1 Tuesday, 5 May 2026
2 **(10.00 am)**
3 **THE CHAIR:** Yes, Mr Carr.
4 **MR CARR:** May I call, please, Emma Robinson?
5 **THE CHAIR:** Yes.
6 **EMMA ROBINSON (sworn)**
7 **Questioned by MR CARR**
8 **MR CARR:** Ms Robinson, you have prepared a statement for
9 this Inquiry dated 26 November 2025. Is that statement
10 true to the best of your knowledge and belief?
11 **A.** Yes, it is.
12 **Q.** You're a Registered Mental Health Nurse.
13 **A.** Yes.
14 **Q.** You've been employed by the Trust, Nottinghamshire
15 Healthcare NHS Foundation Trust, since October 2000.
16 **A.** Yes, correct.
17 **Q.** You're currently Band 8a; is that correct?
18 **A.** No, I'm currently an interim 8b. I've got
19 an operational secondment in the current post that I'm
20 in.
21 **Q.** At the time of your statement you were working at the
22 Wells Road Centre, so that's a low secure forensic
23 inpatient hospital.
24 **A.** That's correct.
25 **Q.** But from 2015 to 2022 you worked in the Trust's Early

1 Intervention in Psychosis team.
2 **A.** Yes.
3 **Q.** EIP. And from 2019 to 2022 you were the manager of the
4 EIP City South team.
5 **A.** Yes, correct.
6 **Q.** And that's the team where VC was a patient.
7 **A.** Correct.
8 **Q.** If we can have on screen, please, paragraph 42 of your
9 statement, it's WITN0315001. It's at page 16. You set
10 out there, at the bottom of the page, the role and
11 responsibility of a team manager.
12 **A.** Yes.
13 **Q.** That's the role that you fulfilled. Dealing first,
14 please, with the training, mandatory training, what was
15 the training required to work in the EIP team?
16 **A.** The training was, I suppose, working in the Trust that
17 everybody does, no matter what area that they work in.
18 So that covers things like basic life, risk management,
19 recordkeeping, infection control.
20 **Q.** So nothing specific to EIP --
21 **A.** Nothing specific to EIP.
22 **Q.** And nothing specific to mental health.
23 **A.** No, that's correct. We do -- well, we do Mental Health
24 Act training, mental capacity, care programme approach
25 training, and they're quite -- more specific to mental

1 health but nothing specific to Early Intervention.
2 **Q.** The Inquiry has heard evidence from members of the team.
3 Is it right that there was no training on managing
4 medication concordance?
5 **A.** To the best of my knowledge that was correct, yes.
6 **Q.** No training on managing disengaging patients?
7 **A.** No, that's correct.
8 **Q.** No training on whether and when to refer to the
9 Community Forensic Team?
10 **A.** Correct.
11 **Q.** If we turn, please, to page 39 of your statement, and
12 it's going to be at paragraph 115, you describe there
13 "challenges" working as a team.
14 **A.** Yeah.
15 **Q.** The first "in terms of not having a risk rag rating
16 meeting", and then not having a duty system. What were
17 the challenges in the team that meant you couldn't have
18 the risk RAG meeting?
19 **A.** So the challenges in the team from when I first went
20 into the team in 2019 is that we was pulling the pathway
21 out of the Local Mental Health Teams. So the Early
22 Intervention Team used to be a standalone team and then
23 the pathway, along with some of the other speciality
24 teams, was pulled back into the LMHTs and then certain
25 areas wasn't working. We wasn't meeting national

1 standards so there was a decision to pull the EIP team
2 out again to a stand-alone team.
3 So some of the challenges we had was that we worked
4 in a different model to the Local Mental Health Teams.
5 Our structure, as set up, was different in terms of MDT
6 members. So for example, our team, when we started and
7 towards the end, we only had I suppose there was myself
8 as a manager, my clinical lead towards the end of when
9 I left, nurses, there was a CBTp therapist, and a peer
10 support worker.
11 The other Local Mental Health Teams was fuller
12 teams: they had OTs, they had psychology, they had
13 matron involvement.
14 So the teams was larger and they had, I suppose,
15 more structured meetings. So they had things like
16 I referred to in my statement, they used to have what
17 they called a RAM meeting every morning which would look
18 at patients that was presenting a higher risk, whether
19 they was at the point of needing Crisis. So discussions
20 were held every single day. So our structure in our
21 team didn't allow for that, and it was the same with the
22 duty system.
23 Some of the differences may be that the Local Mental
24 Health Teams had outpatients, so they had patients that
25 were not attached to care coordinators; they was just

1 under doctors, where all of our patients did have care
2 coordinators attached. So on reflection with regards to
3 the duty system, because of all of our patients had
4 direct access to the care coordinators, we may have not
5 needed a duty system in place, but for me, I think it
6 was just an extra layer that was there that could take
7 calls or field calls if the care coordinators were --
8 *(overspeaking)* --
9 **Q.** Sorry to interrupt. As to the challenges in the
10 structure, does it boil down to ultimately insufficient
11 numbers and more slender team?
12 **A.** Yes, and also I think also the model. So yes, the MDT
13 was a lot smaller than the Local Mental Health Teams,
14 but I think the model itself, we didn't have the same
15 kind of meetings or robust structures in place --
16 **Q.** *(overspeaking)* -- Can we do -- sorry, forgive me. Carry
17 on.
18 **A.** Sorry. I was just going to say that some of that was
19 still about building and developing the team. So when
20 the team -- when we first started taking those numbers
21 of patients out, we, before we recruited into more
22 staffing numbers, we had a couple of care coordinators
23 in each of the Local Mental Health Teams. One of the
24 other difficulties was that the team was not based on
25 one base. So I was team manager for one team that was

1 over five geographical areas of Nottingham, so I had two
2 teams in the city and three teams in the County South.
3 **Q.** Can I deal please briefly with the last sentence on this
4 page.
5 **A.** Yeah.
6 **Q.** You refer to having CBTp therapists but not having
7 psychology provision for the patient.
8 **A.** Yeah.
9 **Q.** Just holding that thought but then looking at your
10 Theemis interview. It's TCLT0000755, page 29. This is
11 the record of your interview with Theemis. It's the
12 bottom box on the page. You refer to not having CBTp
13 therapists.
14 **A.** Yes.
15 **Q.** Finding it very difficult to recruit them.
16 **A.** Yeah.
17 **Q.** Then over the page, page 30, second paragraph:
18 "... EIP staff wasn't even allowed to access the
19 psychologists ..."
20 **A.** Yes.
21 **Q.** So what was the limitation, what was the difficulty with
22 not having therapists or access to them?
23 **A.** I think for some of the staff -- so I know certainly
24 some of the supervisions with the some of the staff
25 they'd previously -- the staff had come -- a lot of the

1 staff had already come on the pathway from the LMHTs so
2 when, in the LMHTs, they accessed psychologists either
3 for themselves when dealing with what they felt was
4 difficult or complex patients to look at kind of risk
5 formulation work with psychologists. And also, access
6 for themselves, sometimes dealing again with quite
7 complex patients, just to have that time with psychology
8 themself, just to talk through caseloads or workloads,
9 and they felt that that was amiss in the EIP team. And
10 I know that's something I'd raised in some of my
11 meetings with my managers, in terms of the resources and
12 feeling that we needed psychology.
13 **Q.** If we could go back to page 29, at the top of the box,
14 there's a reference there to not getting finance, was
15 the issue one of -- you've just mentioned resources --
16 was the issue here caused by a lack of resources?
17 **A.** Yeah, I think at the time when they was putting the
18 model together, if I can recall, there was three
19 different models in terms of what they wanted to
20 achieve, kind of the national standard, and, if
21 I remember right, we wasn't funded for the model that
22 would have been, I suppose, the gold star in terms of
23 doing what we did. But I don't know, I can't answer
24 much more, really, about that. Sorry.
25 **Q.** If we go back to your witness statement, WITN0315001, at

1 page 21, paragraph 56, you're describing here MDT
2 meetings, so Multi-Disciplinary Team meetings and you
3 describe in this paragraph that there was no
4 administrative member of staff to take a relevant minute
5 but there was one in EIP North. As team manager, did
6 you not consider it important that somebody was
7 allocated to this role?
8 **A.** Yeah, and it was again something that I'd raised in my
9 meetings with my seniors, alongside lack of psychology,
10 lack of matron cover and admin. Admin was a constant
11 conversation I was having about needing that.
12 **Q.** What was the reason that there wasn't one there or there
13 was --
14 **A.** I don't know. I don't know whether, again, that was
15 around finances.
16 **Q.** If we go to the following paragraph, again, dealing with
17 MDT, second sentence, you say:
18 "The CCO would be expected to make notes but there
19 was no policy in force at the time requiring a minute to
20 be taken."
21 Do you have that? It's on the screen at the top.
22 **A.** Yes, yeah.
23 **Q.** Was your expectation, then, that, although there wasn't
24 an admin member of staff to keep a minute of the
25 meeting, the CCOs attending, where there was something

1 discussed about their patient, they should be entering
2 it into the RiO note?
3 **A.** Yes, I did but on reflection, I think, also I should
4 have had oversight of looking at the notes and I'm
5 sure -- I'm not sure if we'll come on to that but, as
6 the team manager at the time, I should have been looking
7 in notes more robustly in terms of audit processes.
8 **Q.** We will deal with that point shortly but just dealing
9 with this first: if it was an expectation of yours, why
10 wasn't there a policy in place for it?
11 **A.** I don't know. I'm sorry. I can't answer that. Sorry,
12 just to add, when I say it was an expectation of mine,
13 I think, as a qualified registered nurse myself, that's
14 the angle that I'm coming from, that I've been
15 previously a nurse. I've not always been a manager and
16 I would have to write in patients' notes if it was my
17 patient.
18 **Q.** You made a point a few moments ago about not having
19 oversight, not checking the notes. Were you proceeding
20 on the basis, was it your belief, that this was being
21 done by the CCOs working under you?
22 **A.** Yes, it was. It was.
23 **Q.** First sentence of paragraph 57, you describe each MDT
24 meeting lasting around an hour and a half, involve
25 discussion of around 20 to 30 patients. Just one point

1 on this, and I can get at the Theemis interview if
2 necessary, but there it's suggested by you that the
3 discussion was of 60 to 80 patients?
4 **A.** Yes, it did vary and I suppose the MDTs, probably the
5 focus is the VC MDT but we had five of those -- I had
6 five of those a week, five MDTs a week, not just the
7 one, because of the different areas.
8 **Q.** As well as attending MDTs, you undertook supervision --
9 **A.** Yes.
10 **Q.** -- of the members of your team and, until Sharon Heath
11 was recruited, you were supervising all the members?
12 **A.** Yes.
13 **Q.** Then, once she was hired, you divided it --
14 **A.** Yeah.
15 **Q.** -- between the two of you. In respect of VC's care
16 coordinators, you supervised Claudia Birtles until her
17 maternity leave --
18 **A.** Yes, correct.
19 **Q.** -- in August 2022. So that would have covered the time
20 she was VC's care coordinator.
21 If we go to page 30 of your statement, it's
22 paragraph 92, you refer there to keeping handwritten
23 notes of the supervision sessions but, second sentence,
24 you state:
25 "... I did not keep robust records of all my

1 supervision sessions and this included this timeframe."
2 Now is it right that, insofar as supervision
3 sessions with Ms Birtles, where VC was discussed, there
4 were no notes of that?
5 **A.** That's correct. My understanding was, sorry, that I had
6 handwritten some and there was some in the personal
7 files but I know, since this Inquiry, that those
8 supervision records, nobody can find them. So ...
9 **Q.** You mentioned a few moments ago in your answer not
10 looking at the records to check whether MDTs were being
11 noted there and you deal with it in your statement as
12 well, page 17, please, paragraph 47. You say there:
13 "My role as Team Leader did not involve inquiring
14 into a patient's records. It was not my practice to
15 look into a patient's RiO records, unless specifically
16 invited or required to do so ..."
17 It's a point which applies to MDTs but also
18 supervision generally. How could you be assured as team
19 leader, as a supervisor, as to the quality and
20 completeness of records, risk assessments, care plans,
21 without reviewing them?
22 **A.** Yeah, I think, on reflection, that was the wrong thing
23 to write. I didn't need to be invited into patient's
24 notes. I think what I was trying to aim at there was
25 I was not in the RiO records as often as what my

1 clinicians were because they had the direct patient
2 contact. In terms of, I suppose, information coming to
3 me -- and I did go in the RiO records, not just for VC
4 but for other patients. When we had referrals coming
5 in, I had to access the notes, look at the notes. In
6 terms of oversight of the quality of the documents, risk
7 assessments, it was usually verbal feedback that
8 I relied on, which I now know is insufficient. But
9 I relied on that information from my CCOs and I'd ask
10 those questions, but I do know that it should have been
11 something, I think -- I think it was just a very, very
12 busy period. But, on reflection now, it's not
13 acceptable as the team manager that I wasn't doing those
14 audits.
15 I think there was one particular audit that there
16 was a step-down of and that was around the
17 documentation, which was like a quarterly audit, and
18 that did happen also, I think, in the LMHTs, and
19 I think, if I was right, I think that was something
20 around Covid, the step-down of certain audits and
21 certain pieces of work that we did, and I think that was
22 specifically around making sure we was meeting the front
23 end of the service and we'd changed the way in which we
24 was working with patients, in terms of like face-to-face
25 contact, the systems that we used. And I think there

1 was a lot of that as well.
2 Q. You mentioned that you did go into VC's RiO records.
3 What caused you to go into his RiO records?
4 A. I think it was just when I was looking at others as
5 well. It might have been something around, you know,
6 discharge or having a look. It wasn't like a thorough
7 overview of his records. It might just have been
8 something we looked at, like, following a discussion in
9 MDT meetings. But it wasn't the oversight that there
10 should have been from myself.
11 Q. Care plans and risk assessments, did you consider those
12 for VC?
13 A. Again, it was just through MDTs and discussions that we
14 spoke about updating risk assessments. I didn't go back
15 in and check that those was done, and it was the same
16 with care plans.
17 Q. In respect of a care plan, we know VC's last community
18 care plan had been June 2021. Now, where he had been
19 discharged from the third admission in October 2021, was
20 that a point at which that care plan ought to have been
21 updated?
22 A. Yeah, I think following any discharge we'd look at care
23 plans being reviewed, risk assessment as well, and the
24 risk assessment can be changed as often as risk changes
25 as well. It's not a static timeframe in terms of it

1 should be done every six months or every year; it should
2 be reviewed regularly.
3 Q. So at discharge, that would apply both to the third
4 discharge and discharge from the fourth admission in
5 February 2022.
6 A. *(The witness nodded)*.
7 Q. And it needs to be update in any event within a year.
8 A. *(The witness nodded)*.
9 Q. Now did you ever discuss with Ms Birtles the need to
10 update those care plans or check whether it had been
11 updated?
12 A. Yeah, we would have had discussions around that.
13 Q. As to the broader team, whilst VC was in the community,
14 so not an inpatient, who did you understand his
15 responsible clinician to be?
16 A. Dr Lloyd.
17 Q. And in terms of supervision and your approach to
18 supervision, were there assessments, be it annual or
19 twice a year, assessments carried out of your members of
20 staff, the members of your team?
21 A. In -- sorry what do you mean by assessments? Apologies.
22 Q. Consideration of the performance of staff, a measure of
23 how they were performing against expectation.
24 A. Yeah, I think -- I wouldn't say formal assessments.
25 There was one person in particular in the team that

1 I had to see, because there was some concerns raised
2 around him visiting patients out of hours.
3 Q. Is that Mr Carter?
4 A. Yes.
5 Q. And when did you have to see him?
6 A. I can't recall the year when it was, but we had a number
7 of staff that raised concern that he would hand over --
8 what we would do if a care coordinator went on leave,
9 they would hand over the caseload to somebody to cover
10 for them while they was on leave, and what come to my
11 attention was that the care coordinators from the team
12 come -- say that they've got concerns that they was
13 trying to pick up the work that had been left them, but
14 they could see by the RiO records that he'd already
15 completed it, which meant that he was working either at
16 weekends or on his leave.
17 Q. What you're describing there essentially responding to
18 concerns --
19 A. Yes.
20 Q. -- about a member of your team. But was there -- as
21 part of the procedures at the EIP, were there regular
22 assessments, quite apart from whether there were any
23 specific concerns raised?
24 A. No. There's the appraisals. I mean, we do the yearly
25 appraisals in terms of looking at people's performance

1 and anything that they raise in terms of what they're
2 wanting to do for training or development, but that's
3 the only assessment process that I'm aware that I've
4 ever done in any of my teams.
5 Q. And just dealing with the point in time when you had to
6 speak to Mr Carter, that you just referred to issues
7 with him working out of hours, taking work home. What
8 was the explanation that you obtained for those
9 practices?
10 A. He said -- I can remember at the time I think that he'd
11 got a lot going off at home and that work was
12 the distraction for him. He -- I had to have
13 conversations because I think within the team, the team
14 felt quite undermined and they felt that he thought that
15 they couldn't do their job as well as him, so we had
16 that conversation. We had conversations around it being
17 dangerous practice as well, to be doing that in terms of
18 seeing patients outside of working hours. We have
19 a Safe and Well Process in the community where we have
20 to phone in at the end of every day, all the care
21 coordinators do when they've been out on visits to
22 report that they're out of patients' homes and that
23 they're safe, and there was a breach of that in terms of
24 Mr Carter doing that.
25 Q. The recommended caseloads for CCOs was 15, wasn't it?

1 **A.** Yes, that's right, yes.
2 **Q.** And it's it right that Mr Carter -- and he wasn't alone
3 in that -- his caseload was in excess of 15?
4 **A.** Yeah, from what I've seen, though, I think there was
5 a document that I've been provided with, I think he was
6 reporting caseloads of 24 and above, but on average I
7 believe that that's not correct. I think he was lower
8 than that. But in fairness to Mr Carter and the other
9 care coordinators, there were times where the numbers
10 did fluctuate and go above 15.
11 **Q.** But when concerns were being raised as to a member of
12 your team working out of hours, taking work home, did
13 you turn your mind to the issue of excessive caseload?
14 **A.** No, I didn't.
15 **Q.** Did you take any steps to reduce the caseload?
16 **A.** No, and I asked -- I mean we had conversations, I had
17 conversations with Mr Carter with regards to his
18 caseload and he never raised any concerns about managing
19 that. We did have conversations about reducing that
20 caseload, and when we tried to move or take some
21 patients off him, there was always a bit of difficulty,
22 just in terms of he was ready to discharge some
23 patients. So in his point of view, he felt that it was
24 no point in taking them because they'll be coming up to
25 discharge soon and that would lower his numbers.

1 There was issue -- I did, I did -- when the times
2 was when the caseloads was fluctuating as well, you
3 know, I did -- I did raise that. Do we need more
4 resources? Do we need more nurses? But equally, people
5 had numbers on the caseloads and some of those were
6 students; sometimes the students would go home for the
7 summer so they wouldn't need visits. So it might just
8 be texts or phone calls. So the caseloads varied in
9 terms of complexities and what needed to be done for the
10 patients.
11 **Q.** Can we put on screen, please, your witness statement
12 WITN0315001, and turn to page 30. I'm going to ask you
13 now about your knowledge of VC, knowledge of his risk.
14 It's at page 30, paragraph 93. You describe Ms Birtles
15 raising "issues" about VC, difficulty engaging, her
16 sense of "unease" about him. And then at page 31,
17 paragraph 95, again reference to difficulties to engage
18 VC.
19 When and how did you become aware of his problems
20 with medication concordance?
21 **A.** I think this was later, a bit later on actually because
22 I know -- I think right at the beginning, like said, and
23 this was before I'd got my clinical lead, I was doing --
24 covering a lot of different areas, but through MDTs,
25 because I was in some of the MDTs, and through

1 supervisions, there was periods where she'd speak about
2 him. So if I remember right, I knew when he'd not long
3 come into the team and then he did go for a period of
4 engagement that I can recall with us, and then started
5 to become more of an issue in terms of him collecting
6 meds and his engagement.
7 So I think it was probably a bit later on, before
8 the discharge, I was aware that this man was quite
9 difficult to get hold of, and also, as I've said in my
10 statement, that Claudia in her supervision spoke about
11 feeling just a bit of unease around him. She'd
12 mentioned that he was a bit guarded at times and
13 struggled to get that therapeutic relationship with him.
14 **Q.** Before we look at some of the entries in the chronology
15 and your involvement in them, you've been involved in
16 a number of reviews, we have interviews --
17 **A.** Yes.
18 **Q.** -- from the internal investigation, Theemis, the Carter
19 investigation, and you will have no doubt reflected on
20 the involvement of the team you managed in VC's care.
21 What do you think went wrong with the EIP's management
22 of VC?
23 **A.** Um. I think, I think we've spoke about some of the
24 things already in terms of documentation being a key
25 point. I think recordings of the MDT. We know some of

1 the documentation from some of the care coordinators
2 could have been better. He was -- he was a very
3 difficult person to -- and I'm saying this from my care
4 coordinators, not from me -- he was a very difficult
5 person to engage with. I know that we had multiple
6 addresses for him, from what I was told from my care
7 coordinators. I think he needed a more robust service
8 than what Early Intervention actually could offer, and
9 I know we did, I suppose, based on the caseloads of 15
10 for a full-time worker, the idea is that they do three
11 visits a day, so that's once a week that somebody's
12 visited. And that varies -- and then that will vary
13 depending on people's caseloads, and other patients that
14 might need more visits. I think, in hindsight, he
15 needed a team that could do more of that follow-up.
16 **Q.** Ms Parsonage, in her evidence last week, I don't know if
17 you saw it, she described VC as an Assertive Outreach
18 patient --
19 **A.** Yes.
20 **Q.** -- on the EIP, or somebody who became an Assertive
21 Outreach patient on the EIP; would you agree with that?
22 **A.** Yes. It became evident, I think, as time went on, and
23 the supervisions that I undertook that, yes, we --
24 **Q.** Is the reality that the EIP were ill equipped to deal
25 with a patient of VC's complexity in his presentation?

1 A. I think due to his non-engagement in trying to work with
2 us, then yes.
3 Q. If we turn to page 29 of your statement, paragraph 87,
4 and you there refer to the fact you had only one
5 face-to-face interaction with VC, which was,
6 essentially, a medication drop, where you gave him
7 medication?
8 A. Yes, I think he'd come to base. The care coordinators,
9 I don't think, was around, and that's why I gave the
10 medication -- reception normally contact us. So this
11 had -- I'd have had a call from reception to say one of
12 the EIP patients is in reception and none of the care
13 coordinators were in. So they was either out on visits
14 at the time and he'd come for a medication collection.
15 Q. You can't recall when it is. This interaction is not
16 recorded in the RiO notes, is it?
17 A. No.
18 Q. And it should have been?
19 A. Yes.
20 Q. If we look at the records, please, it's NHFT0000168, and
21 go to page 135, it's the entry in the middle of the
22 page. 9 October entry by Ms Parsonage. That's when she
23 has gone with Anthony Walthall to VC's home address.
24 They don't find him but they speak to a housemate who
25 said that VC is okay and Ms Parsonage gave evidence on

1 this last week.
2 A. Yeah.
3 Q. The final entry in that box is:
4 "I will email ..."
5 I think it should say:
6 "I will email [the manager, Emma Robinson,] to
7 follow up next week."
8 The context of the attendance, it's just in the box
9 above, if we can see that, is a telephone call from VC's
10 mother, who's raising concerns because VC has told her
11 he doesn't want to speak to her for the next two months
12 and that's unusual.
13 Now, we can see that, following the 9 October 2020
14 entry, there is nothing entered until the following
15 week, 15 October, after a further discussion with VC's
16 mother. Did you discuss this attendance with
17 Ms Parsonage or Mr Carter?
18 A. Yeah, I can't recall. My usual practice would be that,
19 if I had an email to follow that up, then that would
20 have been handed over to one of the other care
21 coordinators to follow up. I can't recall that
22 conversation, unfortunately.
23 Q. We can see the email dealing with this. It's
24 NHFT0017917, an email from Ms Parsonage to you and Gary
25 Carter. Again, it reflects what was in the RiO note we

1 just saw, final sentence:
2 "Can this be followed up next week?"
3 A. Yeah.
4 Q. Did you respond to this email?
5 A. I would have passed it on to one of the care
6 coordinators to follow up but I can't recall.
7 Q. Can't recall who you passed it on to?
8 A. No.
9 Q. Looking at the notes, it doesn't look like it was
10 followed up.
11 A. Yeah, I can't recall, sorry.
12 Q. If we can move on to January 2022 and it's reference
13 NHFT0018181. We can see an email at the bottom of the
14 page or the second email on the page from Ms Birtles to
15 Dr Lloyd and yourself, referring to an abrupt message
16 from VC and Ms Birtles saying she doesn't think he's
17 going to come. You respond, at the top of the page:
18 "... we may need to consider discharge, we know he
19 can become unwell and has had admissions but he is not
20 engaging at all."
21 Then you refer to the potential plan of a different
22 care coordinator but you say you don't think that:
23 "... will change engagement with services, but happy
24 to discuss."
25 Can you explain your rationale in that email? If

1 you know he can become unwell and that's led to
2 admissions, admissions following violence, why would
3 disengagement be a reason here to discharge him?
4 A. Yeah, and because of that time, as well, I'm not sure
5 specifically around that time. So we know that we
6 discharged him later in the September. I suppose it was
7 looking at kind of treatment options. So we may have
8 known that he'd become unwell, but it was, I suppose,
9 trying to provide treatment for somebody who we can't
10 get ahold of. And I think I said that we'd bring that
11 to discuss further, which I think we did, in terms of
12 looking at different ways of engaging him. Sometimes
13 it's -- it is quite difficult to -- in the community, to
14 give somebody treatment or offer therapeutic
15 interventions and which --
16 Q. We'll come on to the steps that followed, in particular
17 the reference to "we may need to consider discharge"
18 because, if you're discharging him, you're not going to
19 be giving him more treatment, are you?
20 A. No, but equally we can't if he's not engaging either.
21 Q. Did you consider that disengagement might indicate an
22 increase in risk?
23 A. I think it was considered.
24 Q. That disengagement might indicate that he's becoming
25 more unwell?

1 **A.** Potentially. But also we have patients that just don't
2 want to interact with the services. I know VC is
3 slightly different because he'd had his admissions
4 previously. I do appreciate that.
5 **Q.** If he's more unwell, then that might raise issues as to
6 his capacity?
7 **A.** Potentially, yes.
8 **Q.** So in those circumstances, wouldn't that call, rather
9 than for disengagement, for a more assertive approach.
10 As you indicated before, VC was becoming an Assertive
11 Outreach patient --
12 **A.** Yeah.
13 **Q.** -- and it would require more engagement rather than
14 none?
15 **A.** Yes, but we're limited with what we could do with that.
16 We didn't have an Assertive Outreach pathway to refer
17 him to.
18 **Q.** If we go to the next -- sorry, no, if we go to
19 NHFT0018114, this is roughly a week later. It's the
20 seconds email on that page from you to Dr Lloyd, and you
21 describe there a discussion that you'd had with Adele --
22 that's Adele Pinder, isn't it?
23 **A.** Yeah.
24 **Q.** One of your CCOs?
25 **A.** Yes.

1 **Q.** She'd raised concerns about going to see VC about his
2 risk to others.
3 **A.** Yes.
4 **Q.** You refer there to the incident over the weekend,
5 locking students in his accommodation. Here you are
6 suggesting, aren't you, setting up a Mental Health Act
7 Assessment?
8 **A.** Yes.
9 **Q.** Now, obviously, just a week after raising the
10 possibility of discharge, and following this email here,
11 we're looking at 18 January, VC went on to have two
12 Mental Health Act Assessments that month, didn't he --
13 **A.** Yes.
14 **Q.** -- and was detained for the fourth time?
15 **A.** Yes.
16 **Q.** Did that cause you to reflect on your earlier suggestion
17 of raising discharge and the appropriateness of it,
18 given that, in such a short period of time, VC was
19 detained?
20 **A.** It has -- I suppose I've reflected on it since. I think
21 during that time, potentially not.
22 **Q.** If we go to April 2022 now, and it's back to the
23 records, NHFT0000168, page 265. The entry at the top of
24 the page is by Ms Birtles. It's from 19 April 2022, and
25 we can see there that VC is requesting a home visit, and

1 in the fifth paragraph Ms Birtles says she's discussed
2 it with you, and you'd agreed:
3 "... given ... historical risks of violence ...
4 hostage taking, home visits were not appropriate unless
5 absolutely necessary ... better to continue with the
6 plan to offer appointments at the Stonebridge Centre."
7 Now at this stage, and since February 2022, it had
8 already been decided, hadn't it, that VC should not be
9 seen alone at home?
10 **A.** Yes.
11 **Q.** So this was a further escalation, as it were, of that
12 restriction on contact with VC.
13 **A.** Yeah.
14 **Q.** And it was an escalation given the risk, as you saw it,
15 to EIP staff.
16 **A.** Yes.
17 **Q.** What thought did you give to his increased risk to the
18 public at large?
19 **A.** We knew that there was potentially an increase, but I
20 suppose at the time, looking back, I just had to ensure
21 that whilst trying to work with this person, that the
22 staff were safe. We'd raised this, discussed this,
23 I believe, with the RC as well. We took these decisions
24 into the MDT meetings.
25 **Q.** In light of these restrictions on contact with VC, the

1 escalation in that restriction here, was there not
2 a need to update and change the risk assessment?
3 **A.** Yes, there would have been.
4 **Q.** To your knowledge, did anybody discuss with VC why he
5 had want to speak to a care coordinator face-to-face?
6 **A.** No. I understood Ms Birtles, but I might be wrong, had
7 a conversation after -- or no, he went -- somebody else
8 went on another visit, didn't they?
9 **Q.** Well, not long after this there was a change in care
10 coordinator, wasn't there --
11 **A.** Yes.
12 **Q.** -- at the end of April, a change from Ms Birtles to
13 Mr Carter. And if we look at, please, NHFT0004708, and
14 it's the second page of this document. This is a note
15 of your interview for the purposes of the Trust's
16 internal interview.
17 We can see there an explanation of the change of
18 care coordinator:
19 "... Claudia [Ms Birtles, feeling] uneasy ... didn't
20 feel safe to see him at his home address ... He was
21 quite guarded ..."
22 The primary reason for the change in care
23 coordinator, was it his violence and unpredictable
24 behaviour?
25 **A.** It was, if I remember rightly at the time, Ms Birtles

1 was a pregnant CPN. So we'd always look at that
2 caseload with eventually going into more admin-type role
3 for a pregnant worker, in terms of face-to-face patient
4 contact.
5 There was other reasons we felt as well that he'd
6 disengaged a little bit from Claudia. We thought that
7 a male worker may have a different approach with him.
8 So there was couple of reasons, really, why we changed
9 care coordinator.
10 **Q.** A number of reasons. Was the primary one because of his
11 violence and risk?
12 **A.** His risk, yes.
13 **Q.** You said in your statement you were not aware of a plan
14 for VC to have two care coordinators.
15 **A.** Yes.
16 **Q.** You will have seen since, the reference in the RiO
17 records to that.
18 **A.** Yes.
19 **Q.** Is that something that would have or should have been
20 flagged with you?
21 **A.** Yeah, and I think we would have, if we was to go out,
22 because the idea that he came to base, but I know
23 equally we needed to try and go out and see him, that
24 there was two people that attended that visit.
25 **Q.** Where there is a change of care coordinator, and

1 particularly where there's a change for --
2 **A.** Yes.
3 **Q.** -- the reasons that we've just considered, is there
4 a need for a formal handover from the previous care
5 coordinator to the incoming care coordinator?
6 **A.** Yes. Ideally there should be a formal handover.
7 **Q.** Did you take any steps to ensure that one was carried
8 out?
9 **A.** No, because Gary and -- sorry, Mr Carter and Ms Birtles
10 worked closely together, worked in the same office
11 space. I may have wrongly assumed, but I thought they
12 would have done that handover.
13 **Q.** If we go to the records, please, NHFT0000168, page 270.
14 The entry at the top of the page, 4 August, by
15 Mr Carter. This is where Mr Carter attempts a cold
16 call. He's at an address that VC does not appear to be
17 at, and he writes at the end of that first paragraph:
18 "... I will take this situation back to Dr Lloyd and
19 Emma on Monday."
20 Do you recall having a discussion with Mr Carter
21 about that third -- *(overspeaking)* -- cold call.
22 **A.** Yeah, not that specific entry but I know around that
23 period Mr Carter was reporting lots that he was going
24 out and visiting, trying to find him, and couldn't get
25 hold of him.

1 **Q.** What advice did you give?
2 **A.** That if he was continuing, that he needed to take
3 somebody else with him, to bring it back to MDT and to
4 discuss with Dr Lloyd.
5 **Q.** The next entry, can we deal with that, please: 9 August
6 2022, an entry by Ms Birtles referring to VC's request
7 for access to his notes, says you will be dealing with
8 the request.
9 **A.** Yes.
10 **Q.** What was the understanding of yourself or the team as to
11 why VC was requesting his records?
12 **A.** I think initially -- I don't think the request initially
13 come to us; I think it came through Information
14 governance. They made a request to them to access his
15 medical records, and there needs to be some work done
16 around that with regards to redacting third parties out
17 of that, and I can remember having a conversation with
18 Dr Lloyd, because it usually has to go through the RC,
19 as to whether we give permission.
20 My understanding of that, why he'd requested, it
21 wasn't uncommon. I didn't think too much about why he'd
22 requested. It's not uncommon that our patients ask to
23 see the medical records.
24 **Q.** We can see that Ms Birtles has gone on to state that VC
25 "has documented a different address to the address ...

1 provided to the EIP team".
2 **A.** Yeah.
3 **Q.** And she has written there the address: 15 Madison Court,
4 Derwent Way. And that's the address, ultimately, that
5 the discharge letter --
6 **A.** Yes.
7 **Q.** -- is sent to.
8 But the application for access to records, if we can
9 put that up, please, WITN0163002.
10 We can see here, this is the application made by VC.
11 We can see that address, the 15 Madison Court one, at
12 the top, which Ms Birtles has ended into the RiO
13 records. But if we go on to page 2 of this document --
14 sorry, page 3 -- we can see halfway down the date given
15 is February 2022.
16 **A.** Okay.
17 **Q.** Do you see that?
18 **A.** Yeah.
19 **Q.** And it's not, if we go back to the records, NHFT0000168,
20 *(Pause)*. And if we go to page 203, please. If we look
21 at the entry at the bottom of the page, 18 January --
22 **A.** Yes.
23 **Q.** -- we see there the entry following contact from the
24 University referring to an assault by VC. Middle of
25 that section:

1 "I was assaulted by a fellow student and flatmate
2 last night at Raleigh Park."
3 That's the same address, isn't it? That's where
4 Madison Court is, Raleigh Park?
5 **A.** My understanding, it is. I'm not sure. I can't know.
6 Sorry, I'm not sure.
7 **Q.** If we look at NHFT0018213, go to page 3. There's
8 an email in the middle of that page which has been
9 copied to you, this is from middle of April, email from
10 Ms Birtles to Eleanor Turner at the University. And
11 below that, so if we turn to page 4, we have
12 a description there from Ms Turner of VC returning to
13 Raleigh Park, security officers interacting with him,
14 him being "escorted off site", the Raleigh Park team
15 being asked to -- "advised to contact the Police if [he]
16 returns and they feel in danger in any way".
17 That point is that Raleigh Park, the Madison Court
18 address, is one that your team ought to have known that,
19 since February 2022, VC was no longer at.
20 **A.** Yeah.
21 **Q.** If we can deal finally, please, with the issue of the
22 discharge of VC as decided at the MDT meeting on
23 22 September, in your statement and in the interviews
24 you've given you say you can't recall whether you were
25 present or not at that meeting. Dr Lloyd, who will be

1 giving evidence later this week, she states that you
2 were at that meeting.
3 **A.** Yes. Sorry, just to say, I suppose, just within my
4 statement as well, I did state that I couldn't recall if
5 I was in that meeting, but I was aware of the discharge
6 around VC when we discharged him on 22 September. I was
7 part of those discussions with the team beforehand. The
8 discharge I think we've been talking about a couple of
9 weeks before that actual date. So I do accept that
10 I was involved in those discussions, regardless if I was
11 in that meeting or not on that date.
12 **Q.** Well, we'll deal with some of the reasons for the
13 decision. Just before we get there, though, if we put
14 your witness statement back on screen, please, page 36,
15 it's paragraph 106. And you're describing there the
16 usual practice being to discuss with the RC, responsible
17 clinician, you've said that that was Dr Lloyd, and the
18 CCO, to get their views. What did you understand the
19 views of Gary Carter to be on discharge?
20 **A.** My views, from discussing with Mr Carter, was around
21 that he'd again tried to get hold of VC at various
22 addresses. I was informed that he'd tried to call him,
23 he'd sent a letter to him to try and engage him, but in
24 fact that he wasn't coming for appointments.
25 **Q.** So what was his view, as you understood it, about

1 discharge?
2 **A.** My view was, after discussing -- and he discussed with
3 me around discharging potentially back to the GP.
4 **Q.** Sorry, say that again?
5 **A.** He was talking about, along with quite a few others,
6 around a discharge back to the GP.
7 **Q.** So your understanding was that he was in favour of
8 discharge?
9 **A.** Yeah, because we couldn't get ahold of him.
10 **Q.** If we just go above, it's paragraph 104, page 35. Yes,
11 go down a little bit. So it's the bottom of page 35
12 into page 36:
13 "There was nothing to suggest he was unwell, and we
14 knew he had been in touch with his sister and, from the
15 handover, from his mother, and he had also made
16 a request to access his medical records."
17 It is just this point about there was nothing to
18 show he was unwell and some of those reasons that you
19 give. The request for medical records, as we've just
20 looked at, that was in February 2022.
21 **A.** Yes.
22 **Q.** In any event, somebody making a request for medical
23 records, does that indicate whether they're well or not?
24 **A.** No, but it indicates that -- I think that was more
25 around the police and the missing -- is he a missing

1 person? And it would indicate that he's obviously
2 reaching out for his medical records and that he wasn't
3 missing.
4 **Q.** Discussion with his mother -- well, that had been a few
5 weeks earlier, wasn't it?
6 **A.** Yes, yeah.
7 **Q.** There's nothing in the RiO entry describing that which
8 is particularly reassuring as to VC's condition, is
9 there?
10 **A.** Not that I'm aware of. But, again, I'm getting feedback
11 from my care coordinators, so I was mindful that I was
12 being told that he'd not been in -- well, he'd had
13 contact with either the brother or the mother, so we
14 didn't believe that he was missing and there was no
15 concerns at that point that was raised to suggest that
16 he was unwell. There was an awareness that he does
17 become unwell, I will say that, but it was just felt,
18 I think, that we just couldn't engage him or get hold of
19 him.
20 **Q.** I'm just going through the different reasons put forward
21 in the statement. If we can put up the medical records
22 again, NHFT0000168, page 270. The final entry on the
23 page, 31 August 2022, this is the last discussion with
24 VC's mother prior to the discharge. She says:
25 "She has not seen VC face to face for many months

1 but she had a telephone conversation with him in the
2 last week. She attempted to go and see him but he was
3 not at the address she was familiar with."
4 Well, there's nothing in that to suggest that he's
5 not a missing person. His mother doesn't know where he
6 is. She's not seen him for months.
7 **A.** Yeah, but I've not read that at the time.
8 **Q.** Then the discussion, the contact with his sister, and
9 that's page 269, it's the last entry on that at page,
10 3 August. So, again, it's some time before the
11 discharge meeting and there's nothing in that
12 description which provides any kind of reassurance as to
13 how well VC is, is there?
14 **A.** No.
15 **Q.** So far as contact with the EIP, well, the last contact
16 by phone was the 16 July contact with Ms Parsonage, and
17 that's when VC lied about being abroad, and the last
18 time he'd been seen was 4 July.
19 **A.** Yeah.
20 **Q.** Standing back for a moment, of course, there'd been
21 multiple admissions for violence.
22 So, in light of all of that, do you consider
23 actually there were indications that he was unwell or at
24 risk of being unwell: not engaging, not --
25 **A.** I think potentially there was a risk of him becoming

1 unwell. But I don't think at that time that there was
2 because we'd even talked about, prior to discharge,
3 whether we needed Mental Health Act, whether we needed
4 Crisis, but because we hadn't been able to assess that
5 risk at the time when we was needing to put those
6 referrals in, we didn't come to that decision of needing
7 to do that.
8 **Q.** Can we look at your Theemis interview, please,
9 TCLT0000755. If we turn to page 19 and it's the second
10 box on this page where you address some of the rationale
11 around the discharge process. You say:
12 "... it ... felt like we'd lost him. He wasn't
13 engaging. I think sometimes, at the back of my mind,
14 it's how long we keep people open to us for? It's dire
15 for me to think this now, but I used to think sometimes
16 is it worse [to] have somebody open on caseloads that
17 you're not engaging with? Should we be discharging them
18 instead?
19 "What does it look like if something happens, and
20 we've got this person open to us, and we haven't seen
21 him for months, and months, and months?"
22 Can you just explain the concern that you're raising
23 there?
24 **A.** Yeah, I think what I meant there was ... I think, when
25 we're working in mental health and we work with lots of

1 different patients, some come through the system quite
2 fast, some slower. It's always at the back of our minds
3 with kind of discharge and moving people on, but there's
4 equal concern that having people open for months and
5 months and months on end, and it doesn't appear like
6 we're doing anything as a care team for that person
7 because we can't see them or we can't engage with them.
8 I suppose at that time when I wrote that report,
9 I suppose from previous experience, I've worried about
10 how that's looked, that we've got somebody that's open
11 to us and perhaps we've not been able to treat them for
12 nine months or find them, or -- so sometimes the
13 decision is better to discharge back to the GP.
14 **Q.** It might be read as you suggesting, "Well, where there's
15 difficulty engaging or tracking someone down, better to
16 get them off the books in case something happens, rather
17 than they're on the books and we've not been able to
18 find them for months and months"?
19 **A.** Yeah, I don't mean to sound it like that, that it's
20 better to get a patient discharged. I just think at
21 that time that's what my thought process was, just in
22 terms of it feels safer to have somebody discharged back
23 to the care of the GP than open to a secondary service
24 when we can't engage them or can't do anything for them.
25 **Q.** Final document from me, please, it's NHFT0004725. It's

1 page 7 of this document. This is the "Do Not Attend" --
2 **A.** Yes.
3 **Q.** -- and discharge related policy. At 7.2.3 there are
4 listed 12 subparagraphs relevant to the issue of
5 discharge. If we can just go through these fairly
6 swiftly and consider which, if any, were complied with.
7 7.2.3.1:
8 "[Where] the patient is not contactable [CCO] or
9 other nominated team member should call all recorded
10 contacts to ascertain the patient's whereabouts and
11 clearly record these attempts in the healthcare records
12 and RiO."
13 That wasn't complied with, was it?
14 **A.** No, not all recorded contacts was in the notes. You're
15 correct.
16 **Q.** Number 2:
17 "A letter should be sent to the person's home
18 address and other usual addresses inviting him/her to
19 make contact and detailing actions to be taken with
20 timescales if contact is not made."
21 That wasn't complied with, was it? Although
22 Mr Carter sent a letter --
23 **A.** Yes.
24 **Q.** -- it didn't detail actions to be taken or timescales?
25 **A.** Not timescales, no. Correct.

1 **Q.** Number 3:
2 "If the patient is not at his/her address, the care
3 coordinator and service team should agree other agencies
4 to be contacted ... GP, housing departments, works and
5 pensions departments etc, including a discussion
6 regarding contact with family members ..."
7 Nothing to indicate that was complied with?
8 **A.** No.
9 **Q.** Number 4:
10 "[Care coordinators] should discuss their concerns
11 with the MDT and agree the next steps to be taken ...
12 may include involvement of the police."
13 Well, Gary Carter wasn't at the discharge meeting,
14 was he, the MDT that considered discharge --
15 **A.** No.
16 **Q.** -- and there was no attempt to contact the police?
17 Ms Robinson, no contact with the police?
18 **A.** Sorry, I thought I said that. No, sorry. My apologies.
19 **Q.** No, I may not have heard you. Forgive me.
20 Number 5: consideration of Community Treatment
21 Orders.
22 We don't have a note of the MDT. Was there
23 a consideration or in your discussions of discharge was
24 there any consideration of the CTO?
25 **A.** I think we talked about that but a Community Treatment

1 Order is not something that we can put somebody on in
2 the community. It follows a Section 3 of the Mental
3 Health Act, which needs to be implemented from inpatient
4 status, and I know that, I think, Ms Birtles had
5 discussions when he was in some of the inpatient wards
6 around potentially a CTO and depot.
7 **Q.** Yes, specifically at the time of discharge. So as part
8 of the discharge process, was consideration given to, as
9 an alternative, discharge --
10 **A.** I think it was in the build-up. I think we'd had those
11 discussions before.
12 **Q.** Number 6:
13 "... need for further assessment including the
14 Mental Health Act, Mental Capacity Act and Adult
15 Safeguarding."
16 Of course, the context here is that when you had
17 raised discharge earlier in the year, as we've
18 discussed, VC went on to be detained a number of weeks
19 later. Was consideration given to the need for an
20 assessment under the Mental Health Act, or an assessment
21 of capacity?
22 **A.** I think, in terms of the Mental Health Act, we'd had
23 those discussions, I think in hindsight we perhaps could
24 have looked at that further but I know that there was
25 discussions in the lead-up to discharge about whether he

1 met that or not.
2 **Q.** 7 and 8 are describing taking advice from other
3 professionals in relation to their requirement, and
4 assessment on the appropriateness of referrals to other
5 services. Were either of those complied with?
6 **A.** Not that I'm aware of, no.
7 **MR CARR:** Thank you very much, Chair. Those are my
8 questions.
9 **THE CHAIR:** Yes, thank you. Mr Moloney.
10 **Questioned by MR MOLONEY**
11 **MR MOLONEY:** Ms Robinson, I ask questions on behalf of the
12 bereaved families, please.
13 May I just ask you about matters that were dealt
14 with earlier in your evidence to begin with. Did you
15 have training in managing non-concordance and dealing
16 with disengaged patients?
17 **A.** No.
18 **Q.** Did you raise that absence of training in any of your
19 annual appraisals or anything of that nature?
20 **A.** Not specifically to concordance or non-engagement. It
21 was not something that I was aware that training was
22 provided for around that.
23 **Q.** And you had difficulties in carrying out some tasks
24 because of workload.
25 **A.** Yeah.

1 **Q.** Did you escalate your concerns with your superiors?
2 **A.** Yes.
3 **Q.** You did?
4 **A.** Yeah.
5 **Q.** You didn't minute MDTs, did you?
6 **A.** No.
7 **Q.** Should you have done that?
8 **A.** There's normally a process in which that's what admin
9 usually does. I did raise the lack of admin support in
10 doing that. In hindsight, I wish that I would have done
11 that in the absence of admin. Yeah.
12 **Q.** Did you minute any discussions with Claudia Birtles
13 about updating care plans and risk assessments?
14 **A.** Not that I'm aware of, but we had those discussions, but
15 not minuted. So I appreciate that.
16 **Q.** Did you note any of your conversations with Gary Carter
17 about what were thought of as being unsafe practices,
18 seeing patients out of --
19 **A.** Yes.
20 **Q.** You did?
21 **A.** Yeah. He was written to. There was a letter with
22 regards to that.
23 **Q.** And that came from your superiors to Gary Carter, was it
24 or --
25 **A.** That came from me.

1 **Q.** Right.
2 **A.** And my superiors had sight of that because I'd raised
3 that with my superiors.
4 **Q.** I just want to ask you finally about discharge, if
5 I may.
6 **A.** Yeah.
7 **Q.** This was somebody who was that dangerous that EIP would
8 only visit him at home unless -- or if it was absolutely
9 necessary, and if there was a home visit, it had to be
10 two people.
11 **A.** Yeah.
12 **Q.** And you've just said you were aware he could become
13 unwell.
14 **A.** *(The witness nodded).*
15 **Q.** And you were aware that he could become violent when he
16 was unwell.
17 **A.** *(The witness nodded).*
18 **Q.** And he might even be violent when not thought to be
19 unwell, such as January 2022.
20 **A.** *(The witness nodded).*
21 **THE CHAIR:** Sorry, do you say "yes" or "no"? We've got to
22 record what you say.
23 **A.** Sorry. Were you asking me? I thought you were still
24 saying what you were saying to me about asking a
25 question --

1 **MR MOLONEY:** No, you nodded, didn't you. -- *(overspeaking)*
2 --
3 **A.** Sorry -- yeah, I was aware of that -- *(overspeaking)* --
4 **Q.** You were aware that he could become violent even when he
5 wasn't thought to be unwell.
6 **A.** Yeah. I suppose it's the nature of the patient group
7 that we work with. All of our patients are under our
8 services for either risk to self or risk to others, and
9 that's why they're under the Care Programme Approach.
10 So we have to balance that.
11 **Q.** There was a clearly identified and identifiable risk to
12 others from VC, wasn't there?
13 **A.** Yes. Yeah, I don't deny that.
14 **Q.** And when you discharged, did you think about the risk to
15 the public from this man, who EIP would not visit alone,
16 would not visit at home unless absolutely necessary?
17 Did you consider the risks to the public from that man?
18 **A.** I think we considered that. We did consider that. But
19 we felt that within the time of decision, we had no
20 holding powers. We couldn't work with him. We couldn't
21 find him. At this point we just couldn't find him to
22 work with him.
23 **Q.** And you said in the Theemis interview that you'd lost
24 him. Had you lost him?
25 **A.** Yes, yeah.

1 **Q.** And is that primarily why you discharged him? You felt
2 you couldn't do any more with him?
3 **A.** Yeah, because we couldn't find him to treat him or
4 engage him, yes.
5 **Q.** And you didn't ask the police to try to find him.
6 **A.** No.
7 **Q.** Because you did have -- and if we could just look at
8 this, please. If we could just look at the address that
9 he gave that the 15 --
10 **A.** Yeah.
11 **Q.** Yeah, you had that, didn't you? Did you ask the police
12 to go round there?
13 **A.** No.
14 **Q.** And Gary Carter had been to 209 Ilkeston Road as well,
15 hadn't he?
16 **A.** Yeah, my understanding from Gary Carter was that he'd
17 visited all the addresses that he'd been given for him.
18 That was the information I'd received from him.
19 **Q.** So you couldn't find him.
20 **A.** Yeah.
21 **Q.** Did you try and find something else for him, apart from
22 EIP?
23 **A.** No, in terms of I think it had been Assertive Outreach
24 pathway and that wasn't there for him. They'd disbanded
25 the Assertive Outreach pathway.

1 **Q.** In effect, you left him to the general practitioner to
2 deal with, didn't you?
3 **A.** We -- we discharged him back to the GP, yes.
4 **Q.** And in effect, by doing that, you left him to the
5 general public to deal with, didn't you?
6 **A.** I wouldn't say the general public to deal with. I see
7 it different to you. It's not uncommon for us to
8 discharge non-engaging patients, unfortunately, at that
9 time. I think things are very different now. Since
10 this incident I think there's various checklists that
11 people need to go through in terms of discharge. That
12 wasn't -- that wasn't the case when we discharged him.
13 **MR MOLONEY:** Yes. Thank you, Ms Robinson.
14 **THE WITNESS:** Thank you.
15 **THE CHAIR:** Yes, Ms Cartwright.
16 **Questioned by MS CARTWRIGHT**
17 **MS CARTWRIGHT:** Good morning, Mrs Robinson.
18 **A.** Morning.
19 **Q.** Can I ask you first of all, and it's not in your pack
20 but the foundation for this question is the interview
21 you had with Marina Gibbs on 28 November 2025 which has
22 recently been added to the disclosure.
23 So for your reference, Chair, it's NHFT0019593.
24 Now you've already dealt with a number of failings
25 in the system of EIP. You dealt with the lack of

1 psychology, the lack of essentially admin support, and
2 also the lack of a matron, but one of the things you
3 said in that interview at page 3 was that "the EIP fell
4 down due to the organisation's structural governance and
5 the structure above us." *(As read)*
6 Can you just be clear of what you meant by that?
7 **A.** Can I see that?
8 **Q.** Pardon?
9 **A.** Can I see that?
10 **Q.** No, I'm afraid it's not there to be displayed. So
11 you're referencing in that interview that how it "fell
12 down" was the organisational "structural governance and
13 the structure above us".
14 **A.** Yes. Sorry, I think I can recall now. I think that was
15 in regards to in all of the community teams you'd have
16 the structure of the team, the team manager, service
17 manager, operational manager, general manager. When the
18 EIP team was formed for the second time as a standalone
19 team --
20 **Q.** Yes.
21 **A.** -- we had a Strategic Lead, and it wasn't until a lot
22 later on that I suppose the operational lead came back.
23 The operational structure wasn't there, initially. It
24 was a different governance structure above.
25 **Q.** And then why did that mean it didn't work?

1 **A.** Because we didn't feed into the wider LMHTs. We was
2 kind of a standalone team. So if there was any changes
3 to be made in processes or structures, we wasn't part of
4 that or to know that.
5 **Q.** All right.
6 **A.** So that's why I felt that it didn't work.
7 **Q.** And I think you've identified above you that there was
8 at that time a Strategic Lead; is that correct?
9 **A.** There was, yes.
10 **Q.** And was that, at the relevant time, Kelly Simpson?
11 **A.** No, Kelly Simpson was my manager. Kelly service --
12 Kelly Simpson was the service manager, and then it was
13 Vidyah Adamson, who was the Strategic Lead.
14 **Q.** Right. Now can we then just, please, briefly look at
15 the "Do Not Engage" policy that Mr Carr took you to, and
16 I'm going to take you not to the first page but page 7,
17 please. It's NHFT0004725. It's page 7, please. Thank
18 you, and paragraph 7.2.
19 Because one of the things I just want to touch upon
20 with you, we can see at paragraph 7.2.1 the importance
21 of risk assessment, and you've already acknowledged that
22 one of the significant failings, notwithstanding in
23 another area where you went there were minutes, is that
24 none of the MDTs have been minuted or logged; is that
25 correct?

1 **A.** From what I can --
2 **Q.** From the --
3 **A.** -- *(overspeaking)* -- Yes.
4 **Q.** From this EIP?
5 **A.** Yes.
6 **Q.** And did it ever occur to you, bearing in mind you had
7 another area of the five you operated where they were
8 doing minuting, that essentially all of the discussion
9 over the 90 minutes that was lost was a significant
10 failing in removal and loss of all of that relevant risk
11 information?
12 **A.** Yes, and --
13 **Q.** So it did occur to you?
14 **A.** Yes, and I raise -- that's why I kept raising it with my
15 managers that we needed that admin support.
16 **Q.** So just be clear then: who were you raising it with?
17 **A.** Kelly Simpson.
18 **Q.** Claire Simpson?
19 **A.** Kelly Simpson.
20 **Q.** Kelly Simpson. And how regularly were you raising it?
21 **A.** In my monthly supervisions, and any meetings that we
22 had. I think we had some managers' meetings with her,
23 myself and the other manager for EIP North.
24 **Q.** And what response were you getting back as to why that
25 wasn't being provided?

1 **A.** I think it was around, again, finances.
2 **Q.** Finances?
3 **A.** I think that's what it was around, the budgets and the
4 finances, and we couldn't use the LMHT admin because
5 they was funded by the Local Mental Health Team and not
6 EIP funding.
7 **Q.** So you say in your own supervision, we should see you
8 regularly raising the issue of the MDT --
9 **A.** Yeah, and meetings that I was in around the lack of the
10 other MDT participants that I felt that we needed in the
11 EIP service.
12 **Q.** All right. Now, Mr Carr has taken you through the
13 emails where we saw you were involved in the January,
14 where you were proposing discharge, but then there was
15 the additional incident in the January with the --
16 **A.** Yeah.
17 **Q.** -- students. So I want to ask you this, really, it's
18 about what was required, and we know that there's
19 a history of non-attendance, both with Dr Lloyd, but
20 with others. If that could be displayed again, please?
21 And really what this is suggesting is that what we
22 should be seeing -- thank you, page 7 -- is that every
23 time when VC did not attend an appointment, either with
24 his care coordinator or with the consultant, that there
25 should be a risk assessment because we see reference in

1 the policy that:
2 "Where it is clear a patient has not adhered to the
3 agreed level of contact the [MDT] should undertake an
4 immediate assessment of the patient's level of risk. In
5 an outpatient's clinic setting as assessment of the
6 patient's level of risk may not necessarily require the
7 oversight of the full MDT and instead may be conducted
8 by a member of the medical staff or another
9 practitioner. The requirement for either a full MDT
10 risk assessment or a risk assessment undertaken by
11 individual staff members as a follow-up to patients who
12 [do not attend] will depend on; balancing the level of
13 concern for the patient's wellbeing with the rights of
14 the patients to disengage, and to refuse contact with
15 Adult Mental Health services, even in circumstances
16 where staff feel this is unwise."
17 Now, can I just expand on that with you, please,
18 because you've been asked questions about the last MDT
19 where the decision was made on 22 December to discharge
20 VC. But would you agree this policy suggests that every
21 time VC failed to attend, there should be evidence of
22 a risk assessment?
23 **A.** I mean, that's what the policy states.
24 **Q.** Yes.
25 **A.** I don't dispute that I think sometimes in practice, it's

1 quite different, and I'm not just speaking from an EIP
2 perspective; I'm talking from other community teams.
3 That you may -- I wouldn't say that you'd update the
4 risk assessment every single time but I could be wrong.
5 And, at the end of the day, that's what the policy
6 states and it wasn't -- it potentially wasn't done.
7 **Q.** And it just wasn't being done?
8 **A.** So whether there's a discussion with Dr Lloyd and the
9 consultant around that, I'm not sure.
10 **Q.** All right. So, even though we don't have the MDT
11 minutes, is it your evidence that, essentially, the
12 policy wasn't being followed in practice, in any event,
13 where there were risk assessments taking place, when
14 there was non-attendance?
15 **A.** Sorry, say that again.
16 **Q.** So we don't have the minutes of the MDT --
17 **A.** Yes.
18 **Q.** -- but what you suggested is yes, that's what the policy
19 says but, in reality, we weren't doing these risk
20 assessments when patients didn't attend or disengaged.
21 **A.** I'm not saying that they wasn't but it may have been
22 every single meeting that he didn't -- yes, it might not
23 have been done straight away after that meeting, that
24 it's failed. That he's failed to come to -- I don't
25 know whether the risk assessment was updated every time

1 he failed to attend an appointment.
2 **Q.** I think probably you'll be aware that one of the issues
3 that was identified for VC is his risk assessments
4 weren't being updated and neither was his care plan.
5 **A.** Yes.
6 **Q.** Were you aware of that?
7 **A.** I thought that was after admission. So my apologies for
8 that, yeah, after his admissions to inpatient.
9 **Q.** But would you agree when, in September 2022, the MDT
10 made the decision to discharge VC, set against
11 a background of risk, so four admissions to detention --
12 to be detained, set against backgrounds of criminality,
13 and the MDT team, as you've had covered with you by
14 Mr Moloney, that essentially the care coordinators
15 weren't even visiting VC in his home because of the
16 risk?
17 **A.** Yes.
18 **Q.** That, really, there should have been a properly
19 documented and considered risk, for all the reasons that
20 you've been through with Mr Carr, as to what then should
21 have taken place for VC?
22 **A.** Yes.
23 **Q.** Then can I ask you about this because we know that the
24 discharge letter that was sent to the GP essentially
25 doesn't deal with the risk assessment at all; would you

1 agree?
2 **A.** Yes.
3 **Q.** That it didn't describe VC's diagnosis; would you agree?
4 **A.** Yes.
5 **Q.** It didn't detail that you didn't know where he was
6 living. In fact, I think it provided the 15 Madison
7 Court address, where, in fact, Mr Carter's evidence is
8 you didn't go and check that address but we know VC
9 wasn't there?
10 **A.** *(The witness nodded)*.
11 **Q.** It didn't tell the GP what the medication was and how
12 that was going to practically be managed because, up
13 until that point, the EIP had been providing the
14 medication, hadn't they?
15 **A.** Yeah, I wasn't aware of that until the Inquiry, the
16 discharge letter.
17 **Q.** So when did you become aware that that discharge letter
18 to the GP -- my words, but, please, do you agree, it was
19 wholly inadequate as a discharge letter back to the --
20 **A.** As a discharge letter you'd expect more, like you've
21 said, and I wasn't aware of that until part of the
22 evidence of the Inquiry.
23 **Q.** Would you also agree that what it didn't do was it
24 didn't append the documents ordinarily that should go
25 with the discharge, such as the core assessment, the

1 risk assessment and the care plan? Would you agree?
2 **A.** Yes.
3 **Q.** -- that they ordinarily should be provided?
4 **A.** Yes, I would, yes.
5 **Q.** Do you know why that wasn't done?
6 **A.** No.
7 **Q.** Can I just ask you then about another policy, just
8 finally, please, because again, this policy doesn't look
9 to be being applied in practice. But can we just
10 display the EIP policy, please, which is NHFT0000460.
11 Thank you.
12 Can we just move forward to page 7, please. Thank
13 you. Now, we can see that the various service model
14 sets out what the core features were intended to be of
15 the EIP, and we can see that one of the references that
16 the policy suggests is that:
17 "Adults with a diagnosis of schizophrenia that has
18 not responded adequately to treatment with at least two
19 antipsychotic drugs will be offered clozapine."
20 Can I ask, was that being looked at in practice in
21 EIP at the time, bearing in mind we know that VC had had
22 haloperidol, he'd had aripiprazole and, obviously,
23 there's documentation of VC still having voices and
24 hallucinations. So was there ever -- was that being
25 applied in principle in the EIP?

1 **A.** I'm not sure whether -- and Dr Lloyd might be able to
2 answer better than me. I'm not sure whether it was felt
3 at the time that the aripiprazole, when he was taking
4 it, was effective. So I'm not -- I can't recall
5 conversations about looking at clozapine but it was
6 something -- it's conversations we usually had within
7 our MDT but I can't recall on that occasion.
8 **Q.** Thank you. We can see then in the next bullet point
9 about being offered evidence-based psychological
10 interventions suggested by NICE, and I think it's right,
11 isn't it, there was no psychologist within the EIP to be
12 able to provide what NICE, for psychosis and
13 schizophrenia, suggested.
14 **A.** Well, the CBT practitioner, eventually when we
15 recruited, would meet part of that NICE guideline
16 because the intervention was CBTp intervention.
17 **Q.** But I think later on in this policy we see reference to
18 a clinical psychologist and psychotherapist?
19 **A.** Yes.
20 **Q.** Was there ever a clinical psychologist?
21 **A.** No.
22 **Q.** So, again the policy was saying something was available
23 that was never there?
24 **A.** Yes, it was.
25 **Q.** Was that something you'd raised in supervisions as well?

1 **A.** Yes.
2 **Q.** Can we look at the bottom bullet point, please, on this
3 page because we also see:
4 "An assertive approach to engagement to reduce the
5 risk of service users being lost to services and
6 potentially experiencing a longer duration of untreated
7 psychosis. To assertively engage in situations where
8 service users miss multiple appointments or are
9 resistant to working with the team. The EIP will be
10 flexible and creative in the approaches it uses to
11 establish engagement with 'hard to reach' service users
12 ..."
13 Was there an assertive approach being used in the
14 EIP?
15 **A.** I think -- I do think at times that there was. But,
16 again, I think some of that comes down to the caseload
17 numbers and people's caseloads, the complexities of
18 those patients. I think I said right at the beginning
19 that I felt like we could have done more but I think the
20 CCOs were quite flexible with trying --
21 **Q.** Thank you. Can we go over the page, please, to page 8.
22 Thank you. If we could just go a little bit further
23 down, please, "Outcomes Measures", which was supposed to
24 be a tool?
25 **A.** Yes.

1 **Q.** We've seen the Health of the Nation Outcome score that
2 Mr Carter completed in August but there's also reference
3 to two other tools: a DIALOG and the Process of Recovery
4 Questionnaire?
5 **A.** Yes.
6 **Q.** I don't know if we've seen evidence of that. Do you
7 know if they were being utilised in EIP?
8 **A.** They was utilised in EIP.
9 **Q.** They were?
10 **A.** Yes.
11 **Q.** Thank you. If we go over the page, please, obviously it
12 highlights the importance of the annual Care Programme
13 Approach review when we know again that VC was due to
14 have one of those in the beginning of August. Was that
15 actively being managed in the team when CPA reviews were
16 needed for those subject to Care Programme Approach?
17 **A.** What do you mean by actively managed, sorry.
18 **Q.** So someone monitoring it when a patient who was
19 receiving a Care Programme Approach and a care
20 coordinator because, obviously, the annual review is
21 essential for making sure the plans are up to date and
22 you've got an appropriate --
23 **A.** Yeah, so the RC, so Dr Lloyd, and the care coordinator.
24 **Q.** So that Dr Lloyd will be involved as well?
25 **A.** Yes, and know when they're due and not due and need to

1 reviewed.
2 Q. If we can just move forward, I'll probably just leave
3 this here then because we're not going to have time to
4 go through all the policy. Can we just look at page 16
5 to pick up on the psychosocial interventions, please.
6 Thank you.
7 If we just go down, I think it references the
8 psychosocial interventions on page 18 and I think
9 references the psychologists. But in terms of the
10 psychosocial, would you agree that notwithstanding CBTp,
11 if you don't have the support of the clinical
12 psychologist, it makes really engagement and a package
13 of care that includes psychosocial engagement very
14 limited for a patient on a Care Programme Approach?
15 A. Yes, it does, yeah.
16 **MS CARTWRIGHT:** Thank you. Those are my questions.
17 **THE CHAIR:** Yes, thank you.
18 Mr Straw.
19 **Questioned by MR STRAW**
20 **MR STRAW:** Ms Robinson, I represent VC's family.
21 Just continuing those questions that Ms Cartwright
22 has been asking you about the ability of your team to
23 meet the NICE Guidelines to ensure there's a full
24 package of care within two weeks of a referral to your
25 team. Ms Parsonage's evidence about CBT therapists was

1 that there was only one CBT therapist for the whole of
2 the city and county team, her job was more difficult as
3 a result and there would be a wait of a year to access
4 the therapy.
5 A. Yes.
6 Q. Would you agree with that?
7 A. Yes. I'm not sure towards the end when I left in 2022,
8 that we had another or potentially a trainee but, on the
9 whole, yeah, Ms Parsonage is correct.
10 Q. Okay. That was something you raised, was it?
11 A. Yes.
12 Q. Okay. What about the psychiatrists? We see in 2022
13 that there's only, during the community period, there's
14 only one face-to-face assessment by Dr Lloyd of VC. Was
15 there sufficient psychiatric resources to perform the
16 sort of face-to-face assessments that were required?
17 A. She had her -- I know sometimes she had a trainee so
18 I know that Dr Burri gave evidence, so Dr Burri was part
19 of the team for a while but then I recall that he left
20 and then we didn't have another -- a junior doctor. It
21 was difficult at times. We could use the medics in the
22 Local Mental Health Team but that was seen as more
23 urgent work, so probably if somebody's prescription
24 needs writing up or -- so yeah, it was problematic and,
25 at times, in terms of we didn't have so many

1 consultants, that it was more that there was on certain
2 sessions that they did for each of the different areas.
3 Q. I think Dr Burri stopped being involved in mid-2021. So
4 is it right, after that point, there was -- it was
5 problematic, there was inadequate psychiatric resources?
6 A. Yeah, I'd say so because there was times when Dr Lloyd
7 was off or on annual leave, so it was things like that
8 where we could access, from what I can gather, doctors
9 from the LMHT but it was urgent. It wasn't like having
10 long overviews of our patients or -- so yes, sorry.
11 Q. Was that something you raised with managers?
12 A. Yeah, and the managers was aware of that. I mean, they
13 was aware of the funding and how the sessions worked
14 within the team. So sometimes it wasn't always about me
15 raising things; they was aware of the practice that we
16 was doing.
17 Q. Next issue is about VC's capacity to refuse consent to
18 share information with this family. Can we have
19 a document on the screen, please, it's WITN0085003, and
20 page 10 of that, please. These are some messages
21 between Celeste Calocane, so VC's mum, and Claudia
22 Birtles. Do you see the first one there on the screen
23 is a message from Claudia to Celeste, dated 16 December
24 2021, in which Claudia says to Celeste:
25 "Going forward, I am ..."

1 Sorry, I should start at the top:
2 "He has called me today to tell me that I shouldn't
3 be contacting you to get in touch with him and going
4 forward I am to have no contact with yourself. I'm
5 really sorry about this ... I am going to discuss this
6 with our manager but as you appreciate if someone
7 expresses a wish that we have no contact with the
8 family, generally we have to respect that (unless there
9 are safeguarding issues ...)."
10 A. Yes.
11 Q. The next message just below that is a response from
12 Celeste to Claudia:
13 "... sorry for taking so long to answer."
14 It's on 22 December.
15 "I didn't mean to be rude, I was just a little upset
16 with [the] ... news and needed time to process."
17 So thank you for the message.
18 Then finally the message just below that is
19 a response from Claudia to Celeste dated
20 30 December 2021, in which Claudia says:
21 "I had ... discussion with my manager about [VC's]
22 wishes and although I won't be able to disclose any
23 confidential information about his care, I can of course
24 ... speak with you and offer you support if required."
25 She mentions the manager there in two of the

1 messages. Do you recall Claudia approaching you about
2 this?
3 **A.** I don't think I do. I don't think I recall that.
4 **Q.** Okay. Would you have been the manager that she was
5 referring to at the time?
6 **A.** Yes, I would have been. Yes.
7 **Q.** And if she had contacted you, would you have advised her
8 to assess whether VC had capacity to refuse consent to
9 communicate with his mum?
10 **A.** No, I wouldn't. If there was any other factors, then
11 I might have done. People can change or -- in terms of
12 giving consent or not giving consent to who they share
13 information with. So I suppose like Claudia said within
14 that email, what we would have done initially would have
15 said, you know, "we can't disclose any information about
16 your son but if there's any more broader information you
17 need, we'll provide you that."
18 But just on the basis of somebody saying that they
19 don't want contact, it's quite -- again, quite common
20 for our patients to do that.
21 **Q.** VC was someone who suffered delusions that there was
22 a conspiracy against him which included --
23 **A.** Yeah.
24 **Q.** -- the medical team, and delusions that his family was
25 at risk. There should have been an assessment of his

1 capacity to communicate in light of that, shouldn't
2 there?
3 **A.** About his delusions?
4 **Q.** Yeah, he's deluded that the medical team are conspiring
5 against him and his family are at risk. That would
6 indicate he may well not have capacity about consenting
7 to communicating between the medical team and his mum.
8 **A.** Potentially.
9 **MR STRAW:** Okay. Thank you very much.
10 **THE CHAIR:** Thank you.
11 Yes, Mr Beggs.
12 **Questioned by MR BEGGS**
13 **MR BEGGS:** Ms Robinson, I'm for Nottinghamshire Police.
14 Just three short points.
15 **A.** Thank you.
16 **Q.** Could we put on the screen for you, please, paragraph 80
17 of your statement, WITN0315001, page 27. Can you just
18 refresh your memory from paragraph 80, please.
19 Do you see, if you've had a chance to read it, in
20 the first sentence you speak of sharing any concerns you
21 have about a patient posing an immediate risk to others
22 with the police.
23 **A.** Yes.
24 **Q.** Do you see that?
25 **A.** Yes.

1 **Q.** Did you ever share any such concerns with
2 Nottinghamshire Police about VC?
3 **A.** No immediate risks, no.
4 **Q.** Is that the reason you didn't share, because you didn't
5 perceive there to be immediate risks?
6 **A.** Immediate risks, yes.
7 **Q.** Thank you. Then in the second part of the last sentence
8 of that paragraph, you say:
9 "There was occasional frustration that ... Police
10 would fail to tell us that a patient had been arrested."
11 But this is right, isn't it: the police won't always
12 know that someone they've arrested or otherwise detained
13 is a patient? Certainly not a patient of yours. Do you
14 see?
15 **A.** No, I think there's been times where the team have
16 communicated to me that they've phoned to enquire for
17 information, and it's not -- I suppose it's not been
18 shared, and I think that works both ways, about
19 a patient.
20 **Q.** Would you agree that's a two-way process, the police --
21 **A.** Yeah, I've just said that. Yeah.
22 **Q.** I'm sorry if I didn't hear it.
23 **A.** My apologies. Yeah, I think it's both ways. Yeah.
24 **Q.** Thank you. Second point, regarding potentially
25 dangerous patients. I understood from your evidence

1 that you accept that it became tolerably apparent by the
2 summer of 2020 that VC was potentially dangerous if not
3 taking his medication; is that right? You accept that
4 he's potentially dangerous?
5 **A.** Potentially, he could have been. He could have
6 relapsed. *(Unclear).*
7 **Q.** But this is right, isn't it: you and EIP didn't
8 routinely notify the police when you accepted such
9 a patient to your service?
10 **A.** No, that's correct.
11 **Q.** And nor did you routinely notify the police when you
12 discharged a potentially dangerous patient from your
13 service?
14 **A.** Yeah, that's correct. And whether it -- I don't know if
15 it's right or wrong but it wasn't routine practice that
16 we did that in everyday practice with our discharges.
17 I think things have probably changed since then and, on
18 reflection, it should have been done.
19 **Q.** Yes, so if it builds on the first point --
20 **A.** Yes.
21 **Q.** -- doesn't it, about information sharing --
22 **A.** Yes.
23 **Q.** -- for the common good, yes?
24 **A.** Yes.
25 **Q.** And finally this: by early August 2022, when you were

1 considering discharging VC from your service, you say in
2 paragraph 104 -- that's page 35 of your same statement.
3 I'll just let you look at it. It's right at the bottom
4 of -- do you see "there were conversations held about
5 the appropriateness of contacting the police"; do you
6 see that?
7 **A.** Yes, just give me a moment, sorry.
8 **Q.** Sure.
9 **A.** Yes, sorry. I've seen it, yeah.
10 **Q.** But I don't think you did in fact contact it police, did
11 you, prior to --
12 **A.** Not on his discharge, no.
13 **Q.** And --
14 **A.** And I think that was in terms of Safe and Well, in that
15 missing persons that I've spoke to, but just notifying
16 the police in general that we was going to discharge
17 him, no, we didn't do that.
18 **Q.** So it comes to this, doesn't it: the local police won't
19 know that a potentially dangerous patient is at large in
20 their community? That's obvious, isn't it?
21 **A.** Well, my understanding was though, if you're saying
22 whether it's a patient, potentially not a patient, but
23 my understanding was the police was aware of this
24 gentleman through a warrant that --
25 **Q.** But not aware that he's now been discharged from your

1 service.
2 **A.** No.
3 **Q.** And, building on the first two points, it would have
4 been better had they been told that --
5 **A.** Yes.
6 **Q.** -- for risk management purposes, yes?
7 **A.** Yes.
8 **MR BEGGS:** Thank you very much.
9 **THE CHAIR:** Yes, Ms Milligan.
10 **Questioned by MS MILLIGAN**
11 **MS MILLIGAN:** Ms Robinson, I ask questions on behalf of Gary
12 Carter.
13 I'm going to start with the issue of caseloads and
14 workings in EIP.
15 **THE CHAIR:** You've got five minutes, Ms Milligan.
16 **MS MILLIGAN:** Yes. Thank you.
17 You -- Mr Carter was taken on as an agency worker in
18 effect due to a shortage of hands in the EIP team; is
19 that right?
20 **A.** Yes, I think we was waiting to recruit to posts, yes.
21 **Q.** And as part of his interview process, you told him that
22 it was likely that his caseload would be above the
23 nationally recommended limit of 15 patients.
24 **A.** Yeah, I think I said that we sit at 15, that's what it
25 should be, but sometimes that fluctuates.

1 **Q.** You've used the word "fluctuating" in your evidence, but
2 it's right, isn't it, that in fact Mr Carter's caseload
3 was consistently above 15 patients rather than
4 occasionally creeping over that number?
5 **A.** I'd need to have a look at what that was over the period
6 when Gary was with us. I think I had a document that
7 was shown me, but I'm not sure if it's part of the
8 evidence, I'd need to check, that shows that he wasn't
9 always above his numbers.
10 **Q.** Perhaps --
11 **A.** I'd need to have a look at that.
12 **Q.** Would you agree more often than not?
13 **A.** Sorry?
14 **Q.** Would you agree with more often than not being above 15?
15 **A.** I don't know off the top of my head without looking.
16 **Q.** It's right, isn't it, that the type of patients and how
17 demanding they are is also relevant to one's caseload?
18 **A.** In terms of the complexities?
19 **Q.** Yes.
20 **A.** It can be, yeah, it can be.
21 **Q.** And you gave evidence to the Trust, in the investigation
22 into Mr Carter's conduct, that Mr Carter worked
23 primarily with young males who had lots of challenging
24 behaviours, risk histories, who were a bit higher
25 profile; is that right?

1 **A.** Yes.
2 **Q.** So those patients required more time, in essence?
3 **A.** Potentially, yes.
4 **Q.** Do you accept that as a manager, you have
5 a responsibility to keep an eye on Mr Carter's caseload
6 and make sure that he's not burning out or unable to
7 look after his patients properly?
8 **A.** Yes, and I did that.
9 **Q.** You also described in your interview with NHFT
10 Mr Carter's nature was wanting to pick up cases and to
11 help out; do you recall giving that -- a summary of
12 Mr Carter --
13 **A.** Potentially. It was more for me sometimes trying to
14 take work off him that was the difficulty, in terms of
15 reallocating some of his numbers.
16 **Q.** Well, I'm not going to take you to it, but the record
17 says, "because of GC's nature (wanting to pick up and
18 help out)", I'm going to put to you that it's not, it
19 wasn't the case that, as you said, Mr Carter found
20 working to be an inconvenience; in fact he was diligent
21 and he struggled to keep up with his caseload.
22 **A.** I never said that it was inconvenience. Sorry,
23 *(unclear)* words?
24 **Q.** In your evidence earlier you said that he had a lot
25 going on in his personal life --

1 **A.** Yes, that's what he reported.
2 **Q.** -- and that work was an inconvenience.
3 **A.** No. I didn't say that work was an inconvenience.
4 I reported that he had a lot going off in his life and
5 that's why he was working weekends.
6 **Q.** So he was working weekends et cetera to keep up with the
7 demands of his role?
8 **A.** No, as a distraction to what was going off in his life.
9 **Q.** You supervised Mr Carter until February 2022, so not
10 while he was VC's CCO; was that correct?
11 **A.** I believe so, yes. Sorry, I can't recall. Because
12 I know Sharon Heath took over me from supervision, but I
13 can't remember at what point that was.
14 **Q.** We don't have records of your supervision meetings with
15 Mr Carter. Did you make any?
16 **A.** I did make some. They was handwritten, as I spoke
17 earlier, in my evidence, and they was in his personal
18 file but I know as part of the investigation they've not
19 been found.
20 **Q.** Sorry, did you say they've not been found?
21 **A.** Yes, that's correct.
22 **Q.** Then finally just a couple of questions on discharge.
23 We have seen the January 2022 email between you and
24 Dr Lloyd --
25 **A.** Yes.

1 **Q.** -- and Claudia Birtles talking about discharge.
2 **A.** Yes.
3 **Q.** That was before Mr Carter was VC's CCO.
4 **A.** Yeah.
5 **Q.** Will you agree with me that Mr Carter was not the
6 individual driving a suggestion of VC's discharge?
7 **A.** I think we worked as a team and I think a lot of us,
8 like I said, we had conversations around discharge.
9 I don't think there was one driver.
10 **Q.** Yes.
11 **A.** Yeah.
12 **Q.** Of course, in your managerial role, would you accept
13 that, if anyone was pushing discharge and you thought
14 that that was incorrect, it would be your responsibility
15 to intervene?
16 **A.** There would be a level of my responsibility but also the
17 RC's as the responsible clinician for the patient.
18 **THE CHAIR:** Thank you, Ms Milligan.
19 **MS MILLIGAN:** Thank you very much, your Honour.
20 **THE CHAIR:** Yes, Mr Beer?
21 **Questions by THE CHAIR**
22 **THE CHAIR:** Just two issues I wanted to raise with you. Did
23 you have any knowledge of what VC's engagement with his
24 GP was, prior to discharging?
25 **A.** No.

1 **THE CHAIR:** Is that not something that you need to take into
2 account?
3 **A.** Yes.
4 **THE CHAIR:** Because the GP was effectively sent very little
5 information.
6 **A.** Yes.
7 **THE CHAIR:** When you say that they were discharging him to
8 his GP, the GP would have to know a bit about him,
9 wouldn't he?
10 **A.** Yes, I accept that.
11 **THE CHAIR:** The other point was that I think when you said
12 you were asked about potentially dangerous patients,
13 you've said "potentially, in relation to patient". Was
14 that because you take the view that, once they were
15 discharged, they were no longer patients of yours?
16 **A.** No, because I think sometimes what's happened is, when
17 we've discharged, some of our service users have come
18 back in and, with the EIP pathway, they have a duration
19 of three years and they can come in and out of that
20 pathway. So it wasn't because of they're not our
21 patients.
22 **THE CHAIR:** They're off your books, effectively?
23 **A.** Sorry?
24 **THE CHAIR:** They're off your books. In relation to the
25 interview you gave to Theemis, you wouldn't want them to

1 be -- want something to happen on your books rather than
2 off your books?
3 **A.** I know that's -- I'm just trying to think how to
4 articulate that, because I know how that comes across.
5 **THE CHAIR:** Well, I think it was -- you were just drawn
6 attention to it because it was what you said at the time
7 and perhaps you can just explain it.
8 **A.** Okay. Yeah.
9 **THE CHAIR:** Do you want to explain any further?
10 **A.** I can't -- I can't articulate it.
11 **THE CHAIR:** You can't. All right, thank you.
12 All right, we'll take a break now until 12.05.
13 Thank you.
14 **(11.45 am)**
15 **(A short break)**
16 **(12.05 pm)**
17 **THE CHAIR:** Yes, Mr Carr.
18 **MR CARR:** Chair, may I please call Sharon Heath?
19 **THE CHAIR:** Yes.
20 **SHARON HEATH (sworn)**
21 **Questioned by MR CARR**
22 **MR CARR:** Ms Heath, you have prepared a witness statement
23 for the purposes of this Inquiry, haven't you.
24 **A.** I have.
25 **Q.** It's dated 19 November 2025.

1 **A.** Yes.
2 **Q.** I understand there are three corrections you wish to
3 make --
4 **A.** Yes.
5 **Q.** -- to the statement, all of which are in respect of
6 dates. If we go first, please, to paragraph 40 which is
7 on page 14. What's the correction you need to make
8 there?
9 **A.** It states: "I do not recall [being] ... attending the
10 MDT meeting on 23 September". It should read the MDT
11 meeting was on 22nd September.
12 **Q.** And it's the same correction, is it, at paragraph 42 and
13 page 15 where it refers to the MDT being on the
14 23 September?
15 **A.** Yes, that's correct.
16 **Q.** And then finally paragraph 54 on page 19. What's the
17 correction you need to make there?
18 **A.** So it states that "until VC's discharge on
19 22nd September", but he was actually discharged with
20 a letter -- I now wrote the letter and requested it, it
21 was for the 23rd.
22 **Q.** Right, so the two 23rds go to 22; the 22 goes to 23.
23 **A.** Yeah.
24 **Q.** Subject to those corrections, is the statement true to
25 your best knowledge and belief?

1 **A.** Yes.
2 **Q.** By way of professional background, you're a Registered
3 Mental Health Nurse.
4 **A.** I am.
5 **Q.** You joined the Trust, the Nottinghamshire Healthcare NHS
6 Foundation Trust, in 2017.
7 **A.** Yes, that's correct.
8 **Q.** And joined the EIP team in 2020.
9 **A.** Yes.
10 **Q.** And you became Clinical Team Leader in December 2021.
11 **A.** Yes, that's correct.
12 **Q.** And subsequent to that and following VC's discharge from
13 December 2022, you've been team leader for the EIP team.
14 **A.** Yes.
15 **Q.** If we can start, please, with document TCLT0000755. And
16 this is a document -- I don't know if you saw your
17 colleague's evidence before the break, Ms Robinson.
18 **A.** No, I didn't.
19 **Q.** Well, this is -- it's page 19. This is a document
20 I explored with her. It's a note of the interview that
21 she gave to Theemis who carried out an investigation
22 into these events on behalf of NHS England. And it's
23 an entry in the middle of the page, it's Ms Robinson
24 describing the discharge process and the rationale
25 towards it. In that middle box, second sentence, it

1 reads:
2 "I think sometimes, at the back of my mind, it's how
3 long we keep people open to us for? It's dire for me to
4 think this now, but I used to think sometimes is it
5 worse have somebody open on caseloads that you're not
6 engaging with? Should we be discharging instead?
7 "What does it look like if something happens, and
8 we've got this person open to us, and we haven't seen
9 him for months, and months, and months?"
10 Now firstly, that sentiment, was that a sentiment
11 you shared at around the time of the discharge?
12 **A.** No, it is not.
13 **Q.** What do you understand Ms Robinson to be describing
14 there, so far as rationale is concerned?
15 **A.** At that time, it wasn't unusual for us to discharge
16 people through non-engagement from the service, but if
17 somebody needs to continue to be under the service,
18 we -- I would have the sentiment that we would continue
19 to try and assertively engage them.
20 **Q.** Was there, or is there, a concern in EIP as to
21 perceptions, what it may look like if something happens
22 with one of the patients that you're struggling to
23 engage with?
24 **A.** Not that I'm aware of.
25 **Q.** We can take that down and I want to deal first with VC's

1 discharge, so continuing on from that point. The
2 meeting itself on 22 September, the position is you have
3 no recollection of attending that meeting.
4 **A.** No.
5 **Q.** You've produced, you refer to it in your statement, an
6 extract from your diary which you say indicates that you
7 weren't there. Your statement, WITN0292001, at page 18,
8 paragraph 52, you discuss there that -- or you state
9 there rather:
10 "The discussion around discharge for an individual
11 is the responsibility of the [care coordinator] or, in
12 their absence, the staff member to whom this
13 responsibility has been allocated ..."
14 At the time of discharge, Gary Carter was the care
15 coordinator?
16 **A.** He was.
17 **Q.** You were supervising Gary Carter --
18 **A.** Yes, I did.
19 **Q.** Was it, in your view, wrong for discharge to be
20 discussed and determined at an MDT which neither you nor
21 Carter nor Ms Birtles, the previous CCO, were present
22 at?
23 **A.** Discussions for a discharge wouldn't be only done on one
24 occasion. With any individual, we would have
25 discussions around discharge several weeks prior to the

1 actual final decision to do that.
2 **Q.** Have you had any conversations with Mr Carter about
3 discharge?
4 **A.** I hadn't with Mr Carter directly, no.
5 **Q.** Did you have any indication as to what his view was as
6 to discharge?
7 **A.** So Mr Carter was in some of the MDTs that I also
8 attended, where conversations around discharging was
9 a consideration prior to obviously that actual final
10 decision on the 22nd.
11 **Q.** We don't have records of those MDTs, do we?
12 **A.** Unfortunately not, no.
13 **Q.** What was Mr Carter's view at those MDTs, insofar as you
14 remember it?
15 **A.** So he -- I remember brief discussions of where he'd
16 bring VC and discuss that he was not engaging, was we to
17 consider discharge or we'd make a plan of perhaps going
18 and doing more cold calls or unannounced visits. So we
19 would make plans but I recall conversations around
20 possible discharge from when I joined the team in
21 January 2022.
22 **Q.** If you had been at the MDT, what would your contribution
23 have been to the topic of VC's discharge for
24 non-engagement?
25 **A.** Like I've previously said, it wasn't unusual to actually

1 discharge somebody due to non-engagement at that time.
2 **Q.** In your view, was it appropriate -- is it appropriate;
3 was it appropriate then -- to discharge a patient with
4 a diagnosis of paranoid schizophrenia who was
5 non-concordant or suspected of being non-concordant, who
6 had disengaged and who had a history of violence, in
7 circumstances where they disengaged and been
8 non-concordant? Was discharge an appropriate step?
9 **A.** On reflection, no, it was not.
10 **Q.** You say "on reflection" but even at the time?
11 **A.** So at the time, when I was in that team, I'd only been
12 in the team a short period of time and I didn't have
13 a lot of information around VC. I relied quite heavily
14 on what the CCOs bought to the MDTs for discussions.
15 I don't recall any in-depth conversations in any of the
16 MDTs around VC's risk to the degree, and I've learnt
17 a lot about the previous violence and aggression through
18 the Inquiry.
19 **Q.** So prior to the attacks and prior to the investigations
20 that followed, you were not on notice of VC's history of
21 violence --
22 **A.** No.
23 **Q.** -- his risk of violence?
24 **A.** Not to the degree that obviously I've become aware of.
25 **Q.** Can we take that down and go to the records, please.

1 It's entry NHFT0000168, and we're going to go to
2 page 271. This is the only entry you made in VC's
3 records, it's the one in respect of the discharge
4 meeting, and you make the entry on 23 September. It's
5 the entry at the top of the page and it refers to the
6 discussion the previous day at MDT and the decision to
7 discharge. Now, given you weren't at the MDT, who was
8 it who informed you of the decision that had been taken?
9 **A.** I don't recall who I was -- I could only assume I either
10 offered to help with an action from an MDT or I was
11 asked to do that action.
12 **Q.** I'll come on to how you came to be doing the note on the
13 discharge letter in a moment but you've entered the
14 details of the decision of the MDT, and I just want to
15 know how did you learn, how were you informed, what had
16 occurred at the MDT?
17 **A.** I would have been made aware that that was the decision
18 by either being asked to do the actual request for
19 discharge letter or if I've offered to help with any
20 work.
21 **Q.** I understand that and I understand somebody might ask
22 you or you might volunteer to enter the note or to draft
23 the letter, but you have to enter what you've entered,
24 which is the decision of the MDT, and you set out the
25 decision as to discharge due to non-engagement with

1 a view to the GP to refer back. Where did that
2 information come from?
3 **A.** It would have come from whoever either asked me or
4 I spoke to, following that -- I actually follow that
5 action up.
6 **Q.** Who was that?
7 **A.** I don't recall.
8 **Q.** Can you recall any discussion following the decision to
9 discharge, whether with Ms Robinson, the team manager,
10 Dr Lloyd, or anybody else, as to whether the planned
11 visit to VC, which Mr Carter had indicated in the notes
12 before he went on sick leave, whether that visit had
13 been carried out?
14 **A.** Never. I don't remember having any of those
15 conversations.
16 **Q.** Did you have any discussion with any of your colleagues
17 as to whether or not the DNA policy had been complied
18 with?
19 **A.** No, I didn't.
20 **Q.** Do you have a view as to whether the DNA policy had been
21 complied with?
22 **A.** My expectation would be that part of that discussion,
23 when you're making that final decision, those factors
24 have been reviewed. So I would have trusted that
25 decision being made in that MDT by colleagues that were

1 familiar with VC.
2 **Q.** Did you have any concern about the decision to discharge
3 VC?
4 **A.** No, I didn't.
5 **Q.** Can we -- in fact, before we leave this entry, this is
6 a three-line entry which is obviously in respect of
7 a fairly significant development in VC's care; would you
8 agree, the decision to --
9 **A.** Yeah.
10 **Q.** -- discharge back to the GP? You can't remember who you
11 got this information from. Do you recall if this is the
12 extent of the information that you obtained?
13 **A.** I would imagine that, if I haven't put any more detail,
14 I wasn't given it, any detailed information.
15 **Q.** So, in your view, it's likely that what you've put here
16 is the extent of what you were told?
17 **A.** Yes.
18 **Q.** Do you think that you ought to have been given more
19 detail in order for a fuller entry into the records to
20 have been completed because that's quite short, isn't
21 it?
22 **A.** It is short and on reflection I feel that, actually, if
23 I was asked to do it because somebody was in that
24 meeting, I shouldn't have been the person doing it; that
25 other person who was there should have completed that

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1 action.
2 **Q.** Yes, well you deal with this in your statement, if we
3 can go back to that. WITN0292001, and it's going to be
4 page 16. Paragraph -- it's at the top of the page, so
5 it's paragraph, part of paragraph 43 at the top of the
6 page where you say there what you've said in your
7 evidence this morning. You assume you were "asked or
8 volunteered to help with ... paperwork."
9 But given you weren't at the discharge meeting and
10 given the significance of the decision -- sorry, I keep
11 saying -- the MDT, given you weren't at the MDT and the
12 significance of the decision made there, you weren't the
13 right person, were you, to be recording this in VC's
14 records or to be writing to his GP as to discharge?
15 **A.** No.
16 **Q.** It ought to have been done by somebody who was at the
17 MDT meeting.
18 **A.** Yes, I agree.
19 **Q.** And so when, if we go to page 29, and paragraph 83,
20 please, where you say:
21 "I have also reflected ... I may not have been the
22 most suitable person to request the discharge letter and
23 that perhaps the discharge of VC could have waited until
24 [his care coordinator], GC [Gary Carter] had returned
25 ..."

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1 Is the position, on reflection, that actually you
2 should not have been undertaking that letter, and the
3 decision or the discussion of discharge at MDT should
4 have awaited VC's care coordinator?
5 **A.** Yes, I agree with that. It should have done, yes.
6 **Q.** And you say towards the end of that paragraph, it's the
7 final sentence:
8 "I have also reflected on whether contact with VC's
9 family and GP should have been attempted again before
10 a final decision in order that they could have had
11 an opportunity to voice any concerns or worries."
12 And you don't quite say what the conclusion of those
13 reflections are but you accept that that should have
14 been done.
15 **A.** Yeah, I do think that before that final decision, and
16 it's really difficult because there isn't any
17 documentation in the records to say whether any other
18 further attempts was done, but I can see in the RiO
19 running records that the last sort of contact was the
20 end of August, and I think we should have tried that
21 again because that's nearly a month later. So I do feel
22 that those conversations and those discussions could
23 have had, or perhaps a case conference with the GP,
24 inviting VC's family, and any other professionals that
25 was aware of VC, that could have happened.

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1 **Q.** Could we look, please, at the discharge letter, it's
2 CHCA0000013. While that's coming up you say you don't
3 recall who it was that told you about the MDT or asked
4 you to complete these records. Who are the potential
5 contenders? Who is it that would have asked you to
6 undertake --
7 **A.** So it could have been my line manager, which was Emma
8 Robinson. It could have been a member of the staff from
9 the actual team. If they hadn't got capacity to follow
10 an action up, they could have just knocked on our office
11 door and asked: have we got capacity to help? Or I've
12 offered and said is there anything that I can help with,
13 if I felt I'd got some capacity to help, because I am
14 aware, by looking at some of the rota that I have access
15 to, that there was a lot of sickness at that time in
16 that base.
17 **Q.** Who did you understand VC's responsible clinician to be
18 when he was in the community?
19 **A.** Dr Lloyd.
20 **Q.** This is the letter which is from you to primary care, to
21 VC's GP, and just to put this into context, this is
22 an important, or should be an important piece of
23 correspondence, shouldn't it, because you are
24 transferring the care back to the GP?
25 **A.** Yes.

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1 **Q.** This letter has a number of omissions, doesn't it?
2 **A.** Yes.
3 **Q.** It is, would you agree, a wholly inadequate letter?
4 **A.** I would agree with that, but the covering letter would
5 usually be sent with the core documents which is a core
6 assessment, a risk assessment and a care plan. So
7 unfortunately I don't know why that -- they didn't get
8 sent.
9 **Q.** So one of the omissions is that it doesn't include those
10 documents: care plan or risk assessment.
11 **A.** No.
12 **Q.** But as I think you recognise in your statement, most of
13 those documents were out of date in any event, weren't
14 they?
15 **A.** Yes, they were.
16 **Q.** It does not provide, does it, any explanation of VC's
17 current or historical risk?
18 **A.** No.
19 **Q.** It does not say, for instance: well, the EIP team, we
20 won't visit him at home --
21 **A.** No.
22 **Q.** -- we require him to come in. It does not set out,
23 does it, the likely risks, as a consequence of likely
24 non-concordance?
25 **A.** No, it doesn't.

1 **Q.** There's no advice at all to the GP, is there, as to how
2 to manage VC, and obviously the GP is not a specialist
3 like you are. They are receiving this patient back
4 without any guidance as to what management needs he has.
5 **A.** Yeah, I would agree with that, but like I've said, in
6 the core documents and I appreciate they are --
7 they wasn't up to date and I should have checked those
8 prior to requesting that letter to be done. All those
9 details should be in those documents.
10 **Q.** The care plan was dated June 2021, wasn't it? It hadn't
11 been updated, the community care plan?
12 **A.** Yes.
13 **Q.** So even if that had been included, it would be missing
14 an awful lot of information.
15 **A.** Yes.
16 **Q.** There is no explanation in the letter, is there,
17 importantly, as to VC's medication? It doesn't say what
18 he's on, the amount.
19 **A.** No.
20 **Q.** It doesn't make clear that he was going to be
21 responsible for prescribing medication to VC, because of
22 course EIP had taken over the responsibility for
23 prescribing from the GP, following the first and then
24 second admission. This letter doesn't give any
25 indication as to what was to occur with medication?

1 **A.** No, it doesn't but, like I said, the expectation is that
2 would be in those core documents and, had I checked and
3 realised they weren't up to date, I wouldn't have
4 requested that letter to be written until those
5 documents were updated.
6 **Q.** Just so that I understand, was it your understanding
7 that those documents were going to be sent with this
8 letter?
9 **A.** Yes.
10 **Q.** So when sending the letter, was it not necessary to
11 check those documents to make sure they were up to date?
12 **A.** I would expect those documents to be updated following
13 the decision.
14 **Q.** Which decision? The discharge decision?
15 **A.** Yes.
16 **Q.** What did you undertake any checks to see if they had
17 been updated?
18 **A.** I didn't, no.
19 **Q.** On the point of medication, what were the arrangements,
20 as you understood it, or what are the unusual
21 arrangements in this situation when there's been
22 a discharge back to primary care? Who was going to be
23 responsible for VC's medication?
24 **A.** Well, usually it would be the GP but we wouldn't usually
25 discharge somebody and transfer that -- the medication

1 to the GP at that point. We would have done that prior
2 to doing that. But I am aware that VC, in this case, it
3 didn't -- that certainly didn't happen.
4 **Q.** So the transfer of prescribing should have already
5 happened prior to discharge?
6 **A.** Yes.
7 **Q.** So it didn't happen prior to discharge, it didn't happen
8 at discharge; did it happen following discharge?
9 **A.** I didn't contact the GP.
10 **Q.** To your knowledge, did it happen following discharge?
11 **A.** Not that I'm aware of.
12 **Q.** So insofar as your understanding of the system,
13 following his discharge to primary care, who was
14 responsible for prescribing his medication?
15 **A.** It would have been the GP.
16 **Q.** Can we go back in time slightly and to the issue of
17 supervision. You confirmed earlier that you supervised
18 Gary Carter whilst he was VC's care coordinator and the
19 supervision sessions were once a month?
20 **A.** Yes.
21 **Q.** But the position that you've explained in your statement
22 is that the onus was on the care coordinator to raise
23 patients at supervision?
24 **A.** Yes, that's correct.
25 **Q.** It wasn't the practice that you'd go through each

1 patient on a care coordinator's caseload?
2 **A.** No.
3 **Q.** Now, you did keep a typed note of supervisions and is it
4 right that the only one at which there was discussion of
5 VC was in July 2022?
6 **A.** Yeah, that's correct.
7 **Q.** The note is NHFT0004909. This is your note, isn't it,
8 of that supervision in July?
9 **A.** Yes, it is.
10 **Q.** If we turn to page 2 and, just before we look at the
11 substance of the VC entry, in box number 3, next to
12 "Note Audits/Patient Tracker", it states "Audits now
13 being completed". What was that a reference to?
14 **A.** So we used to do note audits, a random selection of ten,
15 every three months, but they had previously been stood
16 down due to Covid and they had then started being
17 completed again.
18 **Q.** If we go to page 3 the final page of this document, this
19 is in a section dealing with patient discussions and we
20 can see the entry there in the middle of the page in
21 respect of VC, and Mr Carter reports that VC had gone
22 missing:
23 "... believed may have left the country -- call from
24 Mum who informed [care coordinator] he is in Nottingham,
25 plan to try and visit ... when previously unwell did

1 need a taser when sectioned."
2 Now, what you've said about this in your statement,
3 I won't put it up on screen, whilst we look at this, but
4 you say, well, no risks or concerns were raised at this
5 point around VC. Accordingly I did not have any
6 in-depth conversations around VC, his presenting or
7 ongoing presentation during supervisions.
8 This is a supervision where VC is discussed but was
9 it not clear from what Mr Carter had told you that, one,
10 VC had lied, so he'd lied to his care coordinator or to
11 the EIP team, Ms Parsonage, about being abroad when in
12 fact he wasn't?
13 **A.** Yes, that's correct.
14 **Q.** That he wasn't taking his medication?
15 **A.** It was believed that he wasn't taking his medication.
16 **Q.** And that he had disengaged, so lying and not taking his
17 medication and not engaging with members of the team
18 trying to contact him?
19 **A.** Yeah, that's correct.
20 **Q.** Now, those factors, were they not all red flags that
21 required escalating?
22 **A.** So when Mr Carter brought VC to that supervision, we
23 discussed and Mr Carter was going out to see him, so
24 that would have been the start of that process to try
25 and locate him and assess his mental state.

1 **Q.** So that was one step. Did you consider that to be all
2 that was necessary at that stage?
3 **A.** So, after that supervision, I went on leave and we spoke
4 about, if he hadn't been able to contact VC or locate
5 him on doing a cold call, then he was going to escalate
6 it in my absence.
7 **Q.** Escalate it to whom?
8 **A.** To Emma Robinson and within the MDT meeting.
9 **Q.** Whether or not VC was contacted, would those factors,
10 those issues we've just gone through, the deception, the
11 indication of disengagement, the issue of
12 non-concordance, wouldn't that call for an immediate
13 update or change to the risk assessment?
14 **A.** Yes, it would.
15 **Q.** Did you tell Carter to undertake an immediate update to
16 the risk assessment?
17 **A.** I don't remember whether we spoke about that or not.
18 **Q.** Was it your expectation that he would?
19 **A.** Yes.
20 **MR CARR:** Thank you, Chair. Those are my questions. There
21 are other questions.
22 **THE CHAIR:** Yes, thank you.
23 Yes, Mr Moloney.
24 **Questioned by MR MOLONEY**
25 **MR MOLONEY:** Just a few questions on behalf of the bereaved

1 families, if I may.
2 **A.** Yeah, of course.
3 **Q.** You've said that VC's case was not discussed in detail
4 at MDTs?
5 **A.** Not in the ones I attended, that I recall, no.
6 **Q.** Can I just ask you, you say in your statement -- I won't
7 waste time by taking you to it, I'm sure you've had
8 a look -- that essentially you attended 22 MDTs out of a
9 potential 38 in the city South EIP --
10 **A.** Yes.
11 **Q.** -- from January 2022 to 23 September 2022, just over
12 half, essentially.
13 **A.** Yes.
14 **Q.** Was there any reason why you didn't go to all the MDTs,
15 and why it would be that number?
16 **A.** So the reason I know why it's that number is because
17 I still hold a paper diary where I tick when I attend,
18 I cross when I don't, for reference, and it could have
19 been because of leave, it could have been because I've
20 had training booked in on those days. Throughout
21 August, I wasn't there for three and a half weeks.
22 I was on extended leave. So those would have *(unclear)*
23 or I could have been supporting a staff member or at
24 another base, because there was five bases that we had
25 oversight over, or I did have a patient on a caseload as

1 well, at that time.
2 **Q.** Now you've acknowledged that the decision to discharge,
3 in your view, should have been taken when the care
4 coordinator was present.
5 **A.** Yes, I agree.
6 **Q.** How did you feel when you were carrying out the
7 administrative task of discharging him?
8 **A.** I trusted my colleagues that that discussion and the
9 expectation what I would have that all the actions would
10 have been done. I was quite new to that role, so still
11 learning, maybe not have the confidence to challenge
12 anything at that point. So -- and I thought I was being
13 helpful.
14 **Q.** Did you think of your, as it were, duties under Freedom
15 to Speak Up or anything of that nature?
16 **A.** No, I didn't.
17 **Q.** The policy for discharging at that time, just one aspect
18 of it that Mr Carr hasn't touched upon, said that the
19 rationale for discharging after DNA must be clearly
20 recorded on the relevant electronic record system and in
21 the patient's notes, didn't it?
22 **A.** Yes.
23 **Q.** And we see the entry that Mr Carr took you to, at
24 page 271 of the RiO records, that you said essentially:
25 "... a period of time despite attempts to make

1 contact and having done cold calls, decision made within
2 the team to discharge back to GP due to non engagement
3 ..."
4 Did you think that that was a sufficient rationale
5 in accordance with the policy?
6 **A.** At that time, that wasn't unusual to do, discharge due
7 to non-engagement. It has changed now, but at that
8 time, that was a practice that was completed.
9 **Q.** And you thought that what you'd set out there was
10 sufficient and clearly explaining the rationale for
11 discharge.
12 **A.** I -- if -- when I documented that, that was the
13 information I had. I would like to think that the
14 expectation would be that the person who was in that MDT
15 had documented.
16 **Q.** And that was the information you had. Where did you get
17 that information from?
18 **A.** Like I've already said to the counsel, that I don't
19 recall whether I've been asked to do it and given that
20 information, or I've offered to help, if there's
21 anything I can help with, which is not unusual, and
22 they've gave me a brief outline.
23 **Q.** Which essentially you've reflected in that entry.
24 **A.** Yeah.
25 **Q.** Yeah. Now we've seen the letter to the general

1 practitioner that was -- was that drafted by you?
2 **A.** I emailed the admin team and asked them to draft.
3 **Q.** Now we know that at this stage the EIP was saying that
4 VC should only be visited at home if absolutely
5 necessary and that any visit should have two people.
6 **A.** Yes.
7 **Q.** Was there any warning to the GP about the concerns that
8 the EIP had about their interactions with VC?
9 **A.** Not that I'm aware of.
10 **Q.** So the GP is there on their own in an office. Did
11 anybody not think to include that risk?
12 **A.** That risk would usually be in the risk assessment, which
13 I believed had gone with that letter.
14 **MR MOLONEY:** Thank you very much.
15 **THE WITNESS:** Thank you.
16 **THE CHAIR:** Yes, Ms Cartwright.
17 **Questioned by MS CARTWRIGHT**
18 **MS CARTWRIGHT:** Ms Heath, can we just be clear about the
19 time you were in the EIP team. Can we just look,
20 please, in your witness statement, WITN0292001 at
21 page 2. Thank you.
22 So I just want to be clear about your knowledge and
23 experience and then when you became the Clinical Team
24 Leader. You tell us at paragraph 6 you joined the EIP
25 service in 2020, and then we see that you were

1 successful in securing that role as a Clinical Team
2 Leader in the South Early Intervention Psychosis Team in
3 December 2021.
4 So can I just be clear, what were you doing in the
5 service in 2020, please?
6 **A.** I was the Community Psychiatric Nurse, so the CPN care
7 coordinator.
8 **Q.** And was that within the South Team or was it in another
9 team?
10 **A.** It was in the North --
11 **Q.** The North Team?
12 **A.** The EIP North Team.
13 **Q.** So was that the team we heard from Ms Robinson earlier,
14 that was the team where you did minute MDTs?
15 **A.** No, that -- Emma -- Ms Robinson is the South, and in the
16 north is the North, the locality, so Mansfield way,
17 mid-north.
18 **Q.** And did the North minute MDTs?
19 **A.** We had a admin support in there that used to minute it,
20 or then it went on to the responsibility of the care
21 coordinators to minute the MDTs.
22 **Q.** So you'd experience of working in a team before moving
23 to this one where you had records of the MDT.
24 **A.** Yes.
25 **Q.** Thank you. Then we can see that in December 2021, you

1 received this Clinical Team Leader role.
2 A. Yes.
3 Q. And can I just be clear, because in terms of ordinarily
4 a Clinical Team Leader's role, would it be right that
5 that deals with responsibility for clinical leadership
6 and governance?
7 A. It does.
8 Q. Okay. And so when you say that you were new to the
9 team, you're principally being asked about your
10 involvement in September 2022, so you had been in the
11 team for ten months.
12 A. So even though I was appointed in December 2021,
13 I didn't officially move to that team until
14 January 2022.
15 Q. Right, so nine months.
16 A. Yes.
17 Q. So there you've also referenced Covid as one of the
18 reasons why clinical audit was stopping, but would you
19 agree essentially all the legal restrictions imposed by
20 Covid were lifted in February of 2022, so really you as
21 a clinical lead should have been making sure that
22 systems and processes post-Covid were being reintroduced
23 within this team?
24 A. They had been stood down for the whole Trust; it wasn't
25 just within our team, and as a new clinical lead,

1 I wouldn't have enforced that, because it was a system
2 that was not in place.
3 Q. So can you help us then when the Trust, post-Covid,
4 started implementing audit again within this team?
5 A. I believe it was in around June time.
6 Q. June of 2022?
7 A. June 2022, that it started again.
8 Q. So actually it was in place before VC's discharge in
9 September 2022.
10 A. It was, yes.
11 Q. But is it your evidence that there had not been any
12 audit that had picked up any issues in respect of
13 Mr Carter?
14 A. I hadn't done any audits that had picked any issues up.
15 Q. So can I just be clear then, when the audit was
16 reintroduced in June 2022, were you the person
17 responsible for doing that dip sampling?
18 A. It was myself and Emma Robinson --
19 Q. All right.
20 A. -- my line manager.
21 Q. So where you've been taken to the paragraph that dealt
22 with audit, you're clear it came back in in June 2022.
23 A. I'm clear it came back in.
24 Q. Right. Then can we just contextualise as well, you've
25 referenced a period of leave and we've had uploaded, in

1 the last tranche, your interview from November, and
2 I think, just so we're clear, I think you went off at
3 the end of July of 2022 for I think your honeymoon and
4 that's your extended leave which essentially took you
5 away for all of August.
6 A. Yes.
7 Q. Is that correct?
8 A. That's correct.
9 Q. So you said you had expected Mr Carter to escalate
10 concerns, but essentially from when you came back, would
11 you agree that Mr Carter had been away the whole time?
12 He'd been on a period of carer's leave from 25 August to
13 2 September, and then he was on sick leave from 6 to
14 25 September.
15 A. So I returned on 25 August, and that was when he was
16 off.
17 Q. Yes.
18 A. But he did have the time prior to that to escalate any
19 concerns that he had.
20 Q. So did you check whether he'd escalated any concerns?
21 A. No, I didn't check, and I don't recall in a handover
22 with my line manager that anything had been raised.
23 Q. But would you not therefore agree that you were being
24 asked essentially to -- not having been at the MDT, to
25 effect essentially the handover of care from secondary

1 to primary care, that it was essential that you, then,
2 as the clinical lead, ensured that that letter you've
3 looked at with Mr Carr contained the most comprehensive
4 information about VC's time with EIP?
5 A. I agree, it should have done, yes.
6 Q. And perhaps if we just look as well, just to give some
7 context to the evidence you've given and how you've
8 sought to assist with who tasked you with it, if we can
9 look at your request, which is essentially to an admin
10 officer to do the letter. If we look at WITN0292005.
11 Thank you.
12 So you, on 23 September, email City South Admin and
13 essentially say:
14 "Could the following people EIP referral be closed
15 ...
16 "VC.
17 "Could a letter be generated for VC to his GP
18 informing them of discharge due to non engagement
19 please.
20 "Any issues please let me know."
21 So can you just help us: City South Admin, who is
22 that who is monitoring that email box?
23 A. So that's the medical secretaries, the admin support
24 that we have that would create those and do our letters
25 for us.

1 Q. So would you agree that the letter that you've looked at
2 with Mr Carr, you've not even written that? You've
3 essentially sent an email to an admin individual to
4 generate essentially a standard discharge letter for
5 non-engagement?
6 A. I did -- they have generated it but they would have sent
7 it back to me and I've then approved that.
8 Q. But would you agree that that's a failing on your part
9 to not have done any of the tasks required for this
10 risky discharge of VC to have yourself interrogated the
11 records and actually bothered to write the letter
12 yourself?
13 A. I wouldn't have wrote the letter because I didn't know
14 VC, so it would have been really difficult for me to put
15 a context on there, which, if we are -- if I was
16 discharging somebody, that's why it's important that the
17 core assessments go, because they are generated and
18 created by the CCO who knows that individual. But I do
19 accept that I wasn't the right person to do that, for
20 exactly that reason.
21 Q. So then why, as the clinical lead, were you absolutely
22 not putting your foot down and saying, "You, Dr Lloyd,
23 as the responsible clinician, should be doing it"?
24 A. At that time, I believe I probably wasn't confident
25 enough to do that.

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1 Q. But you are the clinical lead. Why are you not
2 confident of simply asking a professional, who's been
3 present at the meeting that you weren't at, to write
4 their own discharge letter back to the general
5 practitioner as essential handing over of care?
6 A. It wouldn't usually be the responsible clinician; it
7 would usually be the care coordinator that writes that
8 letter.
9 Q. Right. So if Mr Carter is not available due to sick
10 leave, did you speak to Claudia Birtles as the care
11 coordinator that had had it before?
12 A. Claudia was on maternity leave at that time.
13 Q. Right. So did you then not say -- well, did you look at
14 when Mr Carter was going to be back from leave to say,
15 "Actually, there's no rush for discharging VC, this is
16 an important discharge and it should be Mr Carter when
17 he comes back that deals with this discharge"?
18 A. So there wasn't a return date at that time for
19 Mr Carter.
20 Q. All right.
21 A. So -- but I do agree that it could have waited.
22 Q. But then, in light of the fact that, essentially, the
23 two care coordinators are not accessible to you, would
24 you not agree that -- I know you say you're not the best
25 person -- that it was absolutely essential as the

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1 clinical lead that you read the letters, you sought out
2 the core assessments, the care plan and the risk
3 assessment, to make sure that they were comprehensive
4 and complete?
5 A. I wouldn't have been able to update them because
6 I wouldn't have known him well enough to update those
7 documents.
8 Q. No, but would you appreciate that if you'd checked,
9 you'd actually have realised that those documents were
10 massively out of date and, in fact, the last care plan
11 related to a time when VC was in hospital?
12 A. Yes, I --
13 Q. And, again, you should have checked that?
14 A. Yes, I should have done.
15 Q. Because, again, that would have been even more of
16 a reason why you should have been putting a foot on
17 a ball for this discharge and saying, "Not only shall
18 I not be writing and asking the secretary to send
19 a discharge but, as clinical lead, this discharge should
20 not be taking place until the fullest review has taken
21 place"?
22 A. Yes, I agree with that.
23 Q. Now, Mr Carter gave evidence that you had raised no
24 issue with him in supervision about his notes, and we've
25 looked at some of his notes. Can you assist as to why

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1 you didn't raise issues about his potential inadequacies
2 in his note keeping?
3 A. So it wasn't routine for me to go through his notes at
4 that point. As I was learning, there was no guidance of
5 what I should have been looking at in his documentation
6 and, after the tragic incident, then it has --
7 obviously, we have done that and put more robust audits
8 in place, just separate to doing those normal audits, as
9 a team and as a Trust. I do a separate one in every
10 supervision, independently as well.
11 Q. Now, you tell us effectively in your statement you
12 hadn't had any induction or training before you became
13 the clinical lead?
14 A. No, I didn't.
15 Q. So you're saying that you didn't spot any issues with
16 his notes because you didn't know what you should be
17 doing in the expectations of your role?
18 A. I wasn't routinely looking at his notes.
19 Q. So would that also follow, where there is not up-to-date
20 core assessments, care plans and risk assessments, would
21 you agree also that that was a failing on your part not
22 to identify that they were not the most up-to-date
23 documentation for VC?
24 A. Yes, I agree.
25 Q. Can I ask you, did you know the policy that was looked

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1 at? Did you follow Ms Robinson's evidence?
2 **A.** I didn't follow it.
3 **Q.** No, but were you aware, to save time, that the policy in
4 respect of Do Not Attend should have been that for every
5 one of those decision meetings or where someone doesn't
6 attend, there should be a risk assessment and,
7 particularly if the MDT is involved, a risk assessment
8 from the MDT?
9 **A.** Yes, there should be.
10 **Q.** Did you know that at the time that was what the policy
11 expected?
12 **A.** I would expect that.
13 **Q.** So then why do we not see you asking anyone, "Can
14 I have, please, the documented risk assessment from that
15 MDT to inform the secretary for writing this letter"?
16 **A.** I don't know why I didn't raise that.
17 **Q.** Now, in terms of the address that we saw on it, we know
18 that that was the address where VC had been living when
19 there was the incident with the students and then VC's
20 fourth admission. Had you been made aware at any point
21 from Claudia Birtles that VC was not -- had given up
22 that accommodation after that incident and returned the
23 keys to the University?
24 **A.** No, I wasn't aware of that.
25 **Q.** And you gave evidence, and so would you agree therefore

1 that actually, the letter not describing to the GP the
2 ambiguity about where VC was living was essentially
3 providing misleading information to the general
4 practitioner?
5 **A.** That would have been the last documented address that
6 was on RiO, and that should be the most up-to-date one.
7 **Q.** Yes.
8 **A.** So if he'd gave a different address, then that should
9 have been updated at that time that address was given.
10 **Q.** But again I think we see that on his request for access
11 to records on 18 August. Did that not raise a concern
12 that actually this was not a patient that was completely
13 out of contact; he'd proactively sought access to his
14 records through the team?
15 **A.** I wasn't aware of that because I wasn't at work at that
16 time when there would have been a discussion about him
17 wanting access to his records and a different address
18 being given.
19 **Q.** Can I ask you, in your paragraph 35, if that could just
20 be displayed. WITN0292001 at page 13. Thank you. You
21 reference that VC wasn't the only patient that -- sorry,
22 paragraph 35 -- who has gone on to kill or seriously
23 injure. And you're referencing being involved with two
24 other such patients, one in 2023, and another in 2024.
25 Did the other incident in 2023 pre-date the June 2023

1 attack?
2 **A.** I don't recall. I believe it did.
3 **Q.** And then if it did, do you know, was there any internal,
4 then, review as to how the EIP operated to pick up any
5 of the thematic systemic issues that this Inquiry has
6 identified?
7 **A.** With that individual, he was handed over to his GP by
8 the care coordinator actually going and having
9 an appointment with the GP to hand that care back over,
10 and I believe the information I had of that incident was
11 that the patient was actually the victim, not the
12 perpetrator.
13 **Q.** All right, but that was another patient from the EIP
14 that had been discharged.
15 **A.** That had come to the end of the pathway, yes.
16 **THE CHAIR:** Yes, Ms Cartwright, do you have any more?
17 **MS CARTWRIGHT:** Then just finally, you gave evidence that
18 you had no concern when you discharged VC, but you've
19 also referenced everything you've learned through this
20 Inquiry as to the previous incidents; would you agree?
21 **A.** Yes.
22 **Q.** Would you therefore agree that whilst you're saying you
23 had no concerns with the discharge, it's because you
24 didn't read the records, but actually everything you've
25 learned through the Inquiry was available in the records

1 if you'd bothered to read them?
2 **A.** I didn't read the records prior, but I'd gone from
3 having a caseload of around 15, 16 people, to having
4 oversight of around 350 people. So needing to learn
5 about 350 patients, realistically I would not have been
6 able to sit and read every single person's notes within
7 that short period of time.
8 **Q.** Then just to finalise that point with you, identifying
9 your large workload, you've been asked about the Freedom
10 to Speak Up route. You'll obviously be aware also of
11 your obligations of candour under the NMC, particularly
12 where there are systemic issues. Did you raise any
13 issues with management or senior leadership in respect
14 of your workload?
15 **A.** So my workload would have been to have the oversight of
16 those patients. I wouldn't be care coordinating them
17 directly. That is obviously for the care coordinators
18 in different bases, and that was a lower caseload and
19 amount of patients that we've got than we have now, and
20 that's in the service. But I didn't raise anything with
21 anybody.
22 **MS CARTWRIGHT:** Thank you, Ma'am.
23 **THE CHAIR:** Thank you.
24 Yes, Mr Straw.
25 **Questioned by MR STRAW**

1 **MR STRAW:** Ms Heath, I represent VC's family.
2 Ms Cartwright has already referred you to
3 paragraph 35 of your witness statement, in which you say
4 "In my role as clinical team leader ... I [was] involved
5 with two other ... patients", in 2023 and 2024 who had
6 killed or seriously injured a member of the public.
7 In addition to -- well, including VC's six victims,
8 how many victims were there in total?
9 **A.** Like I said, the one in 2023, the information I had at
10 that time I'll say was actually a -- he was the victim,
11 not the perpetrator, and then, including VC's, the other
12 person injured five people.
13 **Q.** So there's six for VC --
14 **A.** So it was --
15 **Q.** -- five for the other person --
16 **A.** *(The witness nodded)*.
17 **Q.** -- and one for the person in 2023.
18 **A.** *(The witness nodded)*.
19 **Q.** So that's 12 victims in total.
20 **A.** *(The witness nodded)*.
21 **Q.** Ms Heath, was your leadership of those teams obviously
22 flawed?
23 **A.** No, I don't believe it was.
24 **Q.** I'd like to ask just a few questions about your
25 supervision of Mr Carter. You accept in your witness

1 statement at paragraph 74 that VC should have been seen
2 by a CCO at least weekly; is that right?
3 **A.** Following admission, that is what I would expect, yes.
4 **Q.** So from the point at which Mr Carter took over as CCO,
5 so from May onwards, when you were his supervisor,
6 Mr Carter saw VC as his CCO on, I think, one occasion.
7 That was insufficient, wasn't it?
8 **A.** I believe it was, yes.
9 **Q.** Were you aware of that at the time?
10 **A.** No.
11 **Q.** What steps did you take as his supervisor to ensure that
12 he was seeing his patients regularly enough?
13 **A.** So we would have discussions and he would bring his
14 patients to MDT on a weekly basis where we would run
15 through all of his patients and update.
16 **Q.** With VC in particular, did you take any steps to ensure
17 that he was carrying out the required visits?
18 **A.** Well, he was reporting that he was -- he'd obviously --
19 that VC was collecting his medications, he'd spoken to
20 him or he'd sent texts and received texts back. So my
21 understanding would be that he was having contact with
22 VC.
23 **Q.** Okay. We've seen an email on 8 September 2022 from
24 Ms Parsonage, to which I think you were copied in, where
25 she was seeking cover for Mr Carter's patients, the

1 patients he had as CCO. What did you do in response to
2 that to ensure that those patients, in particular VC,
3 had an allocated CCO?
4 **A.** I wouldn't be able to tell you where I was on that day,
5 but cover is usually sorted out by the actual team, not
6 us as managers. We have oversight and people will come
7 and talk to us if they haven't managed to get everything
8 covered but how the EIP team is set up over five
9 different bases around for South -- around both county
10 and City South, we could have been at a different base
11 on that day, and that, so it would be left to the care
12 coordinators around the *(overspeaking)* --
13 **Q.** Ms Parsonage said there was no discussion about who was
14 covering -- who was VC's covering CCO after that point.
15 Wasn't it your responsibility, as Mr Carter's
16 supervisor, to ensure that there was an allocated CCO
17 when he wasn't there?
18 **A.** Like I say, that is something that is sorted between the
19 CCOs. The CCOs are -- in EIP are all experienced CCOs,
20 and professionals. They have a lot of autonomy in the
21 way that the EIP team is set up.
22 **Q.** Okay, and finally, please, you've mentioned earlier that
23 the question of discharging VC to his GP was raised with
24 you at a time in 2022. Did you do anything to ensure
25 that relevant people were consulted about that? So, in

1 particular, I mean VC's mum, Celeste, the GP and the
2 police? Did you do anything?
3 **A.** I didn't do anything but the expectation would be you
4 wouldn't ring them on the day that you were actually
5 finally discharging. Those conversations should have
6 been had several weeks, if not months, before. As soon
7 as he was even considering it, you should have been
8 having those conversations.
9 **Q.** But you didn't do anything to make sure those happened?
10 **A.** I didn't, no.
11 **MR STRAW:** Okay, thank you very much.
12 **THE CHAIR:** Yes, any questions, anybody else?
13 Ms Milligan?
14 **Questioned by MS MILLIGAN**
15 **MS MILLIGAN:** Thank you.
16 Ms Heath, I ask questions on behalf of Gary Carter
17 and I also stand between us and lunch so I just have
18 a few questions for you.
19 **A.** Okay.
20 **Q.** First, Mr Carter was effectively given VC as a patient
21 at an MDT that he wasn't present at and that was because
22 of his gender. He was the only male nurse; is that
23 right?
24 **A.** I don't believe that being the only reason he was
25 allocated VC.

1 **Q.** But do you accept it was a reason?
2 **A.** I think at the time, I believed that we had a discussion
3 of trying a different approach. He'd -- his
4 relationship with Claudia had broken down, so we was
5 trying a different approach and perhaps he may engage
6 better with a male rather than a female.
7 **Q.** The entry in the RiO notes states that VC should
8 preferably have two CCOs. Why was a second not
9 allocated to him?
10 **A.** I don't recall it being needing two CCOs. It may have
11 meant two staff members, which could be a support worker
12 alongside a CCO.
13 **Q.** But that didn't happen either, so why was no second
14 person allocated?
15 **A.** So my understanding was the support worker, Paul
16 Williams, was going to go out and see VC with Gary.
17 **Q.** So that was on one occasion: a cold call in August. Is
18 it your evidence that you understood Mr Williams to be
19 a general second pair of hands as far as VC was
20 concerned?
21 **A.** So my understanding was that we was going to introduce
22 Mr Williams in -- alongside Mr Carter, so we'd got all
23 aspects covered, and we find that some of our patients
24 don't engage as well with nurses but do engage with the
25 support workers.

1 **Q.** Mr Carter raised his excessive caseload with you on
2 a number of occasions. You say in your witness
3 statement it didn't take place in supervisions but is it
4 right that there was a number of conversations with you
5 about caseloads?
6 **A.** So we did talk about it in supervisions. Part of the
7 template does look at how many is on somebody's
8 caseload. We would look at the acuity of the
9 individuals on somebody's caseload. Somebody may have
10 slightly higher numbers, but there could be a number of
11 factors of contributing to that. So it could be
12 somebody is coming to the end of the pathway, either to
13 be discharged or to go to the Local Mental Health Team.
14 We wouldn't be routinely doing intense work where we've
15 seen them weekly. So that frequency of contact would be
16 reduced at that point.
17 We also have people on caseloads that when we've
18 done assessments or we've used our screening tool, then
19 they are allocated to effectively work within our KPIs
20 of stopping the clock, of a two-week standard. That is
21 regardless of whether they're actually for our service
22 or not. So even though there might be numbers on there,
23 it doesn't mean that you're intensely seeing them every
24 single week.
25 **Q.** Perhaps in general, but we've heard evidence that

1 Mr Carter's caseload was consisting of difficult
2 patients that required intensive time; do you agree with
3 that?
4 **A.** Some of them would have been, yes.
5 **Q.** Then finally, do you agree that it fell within your
6 managerial responsibilities to keep Mr Carter's caseload
7 at a manageable level, particularly given your knowledge
8 of his personal difficulties at the time?
9 **A.** We did talk about his caseload every time in
10 supervision, and Mr Carter never raised any concerns
11 around his caseload. I offered additional support
12 should he need that, but he declined that. But we did
13 look at his caseload.
14 **Q.** But my question was: do you accept that that fell within
15 your managerial responsibilities?
16 **A.** It is in my role.
17 **MS MILLIGAN:** Thank you. Those are my questions.
18 Thank you, your Honour.
19 **THE CHAIR:** Yes, Mr Beer.
20 **Questioned by MR BEER**
21 **MR BEER:** It's less than five minutes, Chair, so I assume
22 you're content for me to take the questions now?
23 **THE CHAIR:** Yes, thank you.
24 **MR BEER:** Four points of detail, please. Firstly,
25 Mr Carter's caseload. Could you look at your witness

1 statement, please, WITN0292001, at page 27. And
2 paragraph 77 at the bottom:
3 "In June 2022 [Mr Carter's] caseload was reported by
4 [Mr Carter] as being 19 during supervision. No issues
5 were raised around his caseload size with me during this
6 supervision."
7 Just stopping there, did you have a monthly meeting
8 with him?
9 **A.** I did, yes.
10 **Q.** And he reported to you what his caseload size was.
11 **A.** Yes.
12 **Q.** Carrying on:
13 "In July 2022 during supervision [Mr Carter]
14 reported his caseload size to be 18 patients. He did
15 not raise any issues around his caseload size during
16 this supervision or on any other occasions."
17 You are unable to confirm what his caseload size was
18 during August 2022.
19 So his caseload in the couple of months in June and
20 July 2022 before the relevant events of September 2022,
21 were 19 and 18 respectively, and he raised no issues
22 with you.
23 **A.** Yes, he raised -- that's correct.
24 **Q.** Secondly, in relation to the questions that you were
25 asked about reviewing Mr Carter's RiO recordkeeping,

1 after that restarted, I think you said because of the
2 Covid interruption in June 2022, can we look at
3 NHFT0004909, please. This is a record of your clinical
4 supervision or managerial meeting with Mr Carter. We
5 can see that this one is dated 27 July 2022. Did you
6 keep records of all such meetings?
7 **A.** All the meetings I had, yes.
8 **Q.** People can look at it later if they want but we can see
9 it's structured. Does that follow the structure that
10 you followed in the course of the meeting?
11 **A.** Yes.
12 **Q.** If we look at the top of page 2, please. Under the
13 heading "Training and Development", against that, it's
14 got "Training up to date -- just recordkeeping to
15 finish". Can you recall what that's about?
16 **A.** So that is an e-learning recordkeeping which is
17 mandatory for all staff within the Trust, and he
18 reported he was halfway through that and he just needed
19 to finish that and then all his mandatory e-learning was
20 up to date.
21 **Q.** So is that you actually picking up with Mr Carter the
22 issue of the adequacy of recordkeeping and the need for
23 him to finish his training?
24 **A.** Yes, I would refer to the training grid.
25 **Q.** Thank you. Thirdly, you've told us that you offered to

1 help out drafting the letter to the GP, which discharged
2 VC from services, and you've reflected on that, and
3 thought that, in fact, you shouldn't have offered.
4 **A.** Yes, that's correct.
5 **Q.** Ms Cartwright put to you that a consequence of you
6 offering was that a standard form letter was written to
7 the GP. Can we look at, please, at your email to admin,
8 WITN0292005. This is your email the day after the MDT
9 and, in relation to VC, you say:
10 "Could a letter be generated for VC to his GP
11 informing them of discharge due to non-engagement
12 please."
13 In that, you don't provide any detail as to what
14 they are to include, correct?
15 **A.** That's correct.
16 **Q.** Can we look at the letter itself, CHCA0000013. We can
17 see in the paragraph there:
18 "No contact has been made with [VC] ... A letter was
19 sent to [VC] ... [on] 17 August ... no response to the
20 invitation."
21 Can you help us, that contains information which
22 isn't standard form, it relates to VC specifically. It
23 must have come from somewhere. My question is: where
24 did it come from?
25 **A.** I can only assume that the admin that actually created

1 that letter may have gone into the notes and looked at
2 the RiO records.
3 **Q.** Okay, so you've asked them to generate a letter, they've
4 gone back to the notes --
5 **A.** Possibly, yes.
6 **Q.** -- decided what to include. You also told us that you
7 were sent a draft of the letter and approved it?
8 **A.** Yes, that's correct.
9 **Q.** Does what is included here reflect what you had been
10 told about the reasons for discharge?
11 **A.** Yes, I believe it does.
12 **Q.** Lastly, you said in answer to a number of questions
13 asked of you, including by Mr Carr, Mr Moloney and
14 Ms Cartwright, that your expectation was that this
15 letter would be accompanied by VC's Trust records?
16 **A.** Yes.
17 **Q.** How would those records be sent?
18 **A.** My understanding is that when we discharge, we ask for
19 a covering letter at that time. The admin would send
20 those --
21 **Q.** Just pause a moment.
22 **THE CHAIR:** Sorry, we're getting some sound effects from
23 outside. Could you just repeat what you were saying,
24 please.
25 **A.** Yes, of course I can. My understanding at that time is

1 that we would ask for a covering letter and it would be
2 usual practice to send the core documents with that.
3 **MR BEER:** So electronically or paper?
4 **A.** At that time, it may have been paper but I wouldn't be
5 able to clarify.
6 **Q.** You'll see this letter, which is actually the letter to
7 the GP, doesn't itself refer to attached or "Please see
8 attached" Trust records, doesn't it?
9 **A.** No, it doesn't.
10 **Q.** Was it in every case that such records were supposed to
11 be attached?
12 **A.** My understanding would be, yes, that would be usual.
13 **Q.** You say your understanding: where did you get that
14 understanding from?
15 **A.** As a CPN prior to this role, being the Clinical Team
16 Leader, when I've discharged people and I've asked for
17 a cover letter, those documents have automatically been
18 sent.
19 **Q.** I take it you didn't notice that this letter doesn't
20 say, "Please see attached Trust records" or similar?
21 **A.** I wasn't aware I'd even requested the letter until the
22 Theemis investigation was taking place and I was made
23 aware I had. So I didn't notice it on that draft that
24 was sent to me.
25 **MR BEER:** Thank you very much.

1 **THE CHAIR:** Thank you.
2 **Questions from THE CHAIR**
3 **THE CHAIR:** Just can we keep that GP letter up. I think
4 Mr Beer was asking about where it -- the content comes
5 from and, in fact, we also have -- some of it is taken
6 from your own note of the -- of what you say you were
7 told, which is in the medical records, the RiO notes, at
8 page 271. So that's the source, isn't it --
9 **A.** Yes.
10 **THE CHAIR:** -- of some of that information? Have you
11 checked that yourself or not?
12 **A.** I know that obviously I documented that that was what
13 was the reason for the discharge to go forward, so
14 I imagine that, because I haven't put it in the actual
15 email, that they've gone back into that, in that entry.
16 **THE CHAIR:** I see. When you say "generated", is this just
17 generated by a computer or by a person?
18 **A.** By a person.
19 **THE CHAIR:** I see. Thank you.
20 I think you'd been asked about the Trust records,
21 your understanding as I understood your evidence -- and
22 correct me if I'm wrong -- was that there were only some
23 documents that would be sent along with this, either
24 electronically or physically, and those would be the
25 care plan and the risk assessment?

1 **A.** Yes, and the core assessment.
2 **THE CHAIR:** And the core assessment, but the rest of his
3 records going back all that time would not be sent?
4 **A.** No, not routinely.
5 **THE CHAIR:** Thank you.
6 Yes, thank you. We'll start again at 2.20. Thank
7 you.
8 **(1.17 pm)**
9 **(The short adjournment)**
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