police officers. They required

15 assistance, and he was led away in ankle restraints

16 which I didn't even think we used in this country.

17 Yes, I was very shocked by that particular

18 description of what happened.

19 Q. Did you, in your mind, if you weren't aware of it

20 before, think: he can be a very violent man?

21 A. Dead right I did, yeah, of course. Anybody would say

22 that, yeah. Absolutely.

23 Q. Did you take that forwards with you in your dealings

24 with him; that you knew that he could be very violent,

25 in the circumstances you have just described?

19

1 A. Well, when we got back to the office, I remember this

2 meeting ended, we had a very brief discussion after we

3 both came out. We headed back to Stonebridge. As soon

4 as Claudia walked through the door she was on the phone

5 to Crisis.

6 Q. Well, we know if we look at NHFT0018141, page 1, she

7 refers for the Mental Health Act Assessment, yes?

8 A. *(Reads to self)*.

9 Q. We know he is assessed on 3 September and we know that

10 he violently attacks a police officer, doesn't he,

11 during attempts to conduct that assessment?

12 A. Yeah, yeah. Well, I --

13 Q. 3 September that happens.

14 A. Yeah, yeah.

15 Q. When did you first learn of what had happened on 3

16 September?

17 A. I'll be perfectly frank with you, I don't know. That's

18 a good question and I honestly don't know how I heard

19 about that. I think it was probably the MDT, because

20 I remember at the MDT, it might have been the next MDT

21 on from this incident, that Claudia came into the office

22 and she did mention to Dr Lloyd he'd been tasered, led

23 away in handcuffs, leg restraints, et cetera. So, you

24 know, a few days later, shall we say.

25 Q. That can come off the screen, please.

18

1 A. I did take it with me, yes, yes.

2 Q. Can we have please NHFT0017897, page 1. This is an

3 email from Ms Birtles to you and others and it was

4 surrounding his discharge. We know he had a period of

5 detention, you'll have known that, at The Priory and

6 Cygnet --

7 A. Yeah.

8 Q. -- immediately after that Mental Health Act Assessment

9 that you'd initiated.

10 Were you surprised that he was going to be

11 discharged at the end of October, 24 October, so soon

12 after admission, or did you not think about that?

13 A. This was his third admission, I believe --

14 Q. Yes.

15 A. -- yes. Well, my understanding is that he spent a month

16 at the Cygnet facility in Darlington, he then

17 transferred to Calverton Priory Arnold, and then he was

18 just discharged.

19 Q. Just to say, while this is on the screen, so this, in

20 context, we know Ms Birtles has attended a ward review

21 over Teams and she says, "Is anyone else free to join?

22 That would be amazing if so".

23 Did you see that at the time? Did you think about

24 meeting over Teams for the ward review?

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

20

1 Q. We know -- and Inquiry has examined the evidence with
2 Ms Birtles -- that she was suggestive and considered
3 that a depot should have been prescribed at this time,
4 that VC needed a depot?

5 A. Mm, yeah.

6 Q. You say, "Yeah"; do you agree with that?

7 A. Absolutely.

8 Q. You say "absolutely", is that because it was common
9 knowledge in the team he wasn't taking his medication.
10 There was no ifs and buts, he just was not taking it.

11 A. Yeah. I -- throughout his kind of time with EIP,
12 I cannot understand how this man has avoided a depot.
13 But this is what I'm saying about this man negotiated
14 his care and for God knows what reason, the medical and
15 nursing staff, the medical staff in particular, went
16 with his kind of desires, his wishes.

17 You know, we -- you know, the medical staff, nurses,
18 we're the healthcare professionals. In theory, we know
19 what we're doing. We know what's best for this man.
20 And in similar situations in history where somebody is
21 having a lot of problems with tablets, can't take them,
22 forget to take them, whatever, a depot could be a good
23 solution for you.

24 Q. Can I just be clear, Mr Carter, because it's a matter
25 for the Chair, but it may be your colleagues have been

21

1 not through reading through his notes from day one
2 onwards., it was from discussions, informal discussions
3 with my colleagues.

4 Q. Can we please, please, NHFT0018957, page 1. And this is
5 an email from Ms Birtles, 17th December:

6 "Hi all ...

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

14 "Thank you so much ..."

15 Et cetera.

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

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

23

1 less clear about the issue of whether you fully
2 understood he wasn't concordant. We've heard would we
3 know if he's taking it; we're not clear if he's not
4 taking it; we don't ask to see him take the medication
5 were you clear he was not taking medication over this
6 time?

7 A. I was clear on that day.

8 Q. Over the period. I'm not just asking you about one day.
9 You go in August 2021. We know in September 2021 that
10 a whole stash of medication --

11 A. My understanding of his non-concordance came from
12 discussions with colleagues. Because I wasn't his CCO
13 at the time and because he was -- his name was brought
14 up on a regular basis at MDTs for instance, people did
15 mention that he was non-concordant, he was very elusive,
16 you know, he didn't engage very well, et cetera. That's
17 what I knew about him. His non-concordance was brought
18 home to me in a major way when I found out how he'd been
19 arrested, you know, like -- because I -- because when we
20 did the visit, we both suspected he'd not been taking
21 his tablets. And that would appear to be the case.

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

25 So yeah, my understanding of his non-concordance is

22

1 Did you know that at this point there was
2 consideration, or appeared to be a consideration of
3 discharge of VC, given he's not engaging at all?

4 A. No.

5 Q. Five days after this email he assaulted Christopher,
6 a flatmate, held his flatmate in a headlock, prevented
7 two of them leaving the premises --

8 A. Yeah.

9 Q. -- in an intimidating manner.

10 When did you learn about the event with his
11 flatmate? Can you remember?

12 A. Again, I do not know when I learnt of it. I don't know
13 who told me about it. I'll be honest with you, I don't
14 know.

15 Q. That can come down please and can we have NHFT0000168,
16 page 264. It's in the last box or the last three boxes.
17 So NHFT0000168/264.

18 This is a time where you are recorded making a phone
19 call to VC. VC agreed to collect his medication at
20 10 am on Thursday, 14 April. We see that.

21 A. Yes.

22 Q. So by this time, this is when you're no longer going to
23 the premises; is that right? You referred to it
24 earlier. He's coming to Stonebridge instead to get his
25 medication.

24

1 A. Well, no, I -- basically -- yes. I stand corrected.
 2 Yes, you're quite right. You're quite right.
 3 Q. But you remember that now, that's why you're phoning
 4 him?
 5 A. Yeah.
 6 Q. You said it this morning. He's coming to you, as it
 7 were.
 8 A. Yeah.
 9 Q. So you don't get a chance, you say, to look at him in
 10 the same way as you would in his home.
 11 A. Yeah.
 12 Q. If we go please to NHFT0000168/265, 20 April:
 13 "[VC] arrived ... collected [two] ... weeks of
 14 medication as agreed. Pleasant on approach, asked how
 15 I was doing then left promptly. Next due on 28th
 16 April."
 17 So these exchanges are very surface, aren't they?
 18 Very brief and very surface. We don't see you doing any
 19 mental state examination or profound conversation with
 20 him.
 21 A. He wasn't -- he wasn't easy to kind of engage with this
 22 man. I think you've got to bear in mind is that I've
 23 often said that all I wanted, or what would have helped
 24 me a great deal, would be if he'd have just given me
 25 30 minutes of his time to sit down with him, have

25

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

27

1 a conversation, and then I could have kind of got to
 2 know him and assessed his mental state as an example.
 3 He never did that with me. He never did that with
 4 me. You know, he was -- by this time, he was -- in the
 5 lead-up to me taking over as his care coordinator,
 6 I think he'd virtually disengaged from contact with
 7 Claudia completely.
 8 Q. And it was 29 April, wasn't it, that you took over as
 9 lead?
 10 A. Yeah, that's right, 29 April, early May. By which time
 11 he wasn't having nothing to do with Claudia. And
 12 I don't think -- again, I didn't have a handover on the
 13 28th when this decision was made.
 14 Q. We'll come to the decision.
 15 A. Yes.
 16 Q. But you were copied in emails, you all were.
 17 A. Yeah.
 18 Q. Everybody knew about him and his case --
 19 A. Yeah.
 20 Q. -- because we see Ms Birtles' emails. That's how the
 21 system seemed to work. Yes? You had information about
 22 him, you'd visited him, you'd had informal chats about
 23 him. So you knew about his case. The lack of a formal
 24 handover didn't prevent you knowing about him, did it?
 25 A. I think it -- I think without a formal handover it was

26

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

28

1 Monday morning to confirm a time."
 2 "When are you picking ... up?
 3 "... come tomorrow.
 4 "Are you coming for your meds ...
 5 "Come around 3".
 6 Over the page, 4.
 7 "... contacted [him] asking him to collect his
 8 medication ... rang me back said he had enough ... until
 9 Friday 1st July.
 10 "I will offer him the option of taking his
 11 medication out to him ...
 12 "If you like I could drop your meds off ... no
 13 bother ...
 14 "... meds are due tomorrow.
 15 "... come around.
 16 "Ok".
 17 Obfuscation, obfuscation, isn't there?
 18 And we see at 27:
 19 "Phone call to [VC's mother] ..."
 20 27. It's the one up, please, on page 4. Box 27:
 21 "Phone call ... explaining VC may have gone to
 22 Africa? [His mother] ... knows nothing about this and
 23 has not heard of anything to suggest [VC] is abroad.
 24 "I phoned [VC] ... [he] did not answer. I left
 25 a voicemail asking him to call me."
 29

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

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1 What had been said that made you think he was
 2 abroad? He said he was abroad, didn't he'd?
 3 A. Sorry?
 4 Q. Did VC tell you he was abroad?
 5 A. I don't -- I don't recall this. I don't think I was
 6 contacted directly with this, somebody else was, they
 7 were led to believe that he'd gone abroad, which was
 8 surprising, obviously. You know, like, if I contacted
 9 Celeste, yes, that appears to be the case. She knows
 10 nothing about it. As far as she's concerned, he's still
 11 in the UK.
 12 Q. Yes, so she poured water on that idea, didn't she --
 13 A. -- yes, yes.
 14 Q. -- that he wasn't abroad, he was in Nottingham?
 15 A. Yes.
 16 Q. So it continues with attempts to find him. So what we
 17 see here is communication between you and VC who is
 18 ducking and diving and not doing what he's supposed to
 19 do?
 20 A. Yeah, yeah, he is.
 21 Q. An ongoing pattern of not getting his medication, not
 22 taking his medication. When a patient is refusing
 23 medication, and it's clearly in their best interests to
 24 take it, should you not be engaging in coercive practice
 25 to make sure that they do?
 30

30

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

32

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

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1 **Q.** How did that fit into risk assessment, his risk to
2 others, as far as you were concerned?
3 **A.** Well, again, it's indicating that this man is -- well,
4 he's quite poorly. He's very poorly. You know, like
5 he's got no understanding of any kind of instructions
6 that he's receiving, he shouldn't have been there, but
7 he was there anyway. You know, like he was -- it says
8 here he was not aggressive or confrontational, although
9 the incident was strange. Yes, it is strange.
10 "... flat and Raleigh Team have been advised to
11 contact the Police ..."
12 And that's probably wise. It's very wise.
13 **Q.** If we go to the bottom of the document, 266, so still
14 page 266, 28 April, this is a Multi-Disciplinary Team
15 meeting, and it's noted:
16 "Following a risk assessment and discussion in MDT,
17 agreed it would be appropriate to transfer [VC] to a new
18 CCO, preferably two CPN's."
19 You were not at that meeting, you say.
20 **A.** No.
21 **Q.** It was after that meeting that you were asked to be his
22 lead care coordinator.
23 **A.** I was -- well, yes, I suppose you could say I was asked
24 to be his lead coordinator -- his care coordinator.
25 **Q.** Did you know that this discussion was taking place and

35

1 **A.** Well, I'm sorry, I did mention it to -- I did have this
2 discussion with several of my colleagues. And I think
3 I recall Dr Burri, I think, I mentioned I had a chat
4 with him about it at one stage. But it were quite
5 a while back.
6 **Q.** Can we have NHFT0000168/266, please, and this a record
7 on RiO, information received from the University. Did
8 you see this? You took over shortly afterwards on the
9 29th. This was 26 April., and we see to Claudia, an
10 exchange between Claudia and Ellie, and reference there:
11 "I've just learned that VC returned to Raleigh Park
12 last Thursday ... One of the Security officers
13 approached him and VC said he was visiting a friend, but
14 gave a false name when questioned [when] he was
15 visiting."
16 You'll appreciate the significance of Raleigh Park
17 was where he assaulted his flatmate and he wasn't
18 allowed to go back there. He wasn't able to go back to
19 that address after that.
20 Did you know, contrary to instructions to him, he'd
21 gone back there and had to be escorted off site by
22 security?
23 **A.** Yes, I was made aware of that, yeah. Yeah, I do recall
24 that. By who, I don't know, but I was made aware of
25 that.

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1 that you were going to be asked to be that?
2 **A.** I didn't know this discussion was going to take place
3 then, no, I did not know, no.
4 I -- I find it unacceptable that I wasn't there,
5 basically. You know, I -- because a risk assessment has
6 been -- "following a risk assessment", now when I first
7 read that, I thought this was a risk assessment on VC.
8 Then it suddenly dawned on me, it was pointed out by
9 somebody that it was actually done by Claudia and
10 because of her, I believe, she was in the early stages
11 of her pregnancy, a new CPN was required, and
12 interestingly, preferably two CPNs. Yes. I agree with
13 that, definitely.
14 **Q.** You agreed with two CPNs?
15 **A.** Well, one is quite obviously not enough.
16 **Q.** Why not?
17 **A.** Why? Because you can't -- one person -- this man is --
18 because he's negotiated everything, he's just
19 permanently unwell. Even when he's reasonably well,
20 he's not terribly well and basically, you know, like
21 even to -- you know, one CCO is not enough to monitor
22 him closely in the community. And I would say that, you
23 know, like even two CPNs, that's not a guarantee, that
24 is far from a guarantee, that he could have been
25 monitored closely, in my opinion.

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

37

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

39

1 A. What, there and then?
2 Q. Yes.
3 A. No.
4 Q. Why not?
5 A. I can only assume, you know, like -- he may have taken
6 the dose in the morning or whatever, when is this,
7 12.30? When was it? When was it? I'm just trying to
8 look at the time.
9 Yeah. He's picking up his medication. I don't
10 think I've ever asked a patient to take a dose of his
11 medication there and then.
12 Q. But you knew, you say, he wasn't taking his medication;
13 that was the concern, wasn't it?
14 A. So basically you feel that I should have asked him to
15 take a dose right there in front of me?
16 Q. I'm just asking you, would you do that if you knew --
17 A. No, I --
18 Q. -- you knew he wasn't taking it.
19 A. Yes, I do. Yes, I wouldn't do that and, you know,
20 because I would have rightly assumed that he might have
21 taken some medication that morning, and he could well
22 have confirmed that, maybe. I don't know.
23 Q. But you said earlier you had known he wasn't taking
24 medication. That's something you had realised before
25 this time, hadn't you, that he wasn't taking his

38

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

40

1 I may well have noted that.

2 **Q.** We see on 24 June further down, you contacting him
3 asking him to collect his medication:

4 "[He] rang back to say he had enough medication
5 until Friday 1st July."

6 Did you challenge that and wonder how he had that?
7 Or did you not just discuss medication with him?

8 **A.** Or did I what, sorry?

9 **Q.** Did you challenge him and say, "How come you've got
10 enough since 1 July?" Or ...?

11 **A.** No, I don't think I did challenge him, no.

12 **Q.** Or discuss it with him?

13 **A.** No, I was basically offering him a choice of taking his
14 medication now. That would have been desirable,
15 certainly.

16 **Q.** 4 July, "Provided [him] with ... oral medications as
17 prescribed". Two weeks. It had run out on 18 July.
18 That's not you; it's someone else, isn't it? Below your
19 entry. Yes?

20 **A.** Yeah, I was out on visits ... yeah, "declined wanting
21 anything passing onto" me.

22 **Q.** 4 July, that's the last time he's seen, isn't it?

23 **A.** What's the --

24 **Q.** 4 July.

25 **A.** -- 18th July note? What's that?

41

1 3 August, again you make a telephone call and no
2 answer.

3 **A.** Mm-hm.

4 **Q.** Why doesn't this trigger rapid escalation?

5 **A.** Probably because I was going to go out and see him with
6 Paul Williams the following day, which I believe I did.

7 **Q.** And you went to an address that wasn't his. That's
8 right, isn't it?

9 **A.** Well, it used to be his. You know, which address were
10 we considering? Because when he was discharged after --
11 on discharge three, after his third admission, it was
12 268 Queens Road Beeston. But if you look at the RiO
13 notes, ten days later, Dave Waldron provides an
14 alternative address, flat 15, Derwent Way. And yet when
15 I went to visit him, I --

16 **Q.** Where did you go?

17 **A.** I visited 209 Ilkeston Road.

18 **Q.** Yeah. That was an address you made a cold call to on
19 4 August --

20 **A.** Correct.

21 **Q.** -- and you were told he doesn't live there. That's
22 right, isn't it?

23 **A.** That's correct, yes. Now --

24 **Q.** Just let me ask you my next question.

25 **A.** Right.

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1 **Q.** Ms Parsonage, "Text sent". Come in for meds. He says
2 "Not in the UK at the moment". "Are you on holiday?"
3 That's the conversation about being abroad.

4 **A.** Yeah, that would appear to be the last time he's seen,
5 yes.

6 **Q.** And it's clear that he's going to run out of medication
7 even if you thought he was taking it. But it sounds as
8 though you knew he wasn't taking that medication over
9 this period; is that right?

10 **A.** I think there were some very strong indications that he
11 weren't taking his medication.

12 **Q.** Clear indications?

13 **A.** Well, certainly the comment made by Abi about him
14 looking very dishevelled would certainly -- might
15 indicate that he's not taking his medication.

16 **Q.** And if we look at the boxes from 25 July down to the
17 3 August, that's where the phone call was made to his
18 mother.

19 **A.** Yeah.

20 **Q.** Who knows nothing about him being abroad.

21 **A.** Yeah.

22 **Q.** You telephone VC, no answer. He doesn't pick up his
23 medication, 27 July. 29 July: attempt to make contact,
24 no answer.

25 Doesn't attend 1 August with Dr Tuhina Lloyd.

42

1 **Q.** The Derwent address, the flat 5 address, was where he'd
2 assaulted his flatmate.

3 **A.** Right.

4 **Q.** And it was clear on the RiO records he wasn't allowed
5 back there, was he, by February? So he was never going
6 to be there, was he?

7 **A.** Well, that's the address Dave Waldron gave, flat 15
8 Derwent Way.

9 **Q.** Well, he may have done, but as his care coordinator, if
10 you'd traced that issue through you would have seen he
11 couldn't possibly have lived there, because he'd come to
12 an agreement with the University that he was going to
13 move out from there. Ellie Turner had told you that,
14 there had been communication about that with the team.

15 So you went to an address he hadn't lived at for
16 a long time. And it may have been you didn't know the
17 right address, that's where you got to, you didn't know
18 where he was living --

19 **A.** Yeah, yeah.

20 **Q.** -- he wasn't living at the Ilkeston Road one, he
21 definitely wasn't going to be living -- and that should
22 have been clear before visiting it -- to the address
23 that the discharge letter was sent to, and it may have
24 been necessary for you to try and find out where he was
25 living then, wouldn't it? And how would you go about

44

1 that?

2 **A.** Yes, it would have been useful to know where he's

3 living, definitely.

4 **Q.** Well, it's vital. You still had his telephone number,

5 didn't you?

6 **A.** Yes, I had his telephone number. I tried ringing him

7 and he weren't --

8 **Q.** You text him, if you couldn't do that; what else would

9 you do to try and find out where someone was?

10 **A.** Well, we could go out and try and find him. Literally

11 go out and try and find him. But the fact remains, you

12 know, the reason why I probably didn't do that was

13 because I had other people to see as well. I weren't --

14 I didn't just have a caseload of one.

15 **Q.** You might have suggested someone else found out where he

16 lived for you. I'm not suggesting you had to do that,

17 but you needed to say, "This man is dangerous, he's

18 relapsing, we don't know where he lives. Can you find

19 out?" You contact the police, you contact the local

20 authority, housing, find out where he was. His mother

21 didn't know.

22 **A.** -- ask one of my colleagues to go out to find

23 a dangerous man?

24 **Q.** No, to find out where he lives. Someone from admin to

25 contact the police to find that out, where he may be or

45

1 raise in this supervision:

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

3 the country ..."

4 That's what Abigail Parsonage's information was.

5 "Call from mum who informed ... he is in Nottingham,

6 plan to try and visit with CSW — when previously unwell

7 did need a taser when sectioned."

8 So you've raised it in your supervision. You told

9 us earlier you could. So what are you sharing with

10 Sharon Stone here? What are you discussing?

11 **A.** I'm just trying to update her on the situation with this

12 man, basically. You know, there's been a question mark

13 about him even being in the country. We seem to have,

14 you know, basically found that that is not the case.

15 He's still here. And we're going to possibly visit him

16 in the near future at an address. You see, the address

17 I went to, 209 Ilkeston Road, was the one on the RiO

18 notes.

19 **Q.** Yes.

20 **A.** On the front of the --

21 **Q.** That's one of them. There's a number of addresses --

22 **A.** No, no, no, no. I would have gone to the address on the

23 front page of his RiO notes. That is his latest

24 address, 209 Ilkeston Road.

25 **Q.** Yes, he'd given that in February 2022. But when you

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1 housing or the local authority. His family had told you

2 he was in Coventry, they didn't know. That's what he

3 had said to them. VC had told you he was abroad. He's

4 not telling people the truth. You needed to know where

5 he was.

6 **A.** Correct, yeah, I agree.

7 **Q.** So how would you go about that?

8 **A.** Well, ultimately it would -- I would -- after they the

9 failed visit on the fourth, you know, like as I look at

10 it, we just had one more card left and that was contact

11 the police.

12 The alternative was discharge him and I don't think

13 that was a good idea.

14 **Q.** Let's come on to that in a minute. So if we go, please,

15 to NHFT0004909, page 3, and the top box, please. Page 3

16 top box. Just the top box. So this is a note of your

17 supervision with Sharon Stone, so that's your

18 supervisor, is it?

19 **A.** Yeah.

20 **Q.** You have monthly supervisions with her. What was her

21 qualification? What was her role in relation to you?

22 **A.** She was -- well, she used to be the clinical lead, then,

23 when Emma left for another position, she became the

24 manager.

25 **Q.** So you have this on 27 July 2022, and it looks like you

46

1 knocked on the door --

2 **A.** Yes --

3 **Q.** -- someone told you they weren't there?

4 **A.** -- yes, yes, I agree -- I agree --

5 **Q.** So it was the wrong one --

6 **A.** But the question I'm trying to raise here is why wasn't

7 the address updated?

8 **Q.** Well, there wasn't an address to update. No one appears

9 to have known it.

10 **A.** Well, what about 268 Queens Road?

11 **Q.** That's not where he was either, was it, at that time?

12 **A.** I don't know where he was. I don't think anybody knew

13 where he was.

14 **Q.** That's the point. What did you do to find out? Did you

15 discuss with Sharon Stone how you were going to find out

16 where he was?

17 **A.** Well, I was -- well, we had one option, as I look at it,

18 and that was to call the police.

19 **Q.** So why didn't you?

20 **A.** Because I was probably slow off the mark, yes, I was

21 probably slow off the mark here.

22 **Q.** Did you discuss it with anyone else, with Sharon Stone,

23 let's phone the police? Did she raise it?

24 **A.** I don't recall, I don't recall, to be honest with you.

25 **Q.** How can the police help you in those circumstances when

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1 you're trying to locate --

2 **A.** Well, they've certainly helped me before with other

3 clients.

4 **Q.** So they've found them for you, they can --

5 **A.** Yes, I can remember one client who went off the radar

6 for ten days. We were both very worried, me and

7 Dr Lloyd. I contacted the police and amazingly they

8 found him within 24 hours and that was great, because

9 I could work with the police, and just give them all the

10 assistance that I could possibly give them.

11 With regards to VC, you know, like that was

12 the last -- that was the last thing we could do, really.

13 **Q.** But you failed to do it.

14 **A.** Yeah.

15 **Q.** NHFT0000179, page 1, please. This is a mental health

16 clustering tool, which I think you filled in on

17 10 August 2022; is that right? We see at page 1, the

18 date, and if we go to page 4 we see "Updated by Gary

19 Carter", yes?

20 If we go to page 2, please. You've only seen him

21 twice, but you complete it at this point. Why do you

22 complete it at this point in August 2022?

23 **A.** Because probably because I've been encouraged by Sharon

24 to make sure that all the necessary paperwork concerned

25 with all my clients, not just VC, is updated wherever

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1 early in his care. I personally never really thought

2 that was the case. I never got the impression that drug

3 misuse was a major issue with this man. But I put that

4 in basically just as a kind of: well, if it is, at least

5 I've acknowledged it.

6 **Q.** You say at number 6:

7 "Problems associated with hallucinations and

8 delusions

9 "Moderately severe problem."

10 **A.** No, that should have been high. That's a mistake on my

11 part.

12 **Q.** That's just wrong, isn't it?

13 **A.** Well, it's a mistake on my part, so ...

14 **Q.** Mistake in what? In assessing the level of problem and

15 risk and difficulty, or you just wrote the wrong thing

16 down?

17 **A.** I'm pretty confident that I understood that, you know --

18 as I said, with the conversations I had with people,

19 with what I knew about this man from reading through

20 parts of his notes that, yes, there were issues around

21 hallucinations, delusions, et cetera. It's probably

22 a mistake that I've made there. They should have been

23 higher than that, certainly.

24 **Q.** That can come off, please. Then NHFT0017920, page 1.

25 17 August, you send a letter to the admin team, City

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1 possible.

2 **Q.** Was that an issue for you, not updating paperwork?

3 **A.** Well, it was something that I had to get on top of.

4 There's no two ways about it. And whenever I could,

5 I did, and if I didn't, I would come to it as soon as

6 I could.

7 **Q.** We see anyway, when you've completed this at the top:

8 "Overactive, aggressive, disruptive or agitated

9 behaviour.

10 "0 = no problem ..."

11 "No problem" appears there. Do you agree? You've

12 put "No problem" there.

13 **A.** No, I do not agree with that.

14 **Q.** So if you were going to complete it, was there a reason

15 for not filling that in?

16 **A.** No.

17 **Q.** Number 3:

18 "Problem-drinking or drug taking ...

19 "1 -- Minor problem requiring no action."

20 Why did you put that there?

21 **A.** It had been suggested that he might have been using --

22 well, it were a question mark using cannabis as an

23 example.

24 **Q.** Who had raised that, or when was that raised?

25 **A.** I think this was -- I'm pretty sure this was raised very

50

1 South Admin:

2 "Hi everyone

3 "Could we just send this chap a quick letter asking

4 him to call me. He's been off the radar for quite some

5 time."

6 **A.** Yeah.

7 **Q.** Then if we have 122 -- so NHFT0000122, page 1 -- sent to

8 the address that the hospital should be fully aware,

9 from the RiO notes and Ellie Turner's communications, to

10 an address he's not at.

11 **A.** "15 Madison Court." Now, I do not recall changing that.

12 I don't know.

13 **Q.** What do you mean changing?

14 **A.** I just do not recall changing that. Because me and Paul

15 went to 209 Ilkeston Road.

16 **Q.** Where he didn't live.

17 **A.** Well, yeah, apparently he didn't live.

18 **Q.** Well, when you spoke to the person --

19 **A.** Yeah, I spoke to --

20 **Q.** -- did you have any doubt that they were telling you --

21 (*overspeaking*) --

22 **A.** Yeah, I did have some doubts actually, yeah, because

23 I think basically this man, I felt, was being assisted,

24 and I think that somebody might have been helping him

25 out here. So I had my doubts about that. However,

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1 there's nothing I could do about it.

2 Q. Well, if you thought that, again, you could contact the

3 police, couldn't you, and say, "We're trying to find

4 this man, VC, can you help us with it?" If you actually

5 thought --

6 A. Yeah.

7 Q. -- you knew where he was and you don't want to take that

8 further?

9 A. *(The witness nodded).*

10 Q. But instead we see -- and it may be admin. You're

11 saying you didn't revert it to the Derwent Way address,

12 but it's a fact that that wasn't --

13 A. Yeah.

14 Q. -- the right address. What address did you think the

15 admin team were going to put on when you said, "Send

16 a letter"?

17 A. They would put the latest address on the RiO notes.

18 Q. And he hadn't been engaging with services at all, had

19 he?

20 A. No.

21 Q. This letter, if we read it, doesn't set out anything as

22 to why he should engage, why you're concerned, why it's

23 necessary to be in touch. Did you think this had any

24 prospect of working in terms of engaging him or getting

25 him on board with what you wanted him to do?

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1 there, to find out where he lived and to visit him at

2 home beyond the ones you've told us about.

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

4 Q. Do you agree?

5 A. Again, I would -- I would say, you know, I had other

6 people to see, and yeah, I wanted to make some progress

7 here. But I also needed to make progress with other

8 people as well.

9 Q. Did you get anyone else to do the attempts to find and

10 visit him, then, either through Crisis?

11 A. Well, I certainly didn't approach Crisis at that time,

12 not yet, no.

13 Q. Why not?

14 A. I was -- I was still hoping that we could find him, and

15 engage with him. And again, I probably -- I was

16 probably slow off the mark on this. I could have

17 contacted him earlier, I suppose.

18 Q. Could have contacted the police?

19 A. Could have contacted the police.

20 Q. Request a multi-agency meeting?

21 A. I'm not really sure how the police might have reacted to

22 this because, you know, like from my experience of the

23 police is that you've got to give them an incredibly

24 good reason to do -- shall we say for them to search for

25 people.

55

1 A. Well, it was an attempt to just kind of reach out to him

2 and basically say, "Look, can we have a chat? Can we at

3 least meet up and just have a chat about things and see

4 where we go from here."

5 Q. Did you know anything about the "Did Not Attend" policy

6 and what should be done if someone did not attend and

7 weren't doing as they should be?

8 A. I was made aware of it, yeah.

9 Q. If we have a look, please, at NHFT0004725, page 7. So

10 7.2.3.3 highlighted, please:

11 "If the patient is not at his/her address, the care

12 co-ordinator and service team should agree other

13 agencies to be contacted eg GP, housing departments,

14 works and pensions departments ... including a

15 discussion regarding contact with family members even if

16 the patient has requested no contact with their family.

17 This requires to be judged on a case-by-case basis

18 determined by the level of risk, whilst at the same

19 time, must respect patient confidentiality in not

20 discussing or passing on clinical information."

21 In terms of risk at the moment, without a doubt he

22 was a serious risk, wasn't he, relapsed and unmedicated

23 in the community?

24 A. *(The witness nodded).*

25 Q. Despite that, there weren't further attempts, were

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1 Q. Well, he was wanted, wasn't he, and the irony, grave

2 irony --

3 A. I'm sorry, was what?

4 Q. He was wanted by September 2022 on a warrant for

5 seriously assaulting a police officer --

6 A. Yes, that was issued on September the 22, yeah.

7 Q. So when you say the police needed a serious reason --

8 A. Yes --

9 Q. They --

10 A. At that time, yes.

11 Q. Yes. So if you had contacted them at 2022, and said,

12 "We have lost this man", they were looking for the same

13 person on a warrant, weren't they?

14 A. They could have done, they could have done.

15 Q. So are you suggesting that they wouldn't have tried to

16 find him if you had alerted them to the fact that he was

17 unmedicated and in the community? -- *(overspeaking)* --

18 A. No, no, the bench warrant was issued on 22nd September.

19 That's the day he was discharged.

20 Q. Yes, of course. So I'm saying around this time they

21 know he's been arrested --

22 A. Yeah.

23 Q. -- for the offence on PC Pritchard. Yes? So when you

24 say would the police be interested in helping you and

25 finding him, they would, wouldn't they, on the evidence?

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

12 Q. You could contact the police --

13 A. Sorry?

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

17 A. I could have done, yes.

18 Q. You knew he had seriously assaulted --

19 A. Yes.

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

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

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

3 A. Yes.

4 Q. And he'd have had medication.

5 A. Yeah.

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

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

10 Q. Not probably. You should have done.

11 A. Yeah.

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

15 A. Sorry, the team? What --

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

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

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

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

25 Q. What's the significance?

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1 Q. Yes, yes.

2 A. That's correct.

3 Q. Yes.

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

7 Q. Mm-hm.

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

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

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

14 Q. And you should have done.

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

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

18 A. On the 22nd, definitely.

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

21 A. Possibly.

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

23 A. Yes.

24 Q. Good chance they would have found him.

25 A. Possibly.

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

9 Q. Which was what?

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

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

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

18 Q. So what --

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

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

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1 please, penultimate paragraph:
 2 "It was my intention to go out to the latest address
 3 noted and see if I can make contact with [VC]. At this
 4 time I considered calling the Police and reporting [him]
 5 as a missing person. ... due to my other caseload
 6 issues and my experience... this did not happen."
 7 **A.** Yeah, okay.
 8 **Q.** That's what you've said and you repeated that today.
 9 **A.** Yes, yes, that's right.
 10 **Q.** Did you think about suggesting somebody else, either
 11 took on some of your cases or made the call to the
 12 police, and took some of the burden away from you?
 13 **A.** No, I -- I think you've got to look at what was really
 14 happening in this team. Asking my colleagues to take
 15 over some of my caseload was not really an option.
 16 Like my colleague this morning, Abi Parsonage, she,
 17 too, was a lady who had a caseload of plus 20 at the
 18 worst. And at my worst it was 24, and I think she had
 19 something similar at one stage.
 20 And asking other members of the team to kind of take
 21 on parts of my caseload and -- I think, I think there
 22 would have been an objection to that. I think there
 23 would have been an objection to that.
 24 **MS LANGDALE:** Chair, those are my questions. I think it
 25 might be a good time for the break, the afternoon break.

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1 **A.** Well, from the door, I didn't actually go in, it --
 2 well, 209 Ilkeston Road is on the main road in an area
 3 frequented a lot by students. It tends to be a little
 4 rundown, shall we say. The house --
 5 **Q.** Can I try and help with a question?
 6 **A.** Yes.
 7 **Q.** Did it look like a settled address?
 8 **A.** Again, I didn't see inside. So I didn't see whether or
 9 not there were any furniture in there, or all the kind
 10 of usual things that someone might have, and say in
 11 a comfortable, settled home.
 12 **Q.** Okay. Can I then just ask you about, and it's just
 13 a brief point, about how in the session before lunch --
 14 and it was from 12.25 onwards -- you told the Chair, in
 15 answer to questions from Ms Langdale King's Counsel,
 16 that you'd not looked back through all the records on
 17 the RiO, for example, when you came to take over?
 18 **A.** Yeah.
 19 **Q.** You said you'd probably look back as far as the third
 20 admission and, really, you start as CCO, as you said, at
 21 page 267 out of --
 22 **A.** Yeah.
 23 **Q.** As a result, you weren't aware, you said, of the -- that
 24 he'd gone to premises at Brook Court on three occasions
 25 requiring arrest on the second occasion, a woman jumping

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1 **THE CHAIR:** Yes, shall we have a break now? Let's start
 2 again at 3.30.
 3 **(3.18 pm)**
 4 **(A short break)**
 5 **(3.30 pm)**
 6 **THE CHAIR:** Yes, Mr Moloney.
 7 **Questioned by MR MOLONEY**
 8 **MR MOLONEY:** Good afternoon, Mr Carter. I ask questions on
 9 behalf of the bereaved families.
 10 **A.** Okay.
 11 **Q.** I've only got two short matters to ask you about,
 12 please.
 13 **A.** Sorry?
 14 **Q.** I've only got two short matters to ask you about and the
 15 first of them is 209 Ilkeston Road, and you and
 16 a colleague went round to 209 Ilkeston Road, didn't you?
 17 **A.** That's correct.
 18 **Q.** You said you weren't completely convinced by the person
 19 you spoke to who said that VC did not live there --
 20 **A.** Yeah.
 21 **Q.** -- and you thought that somebody probably was assisting
 22 him at this time in any event?
 23 **A.** Yeah, might have been.
 24 **Q.** Might have been, yeah. Can I just ask you what sort of
 25 impression you got of 209 Ilkeston Road?

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1 from a first-floor window requiring back surgery as
 2 a consequence. And on the third occasion, in July,
 3 requiring a number of people to restrain him, a number
 4 of men to restrain him. And you said you didn't know
 5 all about that and it would have been useful to know
 6 about it.
 7 **A.** Well, I knew about the third admission, the nature of
 8 his arrest. Because me and Claudia, we'd met up with
 9 him the day before, or whatever, he was arrested, and
 10 I'd found out very quickly the nature of the arrest.
 11 **Q.** So did you think that was an arrest for something to do
 12 with Brook Court or did you think it was a -- the
 13 execution of a warrant?
 14 **A.** Well, my understanding was the Crisis Team were in the
 15 process of attempting to conduct a Mental Health Act
 16 Assessment. Unfortunately, in some cases such as this
 17 one, the patient or prospective patient is not very keen
 18 on that to happen, and has no insight, as an example, to
 19 cooperate or --
 20 **Q.** Because we know all about the circumstances of the 3
 21 September, Mr Carter, so I won't -- if you'll forgive
 22 me, I don't mean to be rude --
 23 **A.** Yeah, that's all right.
 24 **Q.** -- I'll just move on.
 25 **A.** Sure.

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1 Q. You knew about that because you'd seen, you'd been there
2 the day before with Claudia?
3 A. Mm.
4 Q. But in terms of knowing about the previous incidents,
5 had you -- and getting to know VC's case -- can we
6 assume that you read the risk assessment that was
7 current at that time?
8 A. I probably did. Because taking over as a CCO, I would
9 have -- well, I'd have said: is the risk assessment and
10 care plan up to date, as an example?
11 Q. Can I ask you this, then, just again to save time. If
12 I could just take you to that risk assessment, which is
13 NHFT0000190. You see this is Claudia Birtles and it is
14 28 February 2022.
15 A. Yeah.
16 Q. If we go to page 2 of this, and we look down at the
17 bottom of this page, we see 14 July 2020, and we see:
18 "Arrested for attempting to gain entry into a random
19 neighbour's flat as he felt that someone is in trouble.
20 [VC] did not gain entry or harm anyone but he was
21 kicking the door.
22 "Prior to previous admission [VC] was involved in
23 a similar incident whereby he entered into another
24 resident's flat whilst experiencing distressing auditory
25 hallucinations. The woman that resided in the flat

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1 A. Right.
2 Q. So that date's wrong. There's something before. And in
3 fact, 14/7/20 is wrong as well, for the -- those two,
4 but those three incidents are there in the risk
5 assessment for VC that was current when you took over as
6 CCO, aren't they?
7 A. Well, yeah, and I don't know why they're wrong. You
8 know, like Claudia wrote this risk assessment which
9 she's got -- you're saying that basically she's got her
10 dates wrong.
11 Q. I'm not bothered about the dates, Mr Carter. But
12 essentially you can see that those three incidents,
13 irrespective of the dates, the incidents that
14 Ms Langdale asked you about at Brook Court, those are
15 contained, described in the risk assessment, dates wrong
16 or right?
17 A. Yes, yeah. The dates are wrong, but, yeah, yeah,
18 I agree.
19 MR MOLONEY: Thank you very much, Mr Carter.
20 THE WITNESS: You're welcome.
21 THE CHAIR: Yes, Ms Cartwright.
22 **Questioned by MS CARTWRIGHT**
23 MS CARTWRIGHT: Good afternoon, Mr Carter. I ask questions
24 on behalf of the survivors.
25 Can I start, please, with one of your paragraphs in

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1 jumped out of the window due to being frightened, she
2 injured herself severely and needed surgery on her
3 back."
4 Then if we go up to 3 September 2021 on that page in
5 this risk assessment that was current when you took
6 over, and the date is wrong in terms of the incident
7 because 3 September was when the Mental Health Act
8 Assessment took place, but we see:
9 "[VC] had gone to a neighbour's flat who was staying
10 above him, knocked at his door to confront him as to why
11 he was discussing him as he heard voices to that effect
12 and he was certain that it was this person living above
13 his flat responsible. He barged into the person's flat
14 and wanted the person to admit what he was doing, and
15 other neighbours came to the rescue and called the
16 police."
17 Those are the three incidents that Ms Langdale asked
18 you about, aren't they?
19 A. Right, okay. 3 September. This is after we'd visited
20 him at home.
21 Q. That's the wrong date, isn't it? Because you know on 3
22 September that that's when there was the assault on the
23 police officer you were describing to us --
24 A. Yeah, yeah.
25 Q. -- the arrest on that date, yeah?

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1 your witness statement, please. It's paragraph 353,
2 which is WITN0358001, at page 86, please. Sorry, I've
3 given a rogue reference there, sorry. WITN0368001. So
4 WITN0368001. Thank you.
5 If we could move to page 86. Thank you. I'm just
6 going to take you through paragraph 353, please. But
7 essentially you've given frank evidence this afternoon
8 that it was blatantly obvious what was needed for VC,
9 namely a lengthy admission in hospital and treatment.
10 A. Definitely, in my opinion.
11 Q. Now, obviously completely contextualising, we know you
12 don't become the care coordinator until the end of
13 April 2022, so I know this isn't the time when you are
14 the care coordinator, but you say this:
15 "After the violence shown by VC before his third
16 admission, I don't understand why inpatient services
17 didn't keep VC in hospital for longer. With the benefit
18 of hindsight, I also think inpatient services should
19 have referred him to forensic services after the third
20 admission as there was clear proof of how dangerous he
21 was."
22 A. Yes, yes, I would agree with that.
23 Q. Now, one of the things I want to ask you about, because
24 we know you became the care coordinator, and obviously
25 Ms Langdale has asked you questions about reviewing of

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1 the records, and you sought to indicate, I think earlier
 2 on today, that you really wouldn't have had the time to
 3 read what I think you've said 263 pages of VC's records?
 4 **A.** Yeah.
 5 **Q.** That's what I really want to cover with you.
 6 Obviously, when you became the care coordinator, do
 7 you accept that you should have reviewed all of those
 8 RiO records and they were only about 266 pages at that
 9 point?
 10 **A.** 266 pages is a lot of reading. A lot of reading.
 11 266 pages of RiO notes.
 12 **Q.** I'm going to suggest it's not that much, actually, and
 13 it was within your responsibility as a care
 14 coordinator --
 15 **A.** Well, I'm sorry, I disagree with that. Because it's not
 16 as if I'd just got this gentleman on my caseload, I've
 17 got other people on my caseload. You know, I come to
 18 work on a Monday morning, and I may have two or three,
 19 four appointments during that day, as an example,
 20 typical day. No, I don't agree with that, I'm sorry.
 21 **Q.** Because what I'm going to suggest is --
 22 **A.** It would --
 23 **Q.** All of that information was there as to just how
 24 dangerous VC was, that was for you as a care
 25 coordinator, after the fourth admission, to be proactive

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1 **Q.** So can we then just deal with culture, then, because
 2 you've helpfully clarified your approach to care
 3 coordination and your approach to records. Can we look,
 4 please, at paragraph 140 of your statement, please, at
 5 page 33.
 6 Perhaps to give a context to evidence you've already
 7 given about the time when VC was discharged from EIP in
 8 September, and I think you've told us in your witness
 9 statement in any event you had a period of carers leave
 10 from 25 August to 2 September, and then you were on
 11 a period of sick leave from 6 to 25 September, so
 12 essentially almost not available for a full month; would
 13 you agree?
 14 **A.** Yes, yeah, that's right.
 15 **Q.** So what I also want to look at with 140 is just really
 16 the culture in this team during the period of time you
 17 were working there.
 18 Now, you tell us at page -- sorry, paragraph 140,
 19 that when you first joined the team, your memory of the
 20 first couple of months was of wondering where everybody
 21 was a lot of the time. The team was very reduced, you
 22 felt isolated and you had a huge number of your own
 23 patients to be concerned about.
 24 So can you just give us an impression, and certainly
 25 there's lots of references to leave within records, but

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1 in advocating for -- (*overspeaking*) --
 2 **A.** What should have happened is that my predecessor,
 3 Claudia, should have said, "Right, Gary, I will bring
 4 your attention to page 25. I think that's worth
 5 reading. That is a very important part. Page 52, that
 6 is another important part. Page whatever, that is
 7 incredibly important make sure you read it."
 8 But, you know, to just expect me to start at
 9 page zero, one example, and start reading, I'm sorry,
 10 that -- I would not have had the time to do that. You
 11 know, I have been criticised by my boss for taking work
 12 home with me, and on many occasions I've thought: well,
 13 I'm glad I have taken it home with me because at least
 14 I've recorded certain things and made sure that certain
 15 things are done. I would have had to take this home and
 16 started reading.
 17 **Q.** So you effectively say it was for Claudia Birtles to
 18 flag the relevant pages you needed to read --
 19 (*overspeaking*) --
 20 **A.** The relevant pages --
 21 **Q.** -- and that's how you say essentially you approached all
 22 the time when you were in EIP, when you were the care
 23 coordinator you wouldn't have read the records.
 24 **A.** Not from the beginning. Not when there's 266 pages.
 25 You know, that's a lot of care records.

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1 what was it like in the team?
 2 **A.** What, when I joined the team?
 3 **Q.** Yes.
 4 **A.** In September 20 -- 2020?
 5 **Q.** Yes.
 6 **A.** Right. Basically it was a -- you see I was approached
 7 by an agency who rang me up out of the blue and said,
 8 "Look, do you fancy working with EIP services in
 9 Nottingham?" And I asked them about details about it,
 10 they couldn't really give me much, but they said, "Look
 11 why don't you go and have an informal chat with the
 12 manager," Emma Robinson, at the time. I said, "Fine,
 13 yeah, okay, I'll do that."
 14 So I turned up at Stonebridge and had a chat with
 15 Emma to find out more about EIP services and what she --
 16 what it was all about, and what she felt was the future
 17 of the service. And I was very impressed by her
 18 enthusiasm, the fact that she felt that it was a great
 19 service, and it was definitely needed. And I thought
 20 yes, this sounds quite interesting. I must admit, I'm
 21 quite interested in this.
 22 However, she did point out that the team at the
 23 moment was -- had not been developed fully, insomuch
 24 that from a staffing point of view, we had a member of
 25 staff who was leaving for another team as an example.

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

10 Q. Right. Well, I think --

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

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

17 A. No, no.

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

20 A. Yes.

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

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

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

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

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

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

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

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

15 A. She was what, sorry?

16 Q. She was unnerved by VC's behaviour.

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

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

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

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

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

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

11 A. Yes, it hadn't been --

12 Q. You were the care coordinator --

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

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

15 A. Yes.

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

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

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

24 A. Yes, yes, I agree, yeah.

25 Q. And in particular they would have been highly relevant

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

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

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

12 A. [reads to self].

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

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

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

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

25 A. Well, yes, yes.

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1 Q. Then finally, for my purposes, please, you give an
2 interesting observation about the senior leadership
3 team's response. Can we move, please, to paragraph 345,
4 please, at page 85. Thank you. You describe
5 essentially what was the catalyst for your resignation.
6 You say:
7 "I went to one of these [meetings] and said
8 something along the lines of 'Do you think we missed
9 something? Do you think we could have prevented this?'"
10 You remember Diane Hull, Dr Lloyd, and Dr Thangavelu
11 all rounded up on you and said:
12 "No. There's no way we could have predicted this
13 and no way we could have prevented it'. After that
14 meeting, I felt like, if I didn't resign from [the
15 Trust], I would be forced to just toe [the] line about
16 what happened and wouldn't be able to express my own
17 feelings about the tragedy."
18 A. Yes, I agree entirely with that. I'm still of that
19 opinion.
20 Q. Can you just be clear. What are you saying about the
21 reaction from those senior members of the Trust?
22 A. I remember, yes, on top of that meeting, I remember it
23 vividly, and I did ask for the date of that meeting
24 which I never received, I might add.
25 On top of that, in conversation with Dr Lloyd and

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1 questions, Mr Carter.
2 **THE WITNESS:** Thank you.
3 **THE CHAIR:** Yes, Mr Straw.
4 **Questioned by MR STRAW**
5 **MR STRAW:** Good afternoon, Mr Carter, I represent VC's
6 family.
7 A. Okay.
8 Q. Just that last point about Dr Lloyd in the car park
9 saying everyone should be singing from the same hymn
10 sheet. Just to clarify that, then, it was Dr Lloyd --
11 what Dr Lloyd was trying to do was to ensure everyone
12 put forward an account which indicated this wasn't
13 preventable; is that right?
14 A. She didn't go into details, I'll be honest with you. It
15 was just a statement she made. She didn't say, "Right
16 we've got to be singing from the same hymn sheet by
17 doing this, this, this and this." She didn't go into
18 details.
19 Q. But essentially she wanted a cover-up.
20 A. I think that's not a word I'd use. I think --
21 I understand why you're using it but it's not a word I'd
22 use.
23 Q. Okay. I'd first like to ask you about training, please.
24 You mentioned earlier you didn't have training in
25 conducting mental state examinations. Does that mean

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1 Claudia, I think it was in the car park, Dr Lloyd turned
2 to us both and said, "Look, we've got to get together
3 and have a meeting because we've got to be singing from
4 the same hymn sheet here."
5 Now, you know, on top of what I've said there, and
6 that conversation, I felt that my position really -- if
7 I wanted to say what I really felt was the truth, in my
8 opinion, that I could not do it by working with --
9 continuing to work within the Trust.
10 Q. All right.
11 A. I just felt as though ... I think either I felt that the
12 Trust lawyers would have pressed me into giving
13 a different kind of statement.
14 Q. All right. Then, finally, can I ask this: you obviously
15 tell us within the statement that you've retired.
16 I think you still retain your PIN within the NMC; is
17 that correct?
18 A. Well, I haven't paid for it. I haven't paid for it.
19 I had a call from the NMC about a week ago, funnily
20 enough, and said, you know, like "We've still got you on
21 the register". I said, "Why? I haven't paid my annual
22 fee, so, you know, I'm not a nurse and I've got no
23 intention of practising again."
24 And I haven't, and that's it.
25 **MS CARTWRIGHT:** Thank you. Thank you for answering my

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1 that you didn't have training in spotting signs that
2 a schizophrenic patient, who masks his symptoms, was
3 unwell?
4 A. Not specific training around that issue, no, no
5 I wouldn't say so.
6 Q. We've heard some people talking about subtle signs of
7 someone like that being unwell.
8 A. Yeah.
9 Q. So long pauses, a stare, a sort of fixed stare.
10 A. Yeah.
11 Q. Being suspicious, looking around.
12 A. Yeah.
13 Q. At the time, were you aware that those sort of things
14 could be signs that someone --
15 A. Yes, yes. A new assessment tool was introduced into EIP
16 not long after I started. It was the CAARMS assessment
17 tool. I think it stands for Clinical Assessment of At
18 Risk Mental States. And this was quite a good tool. It
19 was a little bit different, and it took some getting
20 used to, but it looked at like speech as an example: is
21 the speech pressured? Is it confusing? Are there
22 examples of what we call neologisms? Is it pressured?
23 And various other aspects of speech. And also other
24 things as well, like hallucinations, passivity feelings,
25 and things like that. It took a bit of getting used to

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1 but it was a good assessment tool.

2 Q. Okay, and that was before or during the time that you
3 were dealing with VC.

4 A. Oh yeah, that was -- I think it was beginning at 2021.
5 I'd only been there a few months.

6 Q. What about paranoid schizophrenia itself? Did you
7 understand that paranoid schizophrenia can lead a person
8 to believe that there's a conspiracy against them?

9 A. Yes, yes.

10 Q. Including a conspiracy by the medical services?

11 A. Yeah, yeah.

12 Q. That it can lead them to mask their symptoms?

13 A. Well, yes, yeah, they can mask their symptoms in various
14 ways. You know, like -- yes, I understand that. Yes,
15 yes, certainly.

16 Q. I'd just like to look at one entry in the RiO notes,
17 please, just to ask you about that topic particularly.
18 It's the NHFT0000168 document, please, and could that be
19 brought up on screen. Page 162.

20 So this is a note of Claudia in your visit on
21 31 August 2021 --

22 A. Right.

23 Q. -- to VC. And halfway down the first paragraph it's
24 noted:

25 "[VC] presented with complex delusional system in
81

1 A. Mm.

2 Q. And that led him to be very guarded with you.

3 A. Yes.

4 Q. That's right, isn't it? Did you bear that in mind going
5 forward? So coming into 2022 when you're assessing him,
6 did you bear in mind that this was someone who was very
7 guarded because of his illness?

8 A. I think it was well understood by then. When you say
9 2022, at what time in 2022? You say I assessed him.

10 Q. Whenever you had contact with him in 2022.

11 A. Well, the only contact I had with him was when he came
12 for his medication. Twice. And that was literally for
13 minutes.

14 Q. Okay. So you didn't have any sort of assessment of
15 him --

16 A. Well, this is -- no, sadly I did not. This is why it
17 would have been fantastic if I could have persuaded him
18 just to sit with me for, say, 30 minutes so we could
19 have that assessment, so I could get to kind of
20 understand his mental state better than what I did.
21 Yes.

22 Q. Then you've been asked a lot of detail about your
23 thinking in 2022. I'd just like to try and understand
24 it in summary, please.

25 You indicate in your witness statement that you
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1 which he believes we are working in collaboration with
2 the judicial system and the hospital (highbury) and
3 we've created a technology to cause his voice
4 experiences/[or] monitor him."

5 The next paragraph:

6 "[He's] ...paranoid/[or] suspicious and is not
7 trusting of the services."

8 "Refusal to engage ... [he] knows we will have to
9 'feedback to the higher powers ..."

10 Then a little bit further down:

11 "[He] Appears to believe he is more at risk by
12 engaging with us ... it was clear he didnt trust our
13 intentions so remained very guarded ..."

14 Would you agree this is a man whose illness led him
15 to mask his symptoms?

16 A. Well, his symptoms were very obvious on that day. He
17 weren't trying to mask anything.

18 Q. No, sure, but his illness led him to this delusion of
19 a conspiracy against him; you'd accept that?

20 A. I'm sorry, could you just repeat that question?

21 Q. His illness led him to this delusion that there was
22 a conspiracy against him.

23 A. Yes, yes.

24 Q. And it led him to believe he was more at risk in
25 engaging with you. That's what's said here.
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1 considered medication was key or vital to avoiding
2 relapse; is that right?

3 A. Yes, I would say so.

4 Q. Okay. You accepted earlier, in response to questions,
5 that if he didn't take it he would get unwell; correct?

6 A. If he didn't take ...

7 Q. If he didn't take his medication, he would get unwell?

8 A. Yes, yes.

9 Q. When unwell, he was at high risk?

10 A. Yes.

11 Q. By the middle of 2022, it was clear he wasn't taking his
12 medication?

13 A. Mm-hm. (*The witness nodded*).

14 Q. I think you say in your witness statement it was clear
15 he'd run out by mid-July; that's right, isn't it?

16 A. Yes, I believe so, yeah.

17 Q. At this point, there's a -- you accepted there's
18 a serious risk, and I think, is it right, that you were
19 very concerned?

20 A. Yes, and this is one of the reasons why I sought to make
21 contact with him, with Paul Williams, why I wrote him
22 a letter, you know, just trying desperately to get in
23 contact with this man and engage with him.

24 Q. You say in your witness statement finding him was of
25 paramount importance; you'd agree with that?
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- 1 A. Yeah, I think finding him was very important, yeah.
- 2 Q. Did you tell anyone in your team about all of this?
- 3 A. Well, yes, yeah. Because this was discussed on
- 4 a regular basis. VC was discussed in MDT on a very
- 5 regular basis, not just during the time I was his CCO,
- 6 but for the previous best part of two years that he'd
- 7 been in contact with the service. You know, it's -- his
- 8 name was kind of coming up, flashing up on a regular
- 9 basis.
- 10 Q. But at this point in particular, so it was July, August,
- 11 2022, you think he's at serious risk, it's of paramount
- 12 importance to find him; did you say that to the MDT?
- 13 A. Well, I told them exactly what I was doing and writing
- 14 letters, going out with Paul to see him.
- 15 Q. But it's quite important, because we're going to hear
- 16 from them later, did you tell the MDT that you
- 17 considered he was of serious risk and that it was of
- 18 paramount importance that he be found?
- 19 A. I would have said to MDT I'm very worried about him,
- 20 there's a good chance he's not concordant, he's
- 21 disengaged, I cannot find him and, you know, we need to
- 22 look at other approaches, basically.
- 23 Q. On those other approaches, you candidly accepted earlier
- 24 that you should have done more to try to find him, for
- 25 example contact the police?

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- 1 that that basically meant that there was no -- there
- 2 would be no proactive management or treatment of his
- 3 mental health problems at all?
- 4 A. I cannot understand why he was discharged, for the life
- 5 of me. I just cannot get my head round it.
- 6 Q. It was disastrous, wasn't it?
- 7 A. Well, you said it. I think you've summed it up
- 8 perfectly: you know, like, I have read through these
- 9 notes over the last year or whatever, or 18 months, and,
- 10 you know, like, I can't work out what happened in that
- 11 meeting on the 22nd to allow the team to discharge this
- 12 man. And, you know, I wasn't there, as you know,
- 13 I wasn't there. Claudia wasn't there. So the two
- 14 people who probably knew him better than most just
- 15 weren't there.
- 16 And even Abi, my colleague, my ex-former colleague,
- 17 she knew a lot about, she'd had quite a few dealings
- 18 with him, and I don't think she has kind of indicated
- 19 that she could remember the conversation that took place
- 20 there. So, you know, I just cannot work out who
- 21 actually made that decision.
- 22 Ultimately, Dr Lloyd has the final say. But
- 23 obviously she will probably seek the advice of other
- 24 people, and I'd like to know who advised her.
- 25 Q. But from your perspective it's an inexplicable

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

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- 1 dereliction of duty by the team?
- 2 A. It was definitely a failure on the team, definitely.
- 3 What, just the discharge, or ...?
- 4 Q. Yeah, discharge to the GP I'm talking about now.
- 5 A. Yeah, dereliction, well okay, I wouldn't disagree with
- 6 you. I wouldn't use that word, but yes, many people
- 7 would use it, and I'm not going to disagree with that.
- 8 Q. You then talked earlier about resourcing problems that
- 9 you had on your team and in your witness statement you
- 10 talk about severe staffing issues; so not enough
- 11 resources to do your job, basically.
- 12 Did you tell management about that?
- 13 A. Yes, yeah. You know, I remember speaking to Sharon
- 14 Heath about my caseload size, and at its worst, I had 24
- 15 people. The national recommendation is 15.
- 16 Q. You made that clear to her that that was a problem --
- 17 A. Now, if I might just raise this one issue. When I came
- 18 to them for that informal chat/interview with Emma in
- 19 late August 2020, before I took up the position with
- 20 EIP, she did warn me that I'd probably have more than
- 21 the 15 recommended national level. And I thought: right
- 22 okay. I'll bear that in mind. But, you know, I imagine
- 23 it would be around maybe 20, maybe a few more than 15.
- 24 But certainly 24 was far too much, and then I started
- 25 making headway into discharging people, transferring

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

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

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1 Mr Beer, do you want to raise anything?
 2 **MR BEER:** No, Chair.
 3 **THE CHAIR:** Ms Milligan.
 4 **Questioned by MS MILLIGAN**
 5 **MS MILLIGAN:** Mr Carter, I'm going to start by asking you
 6 some questions about your knowledge of VC prior to
 7 becoming his CCO in April 2022.
 8 You were taken to the care plan that VC was given in
 9 September 2020 when you visited him with Ms Birtles.
 10 **A.** Mm.
 11 **Q.** You said, when you were asked, that you would have had
 12 a basic knowledge based on discussions in MDT and
 13 informal conversations with the team. So a basic
 14 knowledge of VC.
 15 **A.** Yeah.
 16 **Q.** Would you have looked at that care plan in detail at
 17 that point?
 18 **A.** I might have done. I can't remember looking at it.
 19 I may well have done. I can't imagine me not looking at
 20 it.
 21 **Q.** You referenced informal conversations with the team. We
 22 don't see those informal conversations noted in RiO --
 23 **A.** No, no.
 24 **Q.** They're informal, so perhaps that's not unusual.
 25 **A.** Yeah.

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

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

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

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1 You gave evidence to Ms Langdale that at the time of
 2 you visiting VC with Ms Birtles for the first time, so
 3 15 September 2020, you weren't aware of those incidents.
 4 I don't want to confuse you, but you said earlier:
 5 14, 15 days after joining the EIP, "I wasn't aware of
 6 the three incidents at Brook Court."
 7 **A.** No, no.
 8 **Q.** It was then put to you by Ms Langdale that there's the
 9 email to Dr Lloyd on 9 November 2020, and that's when
 10 you say: "I've taken this gentleman a month of tablets
 11 but he told me he had about 10 left."
 12 Do you remember that email?
 13 **A.** Yes, vaguely, yeah.
 14 **Q.** It was put to you that at that point, 9 November 2020,
 15 that you knew VC was non-concordant and that he had been
 16 violent prior to his admissions as an inpatient, and you
 17 agreed; you said "yes".
 18 **A.** Mm.
 19 **Q.** Now, I just want to clarify: when and how did you become
 20 aware of those three incidents at Brook Court?
 21 **A.** Well, put it this way: it was after the sad events of
 22 June the 13th, and I don't know who told me, I don't
 23 know where I found out, or in what way. But it came out
 24 somewhere. I was made aware of it. And even then,
 25 I wasn't made aware of the finer detail of it. You

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

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1 Gary, I think you know him from before. He's agreed to
 2 become your next CCO, with your permission, of course,
 3 and with your agreement".
 4 And if that was the case, that's fine.
 5 This meeting, no, I didn't know about this meeting.
 6 No, I didn't.
 7 **Q.** All right, if I can take you now to another document,
 8 INQY0000007, please. Page 2. This is a document
 9 created by the Inquiry setting out some text messages.
 10 I'd just like you to look at paragraph 3 with me,
 11 please:
 12 "[Ms] Birtles exchanged text messages with VC on the
 13 morning of 29 April ..."
 14 That's surrounding the visit we've just seen:
 15 "Otherwise, on 3 May ... she exchanged the following
 16 texts with VC:
 17 "... texted to say ... 'Gary Carter (the other nurse
 18 in our team) will be taking over as your care
 19 coordinator'."
 20 At "b" we see:
 21 "VC replied ... 'What does that mean?' Claudia
 22 replied ... to say ... 'Rather than me, Gary will be
 23 your CPN' as she was having to 'reduce my caseload'.
 24 Then:
 25 "VC [replies] ... as follows..."

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1 Honour.
 2 **THE CHAIR:** Yes.
 3 **MS MILLIGAN:** I'll be as quick as I can.
 4 **THE CHAIR:** Yes, thank you.
 5 **MS MILLIGAN:** I'm going to ask about your caseload very
 6 briefly. You said your caseload was high, and there's
 7 a passage in your witness statement, but to save time
 8 I'll read it to you:
 9 "Emma, in her interview for my conduct
 10 investigation, explained that I tended to work primarily
 11 with young males who had lots of challenging
 12 behaviours/risk histories or who were 'a bit higher
 13 profile' as I worked well with that particular group.
 14 She went on to explain:
 15 'I can always remember him having a caseload of
 16 quite challenging younger patients. There were various
 17 reasons for this. He had those good relationships, but
 18 there were also times when the other CPNs didn't feel
 19 comfortable working with those patients - so GC would
 20 pick those patients up."
 21 You were asked by Ms Langdale about whether you had
 22 ever suggested to anyone that could someone else pick up
 23 some of your cases to help you out, to reduce your
 24 caseload?
 25 **A.** No, because, you know, like I didn't ask anybody to do

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1 '... You should move someone else. Since you've
 2 been looking at my case since the beginning, it's not
 3 really convenient having to build a rapport all over
 4 again'.
 5 "... Claudia replied ... to say she did 'appreciate
 6 [it could be] ... frustrating but unfortunately I won't
 7 be able to do that' ... 'really sorry' ... 'Gary has met
 8 you a few times and we do work as a team so that he has
 9 [a] ... good understanding of your [case] ...' and that
 10 'everything should just remain the same'.
 11 Were you aware of those text messages?
 12 **A.** No, I wasn't. No, no.
 13 **Q.** Do you think it would have been helpful to be aware of
 14 them?
 15 **A.** Well, VC doesn't sound very keen on the idea of changing
 16 his CCO and I think I would have taken that up with
 17 Claudia and said, "Look, you know, is there a way round
 18 this? Can we perhaps meet him together face-to-face?
 19 Would that be possible so that we can explain to him the
 20 situation?"
 21 I'd have been very happy to do that. But no, he
 22 doesn't sound very keen on the idea at all. So no,
 23 I wasn't aware of that, no.
 24 **THE CHAIR:** Ms Milligan, do you have much more?
 25 **MS MILLIGAN:** I have probably about five minutes, your

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1 my job, you know. I had a caseload, I tried every
 2 opportunity to develop good working relationships with
 3 my clients. And I don't -- you see, I took on some
 4 very -- well, not so much challenging, but interesting
 5 characters, who made people feel very uncomfortable.
 6 Can I give you an example, perhaps?
 7 **THE CHAIR:** I don't think it's necessary.
 8 **A.** No?
 9 **THE CHAIR:** No.
 10 **A.** Okay, thank you.
 11 **MS MILLIGAN:** New topic, Crisis and referring to the Crisis
 12 Team. The Inquiry has heard evidence from other
 13 witnesses about their opinion on the threshold that was
 14 required to be reached before one could refer to Crisis
 15 and seek a Mental Health Act Assessment.
 16 What is your view on that? Where is the threshold?
 17 What is required before Crisis will take on a patient?
 18 **A.** I think basically when a patient is well, just not
 19 engaging any more, just not taking any of the
 20 medication, where you can't come in contact with the
 21 patient and, yeah, you know, like what -- it was
 22 mentioned earlier on that I were a bit slow off the mark
 23 referring this guy to Crisis as an example. But one
 24 thing that was interesting during this period was his
 25 parents, specifically his mother, never rang me and

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1 said, "I'm very worried about this man, Gary. I think
 2 you need to look at him. I think someone needs to look
 3 at him."
 4 That was never the case and perhaps I put perhaps a
 5 little bit too much emphasis on that. Whilst Mum was
 6 happy, maybe he was getting by, maybe he was not --
 7 whilst not fully concordant, he might have been
 8 partially concordant. But that aside, yes, I should
 9 have probably contacted the police earlier, or I should
 10 have contact Crisis.
 11 **Q.** VC's discharge. You were not at the MDT meeting on
 12 22 --
 13 **A.** No.
 14 **Q.** -- September. It was said by Ms Parsonage this morning
 15 that in fact VC's discharge had been discussed at MDTs
 16 prior to that. What is your recollection of that?
 17 **A.** I never recalled that being mentioned, to be honest with
 18 you.
 19 **Q.** Then finally, you were asked questions about the steps
 20 that you took, or ought to have taken, following your
 21 visit to VC, or your attempt to visit VC on 4
 22 August '22, and you said you didn't get a chance to
 23 visit Madison Court.
 24 You've given some candid evidence about what you
 25 could and should have done. I'm not going to explore
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1 **A.** Yes, and they were on a different pathway, then, yeah.
 2 **THE CHAIR:** Yes. Did you have any sort of handover with any
 3 of those people, the 12 who you transferred them to?
 4 **A.** Yes, oh yeah, I look, like, I took members of the LMHT
 5 to meet my clients, and that, I thought that was good
 6 practice. And introduced them. I gave them all the
 7 information I could about the client, and answered any
 8 of their questions. And yeah, and so that was the way
 9 I kind of did that. Yeah.
 10 **THE CHAIR:** Yes, thank you.
 11 Right, well, we'll finish there for today. Thank
 12 you. We'll start again on Monday -- Tuesday, in fact.
 13 So it's Bank Holiday, isn't it? Thank you.
 14 **(4.28 pm)**
 15 **(The hearing adjourned until 10.00 am on Tuesday,**
 16 **6 May 2026)**
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1 that with you, but is it right that in respect of late
 2 August and September, in fact from 25 August, you were
 3 off on carer's leave dealing with someone who was
 4 terminally ill.
 5 **A.** Yeah.
 6 **Q.** And so you were not around for that period, not around
 7 until after the discharge had taken place?
 8 **A.** Yes, yeah, that's right, yeah. He was discharged before
 9 I came back to work.
 10 **MS MILLIGAN:** Right, those are my questions. Thank you,
 11 Chair.
 12 **Questioned by THE CHAIR**
 13 **THE CHAIR:** There's just one question about one thing you
 14 told us. You've told us, I think, that you had up to 24
 15 for your caseload.
 16 **A.** That was the worst, yeah.
 17 **THE CHAIR:** Yes, and then that you transferred and
 18 discharged people, so that you reduced that to around 12
 19 or 13, so you halved that.
 20 **A.** Yes, that's right, yeah.
 21 **THE CHAIR:** How did that take place? How did you and who
 22 did you discharge -- who did you transfer them to?
 23 **A.** Back to their GPs, mainly, or to the LMHT. So those are
 24 the two main places I discharged to.
 25 **THE CHAIR:** So they were simply out of the EIP system?
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1 **I N D E X**

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5 Questioned by MR STRAW 79

6 Questioned by MS MILLIGAN 90

7 Questioned by THE CHAIR 102

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