Witness Name: Gary Carter

Statement No: WITN0368001

Dated: 22 December 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF GARY CARTER

I, Gary Carter, will say as follows: -

Introduction

1. My full name is Gary Carter.

2. Until recently I was a Community Psychiatric nurse ("**CPN**") and Care Coordinator ("**CCO**") in the City (South) Early Intervention in Psychosis ("**EIP**") team of Nottinghamshire Healthcare NHS Foundation Trust ("**NHFT**"). While there, I was based at the Stonebridge Centre. I worked there from 1 September 2020 until 30 April 2025 when I resigned my position.

3. This witness statement is made to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 Request addressed to me dated 17 October 2025 (the "**Request**"). This witness statement was drafted with the assistance of my lawyers. We communicated before the wording was finalised, and I then approved my statement and signed it.

4. This statement covers my career and role in the EIP team, my interactions with Valdo Calocane ("**VC**") and my reflections on the tragedy that occurred on 13 June 2023.

Documents

5. I refer to the following documents in this witness statement:

- NHFT Procedure, Do Not Attends (DNA's) / Was Not Brought / Cancellations & Management of Patients Who Fail to Engage with Services or Seek to Disengage from Care, in an Unplanned Way – 01.08, Issue 8 (November 2018) **[NHFT0000417]**;
- The Patient Record Summary for VC (24 May 2020 – 14 June 2023) **[NHFT0000168]**;
- A Summary & Care Plan for VC (14 February 2022) **[NHFT0000198]**;
- NHFT Procedure: 01.08a, Merged Do Not Attends (DNA's) / Cancellations & Management of Patients Who Fail to Engage with Services or Seek to Disengage from Care in an Unplanned Way Procedure (7 September 2021) **[NHFT0004725]**;
- A Risk and Safety Assessment for VC (28 February 2022) **[NHFT0000190]**;
- EIP Managerial / Clinical Supervision Record (27 July 2022) **[NHFT0004909]**;
- A letter from myself to VC (17 August 2022) **[NHFT0000122]**;
- Transcript from my interview with Theemis on 11 June 2024 (my "**Theemis Interview**") **[TCLT0000750]**;
- Transcript from my interview for the conduct investigation on 17 April 2025 (my "**17 April 2025 Interview**") **[NHFT0004882]**;
- Transcript from my interview for the conduct investigation on 23 April 2025 (my "**23 April 2025 Interview**") **[NHFT0004880]**;
- My letter of resignation from NHFT (30 April 2025) **[NHFT0004731]**;
- NHFT Investigation Report v.2 Gary Carter (18 June 2025) (the "**Investigation Report**") **[NHFT0004872]**;
- Document summarising my interactions with VC (undated). I cannot remember writing this. I can only assume it was written after 22 September 2022. **[NHFT0004916]**;

- NHFT Early Intervention in Psychosis Service Operational Policy (undated) (the "**Operational Policy**") **[NHFT0004012]**;
- Document titled '*Interview with Gary Carter (8th Jan)*' **[NHFT0004711].** I think this is a record of my interview with Psychological Approaches that took place on 8 January 2024 (my "**8 January 2024 Interview**");
- The latest version of my CV (undated) **[WITN0368002]**;
- A document showing what documents and information I requested before my conduct interviews and what I received **[WITN0368003]**.

Career and role

6. I started training to be a nurse on 13 January 1986 and qualified as a registered mental health nurse ("**RMN**") in March 1989. I completed my nurse training at Stanley Royd Hospital in Wakefield, West Yorkshire, UK. While training, I spent two months in Canada observing the mental health services in Ontario. I do not have any specialist nursing qualifications. I was a Band 6 nurse for the entire time I worked in the EIP team. Since qualifying as an RMN, my career has been long and varied. I have worked both in the private and public sectors. I have worked in many areas of psychiatry such as acute services and rehabilitation of people who had spent many years in large mental health hospitals. I have worked with the elderly, mentally ill, people with addictions, and forensic services for both men and women. I have worked as a nurse in many places in the UK. I spent one year working at the Chelsea and Westminster Hospital, London as a CPN, around the year 2000. I have exhibited a copy of my CV which provides further details of my career **[WITN0368002]**.

7. Between July 2015 until around November 2017, I took time off from nursing for purely personal reasons. I did not have any other employment during this time. After this career break, I worked in various roles between 2017 and 2020 before starting at NHFT.

8. I joined the NHFT EIP service on 1 September 2020. I can see that in my 17 April 2025 Interview, I said I started working in the EIP team on 2 September 2020 **[NHFT0004882, p.4]**. This was a mistake – I actually started on 1 September 2020.

9. Before starting at NHFT, I was taking some time off and was contacted by an agency who offered me the opportunity to work at Stonebridge for a period of 6 months or perhaps longer. Whilst I had my reservations about working in the community after so many years, I agreed to meet with the manager of EIP services, Emma Robinson, for an informal chat about the role. I was impressed by Emma's attitude and enthusiasm for EIP services, and so decided to accept the offer of a 6-month placement which could be extended as required.

10. I resigned from NHFT on 30 April 2025. I exhibit a copy of my resignation letter dated 30 April 2025 **[NHFT0004731]**.

11. Since resigning my position at NHFT, I have not held any other position in nursing or otherwise. I am now retired.

12. I have no other relevant appointments or memberships.

Early Intervention in Psychosis team and role of the Care Co-ordinator

13. A patient is usually referred to EIP services if they are suffering from a First Episode Psychosis ("**FEP**") or are in an At-Risk Mental State ("**ARMS**"). Referrals to EIP mainly come from General Practitioners ("**GPs**") asking for advice after expressing some concerns about a patient, or via other sources such as therapy services. I have exhibited the Operational Policy **[NHFT0004012].** I do not recall being particularly familiar with this document and think that very few nurses would have looked at it extensively. From looking at it now, it reflects how we operated within the EIP team.

14. The aim of the EIP service is to be proactive and quickly assess and treat a patient before their mental health deteriorates into a more chronic condition. This approach has been informed by significant evidence over many years that people with long-term psychosis fare less well than the population as a whole, in terms of negative physical health outcomes and longevity of life generally.

15. Treatments such as oral and injectable medication are at the forefront of interventions by the EIP service, but other 'talking therapies' such as Cognitive Behavioural Therapy (psychosis) ("**CBTp**") and family therapy are offered where possible. If patients are offered medication, they are usually started on a low dose, but this can be increased as required depending on how the patient progresses.

16. The EIP service monitors patients by regular meetings. In initial meetings with patients, we will negotiate what is the best way forward to help the patient (for example, whether to meet weekly, fortnightly or monthly). This would be determined by the mental state of the patient and their willingness to engage regularly. The agreed frequency of the meetings would be recorded in the patient's care plan. We would regularly consider whether the frequency of the meetings is still appropriate based on how the patient progresses.

17. Medication is usually supplied at least initially by the Trust and at a later stage by the GP. The object of the exercise was to make sure the patient had his/her medication and would not run out. The mental state of the patient and his/her historical concordance would determine who supplied the medication.

18. Medication concordance was monitored by the CCO in the first instance. Asking the patient about the medication is very important to determine if the patient is suffering any side effects. Side effects are the usual reason why patients do not take their mediation. Close consultation with the Responsible Consultant is essential in this regard (for example, considering whether it is appropriate to reduce the medication or consider an alternative medication).

19. As far as I can recall, I did not receive any formal training on non-concordance.

20. Non-engagement is the worst possible situation for an EIP patient to be in. I discuss NHFT Policy & Procedure documents relating to patients seeking to disengage from care in an unplanned way in paragraphs 86 to 87 below. I was not given any training about non-engagement. As far as I can recall, the only advice and guidance (other than in the NHFT Policy & Procedure documents on this) that was given to me about non-engagement was informal advice from other colleagues.

21. If faced with a patient who was not concordant with their medication, I would raise this in Multi-Disciplinary Team ("**MDT**") meetings (see paragraph 41 below), with my manager and with the Responsible Consultant or their ST6 (i.e. a doctor taking part in speciality training). I may also ask my other colleagues for informal advice. I do not recall there being a specific policy on concordance or receiving specific training on it.

22. Some patients are not suitable for EIP services - in particular, people who have previously received treatment for a psychotic episode or people who have been experiencing symptoms of a psychotic nature for over three years. Patients being treated by EIP services have a maximum of three years along this pathway until they would be referred to continuing care services in the form of the Local Mental Health Team ("**LMHT**") or discharged back to the GP with advice on further care and treatment. Patients with extensive forensic or offending history who are considered to be at high risk of re-offending may also not be suitable for EIP services, as they would likely be more suitable for community forensic services.

23. We made referrals when needed to the Community Resolution and Home Treatment ("**CRHT**") team (known as the "**Crisis Team**") – for example, when there were serious concerns about a patient relapsing or persistently not taking mediation – but they are a very understaffed team and would usually only be brought in in extreme situations.

24. The EIP City (South) team covers both Universities in Nottingham. GPs covering the Universities often contact the EIP service for advice and to update the EIP service on developments with students who have a mental illness.

25. Inpatient services are part of the services of the Trust. Sometimes my patients have been unwell and needed inpatient services. I have worked hand in hand with inpatient services for the benefit of the patient concerned, for example, if my client required hospital admission. This would also involve the Crisis Team, who would have to find a bed for my client. I would then work with inpatient services throughout the admission until discharge.

Caseload

26. The recommended caseload size for CCOs was 15 patients. For example, the Investigation Report refers to the Mental Health Policy Implementation Guide (Department of Health) 2001, explaining that it provides details of suggested 'service user to care co-ordinator' ratio – 15:1 **[NHFT0004872, p.105]**. I think this is based on the idea that then, if you saw three patients per day for five days a week, you would be able to see all of your patients within one week if needed.

27. After I started working for EIP, my caseload increased almost daily for the first month. At the time we had one nurse leaving for another team and one nurse on sick leave. I was surprised to say the least by how reduced the team was when I started. I remember sometimes finding the office, which was large enough to accommodate a dozen or so people, mostly empty. We were never not short staffed.

28. I recall Emma Robinson (my manager) explaining in my interview, and in discussions shortly after I started, that my caseload would likely be higher than the recommended 15. It was pointed out to me that I would be expected to accept more than 15 patients, partly as most people would have had more than 15, and partly because I would be the only male in the team (and it was

felt that some patients needed to be cared for by a man). During my time with the EIP team, I think (to the best of my knowledge) I had maybe three female clients. In particular, male patients who had been inappropriate with female colleagues were given to me. I discuss this further at paragraphs 35 and 180 to 185.

29. For my first few weeks, I was still trying to find my feet and get to grips with the IT systems like RIO (where you record patient notes), but I inherited a number of patients and was receiving new referrals almost straight away. My caseload reached the recommended 15 within a couple of weeks.

30. At one point not long after I joined, I was briefly the only available nurse in the team. In the note from my 8 January 2024 Interview, it notes: "*From joining, thrown in at the deep end. Chronic shortage of staff – ended up as the only EIP nurse at one point (for 2 or 3 weeks). When I took over VC, I had a caseload of over 20*" **[NHFT0004711, p.1]**.

31. My caseload rarely dropped below 15, and often exceeded it. I was always extremely busy. At its worst my caseload was 24. I can't remember exactly when this was. I remember speaking with my manager at the time, Sharon Heath, who advised me to refer people on if at all possible. By the time I was suspended in September 2024, it was around 13.

32. I explained in my 17 April 2025 Interview:

> *We were only supposed to have 15 patients. If you look through the EIP recommendations supplied by the Department of Health (or whoever), it states quite clearly that a CPA should not have more than 15 clients in the community. The object of that is that in theory, they can see 3 clients/day. But, very, very quickly after joining the service I found that this was just untenable. It couldn't be done.*
>
> *I inherited a lot of people, then we had new referrals and as a result my caseload started going up and up.*

It was full on, especially in the early days.

I had to put some time in (outside of my normal working hours) just to make sure that my notes were clear. **[NHFT0004882, p.4]**

33. In my Theemis Interview, I explained:

[W]hen I joined EIP in September 2020, there was a staffing crisis. One nurse was moving to another unit. I think there was a vacancy, maybe even a couple of vacancies. I found myself in a situation where it was just thrown in at the deep end. You know, on day one, I was given a number of names, and RiO numbers, and said, "Can you make contact with these people?" **[TCLT0000750, p.13-14]**

34. The Investigation Report says that my average daily caseload during the period 12 June 2020 to 23 September 2022 was 18.7 patients but during the period I had VC as a patient, my active caseload was higher, peaking at 20.9 patients with an average daily caseload between May – September 2022 of 19.7 patients **[NHFT0004872, p.114]**. The report noted "*Whilst this data does not provide detail around the complexity of individual patients / cases, it does appear to reflect the fact that GC held a sustained heavy caseload, particularly whilst acting as Patient V's CCO*" **[NHFT0004872, p.115]**. I think this sounds broadly correct, except that I did not start working at the Trust until September 2020.

35. I can see that Sharon said in her interview for my conduct investigation that this was "*on a par*" with other colleagues within the Team but also said "*At that time GC was the only male CCO in the team and with some of our patients it was not appropriate to give them to female members of staff, so he may have been given extra patients*" **[NHFT0004872, p.17]**. I don't think that my caseload was generally on a par with most of my colleagues, but it will have depended on the time period. My recollection is that the only colleague that regularly had a larger case load than me was Abi Parsonage.

36. In my 17 April 2025 Interview, I explained that when VC was transferred to me:

> *I had well over 20 at that time. I have always had the biggest caseload in that office. […]*
>
> *It was bigger, much bigger than everybody else's. I knew that it was becoming unworkable and the client group in Nottingham were much more active. They were much more mobile. Some of them were acutely ill at times — hospital admissions etc* **[NHFT0004882, p.13]**.

37. I remember we had a whiteboard in the office which had everyone's caseload on it and it was clear I often had one of the largest. I remember feeling concerned at various times about my caseload but I knew I had to battle on and do what I could. My managers were fully aware of this and tried to assist me. I expressed my concerns to both my managers (Emma and Sharon) more than once that my caseload was very high.

38. Emma explained in her interview for my conduct investigation that my caseload had risen to well beyond 15. She said that I had not complained about my caseload, though I had sometimes raised the fact that I had high numbers of patients **[NHFT0004872, p.39]**.

39. I remember once coming back from a day off to an email from Emma asking me to pick up two new patients. I didn't understand why they had been allocated to me but felt I had to accept. Another time I had a phone call from a senior manager (Emma's manager) who asked me to take on a new patient from another of EIP South's five teams, as the patient's previous CCO was off sick. I ended up having that client for two years until I had to put some pressure on both Sharon and the service for him to be reallocated.

40. I did manage to get my caseload down at some points but it was difficult. Even when I was managing to discharge clients, I would still be getting new referrals so it felt like I was treading water.

EIP meetings

41. MDT meetings were held every Thursday morning and were attended by as many people as possible involved with patients being cared for by the City (South) team. This would include CPNs, CBTp therapists, Occupational Therapists, employment specialists, the Consultant Psychiatrist and other doctors. The object of the exercise was to give CPNs the chance to bring up patients of concern or indeed patients who were doing well. These meetings would discuss multiple patients. Usually there would be around five to six CPNs attending who may want to discuss particular patients so we would end up discussing around 12 to 20 patients. Typically, the CPN would be the person to initiate a discussion about a particular patient.

42. The note of my 8 January 2024 Interview explained that:

> *The psychiatrist always attends the MDT with junior doctors […] Everyone has a chance to raise things in MDT, no need to form lists in advance.* **[NHFT0004711, p.1]**.

43. MDTs were the only regular whole team meeting. I don't remember "weekly review" meetings being a separate type of meeting.

44. In my experience, risk assessment meetings occurred very rarely. The goal was that, if someone (such as a CCO) was facing challenges when writing a risk assessment, they would call a meeting with colleagues to discuss it. I never attended one (either for my own patients or someone else's patients). I would do the risk assessments by myself (as the other nurses did). I would often ask my colleagues for their opinions and chat through particular issues with them relevant to the risk assessment, but this was either in an MDT meeting or on an informal basis.

45. I was supervised by Emma from September 2020 until January 2022. From January 2022 until I was suspended, I was supervised by Sharon. After I was suspended, I did not have a formal supervisor. I had contact with Jonathan Guy (who was Sharon's manager). He acted as a sort of go-between with the Trust, but was not my supervisor.

46. Supervision meetings were held monthly between the CPN and his/her manager. These would occur monthly (unless, for example, one of us was on annual leave or ill). At this time, there was one supervision meeting for both managerial and clinical supervision. Areas of discussion would include how the nurse was coping (or not) with their caseload, any problems at a personal level and discussion of any patients who were causing concern. I would usually decide which patients I wished to discuss in supervision meetings (although my supervisors would already have a relatively good understanding of any issues I was having with particular patients as I would raise these at MDT meetings). I found these meetings helpful.

The role of CCOs

47. A CCO is the person who is responsible for organising and monitoring the care of an individual patient. Normally, patients see their CCO more often than they see other NHS staff. CCOs can be nurses, social workers, CPNs or occupational therapists. While I was working in the City (South) team, all of the CCOs were RMNs.

48. As a CCO I would maintain contact with my clients by regular visits to their home, phone calls and texts. In a typical day, I might see three patients, sometimes more. I always made sure the next of kin (if there was one) had my phone number and could contact me with any concerns. I always attempted to care for and maintain my clients in the community.

49. The frequency of contact with patients would be decided based on the patient's mental state and their willingness to engage with us regularly. Ideally,

whenever we saw patients, we would do some sort of therapeutic intervention (even if, for example, it was a patient coming to collect their medication). This would mean the meetings would last longer (up to around an hour, depending on the issues to be discussed). However, whether or not this was feasible depended on the willingness of the patients to engage with us on that visit. This was a recurring problem with VC (I discuss this in paragraphs 220 to 224 below).

50. As far as I recall, we weren't given specific training or guidance on the ideal frequency and length of contact with patients. It depended on the patient, and was more based on informal norms rather than strict rules.

Managing and monitoring medication concordance

51. Managing medication concordance was always a challenge for some patients. Those who had close family support were usually less problematic with this issue. However, patients who lived alone and were more mentally unwell were more of a concern. To monitor concordance, acute observation is necessary. This can be problematic if seeing the patient is difficult (though difficulty seeing a patient might itself indicate non-concordance). The ultimate key to monitoring concordance is regular interaction with the patient in whatever way.

52. Assuming I was able to see the patient, I would ask them about their medication (which I would do in every meeting) and consider any signs in their behaviour which may indicate non-concordance. It would sometimes be clear that there were concordance issues because a patient had medication left over when they shouldn't have, or if they hadn't picked up or received their medication when they should have. I had several patients in that position over my career, and it was also a concern. The worse their mental state, the higher the level of concern. I would always bring it to the Responsible Consultant's attention.

Care Plans

53. Devising care plans was done by individual CCOs. I might ask for advice from my colleagues, but the care plan would be mine and I would review and change it as required. Where I was taking over a client from someone else, I would adopt the existing care plan if it was still appropriate, and would use it as the base for any future care plans.

54. The Operational Policy says that details like the following should be included in care plans:

- interventions agreed for the patient and the anticipated outcomes of the interventions;
- agreed goals and the actions needed to achieve those goals;
- details about whether any other agencies were involved;
- any appropriate crisis and contingency plans. **[NHFT0004012, p.10]**.

55. I agree that these things should be included in care plans.

56. Reviews of care plans should happen as and when required based on the particular patient (but at the very least should happen every 12 months). If a care plan continues to be valid, it should remain in place.

57. It is best if patients agree with their care plans. This means there would usually be some negotiation where you are asking "*are you happy with this?*" and "*shall we give this a go?*". If a patient doesn't agree with the plan, it is likely that they won't want to comply with it, and working with that patient will then become very problematic. Negotiating care plans with patients in community settings is especially important, because there is less scope to monitor compliance.

58. In terms of reviewing care plans, the expectation is that they will be reviewed every 12 months as a minimum – though they will not always need to be changed as a result of the review – and should be reviewed and updated more frequently if needed. For example, I can see that the Operational Policy provides that reviews should be "*every 12 months as a minimum standard*

unless the service user requires reviews on a more frequent basis depending on complexity, needs assessment and risk" **[NHFT0004012, p.16]**.

59. When developing care plans you would consider all the information available to you such as the patient's mental state, whether they have support, what their living situation is, whether they have a job, whether they can attend to basic hygiene, their presentation and any evidence of disordered thinking (such as using "neologisms", i.e. new words). You would consider everything, from the patient's basic needs to their higher functioning needs. You would consider everything your senses can take in when you see that patient (including smell, appearance and speech). Part of it is a question of intuition. I remember Dr Burri would always ask me, when I raised concerns about patients, "*how do you feel about the situation?*"

60. Developing a care plan for a patient in a community setting is different than for an inpatient setting in some ways, even though their fundamental needs might be the same. This is because in the community it is more difficult to monitor and observe patients and it may be more difficult to enforce the care plan in the community (for example, if the patient refuses their medication) because it is not a controlled environment.

61. Care planning for an EIP patient would be different to care planning for a patient with an established diagnosis of schizophrenia. This is because the main aim of care plans for an EIP patient is to intervene early on (e.g. after their first presentation of psychosis) to prevent relapses and hopefully prevent them from getting to the point where they do have an established diagnosis of schizophrenia. If you have an established diagnosis of schizophrenia, there are treatments but there is no cure.

62. In terms of care planning for a patient who is not engaging, I would discuss this with the Responsible Consultant. When a patient isn't engaging, we start involving anybody and everybody in discussions about how to engage them. For example, I would be asking my colleagues, in MDT meetings and

informally, about any ideas they have to engage the patient. We would also consider discussing this with the patient's family.

63. In terms of care planning for a patient who is not concordant with their medication, we would be considering why the patient is non-concordant. Does the patient have any insight? Do they believe that they are not unwell? Is it because of side effects of the medication? If it is the latter, we would maybe consider whether it is possible to tinker with the medication or dosage to alleviate side effects. It can be very difficult to know if a patient is concordant. If a patient's pretending to take medication but throws it away, it is hard to be sure of that unless they admit it.

64. In an extreme situation you would contact the Crisis Team but, in my experience, that team doesn't work well in practice, as they are very understaffed. We would also consider whether to make contact with the police (though this would depend on how long the patient hasn't been engaging).

Decision-making

65. Sometimes whether or not to discharge a patient would be raised by me or another CPN. At other times, it would be raised by the Consultant. Whenever possible, I sought to attend all MDTs and contributed to any discussions regarding discharge with the team. I always felt my views were considered even if I disagreed on the final outcome.

66. Dr Lloyd would listen to everyone's views when considering discharging a patient, especially the CCOs. However, ultimately the decision to discharge is not made by a CCO – it is made by the Responsible Consultant.

67. As explained, in my 23 April 2025 Interview:

> *I have never discharged anybody in my career. It's not my job. Responsible Consultants discharge people. I can put my view forward, but ultimately it's other people who discharge.* **[NHFT0004880, p.5]**

68. Similarly, in my Theemis Interview, I explained:

> *[I]t's not on my shoulders. I've never discharged anybody in my life. I'm a nurse. But [Dr Lloyd] is really good in that respect. She will ask everybody's opinion. "Come on. What's everybody's opinion?" […] And as a group of people, then we make that decision* **[TCLT0000750, p.32]**

69. In terms of medication, the CCO certainly had an opportunity to discuss any medication that was prescribed. I would make suggestions as to what medication might be of use, and this was considered.

70. Again, ultimately decisions about prescribing medication would be taken by the Responsible Consultant.

71. My views and attitudes were those of a nurse and CCO. I was certainly listened to and my views were noted. How much weight my views counted for was debateable.

Record-keeping

72. In my 17 April 2025 Interview, I explained that I wasn't given training in relation to the completion of clinical records or specifically the completion of RIO records. I explained:

> *I was new to the service and the RIO system was quite daunting, but I only received 45 minutes training on the system. That was it. It basically meant that I learned how to log in. I then basically had to work it out myself.* **[NHFT0004882, p.5]**

73. I remember this training covered things like how to open RIO. It didn't cover what I should include in RIO notes.

74. When asked in my 17 April 2025 Interview how I knew what to record in the clinical notes, I explained:

> *That was very open ended for everybody. It was left to individuals to record in whatever way was clear for them. In whatever way they thought was appropriate. There were no rigid guidelines i.e. you must record this, this and this... At that time, this didn't exist.* **[NHFT0004882, p.5]**

75. I understand that, in her interview for my conduct investigation, Claudia Birtles (another CCO in the City (South) EIP Team) said that we did record keeping training every three years but she had not received specific training around what to include within RIO entries **[NHFT0004872, p.55]**. Abi Parsonage (another CCO in the City (South) EIP Team) said she had not received training or guidance regarding the completion of clinical notes / records before this had all happened **[NHFT0004872, p.66]**.

76. With regards to recording what was said at MDT meetings, if anything of significance or importance was discussed about a patient, or any actions agreed, it was usually their CCO who recorded this. At this time, we had no administrative support.

77. I understand that Sharon explained in her interview for my conduct investigation that:

> *We are very aware there was no MDT documentation […] We knew rich discussions did take place in MDT's, but this was just not documented, and we needed to capture this. As a Management Team we were clear that this needed to be implemented, even before we had the external review that the Trust commissioned.* **[NHFT0004872, p.23]**.

78. The note of this interview also says Sharon said that:

> *[A]ny discussions regarding a specific patient, held during an MDT meeting, should be recorded directly into that patients clinical records.*

This was the responsibility of that patients CCO (or anyone representing that CCO during the MDT meeting) […] this had not always happened in the case of Patient V, despite Patient V being discussed on a regular basis within MDT meetings **[NHFT0004872, p.23]**.

79. I understand that the Investigating Officers also noted that (based on a random sample of the City (South) EIP Team's notes):

> *There was no consistency around the way in which discussions within MDT meetings were captured and documented within clinical records (RIO notes) e.g. entries often failed to record who was present at the meeting, who was directly involved in key conversations and often failed to capture clear discussion points, a formulation or agreed actions.* **[NHFT0004872, p.144]**

80. In my 17 April 2025 Interview, I explained that to "*the best of my knowledge*" I always recorded actions agreed at MDT meetings in relation to my patients. I also explained:

> *[I]f we discussed Patient V during that period, if there was an extensive discussion of whatever nature, it was up to the CCO, to put in the main themes. Sometimes the Clinical Lead might perhaps make an entry as well. Sometimes [Emma Robinson] — but the main person would have been the CCO, who would be responsible for recording some kind of note or bullet points about the issues discussed, and the plan of action afterwards.* **[NHFT0004882, p.11]**

81. After the tragedy that occurred on 13 June 2023, the procedures for recording MDT meetings changed. Suddenly, we acquired administrative support from a person who had worked at Stonebridge for some years. After this time, she would remind CCOs like me to place entries in the progress notes of clients who had been discussed at MDT.

82. In the note of my 8 January 2024 Interview, it says:

Now — what's changed. Admin come in to MDT and all the discussions are logged, and the plan all recorded. Started about 3 months ago. All on Rio. The Service Manager, Jonathon Guy, is developing a DNA flow chart for future use. **[NHFT0004711, p.2]**

Liaising with colleagues

83. Liaising with my colleagues was usually quite straightforward when issues arose. If the Consultant wasn't available then her ST6 was usually available but not always.

84. In the note of my 8 January 2024 Interview, I explained:

> *The psychiatrist always attends the MDT with junior doctors, and if I'm concerned about an individual, I will seek out the doctors. There was a period when Dr L was by herself (9 months), and it was slightly more problematic when I had a concern (she works part time).* **[NHFT0004711, p.1]**

85. As I explained in that interview, there was a time when Dr Lloyd found herself working as the only EIP doctor due to having no ST6 doctor to assist. This occurred over a period of around 6-8 months. I can't remember when this was. Dr Lloyd only worked three days a week and obviously needed to take leave at times. Therefore, during this time there were occasions where there were no doctors available except on-call services. I would often have to go to the LMHT doctors to ask them to advise me on something and I remember on multiple occasions having to ask the admin staff if there were any doctors anywhere in the building. It was a frustrating period.

Do Not Attends

86. I have exhibited the following two NHFT documents:

a) Procedure: 01.08a – Merged Do Not Attends (DNA's) / Cancellations & Management of Patients Who Fail to Engage with Services or Seek to Disengage from Care in an Unplanned Way Procedure, Version 1 – September 2021 (the "**DNA Policy**") **[NHFT0004725]**; and
b) Procedure 01.08 – Do Not Attends (DNA's) Was Not Brought / Cancellations & Management of Patients Who Fail to Engage with Services or Seek to Disengage From Care, in an Unplanned Way, Issue 8 – November 2018 **[NHFT0000417]**.

87. I am only familiar with the first document. I don't remember regularly looking at this document and I doubt any of the nurses did. I remember being sent this document when I was suspended but cannot remember if I had previously been made aware of it. When I had a patient that wasn't engaging, I would ask for advice and guidance from my colleagues and none of them would ever suggest looking at the DNA Policy. A lot of what it recommends would, however, be done on a regular basis.

88. When a patient missed an appointment, I would immediately try to contact them and find out if there was a problem. If necessary, I would go out and visit the patient to see if I could meet and discuss any issues. If I had no success at this, then contacting the next of kin might be an option if there was one. Not all of my patients had next of kin who were in contact with the patient and known to me. If I had difficulties with a patient missing appointments, I would likely raise this in MDT meetings and with the Consultant or ST6s. We may also consider referring the patient to the Crisis Team, potentially the police or consider discharging the patient back to their GP if they continued to disengage.

*Community Treatment Orders ("**CTOs**") and depot medication*

89. CTOs are orders to give a patient supervised treatment in the community with the proviso that, if they refuse the treatment, they can be recalled to hospital. In theory, CTOs sound like a good idea, but to work they require knowledge of where exactly the patient is residing at any given time. If the patient is

mobile, avoiding services, refusing to engage and / or being actively assisted by others to avoid us, then the value of a CTO diminishes. If the patient cannot be found then the CTO is worthless.

90. A depot medication is a slow-release form of antipsychotic medication. It would have to be administered as an injection by a CPN (usually in monthly or fortnightly doses depending on the severity of the patient's condition and the medication that is being administered). When a depot medication was prescribed by the Responsible Consultant, its nature and requirements were fully explained to the patient, especially the benefits to the patient in limiting the need for oral medication. It was then up to the CCO and patient to agree a time and date when the depot would be given.

91. Like CTOs, depot medication sounds like a good idea, and it can work really well if there is a degree of cooperation from the patient and they understand that they are ill. However, it can be difficult in a community setting if the patient doesn't co-operate and has no insight about the fact that they are ill. If you can't find a patient in order to give them the depot medication, or if you find them but they refuse to take it, there is not much you can do. If there was a CTO in place and a patient refused depot medication, you may be able to recall them to hospital but again this would depend on being able to find the patient.

92. We discussed things like depot medication and CTOs as a team, and Dr Lloyd would listen to everyone's views, but ultimately she would make the final decision on these things.

Assessment of risk

93. The assessment of risk is difficult in the community because contact with patients can be sporadic or indeed difficult. My primary role in assessing someone's risk was to meet, observe and listen. I would discuss the patient and particular risks identified with the doctors, my manager, with the clinical

lead and with other colleagues (for example, in MDT meetings) but ultimately it was up to me to put the risk assessment in place.

94. I remember we would sometimes use tools such as the Beck Depression Scale when assessing risk if we were concerned about a patient's mood. We would also use the "**CAARMS Assessment**" (Comprehensive assessment of at-risk mental states) to assess people who had just been referred to the EIP Service. I can't remember any other particular tools available to me from NHFT on assessing risk but there may have been others, as it has been nearly two years since I attended training on this.

95. There are many important factors when assessing risk including historical behaviour of the patient, statements of intent, risk behaviour (such as previous aggression or violence) and planning (for example, has the patient taken steps to put an intention into action?).

96. Risk assessment should be started before a patient is discharged from hospital, and continued in the community, as risk often changes in the community setting. If the patient was already in the community, I would invite the patient for a face-to-face meeting about any issues that concerned me or them, and I would then formulate a risk assessment.

97. In a hospital setting the behaviour of a client on the ward would be considered important as it might reflect behaviour in the community. If a client was aggressive on the ward this might also occur in the community. Liaising closely with ward staff might generate some insights into what issues might be challenging in the community setting. What were the circumstances that triggered any challenging behaviour? Would similar circumstances generate a similar response? How could the context be managed?

98. Monitoring risk assessments was ongoing. The risk assessment would be reviewed and updated as and when required. If it was still valid it would continue, if it needed to be amended (for example, if something happened that I didn't expect or something made me question my perception of the

patient's situation) then that would happen. For example, if a patient went from being very co-operative and progressing well to suddenly missing lots of appointments, I would consider updating the risk assessment. If they missed one appointment, the alarm bells might start going but the patient may just be having a bad day or be genuinely busy. If they started missing appointments regularly, the alarm bells would get louder.

99. NHFT gives training on a whole range of subjects including risk assessment. I can't recall exactly when I last received the training or who provided it.

100. The typical risks encountered by the EIP team included non-concordance with medication and patients failing to engage with services. Sadly, some of our patients died by suicide, and we were given regular training on suicide prevention. This was important and made us better at spotting and handling suicide risk. However, as far as I can recall, I never had any training on when someone is dangerous to other people or on forensic investigations etc.

101. I am not familiar with the Royal College of Psychiatrists' publication concerning the assessment and management of risk to others.

Capacity

102. As CCO you would also need to consider a patient's capacity, and whether they were capable (for example) of weighing up the options available to them in terms of treatment, and making a decision in their own best interests. The starting point is that everyone has capacity until proven otherwise. However, when we thought a patient wasn't fully able to understand things or make decisions in their best interests, this would raise a question about whether they had capacity. Some patients were able to mask their symptoms in a way that made it harder to assess this. Ultimately, if we thought a patient had lost capacity to make decisions about their treatment, we would have to consider whether they needed a formal Mental Health Act Assessment (a "**MHAA**"), and potentially to be admitted to hospital.

103. I think that the Trust provides training on capacity but I cannot remember when I last received it, who it was by, or the exact nature of the training.

Raising concerns

104. If I had any concerns about a patient (including about the risk of harm posed to members of the public), I would immediately discuss these with my manager and the Responsible Consultant or ST6.

105. If the patient was not engaging, I would speak with my managers and my colleagues to ascertain their thoughts on how this should be handled. This is also the case with non-concordance or if I had concerns that the patient was unsuitable for EIP.

106. If I had concerns the patient was relapsing, I would consider referring them to the Crisis Team. The difficulty with this is the Crisis Team, in my experience, was always at full capacity. In other scenarios, I would potentially speak to the social workers and explain that, in our opinion, we think it would be appropriate for a patient to have a MHAA.

107. In some cases, GPs would refer patients to us and, after undergoing the CAARMS Assessment, we would find that there was no strong evidence of the patient having had a first episode of psychosis. Sometimes in those scenarios, we would take the patient on for a few months as, even though they were not exhibiting full blown symptoms of psychosis, we wanted to keep an eye on them. If no further symptoms developed, we would determine that they were not suitable for EIP treatment and discharge them back to their GPs.

108. A full referral to forensic services could be considered if the patient exhibited aggressive or violent behaviour towards members of the public or his/her family members. This of course extends to staff of the Trust who were assaulted. In such circumstances contacting the police to attend would also be reasonable. If such behaviour resulted in police action and prosecution,

then this would warrant a full assessment and possible hand over to forensic services on a permanent basis.

109. In my experience, we would very rarely refer a patient to forensic services or request a forensic assessment of a patient. In my four years at the EIP team, I don't know of anyone referring a patient to forensic services. I would sometimes ring forensic services for advice if I had a particular concern about a patient but this was the only time I dealt with them.

Information sharing

110. Sharing information could be done by various means depending on the urgency of the situation, for example, phone calls, text messages, and email (if available and convenient).

111. I shared information with various organisations (for example, with GPs and the Student University welfare team), usually via phone and email, and this is how they shared information with me. Typically, I would try to discuss issues via the phone where possible and this usually led to email communication afterwards.

112. There were some issues with sharing information between different agencies. For example, I understand that after VC's third admission (see paragraphs 170 to 171 below) he was looked after by two independent hospitals for around two months. I wasn't his CCO at the time but understand there were some significant issues with communication between the hospitals and the EIP team including the hospital failing to tell the EIP team that VC had been discharged (see **[NHFT0000168, p. 194]**).

113. As well as that, there was a bench warrant issued for VC's arrest on 22 September 2022, the day before he was discharged from the EIP Service (see paragraphs 310 to 311 below). The EIP team were not aware of this and I think, if we had been, a different decision may have been made on whether to discharge VC.

114. Sharing information with the patient's family could involve phone calls, text messages or emails (again depending on the urgency of the situation). On a few occasions interviews were held in neutral surroundings for family members to discuss concerns or raise issues. I always supplied family members with my work phone number should they wish to talk to me quickly.

115. The patient's permission to contact family members was always sought - if objections were raised then that would be respected. If a patient withdrew their consent then I would ask for their reasoning and seek to determine if the patient's mental state was deteriorating or if they had capacity issues. For some, just having contact with mental health services was stigmatising so they would not want information shared on this basis.

116. If a patient expressly wished that relatives should not be contacted, then I would inform the Responsible Consultant and my manager and discuss this with them. We would generally respect those wishes, but in some scenarios, it would still be necessary to share information with a patient's family and to seek information from the family, despite objections from the patient. I believe family should generally be aware of the patient's condition, even if only at a high level.

Related experience

117. As far as I'm aware, I have never been involved in the care of any other mental health patient who killed or seriously injured a member of the public.

Chronology of events

118. I first met VC Calocane on 15 September 2020 when I accompanied Claudia Birtles (VC's CCO at the time) to visit VC at his new address in Sneinton. This was around two weeks after I had started working at the EIP service. I can't remember a specific reason why I accompanied Claudia on this visit. CCOs accompanying other CCOs on home visits was relatively standard practice.

119. Claudia's note from this visit said VC "*appeared well*" and was "*continuing with his medication"* and "*understands the importance of concordance given recent relapse. No identified risks to self / others."* **[NHFT0000168, 134]**.

120. Up until meeting VC on 15 September 2020, I knew virtually nothing of VC. I knew he had just been discharged from hospital and Claudia was his first CCO. I assume I would have asked Claudia to give me some background information and that she would have explained his previous admissions. As far as I recall, I did not have the chance to look through his progress notes to find out more about him before this meeting. I had only started working in the EIP team a couple of weeks before. I don't recall whether he had been discussed in the few MDT meetings I had attended by this point.

121. VC seemed pleasant and sociable in that first meeting, though he was clearly a man of few words. He seemed to be doing well and didn't seem ill at all (as discussed in my 17 April 2025 Interview **[NHFT0004882, p.9]**, my 23 April 2025 Interview **[NHFT0004880, p.15]**, and my Theemis Interview **[TCLT0000750, p.6-7]**).

122. Following this visit, Claudia was off work sick for a period. I understand from VC's Patient Record Summary that VC's mum, Celeste Calocane, raised concerns regarding VC on 9 October 2020 as she had not been able to contact him **[NHFT0000168, p.135]**. The Summary shows that Abi and someone else went to VC's home address on the same day to check on him. VC was not at home but his housemate stated he was okay. After speaking to her supervisor, Abi decided a further cold call wasn't necessary. I can see that on 15 October 2020, Celeste spoke to someone called Kehinde Hassan to ask if anyone had made contact with VC. Kehinde tried to call VC but did not get an answer, so emailed Emma (Service Manager at the time) to follow up that week, as Claudia and Abi were on leave **[NHFT0000168, p.135]**.

123. On 19 October 2020, I spoke to Mr Calocane, VC's dad, and made the following note:

Spoke with Mr Calocane who took my name and number for future reference. He says he has spoken with Valdo who says he [is] fine. I will try to call in on Valdo tomorrow morning to chat with him. **[NHFT0000168, p.135]**.

124. I cannot remember any other details about this call. I assume the purpose of the call was to find out how VC was and if Mr Calocane had had any contact with him. I can't remember if Claudia was still off work at this point. It was relatively common for us all to help out with each other's patients if needed.

125. I don't remember speaking with Claudia regarding the call. This was the only time I ever had contact with VC's father.

126. I did not visit VC on 20 October 2020 in the end. I don't remember why. At the time, I was new to the EIP service and had a lot on my plate. I assume I didn't visit VC as I was busy with other patients, and his father appeared to not be concerned, so I didn't think I had an emergency on my hands.

127. In my 23 April 2025 Interview, I said the following about this:

I probably didn't call in on him. I know that I keep harkening back to this caseload size. It had been a concern for, I would say, about 6 months after me joining the Trust, about the size of my caseload. [Emma] had raised it on several occasions. [Sharon] certainly raised it, when she became manager. My intentions might have been to call in on him the following day but I just did not get around to it because of other things [...] All you need is one client giving you a lot of problems (or even a few problems) and then everybody else has to get in the queue. They all want a piece of you. They all want to talk to you. They all want to discuss issues with you, but you just have to say, 'I'll get back to you asap'. It's not desirable — it's a fact of life. I've only got one pair of hands. **[NHFT0004880, p.9]**.

128. I believe most of my knowledge of VC at this point would have come from that first meeting with him. I can't recall if I had discussed him with any colleagues (for example, in MDT meetings). I can't remember any specific discussions with Claudia about VC since that first visit.

129. Abi made the following note on the morning of 23 October 2020:

> ***LMHT CITY SOUTH EIP***
> *Can you please call Mum of VC […] on her home phone […]*
>
> ***T/C to Celeste***
> *No answer. I will try again shortly.* **[NHFT0000168, p.135]**.

130. At 3:40am on 24 October 2020, I included the following note:

> *I spoke with Celeste this afternoon who is worried about Valdo as he is not talking to her and her hu[s]band. I have given her my name and number and will attempt to visit Valdo on Monday morning. I will then report back to her. She seemed fine with this arrangement.* **[NHFT0000168, p.135]**.

131. In my 23 April 2025 Interview, I explained that this was a retrospective entry (I included it in the early hours of Saturday morning as I would often go through notes at weekends to avoid falling behind **[NHFT0004880, p.10]**). I assume I made the call to Celeste on Friday 23 October 2020 following Abi's entry of that morning.

132. Sometimes if EIP patients stopped communicating with their families, this was concerning. I don't think I was overly concerned at this point. VC was a student at university, and university students often want to do their own thing.

133. I don't recall if I spoke to anyone in the EIP team about this call. I may have mentioned it to Claudia or others.

134. On the morning of Monday 26 October 2020, I visited VC and made the following note:

> *Visited Valdo this am. I explained that his mum and dad were worried about him and I asked him to consider giving them a ring. Valdo said he would? He then went back into his room without another word.* **[NHFT0000168, p.135]**.

135. From what I recall of that meeting, it was brief. I told him his parents were concerned and that he should consider giving them a call. I don't recall specifically what my view of his condition was at this point, but I don't remember coming away with any significant concerns. It's important to bear in mind that at this point I didn't know VC well. I had only met him once before. I don't remember if I discussed that visit with anyone else.

136. In my 23 April 2025 Interview, I explained:

> *On that particular day (26th October 2020) he was upstairs because I remember that one of his housemates answered the door. I asked if I could speak to Patient V and was told that he was upstairs in his room. The housemate shouted up the stairs and Patient V appeared at the top of the stairs and looked down. I explained that I had been in contact with his mum and dad and that they were a bit concerned about him. I asked him if there was any chance of him giving them a ring perhaps (or words to that effect). He said, 'Yeah, Ill do that', then left.*
>
> *In a nutshell I didn't get any chance (to engage in conversation). This was the same sort of contact that I had with him as his CCO. I only actually spoke to hi[m] face to face, twice.* **[NHFT0004880, p.11]**.

137. In this interview, I was asked whether it was an option for me to try to engage in some sort of therapeutic intervention with VC. I explained "*not at that time I don't think because he just went straight back in his room*" **[NHFT0004880,**

p.11]. I discuss the difficulties I had engaging VC for a therapeutic intervention when I was his CCO at paragraphs 220 to 224 below.

138. On 5 November 2020, the following note was made by Dr Faizal Seedat:

> ***T/C with Valdo***
>
> *I was surprised that Valdo rang my PA asking me to call him back which I did. He was somebody I managed when he was an in-patient. I was unclear what he wanted or why he had called me.*
>
> *I told him that I was not able to discuss his care as I was not currently involved in his care and it was not right for me to be involved. I said to him that he needed to contact his community team. He understood this and I then asked who his team was and if he had contacted them. He seemed a bit cagey about this and unsure.*
>
> *He said I should look into his records and let him know who his team was and his nurse, which I did. I told him I was going to contact the LMHT to let them know about this contact.*
>
> *I told him that I will urge the LMHT to visit him face to face, assess his mental state and make sure he is okay. I feel based on the interaction that he needs more close monitoring and regular visits otherwise will end up in hospital.*
>
> *I also reminded him that he should call the LMHT for any help or support he requires and he assured me that he had the numbers.*
>
> *Dr Seedat - in-patient consultant.* **[NHFT0000168, p.136]**.

139. Dr Seedat rightly explained to VC that he was no longer under his care and that he would have to talk to Dr Lloyd or her ST6. After this, Dr Seedat recommended closer observation and more regular visits. I can't remember if

Dr Seedat emailed or called the EIP team regarding this, but I must have been aware of it given I then visited VC the next day to address Dr Seedat's concerns.

140. I can't recall what the nature and frequency of VC's monitoring / visits was at that point. I assume he wasn't being visited that frequently as we were so short staffed and I think Claudia, his CCO at the time, may have still been off. My memory of my first couple of months in the EIP team was of wondering where everybody was a lot of the time. The team was very reduced, I felt quite isolated, and I had a huge number of my own patients to be concerned about.

141. I appreciated what Dr Seedat was saying, but I'm not sure if increased monitoring was possible given the resources we had. I was only around two months into starting in the EIP team, and the severe staffing issues were already evident.

142. Following Dr Seedat's communication, Abi and I visited VC the following day, 6 November 2020. I can't remember exactly why both of us went, but I expect I joined Abi as I had some knowledge of VC (having already met him). As explained previously, this was relatively common practice.

143. I made the following note of this visit:

> *Following on from Dr Seedat's communication I visited Valdo with a colleague CPN Abi Parsonage.*
>
> *Valdo answered the door and after introductions welcomed us both in. We explained the reason for our visit and offered our assistance with any problems or issues he might have. Valdo explained he had been curious as to whether he could contact Dr Burri (or any of the medical team) for advice. He seemed reluctant to explain what advice he needed but stated he was fine and did not need any help at the moment.*

I took with me one months supply of medication because they were due (overdue indeed) Valdo said he had about 10 left. I will visit again in a weeks time to determine if he needs any more.

No issues of concern at this time and Valdo assured us he would ring Claudia or Stonebridge if he had any problems. **[NHFT0000168, p.136]**.

144. I do not recall VC giving us any indication of what he wanted to discuss with Dr Burri or the medical team. I recall that he seemed a bit defensive about it, but I just thought that he wanted to discuss something confidentially with a Doctor, and I respected that.

145. I do not recall whether Abi or I raised with VC, during that meeting, why he had medication left over. As explained in my 23 April 2025 Interview, this was a brief visit, with no real chance to interact with VC at length and make an ongoing assessment **[NHFT0004880, p.12]**. At the time, I expect it seemed possible to me that VC, being new to the service, was simply not fully understanding his medication regime yet, and needed a bit of further support with working out when to take his medication, as discussed in my 23 April 2025 Interview **[NHFT0004880, p.11]**. I do not recall whether Abi and I discussed this apparent non-concordance after the meeting.

146. Neither Abi nor I were VC's CCO. Any potential non-concordance would have been best addressed by Claudia (his CCO), who had a deeper understanding of VC and his history **[NHFT0004880, p.11]**.

147. I can't remember why I wrote "*no issues of concern"* in the RIO note on Friday 6 November 2020, but clearly I was concerned to some degree, as three days later (on the morning of Monday 9 November 2020) I recorded that:

I mentioned the visit to Valdo and his possible lack of concordance re his medicine regime. An OPA has been arranged for Thursday 12th Nov at 1430hrs with Dr Burri and Claudia to determine possible deterioration in mental state. **[NHFT0000168, p.136]**.

148. In my 23 April 2025 Interview, I was asked who I mentioned this to and I said it "*could well have been Dr Burri or maybe Dr Lloyd – maybe*" **[NHFT0004880, p.13]**.

149. At this point Dr Seedat's concerns had been addressed to some extent. Abi and I had visited VC and, following concerns about his concordance, an outpatient appointment ("**OPA**") had been arranged.

150. The Patient Record Summary explains that, before the planned OPA could take place, VC requested an urgent appointment on 10 November 2020, and Dr Burri and Claudia visited him at home on the same day. They recorded that VC "*Came across psychotic with escalation of symptoms (2nd & 3rd person auditory hallucinations with some underlying perplexity with partial insight). Risks are currently contained, needs to optimise anti psychotic treatment and monitoring.*" **[NHFT0000168, p.137-138]**.

151. I did not visit VC a week later (as I had originally said I would in the note on 6 November 2020) as, by that time, Dr Burri and Claudia had already visited him.

152. I was involved at this point purely to support Claudia, as indeed other people in the team were involved in similar ways. We would regularly help out other CCOs with their patients if needed.

153. As far as I can recall, I did not have contact with VC again until I delivered his medication on 8 June 2021. On this day, I made the following note "*Delivered Valdo's Aripiprazole medication today. Valdo looked good, sounded positive and said he was feeling fine.*" **[NHFT0000168, p.154]**. I can't remember anything else about this interaction.

154. I next saw VC on 6 August 2021, as it had been arranged that I would again visit him to deliver his medication while Claudia was on leave **[NHFT0000168, p.157]**.

155. I remember VC being quite short with me on this visit (as recorded on the Patient Record Summary **[NHFT0000168, p.157]**). At first, he misunderstood who I was, as he hadn't seen me for a while, but then he realised. I remember he seemed quite irritated that I was there, and was unwilling to chat and seemed keen to get rid of me. I interpreted his behaviour as being quite rude, but that is a subjective assessment, as I discussed in my 23 April 2025 Interview **[NHFT0004880, p. 15]**. I knew I might have just caught him at a bad time. There was nothing to make me think we had a serious issue on our hands.

156. I cannot recall if I spoke with anyone else about this visit.

157. I next saw VC on 31 August 2021 when I carried out a home visit with Claudia. I can see from Claudia's note of this visit **[NHFT0000168, p.162]** that we visited him due to concerns he may be relapsing. I can't remember the reason for those concerns.

158. I remember that VC seemed confrontational and suspicious as soon as we arrived. He seemed very, very unwell, and very different to the person I had met on previous visits. He was experiencing delusions, accusing us and other authorities of creating his auditory hallucinations through technology. I had to show him my identity badge in an attempt to convince him that Claudia and I were both nurses, working with his best interests in mind. It was an uncomfortable meeting. I discussed it in my 17 April 2025 Interview **[NHFT0004882, pp.8-9]** and my Theemis Interview **[TCLT0000750, p.8-9]**.

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

160. Claudia's note recorded that he seemed to be taking care of his Activities of Daily Living ("**ADL**") and preparing food for himself, but that he could be "*unpredictable when unwell*" (noting that he had previously broken down a

neighbour's door because he thought he could hear someone in trouble inside) **[NHFT0000168, p.162]**. The risk appeared to be towards others rather than himself. I felt uncomfortable during this visit, and I had some concerns about whether his behaviour might escalate – I remember noting at the time that we were sat on the sofa near the exit to the flat, which felt like a safer position - but I didn't feel like I or Claudia were in danger.

161. On leaving his flat Claudia and I agreed that his mental state was deteriorating. I think that we agreed an admission to hospital might well be necessary. When we returned to the office, Claudia called the Crisis Team explaining the situation. As far as I remember, the situation was not discussed with Dr Lloyd immediately. I cannot comment on why Claudia only wrote that a MHAA "*may*" be required.

162. Someone called Rachel Masterson made the following note on 31 August 2021:

> ***Gatekeeping discussion***
>
> *T/C to CCO Claudia. Current presentation discussed, currently presenting as psychotic, delusional and suspicious. Has stopped his medication - not clear when he last took it, CCO believes he has been deteriorating for several months. Refusing to have further contact with his CCO or CRHT. Very accusing and confrontational in nature.*
>
> *Risk primarily to others -when unwell last time, broke into a neighbours home and she jumped out of a window.*
>
> *Agreed that [MHAA] seems viable as not willing to engage with community treatment or visits.*
>
> *CCO to discuss further with AMHP's [Approved Mental Health Professionals]*

I will contact BMT [Bed Management Team]. **[NHFT0000168, p.163]**.

163. On 1 September 2021, I also spoke with Neville Freestone (a social worker and an Approved Mental Health Professional ("**AMHP**") for the purposes of a MHAA). I made a note of this stating:

> *Spoke to Neville Freestone about Valdo and how things are at the moment. I explained we did not have an absolute emergency on our hands but a MHA was considered the way forward in the near future.*
>
> *Plan*
>
> *Discuss situation at MDT with Dr Lloyd*. **[NHFT0000168, p.163]**.

164. I spoke to Neville Freestone because a MHAA was on the horizon and, as one of several AMHPs, he could be involved. In the meantime, the Crisis Team were arranging the MHAA. Due to VC being very unwell I believed that a hospital admission was appropriate. I told Neville that we didn't have an "*absolute emergency on our hands*". To me, we would have had an absolute emergency if, for example, VC was violent towards me and Claudia and I had to immediately ring the police to ask them to attend. This situation was still very serious and urgent and Claudia and I escalated it very quickly. When I said a MHAA was considered in the "*near future*", to me the near future meant within the next 24 hours.

165. In my 23 April 2025 Interview, I explained the following about my discussion with Neville Freestone:

> *He was a senior social worker, an approved mental health practitioner. Me and Neville have always got on very well together and if I ever wanted advice from anyone around detention, mental health act assessments, then I would invariably knock on his door and have a chat with him. I got on well with the guy and I had probably just called in on him to just to let him know and prepare him...I told him that we had a potential problem*

here; that it hadn't reached crisis but it could do quickly. **[NHFT0004880, p.16]**.

166. There would have been an MDT meeting on the morning of Thursday 2 September 2021. I don't recall if I attended the meeting. Dr Lloyd made a note on the morning of 2 September 2021 explaining that an MHAA had been arranged for VC at 11:30am that day **[NHFT0000168, p.163]**.

167. When asked in my 23 April 2025 Interview whether I had spoken to Dr Lloyd before VC was detained, I said:

> *I don't recall, but again [Claudia] was with me as CCO and I would find it hard to believe that she didn't. I appreciate that I made the entry, giving you the impression that I would have a chat with her, but the fact remains that I don't recall. I may have done, but I don't recall it - but I would be very surprised if [Claudia] didn't, because she was his CCO. I was there to support [Claudia] and I'm glad I was there to support [Claudia] on that day. He was very, very poorly. Now he was different that day and I'd never seen him like that. For me, that was a turning point in the whole of his care.* **[NHFT0004880, p.16]**.

168. The arranging of the MHAA was done by the Crisis Team.

169. On 1 September 2021, I tried to contact VC's mother, Celeste, by phone, but there was no response **[NHFT0000168, p.163]**. I can see from the Patient Record Summary that Claudia had tried to ring Celeste the previous day (after our visit to VC) and hadn't been able to get through **[NHFT0000168, p.163]**. As far as I can recall, I did not try to call Celeste again.

170. The Patient Record Summary explains that on 2 September 2021 multiple attempts were made to conduct a MHAA with VC and on 3 September 2021 VC was detained using a warrant under section 135 of the Mental Health Act **[NHFT0000168, p.164]**. During this admission, VC was aggressive and

needed to be tasered twice. Police had to use pepper spray and leg restraints and he assaulted an officer **[NHFT0000168, p.164-165].**

171. I spoke about this third admission in my Theemis Interview **[TCLT0000750, p.10]**.

172. I next had contact with VC on 12 April 2022 when I made the following note:

> *Phone call to Valdo.*
>
> *Valdo agreed to collect his medication at 10am on Thursday 14th April.* **[NHFT0000168, p.264]**.

173. A significant amount of time had passed since I'd last seen or spoken to VC. I knew that VC had finally attended an OPA with Dr Lloyd in March 2022. She felt he was doing well and was not psychotic on the day of their meeting. It therefore sounded like he was making progress with his concordance. Nothing else was discussed on our phone call on 12 April 2022 as far as I can remember.

174. On 20 April 2022, VC attended the Stonebridge Centre to collect his medication. I made the following note:

> *Valdo arrived at SBC and collected 2/52 weeks of medication as agreed. Pleasant on approach, asked how I was doing then left promptly. Next due on 28th April.* **[NHFT0000168, p.265]**.

175. I remember VC looked well, dressed in a black hoodie, and clean and well presented. His facial expression was friendly and he remembered me. He asked how I was, which I was struck by. However, as soon as I gave him his medication he promptly left. I had hoped to sit down for 30 minutes with him, but this did not happen. The whole interaction was less than a few minutes. I discussed this meeting in my 23 April 2025 Interview **[NHFT0004880, p.17]**.

My appointment as VC's CCO

176. On 28 April 2022, there was an MDT meeting and it was noted that "*Following a risk assessment and discussion in MDT, agreed it would be appropriate to transfer Valdo to a new CCO, preferably 2 CPN's.*" **[NHFT0000168, p.266]**.

177. I was not at the MDT meeting on 28 April 2022 as I was on annual leave that day (as discussed in my 8 January 2024 Interview **[NHFT0004711, p.1]**). I assume it was suggested that two CCOs would be appropriate for VC because of his history of aggression and violence. This I think was wise. But, after the idea was raised at the MDT meeting on the 28 April 2022, I assume that no-one volunteered to work with me as VC's second CCO (and no-one ever offered to work with me after that meeting either).

178. Following the meeting, I became VC's sole CCO. On 29 April 2022, there is a note from Claudia, which records that "*Valdo will be transferred to a new CCO Gary Carter (CPN)*" **[NHFT0000168, p.267]**. It also records that she had met with him that day, and that "*Although Valdo remains guarded and difficult to engage, there was no overt evidence of psychosis evident today*" **[NHFT0000168, p.267]**.

179. Why VC was not given two CCOs as suggested is not clear. My view is that none of my colleagues were really willing to work with VC unless they had to. He was known by that point to have a history of violence. The Risk and Safety Assessment (updated on 28 February 2022) stated that "*Given history of violence and aggression, community appointments to take place at Stonebridge Centre. Should home visits be required, no lone working, joint visits recommended*" **[NHFT0000190, p.5]**. Again, I think this was wise.

180. I was still the only man on the team, and I believe that that was primarily why I was made VC's CCO, with no second CCO. By that time, I felt my colleagues were frightened of what he could do. The other CCOs would have had conversations with Claudia about VC, including in MDT meetings, and knew the circumstances of his third admission. They were therefore anxious about

working with him. I don't believe I was assigned VC because I knew him particularly well - I think Abi had had more contact with him than I had at this point. (If it had been felt that the second CCO had to be a male, one could have been brought in from another team – this had been done before – but as far as I know it was not considered.)

181. I discussed these issues in my 23 April 2025 Interview, and said that I considered Claudia herself to have become unnerved by, or fearful of, VC at the point when he was handed over to me. She was also pregnant by that point, which I believe heightened her concerns **[NHFT0004880, p.21]**.

182. I can see that Sharon also recognised this point in her interview for my conduct investigation:

> *At that time [Gary] was the only male CCO in the team and with some of our patients it was not appropriate to give them to female members of staff, so he may have been given extra patients*
>
> *[…]*
>
> *[Claudia] was pregnant, so we felt that this was a good time (because there was fluctuating engagement with him at the time), to change CCO and perhaps try a male to see if engagement increased.* **[NHFT0004872, p.17; 22]**.

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

> *I can always remember him having a caseload of quite challenging younger patients. There were various reasons for this. He had those good relationships, but there were also times when the other CPN's*

didn't feel comfortable working with those patients - so GC would pick those patients up **[NHFT0004872, p.38]**.

184. Claudia explained in her interview for my conduct investigation that the decision to move VC to a different CCO had been made due to her being pregnant at the time and because there were certain risks around VC given his previous aggression. She also said that her relationship with VC had been quite difficult at this time (due to the content of a report that she had written about VC prior to his attendance at a tribunal for his section). When asked why I had been chosen to take over from her, Claudia explained "*I think that it was to do with the risks around violence and aggression and him being a male worker*" **[NHFT0004872, p.57]**.

185. I discussed this in my 17 April 2025 Interview **[NHFT0004882, p.12; 16]**, and in my Theemis Interview, where I explained:

> *I've got two feelings about it. One, I'm very happy to help my colleagues. They've helped me a great deal over the years, especially in the last few months. But two, and I had this chat with, I think, my manager some time ago. I said, "I get all these people. Have you seen the size of my caseload?" You know, all these people are coming on my desk. They're all problematic.* **[TCLT0000750, p.12-13]**

> *You see, sometimes... this is not unknown, switching CCOs. And it's often because the CCO just cannot make contact, cannot make contact with the patient and, "Perhaps he'll respond better to a man, G. What do you think?" and yes he might do, he might not. But I've done this on a few occasions.* **[TCLT0000750, p.38]**

186. As I said in my 23 April 2025 Interview, it felt like VC was delivered to me "*as a fait accompli*" – meaning it had already been decided that he would be assigned to me in the 28 April 2022 meeting while I was on annual leave, so I had no chance to feed into the decision before it was made **[NHFT0004880, p.6]**.

187. I felt a little irritated by the fact that my absence from the MDT meeting had led to me being given yet another particularly challenging patient. Similar things had happened before - as explained in paragraph 39 above, once when I was off for the day, I was given two new patients by email. My view was that I should have been involved in the decision and that it could have waited until I was back.

188. The record of Sharon's interview for my conduct investigation said she "*suggested that [I] had been happy to work*" with VC **[NHFT0004872, p.22]**. I disagree. It wasn't a case of whether or not I was happy with it. I just had to take VC on. He was assigned to me and there was nothing I could do about it at the time. I was trying to be a team player, but that doesn't mean I was happy about the allocation. It wasn't just that I had a particularly large caseload compared to my colleagues. I also had the majority of patients who had a history of violence and aggression.

189. I discussed this in my 17 April 2025 Interview **[NHFT0004882, p.12; 16]** and in my Theemis Interview, where I explained:

> *[A]s a team, we just weren't making progress. It was like a revolving door syndrome. He was discharged, he stopped taking medication. He was brought back in, discharged, stopped taking his medication, brought back in. It was that situation. It can get very frustrating.* **[TCLT0000750, p.33]**.

190. The note from my 8 January 2024 Interview states that by the time VC was handed over to me he was being discussed at every MDT **[NHFT0004711, p.1]**.

191. A formal handover would usually be necessary when transferring a patient between CCOs. This should have been recorded by the CCO handing over the patient, but was not in this case. Sharon in her interview for my conduct investigation said that it was "*recommended*" that there should be a handover

with the new CCO and a joint visit to see the patient concerned **[NHFT0004872, p.22]**.

192. In the note of my 8 January 2024 Interview, it stated: "*I don't recall a formal handover, I can't quite remember, but I find it inconceivable that I didn't get one from Claudia*" **[NHFT0004711, p.1]**.

193. I can't remember a formal handover, and there was no record of one. My suspicion now is that a formal handover did not happen.

194. In my 17 April 2025 Interview, I also stated:

> *When I was interviewed by Psychological Approaches (an internal investigation), I was prepared to give CB the benefit – she must have talked to me, but the more that I have thought about this over the months, I have thought 'Hang on Gary, can you actually remember that?'*
>
> *I can't remember that.*
>
> *Alright, I'd attended MDT's where he was discussed. I had a feel for the guy, as we all did, but when it came to a sit-down conversation — 'Right Gary, these are the issues' — I can't recall that ever happening.* **[NHFT0004882, p.14]**

195. Claudia in her interview for my conduct investigation said that:

> *[Gary] had met Patient V before anyway on a visit and I think that he'd seen him when he popped in to get tablets and things like that. He was also familiar with Patient V because we talked about him a lot. Sometimes it's quite a formal process when we hand over - but it can also be a case of 'over to you'. We had a conversation. We work individually but because we are such a small Team it does sometimes feel that it's a bit of a Team approach. I was still there until I went off on*

maternity and in the background if [Gary] needed information **[NHFT0004872 p.119]**.

My knowledge about VC when I took over as his CCO

196. When I took over as CCO, I knew that, when VC didn't take his medication, his mental state deteriorated. The circumstances of his third admission showed that this could result in him being violent towards others. Given his history of non-concordance, I knew that VC's concordance was a key issue I would need to monitor.

197. In my 17 April 2025 Interview, I said (when asked about my involvement with VC from August 2020 to May 2022):

> *I knew that he wasn't an easy patient from brief conversations that I had with CB and other members of the team e.g. AP. I knew that there were doubts about his concordance. He was very elusive. He didn't turn up for appointments. He was difficult to maintain contact with. He was difficult to assess because he would only give you so much time. This was also my experience when I was his CCO.*
>
> *The general feeling was that his mental health was on a knife-edge. He seemed to be functioning to the point that he could complete his degree, but his mental health was unstable.* **[NHFT0004882, p.7]**.

198. Claudia updated the risk and safety assessment for VC on 28 February 2022 **[NHFT0000190]**. The care plan for VC had also been updated in February 2022 but this was an in-patient care plan **[NHFT0000198]**. I do not know why Claudia had not updated it following VC being discharged.

199. The note from the MDT meeting on 28 April 2022 (see paragraph 176 above) also suggested that a risk assessment was carried out at that point ("*Following a risk assessment and discussion in MDT, agreed it would be appropriate to transfer Valdo to a new CCO, preferably 2 CPN's*" **[NHFT0000168, p.266]**),

though it is not clear if that was just a risk assessment in relation to Claudia being pregnant.

200. I am sure that I would have reviewed the risk assessment and care plan when I took over as VC's CCO – I would do this as a matter of course for new patients I was taking on from another CCO – but I cannot recall when specifically I did so. I discussed this in my 17 April 2025 Interview **[NHFT0004882, p. 15; 17; 27].**

201. I can see that I did not update the risk assessment or care plan at that point. I was inheriting the risk assessment from someone who had worked with VC as his CCO for 22 months, whereas I had had extremely limited contact with him. As far as I can recall I didn't think it made sense to change the risk assessment immediately. VC had the same problems the entire time he was involved with the EIP team (e.g. non-concordance and disengagement). What had changed was Claudia's ability to work with him, partly because she was pregnant, not VC's own circumstances as such. Given the most recent care plan was an in-patient care plan, however, I should have updated this. I do not recall why I did not.

202. In my Theemis Interview, I explained that "*taking V on was a bit of a challenge*" and that "*I knew that this man would take some monitoring*" **[TCLT0000750, p.14]**. This was clearly why Claudia had recommended two CPNs. In an ideal world, VC should have contact with the EIP team on a regular basis – even if just a phone call - every week, or failing that every fortnight. He was supposed to collect his medication every fortnight which I always hoped would be an opportunity to engage with him (though as explained, he would usually just take it and leave). When he was actively trying not to engage with us, it was hard to have contact with him.

203. By the point I took over as his CCO, ideally VC was supposed to come to the Stonebridge Centre rather than us visit him and, if home visits were required, these should have taken place with at least two people from the team.

204. My view is that VC often did not have the capacity to make decisions in his own self-interest, even when he was out of hospital and seemed to be doing well. In hindsight, I think he was good at masking his symptoms and it was not necessarily easy for people to work out whether he had capacity or not. I can see that the February 2022 care plan, for example, says that "*Valdo currently does have capacity to understand, retain and weigh information provided to make an informed choice about his care and management of mental health condition, including prescribed medication*" **[NHFT0000198]**. I am not sure if that was the case, at least by the point when I took over as his CCO. But it was difficult to take an informed view on VC's capacity when he was refusing to engage.

205. In my Theemis Interview, when asked whether I got the sense that VC used drugs or alcohol, I said:

> *I never got the impression that he was a heavy drug user. He might have used recreational drugs or whatever, but I never considered that to be a significant factor. It was not something that concerned me or that I felt as though I had to say, "V, you've really got to knock this on the head. It's damaging you." I never got that chance.* **[TCLT0000750, p.42]**.

206. The point I was trying to make was that there was no evidence that VC was a heavy user of drugs or alcohol, in a way that might have been apparent to me in our brief encounters. Given how little time I was able to spend with him, I would not, however, necessarily have been able to identify if he was a recreational user of drugs or alcohol. I certainly did not see any evidence that suggested he was.

207. I spoke to his mum, Celeste, when I was his CCO, as I felt it was necessary. I recalled that Claudia had shared information with his mum when she was CCO, and that his mum had been in contact with us quite a lot.

208. In her interview for my conduct investigation, Claudia said that VC had originally agreed to the disclosure of certain information to his mother but had subsequently withdrawn his consent to this **[NHFT0004872, p.58]**. I don't think I was aware, when I took over as CCO, that VC had asked us not to contact his mother. If I'd realised he was withdrawing from contact with his family, I would have been concerned about that.

209. I never offered VC behavioural family therapy. My primary concern was his medication concordance and I did not think family therapy was appropriate or realistic.

210. His family lived in North Wales so it would have been difficult to arrange a joint meeting. I understand that Sharon said in her interview for my conduct investigation that there was a possibility that family therapy could be done online if the family did not live locally **[NHFT0004872, p.30]**. At the time I was VC's CCO, he would not engage with me. I definitely do not think that he would have come to a Teams meeting to have a virtual family therapy session.

211. I can see that the Investigating Officers said that, from the random City South EIP Team sample that they carried out:

> *There was limited evidence of patients being offered provision within the nationally mandated pathway including Brief Family Interventions and Cognitive Behavioural Therapy for Psychosis (CBT-P)* **[NHFT0004872, p.144]**.

212. In my experience, family interventions were offered where possible. However, family therapy is a very time-consuming intervention so in a lot of cases it wasn't possible.

213. I had no contact with VC's GP during my time as CCO.

My engagement with VC as his CCO

214. My first interaction with VC after becoming his CCO was on 13 May 2022. I made a note on 13 May 2022 explaining that I texted VC to let him know his medication was due, then phoned him to find out when he was coming to collect it. I noted that "*Valdo arrived on time and accepted his medication then promptly left without any chance of me having a chat with him*" **[NHFT0000168, p.267]**.

215. I remember VC arrived to collect his medication and then, once he had his medication, he left without a word. I asked to have a talk with him but I was ignored. I was disappointed he would not talk with me as I could not make a judgement on his mental state at the time. I think he was trying to have minimal contact with the service, as he realised that when he had more involved contact with the service he often ended up being admitted to hospital.

216. My second contact with VC was on 27 May 2022 when he arrived to pick up his medication. I made the following note:

> *Valdo arrived early this morning and picked up his 2/52 weeks of Aripiprazole 10mg bd. Valdo seemed in a good mood and enquired about how I was doing and also Claudia. When I asked how things were going Valdo told me "im fine just maintaining myself and trying to keep fit". With that Valdo thanked me and left.* **[NHFT0000168, p.267].**

217. My recollection of this interaction was that it lasted just a few minutes. VC was at least pleasant and I was happy he again asked how I was. However, he declined any further interaction. VC was well presented, clean and clean-shaven and I noted a pleasant smell of cologne. Overall, that was a brief but pretty positive meeting. VC looked okay, seemed okay and tried to be pleasant, and I didn't get the impression of any overt psychosis. But even then, as I discussed in my Theemis Interview **[TCLT0000750, p.17-18]**, there was no chance of breaking into a lengthy conversation about his mental state, general wellbeing or anything at all.

218. As time went by he would come and stand outside the building so we could bring his medication down, but wouldn't come in. I discussed that in my Theemis Interview **[TCLT0000750, p.17-18]**.

219. I wanted to have longer chats with him, but he would just refuse to engage. Ultimately, I think he didn't trust us, and he didn't know me as well as he'd got to know Claudia. But I was glad he was at least turning up to collect his medication.

220. Ideally, even when a patient had just come in to collect medication, we would have some sort of therapeutic intervention with them. Even a brief chat can be "therapeutic" as it can help us understand the patient's condition. Ideally, you would meet for up to an hour, but even 15 minutes chatting with a patient could be valuable and important. However, with VC, my colleagues and I had real trouble getting more than five minutes from him. This is not enough time to make an assessment about someone's condition and it was very hard to work with someone on that basis.

221. In my 23 April 2025 Interview, when asked whether I thought it was unrealistic to have a therapeutic intervention when a patient collected their medication, I explained:

> *It's not unrealistic if they will just give you some time. If I give him his medication he heads straight for the door, without saying goodbye or whatever. Then, it's just not possible.* **[NHFT0004880, p.18]**.

222. When asked if VC was unique in the way that he took his medication and then left, I explained:

> *He was to me, probably, from my experiences. I feel that I've got enough about me from a social skills point of view to engage with difficult people, not only at Stonebridge, but throughout my career. But he was one of those people (and I've met similar clients in the past) who would just not give you the time of day and who just don't want to talk to you, for*

reasons best known to themselves. He was very difficult to engage with. **[NHFT0004880, p.18]**.

223. When asked if Claudia suffered the same difficulties that I did in engaging him when it came to giving him his medication, I said:

> *I think that CB was probably more successful to be perfectly honest with you. […]*
>
> *Because she knew him better. She had known him right from the start. He developed a working relationship with her, albeit not a terribly good relationship. I found myself at a disadvantage when I took over because I didn't have that relationship with him.* **[NHFT0004880, p.18-19]**.

224. I can see that, in her interview for my conduct interview, Claudia explained:

> *[I]f Patient V came in for his tablets he would then just want to leave. If [I] wasn't there he would just want to go - no matter how people tried to engage him. You would at least want to have a conversation with him - bring him into the room, speak to him and then give him the tablets. Not just collect the tablets then leave.* **[NHFT0004872, p.58]**

225. VC's medication was next due on 10 June 2022. Following our brief interaction on 27 May 2022, I hoped that meeting him again on 10 June 2022 would give me another chance to talk him into sitting down with me and having a fact-finding conversation. This would give me the chance to assess his mental state.

226. I made the following note on Friday 10 June 2022: "*Valdo could not collect his medication today. He will collect his medication on Monday. I will ring him on Monday morning to confirm a time*" **[NHFT0000168, p.267]**. I can't recall why he couldn't pick up his medication that day.

227. This meant he would be a couple of days late for his medication. It is always concerning with any patient if they don't receive their medication when they are supposed to.

228. There is no record of me ringing VC on 13 June 2022 in the Patient Record Summary. I can't recall if I did ring him or not. I may well have done if his medication was overdue as I imagine I would have included a reminder in my diary to do so.

229. In my 23 April 2025 Interview, when asked about there not being a record of me ringing him on Monday 13 June 2022, I said:

> *I may well have been sidetracked to other things. I should have made an entry to that effect. This is why I made an entry at 0345hrs in the morning — trying desperately to catch up entries and making sure that things had been recorded.* **[NHFT0004880, p.19]**.

230. On 13 June 2022, Dr Lloyd noted that VC didn't attend his 10am appointment and the CPN was to reschedule it.

231. On 15 June 2022, Abi Parsonage noted:

> ***City South EIP***
>
> *2 weeks of Aripiprazole 20mg given*
>
> ***Next due:***
>
> *Wednesday the 29th of June*
>
> *Valdo came to see Gary today at 3pm, stated to reception he had an appointment. Gary is out on visits so I gave Valdo his medication. Valdo was well kempt but his facial hair and head hair was overgrown. He looked suspicious, was looking around. Valdo took his medication off me*

as I asked how he was he walked off. He did not put the medication in his pocket but held it and examined it as he walked away. I will update Gary **[NHFT0000168, p.268]**.

232. In my 23 April 2025 Interview, I said I did not recall being updated about this by Abi but she may have updated me **[NHFT0004880, p.19-20].**

233. I explained in my Theemis Interview:

> *Well, it started breaking down, shall we say, I would say from May-June onwards. Everyone was... you know, this man was discussed probably at every MDT, V. "Well, he did pick up his medication, but I didn't get a chance to talk to him. He didn't want to engage with me. So at least he's got his medication."*
>
> *But even by that time, you know, I knew enough about this guy to know that he could throw it in the bin as soon as he walked out of there. So I wasn't entirely trustful of him.* **[TCLT0000750, p.18]**.

234. On 16 June 2022, I left a note saying that a Care Programme Approach ("**CPA**") meeting was rebooked for 1 August 2022 at 11am **[NHFT0000168, p.268]**. This is a meeting where we invite various stakeholders to discuss how the patient is doing (including the patient, their family members etc.). I do not recall why the appointment was rebooked.

235. On 24 June 2022, I included the following note in the Patient Record Summary:

> *I contacted Valdo asking him to collect his medication. Valdo rang me back to say he had enough medication to [last] until Friday 1st July.*
>
> *I will offer Valdo the option of taking his medication out to him if I can find another colleague to accompany me.* **[NHFT0000168, p.268].**

236. I cannot recall if I did make arrangements for a colleague to accompany me out to visit VC with his medication. The fact that he wanted to meet at a later date would have concerned me because of his erratic concordance in the past. When I contacted him on 24 June 2022 about his medication, he would likely have been about to run out but not yet on his last day's supply.

237. The risk of VC not taking his medication was that his mental state would suffer. As shown with the third admission, this could lead to him being aggressive and a risk to others.

238. In my 17 April 2025 Interview, when asked whether I followed up with offering to take the medication out to VC, I explained:

> *If his medication was due I would have done everything in my power to make sure that he got his medication — recorded or not. I would have tried desperately to get him his medication because by this time concordance (now we knew him a lot better after two years) was a serious issue. Even if I didn't record it I would have made every attempt to contact him and give it to him in his hand, either at home or at Stonebridge or wherever.* **[NHFT0004880, p.20-21]**.

239. The next entry on the Patient Record Summary is 4 July 2022, when Kaisha Dennis-Butterworth made the following note:

> *Valdo attended SBC to collect his medication, CCO Gary Carter was out on visits so I provided him with his medication. He declined wanting anything passing onto CCO Gary, highlighting no concerns and was asking about previous CCO Claudia Birtles, stated she was currently out on visits and he abruptly left after taking the medication from me.* **[NHFT0000168, p.268]**.

240. I do not recall speaking with Kaisha about this but I am sure she would have mentioned it to me.

241. When asked about this entry in my 23 April 2025 Interview, I said the following:

> *He abruptly left yet again. He abruptly left [Abi] & [Kaisha], he abruptly left me, so we were all having the same problems in engaging with this man.* **[NHFT0004880, p.21]**.

242. When asked about the nature of my relationship with VC at this time in my 23 April 2025 Interview, I explained:

> *Considering the limit of our interaction, I'm going to say that I had a very superficial, reasonable relationship with him. [I]t certainly can't be described as a trusting relationship, as a client and nurse working together, being comfortable in each other's presence, sharing things. No way can it be described as that and that was from day one.* **[NHFT0004880, p.21]**.

243. On 18 July 2022, Abi Parsonage made the following note:

> ***CCO Gary Carter on leave***
>
> *18th July - Valdo GRO-D 5 His meds are due he may come to SBC at anytime. I'd ring or text him in the morning to get a estimated time.*
>
> ***Text sent to Valdo this morning***
>
> *Hi Valdo it's Abi from Stonebridge are you coming to collect your meds today? what time are you thinking?*
>
> ***Valdo***
>
> *Not in the UK at the moment*
>
> ***Me***

Are you on holiday? Hope you're having a nice time. When do you think you'll be back to get your medication?

Valdo

I'm good. I'll probably be back in Nottingham in October

Me

What about medication?

Valdo

Still have some. Won't make much difference.

Me

You'll run out by October. Do you not find the medication helpful? **[NHFT0000168, p.268-9]**.

244. If VC had been concordant with his medication, he should have run out of medication by 18 July 2022, or certainly have been close to it. This text exchange demonstrates VC's attitude towards medication and the service.

245. On 25 July 2022, I made the following note:

Phone call to Celeste explaining that Valdo may have gone to Africa? Celeste knows nothing about this and has not heard of anything to suggest Valdo is abroad.

I phoned Valdo who did not answer. I left a voicemail asking him to call me. **[NHFT0000168, p.269]**.

246. I assume the text exchange with Abi and VC was the reason why I spoke with Celeste. According to Abi's note from 18 July 2022, I was on annual leave. I don't recall when I was back from annual leave but this may have been part of the reason I did not try to contact Celeste sooner.

247. Following the text exchange between VC and Abi and my call with Celeste, VC could have been anywhere. However, I felt he was likely in the UK, especially as Celeste knew nothing about him going abroad. VC's recent engagement with the service had already proved to be minimal. His mental state could have been deteriorating and he could have been heading for another psychotic experience.

248. When asked in my 23 April 2025 Interview whether there was evidence of VC becoming unwell at this stage, I said:

> *Well, yes, there probably was because we just didn't know where he was. His mental state could have been good — it could have been terrible. I don't know. Nobody knew where he was. We weren't even sure if he was in the country. On 29th (July 2022) I attempted to call Patient V but got no response and was unable to leave a voicemail. So, he's totally disengaged from me.* **[NHFT0004880, p.23]**.

249. The note of my 8 January 2024 Interview states (in relation to VC saying he was abroad):

> *Why would he have said that? Perhaps to get us off his back, as a way of disengaging? With the changing of addresses, this was very awkward. There were times when we didn't know where this man was. I did wonder if he was abroad at one point.* **[NHFT0004711, p.2]**.

250. On 27 July 2022, I noted "*I phoned Valdo up this morning. No answer. I was not able to leave a voicemail. I then phoned Celeste to see if she had heard anything from him. No answer*" **[NHFT0000168, p.269]**. I can't recall exactly what the intended purpose of these calls was but I was probably trying to

speak with both of them and find out more about the current situation VC was in (including where he was, his medication concordance and general wellbeing / mental state).

251. Later on in the morning of 27 July 2022, I made the following further note:

> ***Valdo did not attend to pick up his medication.***
>
> *I have spoken with Celeste and she says Valdo is in Nottingham. I have agreed with my colleague Paul Williams that we will call in on Valdo at home to deliver his medication on Monday 1st August at around 1230hrs.* **[NHFT0000168, p. 269]**.

252. If VC had been concordant, his medication should have run out by this point. The entry from Kaisha (see paragraph 239 above) had said that his medication was next due on 18 July 2022 **[NHFT0000168, p. 268]**.

253. I was very concerned at this point – it was not a good situation. All I could hope for is that he had been taking some of his medication and that would have held his mental state for a time being. However, the only time we know he was fully concordant with his medication was when he was an in-patient. If he wasn't taking his medication, then his mental state would deteriorate rapidly.

254. On 27 July 2022, I also attended a supervision meeting with Sharon where we discussed VC. The note from that supervision meeting stated: "*Valdo-went missing and believed may have left the country – call from mum who informed CCO he is in Nottingham, plan to try and visit with CSW – when previously unwell did need a taser when sectioned*" **[NHFT0004909, p.3]**.

255. I don't recall that specific supervision meeting or what was discussed about VC or any other patient. I understand that Sharon said in her interview for my conduct investigation that there was only one occasion that I brought VC up in a supervision meeting **[NHFT0004872, p.16]** and this was mentioned to me

in my conduct meeting. I believe that I mentioned him in others. Prior to the conduct meeting, I requested copies of all my supervision sessions for the six months prior to VC's discharge. These were never provided to me (see paragraph 347 below). I therefore cannot say when he was discussed and what was said. At this time, I was also discussing VC in the majority of MDT meetings, so Sharon would also have had a good understanding of the issues I was having with VC from these meetings. I discussed this in my 17 April 2025 Interview **[NHFT0004882, p.18]**.

256. On 29 July 2022, I noted the following on the Patient Record Summary "*Attempted to make contact with Valdo. No answer unable to leave a voicemail*" **[NHFT0000168, p.269]**. I can't recall the exact purpose of this call but I assume it was another attempt to make some contact with him to find out about his current situation.

257. Paul Williams (a Healthcare Assistant) and I had planned to attempt to take VC his medication on Monday 1 August 2022, which may have been the earliest time Paul could accompany me. At this time, we were not supposed to make solo visits to VC. I do not know when this decision was made but it was included in the risk assessment (see paragraph 179 above), and I followed it.

258. On 1 August 2022, Dr Lloyd left the following note: "*Valdo did not attend his 11 am appointment. Another will be arranged by his CPN*" **[NHFT0000168, p.269]**. There is no note saying that we did visit on 1 August 2022. I cannot recall why we didn't visit on this date as planned. I assume it was because VC was due to have an appointment with Dr Lloyd that day so I would have planned to give him his medication then rather than needing a home visit as well.

259. In this situation where VC missed his appointment with Dr Lloyd, as with all patients, I would have tried to contact the patient to rearrange the appointment and, if this could not be done, I would have organised a time and date with the

medical secretary and asked her to send a letter to the patient. I assume I did this at this time but cannot recall.

260. On 3 August 2022, I made the following two notes:

> *Phone call to Valdo. No answer and his phone appears to be turned off. I could not leave a voicemail. I tried ringing Valdo's mother Celeste but again no answer.*
>
> *Plan*
>
> *Both myself and SW Paul Williams will visit Valdo's address tomorrow in an attempt to make contact with him.* **[NHFT0000168, p.269]**.
>
> *Phone call from Celeste. Valdo has been in contact with his sister and I explained I would be visiting Valdo with a colleague tomorrow.* **[NHFT0000168, p.269]**.

261. I don't recall what Celeste said about VC or his situation in this phone call.

262. I was concerned about VC's condition, medication concordance and risk to others because I had still not been able to meet with VC face to face, and because I knew VC was very overdue in receiving his medication, which we knew could lead to quite a quick deterioration in his mental state. Our suspicions that he had not been taking his medication properly had been ongoing since 2020, and non-concordance had led to three hospital admissions. I discussed that in my 17 April 2025 Interview **[NHFT0004882, p.25]**. I knew from those past admissions that non-concordance could mean VC was at risk of unpredictable behaviour, including violence.

263. On 4 August 2022, I made the following note:

> *Cold call this afternoon with my colleague SW Paul Williams.*

I knocked on the door and a young answered. I asked for Valdo and he told me that no one of that name lived there. Valdo has a history of giving false addresses so I will take this situation back to Dr Lloyd and Emma on Monday.

To consider -
discharge to GP?
report as a missing person? **[NHFT0000168, p.270]**.

264. Paul Williams was a Healthcare Assistant working with the City South Team. He had a good manner and got on well with all the clients he had dealings with. I have asked him on several occasions to help me with my clients and he has always done an excellent job. Paul is also a man of colour and I felt that having him stood next to me might just help me to talk to VC if we met him face to face, as I explained in my Theemis Interview **[TCLT0000750, p.19]**.

265. I can see that Sharon, in her interview for my conduct investigation, stated in relation to Paul's involvement that: "*We felt that involvement from a different cultural background might also aid engagement…*" **[NHFT0004872, p.22]**.

266. I had never felt ethnicity was necessarily an issue. I was just trying to rule out any factors that might be preventing VC from engaging with me and meeting me face to face.

267. In the event, someone answered the door and said he didn't know anyone called VC. My view at the time was that that might have been true, and VC could have been moving between addresses. It also might not have been true – he could have been there but asking people to cover for him (as I discussed in my 23 April 2025 Interview **[NHFT0004880, p.4]**). Either way, he was clearly still trying to avoid seeing us.

268. At this point, I knew that VC was not concordant with his medication, and that his mental health condition could well have been compromised. As his mental

health deteriorated, it would make him less likely to take his medication, so his concordance would have likely got even worse. I had no evidence at that stage that he was in crisis, as discussed in my 17 April 2025 Interview **[NHFT0004882, p.30]**. But I knew I needed to see him and have a conversation, to work out what was going on and agree a way forward.

269. I did not report VC to the police as a missing person. While I considered it, I concluded that it would not be helpful. In my previous experience of dealing with the police, they were very reluctant to help unless you had concrete evidence that something was wrong. At this point, as VC had had some relatively recent contact with his family (see paragraph 260 above), and my view was that the police would be reluctant to treat him as a missing person. I had previously reported another client as a missing person, and the police had been unwilling to accept that he was missing because I had spoken to him on the phone a week or so previously, as I discussed in my Theemis Interview **[TCLT0000750, p.21-22]**.

270. I can also see that, in her interview for my conduct investigation, Emma said that:

> *We questioned whether this young man was a missing person, but if I remember correctly his mother had contacted the Team to tell us that Patient V had contacted her or the brother. So, we knew at this point that he wasn't a missing person as such, so that's why we didn't raise that or escalate it to the police.* **[NHFT0004872, p.127]**.

271. I don't recall talking to either Dr Lloyd or Emma on the day of this attempted visit to VC on 4 August 2022, but I may have done so. We went on a Thursday afternoon so I assume I would have mentioned that we were intending to visit VC in the MDT meeting that would have been held that morning. At this point, I was regularly discussing VC with colleagues, both informally and in MDT meetings.

272. Discussions about whether to discharge VC came up during this period. Dr Lloyd would regularly discharge patients back to their GP if they didn't engage with the service. I can see that she considered discharging VC as early as 17 January 2022 when she made the following note:

> *Valdo did not attend his OPA at 12 noon. This is his 5th missed appointment. We will discuss the plan at MDT on Thursday. Consideration will need to be given to discharge as Valdo has essentially disengaged and we have not been able to monitor him. Perhaps a conversation with his mum and course tutors to see if there are any concerns currently will be prudent before considering discharge.* **[NHFT0000168, p.203]**

273. In my 17 April 2025 Interview, when asked about whether I thought VC was moving towards becoming unwell in August 2022, I said:

> *On 29th September, I said to Dr Lloyd that I really didn't know what she wanted me to do with this man because I didn't know how to make contact with him and was having very little success with him. Then he was discharged.* **[NHFT0004882, p.20].**

274. VC was discharged on 22 September 2022 so I think I must have been referring to a discussion with Dr Lloyd that took place around August 2022. I don't remember what she said in response.

275. On 9 August 2022, Claudia noted:

> *City South EIP;*
>
> *Valdo has requested access to his notes. Emma Robinson (Team Leader) will be dealing with this request.*
>
> *Valdo has documented a different address to the address he provided to the EIP team post discharge.*

Note 15 Madison Court
Derwent Way
NG7 2EG.

CCO informed via email. **[NHFT0000168, p.270]**.

276. I can't recall exactly but I am sure I would have received the email referred to in Claudia's note. I also recall discussing with Emma in her office that VC had requested his notes, and I recall looking at the request and seeing that VC had provided an address (15 Madison Court) that I had not previously seen.

277. Since looking at the Patient Record Summary, I can see that 15 Madison Court was actually mentioned for the first time in November 2021 by the Out of Area Co-ordinator as VC's new address **[NHFT0000168, p.196]** and recorded again in RIO in January 2022 by Abi **[NHFT0000168, p.204]**. I don't recall being aware of this address until VC's request on 9 August 2022. I assume that VC's record was never updated following the entries in November 2021 and January 2022 to show 15 Madison Court as his current address (the address that would have shown up on the first page of his RIO entry). I think the Madison Court address was the fourth noted address for VC since EIP had been caring for him.

278. As far as I am aware, no one ever went to this address. I planned to visit the new address to check if he was there, but I never got the chance to because I was so busy. I didn't feel like I would have been able to ask another colleague to visit as everyone else was scared of VC, and I don't believe they would have risked going to visit this address even if they went in a pair.

279. I also wasn't sure if this address was actually VC's. He had moved frequently during his engagement with the service. The Risk and Safety Assessment explained that "*Valdo has always been very vague about his social circumstances. He appears to have given a false address to his care team*

following his last admission. University have since provided an accurate address" **[NHFT0000190, p.3]**.

280. Claudia explained in her interview for my conduct investigation that: "*There was a lot of confusion and even when I read the notes, [I] don't know where Patient V was at that point. There were so many addresses. He moved a lot — even in the first year that I was working with him ...it was all very odd*" **[NHFT0004872, p.59]**.

281. Abi also recalled a time where she and Claudia had tried to do a home visit but VC had given the wrong address **[NHFT0004872, p.66]**.

282. On 17 August 2022, I noted that I had sent the following letter to VC at his latest address:

> *Dear Valdo,*
>
> *It seems like a long time since we last met. Could I do something to help you? Do you still want to engage with our services at this time?*
>
> *Perhaps you could give me a ring on […] and we could have a chat. I still have a supply of your medication here at Stonebridge if you want them. Can we have a chat and work something out together.*
>
> *Kind regards*
>
> *Gary* **[NHFT0000168, p.270] [NHFT0000122]**.

283. I have exhibited a copy of this letter at **[NHFT0000122]**. As far as I am aware, I never received a response to this letter.

284. Procedure: 01.08a – 'Merged Do Not Attends (DNA's)/Cancellations & Management of Patients Who Fail to Engage with Services or Seek to Disengage from Care in an Unplanned Way Procedure' (the "**DNA Policy"**)

states that the letter sent to a non-engaging patient should detail actions to be taken with timescales if contact is not made **[NHFT0004725, p.6]**. I was not aware of this at the time.

285. On 18 August 2022, I made the following note:

> ***Discussed at MDT.***
>
> *Valdo has applied for access to his documentation and notes. This has now been submitted by Emma Robinson. Valdo has still not contacted me after being sent an invite to do so. He has not been supplied with medication now for several weeks. I will contact his mother for any help or assistance.* **[NHFT0000168, p.270]**.

286. I do not recall specifically what was discussed at this MDT discussion or what decisions were made (other than to the extent included in my note from the time). In my 17 April 2025 Interview, I explained that when I discussed VC at MDT during this period it was: "*Just a general discussion about the fact that he was very elusive and nonconcordant. I think that we were all probably in agreement with this"* **[NHFT0004882, p.21]**.

287. The advice from others in the EIP team was just to keep persevering and trying to get in touch with him (as I also mentioned in my Theemis Interview **[TCLT0000750, p.18-19]**). That was the approach I took, though given the size of my caseload it was difficult to commit a huge amount of time to trying to chase him down.

288. In August 2022, my manager, Sharon, was away. I understand that Sharon said in her interview for my conduct investigation that she gave me "*the option to arrange supervision in [her] absence*" **[NHFT0004872, p.17]**. I don't remember this being said.

289. At this time, I remained very concerned about VC's condition and mental state. The lack of medication for a patient with a history of non-concordance was

concerning. I had only been able to meet with him twice since taking over as his CCO, and I did not consider that I had any basis on which to update his risk assessment. The risk assessment already reflected his problems with non-concordance and poor engagement – "*Valdo has disengaged from community support and we suspect he is non-concordant*" – and his history of violence and aggression **[NHFT0000190, p.5]**.

290. Again, I considered reporting VC as a missing person at this point but did not think it would be helpful, partly as he had had recent contact with the EIP team on 9 August 2022 (see paragraph 275) and his family before that (see paragraph 260).

291. The Investigation Report explains that I was on carers leave from Thursday 25 August 2022 to Friday 2 September 2022. Around this time, one of my closest friends was dying of cancer and I took some time off to care for her. I was then on sick leave from Tuesday 6 September 2022 to Sunday 25 September 2022 **[NHFT0004872, p.6]**. I don't remember the exact dates I was off but assume the Investigation Report has the correct dates. Assuming these days were correct, between 25 August 2022 and 25 September 2022, I only had one working day where I was not on leave (Monday 5 September 2022).

292. On 31 August 2022, I made the following note:

> *Telephone conversation with Celeste (mother).*
>
> *She has not seen Valdo face to face for many months but she had a telephone conversation with him in the last week. Celeste attempted to go and see Valdo but he was not at the address she was familiar with. I have given Celeste Valdo's latest address and she may write a letter to him and attempt to contact him.*

I feel in the circumstances I will arrange a visit with a colleague to go out and see Valdo to determine his mental state and general wellbeing. **[NHFT0000168, p.270]**.

293. I understand from the Investigation Report that I must have been on carer's leave at this point. Since I was on leave, I suspect Celeste may have rang me rather than vice versa but I can't recall. I was very concerned about VC so would have thought it was important to speak to Celeste despite being on leave.

294. The circumstances that I thought necessitated a visit were his lack of medication and his continued non-engagement with the EIP team and his family. I was very concerned at this point. I don't recall if I took steps to arrange a visit to VC at this time – I may have intended to do this when I was back from carer's leave, but as discussed at paragraph 291 I went off on sick leave shortly after that (on 6 September 2022).

VC's discharge from the EIP service

295. VC was discharged on 22 September 2022. I was still on sick leave so I was not at the meeting. I do not think anyone visited the Madison Court address before deciding to discharge VC.

296. On 23 September 2022, Sharon included the following note:

Discussion within MDT on 22.09.22, as no contact has been made with Valdo for a period of time despite attempts to make contact and having done cold calls, decision made within the team to discharge back to GP due to non engagement with view for GP to refer back to services in the future if needed. **[NHFT0000168, p.271]**.

297. The Investigation Report states in respect of the 22 September 2022 MDT meeting:

Unfortunately, GC was absent from work (25th August -2nd September 2022 (carers leave) & 6th — 25th September 2022 (sick leave)) and therefore did not attend this final meeting, nor did he contribute directly to the final discharge decision. **[NHFT0004872, p.6]**.

298. In my 23 April 2025 Interview, I referred to the date of his discharge as having been 29 September 2022, after a meeting at which I was present **[NHFT0004880, p.4].** I was clearly confused about the dates. VC was discussed regularly at MDT meetings so I must have been thinking about a previous meeting at which the option of discharging him was discussed.

299. I imagine that in the MDT meeting on 29 September 2022 we discussed the fact that VC had been discharged the previous week, because it was my first meeting back after sick leave, though I do not remember this specifically. I had a lot of work to catch up on when I was back from sick leave and I do not remember exactly when I found out about VC's discharge.

300. If the CCO was not present at a meeting for whatever reason, a patient could still be discharged, but I don't think it would be considered good practice. Usually you would expect the CCO's views to be sought, as I discussed in my 23 April 2025 Interview **[NHFT0004880, p.7]**.

301. In her interview for my conduct investigation Emma explained that:

[W]e had weekly MDT meetings up until the point of discharge, where Patient V was discussed, due to the non-engagement. It was quite a small CPN Team and we all know each other's patients - so it felt okay to make that decision. [I] think before the actual discharge of Patient V, we had already started to discuss this in MDT anyway, so it wouldn't have come as a surprise to the CCO **[NHFT0004872, p.44]**.

302. My personal view is that, by the point he was discharged, they should have seriously considered reporting him to the police as a missing person. As explained in paragraph 269, I was previously unsure if the police would be

helpful, but I think by this point contacting the police was probably the only thing we could do. We now know that a warrant had just been issued for his arrest, but the EIP team weren't aware of the warrant at the time. It wasn't ideal to simply discharge him to his GP.

303. In my Theemis Interview, I explained:

> *[W]ith regards to the internal investigation, they seem to be quite critical of the discharge procedure, and I think that was fair. I don't think it was handled well. I must actually take some blame for that, to be honest, as his CCO.*
>
> *But it just seemed at the time that we were just, kind of, giving up on this man. And I must admit, after being his CCO for about five months, six months maybe, I could understand why people were saying, "Look, he's just not engaging with us. He's having nothing to do with us." But with hindsight, and we never have hindsight, do we?* **[TCLT0000750, p.40]**

304. I understand that the DNA Policy says that the following actions may be considered depending on an assessment of risk to the patient:

i) "*If the patient is not at his/her address, the care co-ordinator and service team should agree other agencies to be contacted e.g. GP, housing departments, works and pensions departments etc. including a discussion regarding contact with family members even if the patient has requested no contact with their family*" **[NHFT0004725, p.7]**

I did speak with VC's mum, for example, on 31 August 2022 (see paragraph 292 above). I didn't think contacting any other agencies would have been helpful. As far as I'm aware, VC didn't have any interaction with housing departments or work and pensions departments.

ii) "*If all contacts fail the care co-ordinator should discuss their concerns with the MDT and agree the next steps to be taken. This may include involvement of the police. If the police are contacted concerns for the patient should be clearly articulated including what assistance is requested from the police*" **[NHFT0004725, p.6-7]**

At various times, we had considered referring VC to the police as a missing person but I did not think this would be helpful (see paragraph 269 above). I was on leave for the majority of the month before his discharge so I do not know if referrals to the police were considered at that point.

iii) "*If the whereabouts of the patient is known and the level of risk has been assessed as high, the care co-ordinator and team should consider the need for further assessment including the Mental Health Act (MHA), Mental Capacity Act (MCA) and Adult Safeguarding*" **[NHFT0004725, p.7]**

At this point in time, finding VC was of paramount importance. We couldn't conduct these assessments (such as an MHAA) without finding him.

iv) *"The care co-ordinator should undertake an assessment on the appropriateness of referrals to other services"* **[NHFT0004725, p.7]**

I did not consider referring VC to the Crisis Team. As the note of my 8 January 2024 Interview explains, "*Crisis really need to know where the person is*" **[NHFT0004711, p.2]** in order to help.

The first thing the Crisis Team would have asked me was "*where exactly is he?*". To that question my answer would have been "*I have no idea*". I would have explained that he had had four addresses since he had been involved with the EIP team and was not engaging with us

by phone or text. From my experience of the Crisis Team, they would not have the resources to help in this scenario.

I don't think we ever discussed referring him to the Community Forensic Team. As explained in paragraph 108, the EIP team did not regularly refer people to the Community Forensic Team and, in VC's case, they would have had the exact same issue as us – not being able to find him.

v) *"The care co-ordinator should undertake an assessment of the patient's capacity and appropriateness for discharge from the service"* **[NHFT0004725, p.7]**

I was not at the MDT meeting on 22 September 2022 so I don't know what was considered when they decided to discharge him.

305. The letter of discharge sent back to VC's GP should have had details of his medication and when it was last supplied. Both a care plan and risk assessment should have been included. I do not recall writing VC's discharge letter, which would usually either be done by the CCO or the doctor. It may have been done by someone else, given that I was on leave when he was discharged. In my Theemis Interview I mentioned one of the admins telling me a letter had been sent detailing "*his medication […] when it had been last dispensed. "Can you prescribe from there onwards?"*" **[TCLT0000750, p.25]**, but I do not now recall what I meant by that.

306. I personally did not have any discussion with VC's family about discharging VC, which may have been because I was on leave at the time of the decision.

307. I personally had no further contact or involvement with VC after he was discharged from the EIP team.

308. At the time, the discharge process in general was quite informal. In hindsight it was too informal – I discussed that in my 23 April 2025 Interview **[NHFT0004880, p.4-6]**. I believe that that has now changed.

309. Emma also discussed the discharge process at this time during her interview for my conduct investigation. She suggested that "*a good, safe discharge*" involved "*making the family aware, getting the patient on board, robust letter to the GP in terms of associated risks, warning signs, treatment, medication etc. I know that things have changed now. I think that they have a safety checklist that has to be implemented before someone is discharged, but at that time we didn't have that*." **[NHFT0004872, p.49]**

310. I am now aware that Nottingham Magistrates Court issued a bench warrant without bail on 22 September 2022 in relation to VC's failure to attend court. However, at the time I was not aware of the bench warrant. I do not remember when or how I became aware of the warrant.

311. If I had been aware of the bench warrant, I would have informed both Dr Lloyd and Emma. I cannot see how the EIP team could have possibly discharged VC on 22 September 2022 if they had known about the bench warrant. If we had known, we could have contacted the Police and explained that we have also not been able to find him.

Conduct investigation

312. I was the subject of a conduct investigation by NHFT to examine a number of alleged concerns that had previously been raised in relation to the care I delivered to VC **[NHFT0004872, p.3]**. I can see from the Investigation Report that the Investigating Officers received the Terms of Reference for this investigation on 30 October 2024 **[NHFT0004872, p.8]**. I was interviewed on 17 April 2025 and 23 April 2025. I did not attend further interviews scheduled for the conduct investigation as I resigned from NHFT on 30 April 2025. The report was submitted on 18 June 2025.

Allegation 1: Failure to recognise VC's serious mental illness, symptomology, and risk factors and implement robust patient safety plans

313. The first allegation investigated was that I failed to recognise VC's serious mental illness, symptomology, and risk factors and implement robust patient safety plans **[NHFT0004872, p.8]**.

314. In relation to this allegation, the Investigating Officers concluded that:

> *In conclusion, there is evidence to suggest that [Gary] and the wider City South EIP Team showed a recognition of Patient V's serious mental illness via the documentation of his diagnosis and the need for, and importance of, concordance with medication.*
>
> *It has been frequently noted that there were concerns about medication concordance but other than speaking with Patient V about this and a lack of assurance about his responses, there is no documentation to show that discussions took place in relation to how Patient V's concordance could be improved, within clinical records.*
>
> *It is generally acknowledged by the CCO's involved in Patient V's care, that without medication there was a high risk that Patient V was likely to experience a relapse into acute psychosis. It is not clear that a risk management plan was in place to pick up early warning signs or how these might be managed.*
>
> *The Investigating Officers have noted that within clinical records and the statements provided to them by witnesses, Patient V's known presentation was that of a private individual, who was reluctant to share information and who remained guarded and uncommunicative. Engagement was challenging and mostly superficial. It is noted within the witness statements that these traits may have been reflective of*

Patient V's personality, but may equally have been symptoms of paranoia, attributable to mental illness. This was difficult to differentiate.

Finally, there is no indication within clinical records or witness statements, that the risk of violence and aggression shown by Patient V, was associated with a risk of relapse. However, it has been noted that Patient V had been violent and aggressive, when unwell. **[NHFT0004872, p.115]**.

315. I agree that I and others in the EIP team recognised VC's serious mental health condition and the importance of his concordance.

316. When I was VC's CCO, I was regularly discussing him with colleagues both informally and in MDT meetings, including regarding how his concordance and engagement could be improved. Since reviewing the notes, I accept that a lot of these discussions weren't documented. However, as explained in paragraphs 76 above, at the time we didn't have administrative support helping us record discussions from MDT meetings, and this was a team-wide problem. Others have also commented on this. For example, Sharon explained that they were aware there was no MDT documentation (see paragraph 77) and the Investigation Report explains there was no consistency around the way in which discussions within MDT meetings were captured (see paragraph 79).

317. I agree that I and the other CCOs involved in VC's care understood that without medication VC was likely to relapse.

318. I very clearly understood that the risk of violence and aggression from VC was associated with a risk of relapse. I disagree that this wasn't shown in the documentation. In the section on Risk to Others in the Risk Assessment, it explains, among other things, the violence and aggression shown by VC prior to his third admission when he was clearly relapsing **[NHFT0000190, p.5]**. The Risk Formulation in that Risk Assessment says:

Risks to others - Male, diagnosis of paranoid schizophrenia, appears to experience persecutory delusional beliefs that thoughts can be influenced and controlled by computer systems specifically developed to interfere with the mind. Hx of violence and aggression when detained (significant assault on police officers), violence and aggression towards housemates and refused to let them leave property, poor insight, does not agree that he has been unwell over the last 12 months. Poor engagement with community services, history of non-concordance with medication. **[NHFT0000190, p.5]**

319. This was included in the February 2022 Risk Assessment and it all still applied when I was VC's CCO, so I did not think it was necessary to update it. I agree with the conclusion that engagement with VC was "*challenging*". I have explained in paragraphs 220 to 224 above how difficult I and others working with VC found engaging him. I also agree that VC was a "*guarded and uncommunicative*" individual and it was "*difficult to differentiate*" between traits that may have been reflective of VC's personality but may equally have been symptoms of paranoia, attributable to mental illness.

320. The note from my 8 January 2024 Interview explains that VC has "*got a way of playing down his symptoms, so we needed to see him face to face. There were 2-3 attempts to see him prior to discharge*" **[NHFT0004711, p.2]**.

321. I can see from the Investigation Report that other colleagues who worked with VC commented on this. Emma said in her interview for my conduct investigation that VC "*probably 'masked' things*" **[NHFT0004872, p.51]**.

322. Claudia, in her interview for my conduct investigation, similarly suggested that VC had struggled to talk about his mental health and had just wanted to get on with his life and his studies. She explained that, whilst there had been times when engagement was slightly better (and therefore it was easier to have conversations with him), there were other occasions when he had perhaps not been as well, when communication was "*more challenging*" **[NHFT0004872, p.53]**.

323. Abi, in her interview for my conduct investigation, said that it was difficult to know when VC was unwell **[NHFT0004872, p.65]**. When asked in this interview if she had ever seen Patient V when he was unwell, Abi replied, "*I would imagine I did, but it was hard to know because there wouldn't have been a distinct difference*" **[NHFT0004872, p.65]**.

Allegation 2: Failure to identify poor engagement and non-concordance with prescribed medication and the impact this had on VC's mental health and risk

324. The second allegation was that I did not identify VC's poor engagement and non-concordance with prescribed medication and the impact this had on VC's mental health and risk.

325. The Investigating Officers concluded the following:

> *In conclusion, it is clear from the statements obtained by the Investigating Officers and the content of clinical records, that all members of the City South EIP Team found it difficult to engage with Patient V despite numerous attempts to contact him via text messages, telephone calls, planned home visits, 'cold calling' and clinical appointments.*
>
> *In addition, concerns were raised on numerous occasions about Patient V's non concordance with medication and that ultimately this was likely to lead to a relapse into acute mental illness.*
>
> *Whilst [Gary] has acknowledged that Patient V had previously used violence and caused damage whilst breaking into flat premises when unwell (and on one occasion had been detained by police officers who had deployed tasers to facilitate his arrest), there appears to have been little consideration regarding future risk and what risk management plans may need to be implemented.* **[NHFT0004872, p.123].**

326. I agree that I and other members of the team found it difficult to engage VC despite repeated efforts and have discussed this extensively in my statement (see paragraphs 220 to 224).

327. I also agree that concerns were raised by me and others in the team on numerous occasions about VC's non-concordance and that this was likely to lead to relapse (for example, on 9 November 2020 (discussed at paragraph 147) and following my and Claudia's visit on 31 August 2021 (discussed at paragraphs 157 to 161)). When I was VC's CCO, as explained in paragraph 233, by around May / June 2022, I was discussing VC probably at every MDT, though I appreciate I did not always record these discussions on RIO. The note from my supervision meeting on 27 July 2022 also discusses VC, explaining that "*when previously unwell [he] did need a taser when sectioned*" (see paragraph 254). As explained in paragraph 255, I imagine I was raising VC in most of my supervisions between May 2022 and him being discharged, although I understand this was not included in the supervision records.

Allegation 3: Failure to follow up on actions relating to VC's care, including discharge

328. The third allegation was that I had failed to follow up on actions relating to VC's care, including discharge.

329. The Investigating Officers concluded the following:

> *In conclusion, there is clear evidence to suggest that [Gary] did not always follow up on actions detailed within Patient V's RIO notes.*
>
> *In addition, the Investigating Officers have noted that [Gary] was not present during the MDT meeting held on 22nd September 2022, where the decision was made to discharge Patient V from the EIP service.*
>
> *In light of this and the fact that no discharge actions were documented within Patient V's RIO notes following the MDT meeting (and in the absence of a specific 'discharge checklist' within the prevailing guidance*

of the day — the Early Intervention in Psychosis Service Operational Policy), it is difficult to state with any degree of certainty whether [Gary] followed through with subsequent actions linked to Patient V's discharge. **[NHFT0004872, p.133]**

330. In some cases, I did not follow up on actions recorded in RIO for specific reasons. For example, as explained in paragraph 151, on 6 November 2020 I made a note saying I would visit VC again in a week's time, but in the end did not, because by that time Dr Burri and Claudia had visited him instead.

331. At other times, I did not follow up due to caseload issues. I accept that I should have visited the other address we were given for VC in August 2022 and I am sorry that I did not. I can only assume that I was very busy with other patients and I was then off work for a significant amount of time. At the time I was VC's CCO, the Investigation Report says my average caseload was 19.7 **[NHFT0004872, p. 114]**. I have explained the difficulties with this in my statement, for example, at paragraph 127.

332. In terms of follow up actions after VC's discharge, VC was discharged on Thursday 22 September 2022 when I was on sick leave. I understand from the Investigation Report that I was on sick leave until 25 September 2022 so I assume I was back at work on Monday 26 September 2022 (though I don't recall the exact dates). I don't remember exactly when I found out that they had discharged VC. The note left by Sharon following that meeting did not say whether any post-discharge follow up actions were agreed other than referring VC back to the GP (see paragraph 296). The note also does not explain whether the discharge letter had been sent or whether someone had agreed to send it. I don't remember sending a discharge letter (but I may have done) or speaking to VC's family, but this may have been because I was on leave when he was discharged. I (and other colleagues) have also explained that at the time there was not a clear discharge process (see paragraphs 308 to 309) like there is now. This is also acknowledged in the Investigation Report **[NHFT0004872, p.5]**.

Allegation 4: Inadequate documenting of risk, including care plan and risk assessment

333. The fourth allegation was that I inadequately documented risk, including the care plan and risk assessment. The Investigation Report makes the following conclusions:

> *[Gary]'s responses to the Investigating Officers suggest that he was quite happy to rely upon previous risk assessments, despite clear evidence of a lack of engagement and potential non-concordance, 'symptoms' which had previously resulted in a deterioration in Patient V's mental health, acts of violence and aggression and which had historically led to his admission to hospital.*
>
> *It is acknowledged that both Patient V's care plan and risk assessment documentation had previously been updated in February 2022. However, there is little (if any) evidence to suggest that these were subject to subsequent 'ongoing' review and evaluation.*
>
> *The Investigating Officers have noted that the care plan remained an inpatient care plan, despite the fact that Patient V was later based in the community and would have been receiving a different package of care.*
>
> *The nature of a further risk assessment conducted at an MDT meeting held on 28th April 2022, later detailed in a RIO entry made by CB the same day, is unclear, as the entry fails to provide details of the matters discussed during the meeting.*
>
> *Furthermore, risk assessment documentation contained within Patient V's clinical records was not updated to reflect the outcome of the MDT meeting.*
>
> *It is also noted that comments contained within CB's RIO entry, regarding the transfer of Patient V to a new CCO, '...preferably 2 CPN's',*

appears to have been ignored and again is not reflected in Patient V's care plan or risk assessment. **[NHFT0004872, p.137].**

334. Some of these conclusions do not relate directly to me. For example, the Investigating Officers have said that the entry from the 28 April 2022 MDT meeting was unclear, that the risk assessment documentation was not updated to reflect the outcome of that meeting and that the note from this meeting regarding VC preferably having 2 CPNs was ignored. I was not at the MDT meeting in question on 28 April 2022, but understand that no one else offered to work with VC alongside me at that meeting, and it was never arranged for someone from another team to help.

335. As explained in paragraph 200 above, I do think that I looked at both the risk assessment and the care plan. I did not think that the risk assessment needed updating as VC had the same problems the entire time he was involved with the EIP team (e.g. non-concordance and disengagement) so these issued were already addressed in the risk assessment. I understand that the most recent care plan was an in-patient care plan and therefore should have been updated. I can't recall why I did not update this.

Allegation 5: Failure to act in accordance with expected standards of professionalism and accountability

336. The fifth allegation was that I failed to act in accordance with expected standards of professionalism and accountability. The Investigating Officers made the following conclusions:

> *The Investigating Officers have not had the opportunity to discuss the audit results with [Gary] due to the cancellation of further scheduled interviews on 30th April & 14th May 2025 (see para 6.5 & 6.6) and [Gary]'s subsequent decision not to engage with the current investigation and to resign from the Trust.*

It is clear, from the enquiries made by the Investigating Officers, that record keeping and certain elements of GC's clinical practice did not meet the expected standards of professionalism.

There is no clear indication as to what level of support and guidance had been offered to improve his clinical practice and, in particular, his documentation, at the time that [Gary] was the CCO for Patient V. **[NHFT0004872, p.145].**

337. Sharon once, after the events of June 2023, told me that I should try to make my RIO notes more detailed. I accept that sometimes they may be briefer than my colleagues', but I always felt that my notes included all the information they needed to.

338. However, no one ever raised this with me before the events of June 2023. I understand that Emma explained that she was not personally concerned with my documentation when she was supervising me **[NHFT0004872, p.38]**. Sharon also said that in the period between January 2022 (when she started supervising me) and September 2022 (when VC was discharged), no one had directly raised concerns with her regarding the quality of my RIO entries though colleagues had occasionally said my notes were quite chaotic **[NHFT0004872, p.18]**. No one has ever approached me, either my peers or either of my managers, and told me that my notes were chaotic.

339. Therefore, I disagree that I didn't meet the "*expected standards of professionalism*". I certainly was never supported to improve my documentation before the events of June 2023 as no one had even told me that it needed to be improved. As explained in paragraphs 72 to 73, I don't recall ever being given training in relation to the completion of clinical records. I was given 45 minutes training on the RIO system, but this included things like how to open RIO, not what to include in RIO notes. I have also discussed documenting MDT meetings at paragraphs 76 to 82 above.

Contributions to other investigations into VC

340. I have looked through the transcripts from my 17 April 2025 Interview, my 23 April 2025 Interview and my Theemis Interview and think that they all look like broadly accurate records of what I said. In respect of the transcript for my 8 January 2024 Interview, as explained before, I think this document must be a summary of my interview with Psychological Approaches. I do not remember writing this document. I think it is an accurate summary of that interview but it is not a verbatim transcript.

341. I have never given any interviews or made any public comments on any aspect of this case.

Reflections

342. I was shocked at the events of 13 June 2023. I was abroad at the time. I found it all heartbreaking due to the loss of life and was traumatised by the savagery of VC's behaviour. I was truly shocked that VC had done this. When I was working with VC neither I or anyone else in the EIP team ever anticipated that he was capable of killing someone. As far as I was aware at the time when VC was a patient of the EIP team, nobody had ever expressed any concerns that VC could kill someone (though I now understand that Dr Seedat made a comment in relation to this discussed in paragraph 352 below). It is devastating to think about the loss suffered by the families of the victims. I couldn't even begin to imagine what they must be going through due to losing their loved ones in such devastating circumstances but they must have been completely destroyed and broken by the loss. Two of them were so young and one of them was looking forward to his retirement. I have my own family and cannot imagine the impact it would have had if one of my family members lost their lives in such circumstances.

343. I believe my distress about those events contributed to me becoming physically ill in late 2024 which culminated in me being hospitalised.

344. I resigned my position on 30 April 2025 because I did not feel like I could trust NHFT.

345. Following the events of June 2023, NHFT held a number of support meetings for people that had been involved in VC's care. I went to one of these and said something along the lines of "*Do you think we missed something? Do you think we could have prevented this?*". I remember Diane Hull, Dr Lloyd and Dr Thangavelu all rounded up on me and said "*No. There's no way we could have predicted this and no way we could have prevented it*". After that meeting, I felt like, if I didn't resign from NHFT, I would be forced to just toe NHFT's line about what happened and wouldn't be able to express my own feelings about the tragedy.

346. It also felt like NHFT were trying to find people to blame for what happened, and I realised I was one of them when I was suspended and my conduct investigation was started.

347. I also didn't feel like my conduct investigation was carried out in a fair way. I requested a number of documents (all of which I previously had access to on my work laptop before I was suspended). NHFT refused to provide a lot of these documents to me. I have exhibited a document showing what I requested from the Investigating Officers and which documents were available to me **[WITN0368003]**. I was offered access to view VC's progress notes under supervision and a number of other documents were publicly available. None of the other documents that I requested were provided to me. I felt this was very unfair as it meant I couldn't go into my conduct interviews with all the relevant information. The documents that weren't provided to me weren't particularly sensitive documents. For example, I asked for my own supervision records but was not provided with them.

348. I was suspended from NHFT in September 2024 so I worked around 15 months after the tragedy of June 2023. In that time, a lot changed in how the EIP team worked (for example, with clearer procedures regarding discharge and documenting MDT meetings (see paragraphs 308 to 309 and 76 to 82)).

Other than these team wide changes, I did not significantly change my clinical practice. I tried to put more details in my notes after Sharon told me I should do this (see paragraph 337 above). Other than this I did not change the way I practiced and was not instructed to.

My overall relationship and interactions with VC

349. In my 8 January 2024 Interview, I said with VC "*we were getting a little bit desperate as to what to do with this man in the community*" **[NHFT0004711, p.2]**.

350. I can't remember exactly when this desperation started but think it was sometime in summer 2022 when I just could not find VC.

351. In my Theemis Interview, I explained:

> *I just feel that he could have been treated more assertively. Perhaps not the first time. Perhaps not the second time, but the third time, the nature of the admission, the aggression, the violence, indicated, to me that this man could be dangerous.* **[TCLT0000750, p.34].**

352. I still believe that VC should have been treated more assertively by being kept in hospital for longer periods of time. For example, there is a note from VC's second admission that says "*Dr Seedat observed that there seems to be no insight or remorse and that the danger is that this will happen again and perhaps Valdo will end up killing someone*" **[NHFT0000168, p.64]**. It seems crazy to me that, given Dr Seedat saying this, VC was only admitted for 16 days on this admission. I never knew about Dr Seedat's observation that VC might end up killing someone until I saw a YouTube video discussing it after the tragedy.

353. After the violence shown by VC before his third admission, I don't understand why in-patient services didn't keep VC in hospital for longer. With the benefit of hindsight, I also think in-patient services should have referred him to

forensic services after the third admission as there was clear proof of how dangerous he was.

354. The note from my 8 January 2024 Interview states:

> ***Depot***
>
> *Mother was the first one to mention a depot, before any doctor. I think he should have had a depot, even if just one dose to see if his mental state improved. I'm less sure about the value of a CTO.*
>
> *Generally in EIP, a depot is a less common intervention (2/24 or 1/11 of my caseload). Most clients are on oral meds.* **[NHFT0004711, p.2].**

355. In my Theemis Interview, I said "*…it was pretty obvious that we had enough information about this guy to warrant at least trying [Depot] because he did not take his medication in the community*" **[TCLT0000750, p.29]**

356. I explained in paragraphs 90 to 91 that depot medication can be difficult in a community setting if the patient doesn't co-operate, if you can't find the patient or if they refuse to take it. There may have been issues with giving VC depot in the community, but my view was that it was worth trying, and I would have been happy to at least approach VC to suggest it if Dr Lloyd had wanted to try it. I remember the option being discussed multiple times in MDT meetings, but I'm not sure why Dr Lloyd never prescribed it. It is certainly true that VC would possibly have simply refused to consider it, and we couldn't have forced him.

357. It would probably have been easier for depot to have been started when VC was in hospital, and then we could have tried to continue this in the community. My understanding is that VC was resistant to the idea of trying depot because he didn't like needles, and so the option wasn't really pushed even when he was an inpatient.

358. As explained in paragraph 89, CTOs sound like a good idea, but the value of them diminishes if the patient is avoiding services, refusing to engage and avoiding us. My issue with VC was that I could not find him. Therefore, I don't think that a CTO would have helped.

359. In my Theemis Interview, I explained that VC was a man who would "*resort to violence*" and that he could be "*a danger to anybody who confronts him*" **[TCLT0000750, p.10].** The way to manage this risk was by ensuring VC was taking his medication.

360. I discussed my concerns about his lack of concordance and engagement regularly with colleagues, including at MDTs. It felt impossible to increase his concordance because he would not engage with us and he lacked any insight into the fact that he was unwell. Ultimately the only way we were able to increase his concordance was putting him in hospital, but he would then play by the rules until they had to discharge him.

361. VC was very intelligent, as I discussed in my Theemis Interview **[TCLT0000750, p.15-16].** I think that he understood that to get out of hospital he had to toe the line. The only time we can be 100% sure he was fully concordant was when he was in hospital as he realised that he needed to be in order to get out of hospital. On 10 November 2020, VC also admitted to Dr Burri and Claudia that, just before he was discharged from Highbury Hospital in July 2020, he told the doctor that he no longer heard voices but that that was not the case and he only said that because he was tired of being in hospital **[NHFT0000168, p.138].** This shows that he understood what he needed to do and say to get out of hospital.

362. In my 17 April 2025 Interview, when asked about whether I thought VC was moving towards becoming unwell in August 2022, I said:

> *I was pretty confident that it was only a matter of time before he would have a breakdown again, because I wasn't convinced of his concordance. And his concordance was vital to him maintaining his*

mental state. This was a man who needed medicating — he needed some medication and he was out there in the community and we didn't know where he was or what he was doing. He could have picked his medication up from me, [you] or anybody — then binned it at the first opportunity that he got. We didn't know what he was up to. I didn't know. **[NHFT0004882, p.20].**

363. I understand that the NHFT's Level 2 Investigation commented that too much emphasis was placed on complying with VC's priorities for his education. I do not think concern for VC being able to finish his degree or for his long term prospects impacted my approach to VC negatively (for example, by making me reluctant to use diagnostic labels or restrictive practices). As I worked in the community, I would not have been able to use restrictive practices on him anyway.

364. I am aware that there are concerns about the disproportionate overuse of Mental Health Act restrictive measures with black African and black Caribbean patients. Again, this didn't impact my decision making in respect of VC (again, as I worked in the community, I would not have been able to use such restrictive practices on him). However, I can see that this may have been a factor in how others treated him.

Recommendations

365. The main recommendations I have for the Chair of the Inquiry to prevent similar attacks in future relate to staffing.

366. As I discussed in my Theemis Interview **[TCLT0000750, p.39-40],** there is a huge shortage of nurses in this country. The EIP team was always understaffed while I worked there. One of the reasons why nurses do not choose to work in community roles is because they do not get the enhanced pay that they would get if they worked unsociable hours on wards. Therefore, to address the staffing shortages in community mental health teams, I think all community nurses should be paid at the top increment of Band 6.

367. I think it would also be helpful if there was a greater diversity of staff working in community mental health teams. I always thought it would be helpful if we had more people from ethnic minority backgrounds working in the EIP team, as the team would then have better reflected the community we were working with. That may not always have made a difference but it may have helped reduce some barriers between nurses and patients.

368. I also think that there needs to be a more even gender split in EIP teams. I have already explained that I often felt like I was allocated a lot of difficult patients due to the fact that I was the only male in my team (see paragraphs 180 to 184).

369. One of the key guiding principles in treating people under the Mental Health Act is the idea that you should treat people using the least restrictive option. I think that this needs to be reconsidered. In VC's case, I think there was too much emphasis placed on ensuring his treatment was in line with least restrictive practice. This resulted in, for example, VC never being tried on a depot (even when he was being detained in hospital) as he didn't like needles and so said he didn't want it.

370. I also think there needs to be greater prioritising of beds on mental health wards so that they are available to those with the most severe conditions. There are very limited beds on mental health wards, and that doesn't seem likely to change any time soon. There was always huge bed pressure when I worked in the EIP team. I think there needed to be a better system of prioritising beds for people who were a genuine risk to themselves or others.

371. In terms of improvements to multi-agency working, I think there could have been a lot of improvements in how the EIP team and the police worked together. As explained in paragraph 269 above, I always felt that it was hard to refer people to the police unless I had concrete evidence that something was wrong or that someone was missing. It would be helpful if there was a specific team or person at the police that we could get involved if we were

concerned about a patient. I also think there needs to be better communication channels between the police and mental health services as shown by the fact that the EIP team weren't aware of VC's bench warrant (see discussion in paragraphs 310 to 311 above).

372. I also think it would be good if it was easier for the EIP team to get forensic services involved with patients. As explained in paragraph 109, when I worked in the EIP team I wasn't aware of anyone referring a patient to forensic services. With the benefit of hindsight, I think it would have been good to have more interaction with forensic services and training on spotting when someone is dangerous to other people and when to refer someone to forensic services.

Statement of Truth

I believe the content of this statement to be true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: GRO-B

Dated: 22 December 2025 | 16:36 GMT

Index to First Witness Statement of Gary Carter

No.	URN	Document Description
1.	NHFT0004916	Document summarising my interactions with VC (undated).
2.	WITN0368002	The latest version of my CV (undated)
3.	NHFT0004882	Transcript from my interview for the conduct investigation on 17 April 2025
4.	NHFT0004731	My letter of resignation from NHFT (30 April 2025)
5.	NHFT0004012	NHFT Early Intervention in Psychosis Service Operational Policy (undated)
6.	NHFT0004872	NHFT Investigation Report v.2 Gary Carter (18 June 2025)
7.	NHFT0004711	Document titled 'Interview with Gary Carter (8th Jan)'
8.	TCLT0000750	Transcript from my interview with Theemis on 11 June 2024
9.	NHFT0004880	Transcript from my interview for the conduct investigation on 23 April 2025
10.	NHFT0004725	NHFT Procedure: 01.08a, Merged Do Not Attends (DNA's) / Cancellations & Management of Patients Who Fail to Engage with Services or Seek to Disengage from Care in an Unplanned Way Procedure (7 September 2021)
11.	NHFT0000417	NHFT Procedure, Do Not Attends (DNA's) / Was Not Brought / Cancellations & Management of Patients Who Fail to Engage with Services or Seek to Disengage from Care, in an Unplanned Way – 01.08, Issue 8 (November 2018)
12.	NHFT0000168	The Patient Record Summary for VC (24 May 2020 – 14 June 2023)
13.	NHFT0000190	A Risk and Safety Assessment for VC (28 February 2022)
14.	NHFT0000198	A Summary & Care Plan for VC (14 February 2022)
15.	NHFT0004909	EIP Managerial / Clinical Supervision Record (27 July 2022)
16.	NHFT0000122	A letter from myself to VC (17 August 2022)
17.	WITN0368003	A document showing what documents and information I requested from NHFT before my conduct interviews and what I received