

Tuesday, 12 May 2026

1
 2 (10.00 am)
 3 **MS HAIDAR:** Please may I call the next witness, Stephen
 4 Quartey?
 5 **THE CHAIR:** Yes.
 6 **STEPHEN QUARTEY (sworn)**
 7 **Questioned by MS HAIDAR**
 8 **MS HAIDAR:** Mr Quartey, you've prepared a witness statement
 9 for the Inquiry dated 19 November 2025; is that correct?
 10 **A.** Correct.
 11 **Q.** The reference for that is WITN0275001. Mr Quartey,
 12 I understand you have two corrections to make to your
 13 statement. Please can you direct the Inquiry as to what
 14 the first correction is?
 15 **A.** Thank you. First correction is on point 14.
 16 **Q.** Paragraph 14. Yes?
 17 **A.** I would like to add that at my latter part of the time
 18 with the Trust I was given limited access to the RiO
 19 system.
 20 **Q.** Just to double check, by the latter part of your time
 21 with the Trust, what year does that refer to?
 22 **A.** I started at the Trust somewhere around 2015 and my last
 23 year for the Trust was around 2022.
 24 **Q.** So at the relevant time you had limited access to RiO?
 25 **A.** I think that will be the latter part of 2021, 2022,

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1 **Q.** I'll start by asking you a few questions around your
 2 role. To start with, you reviewed VC twice in
 3 January 2022; is that correct, Mr Quartey?
 4 **A.** Correct.
 5 **Q.** At the time of those interactions, you were the nurse
 6 allocated to the Cassidy Suite for the relevant shift?
 7 **A.** Correct.
 8 **Q.** Can you briefly explain what tasks an inpatient nurse
 9 who is allocated to the Cassidy Suite has to complete
 10 while working those shifts?
 11 **A.** Usually the nurse will take a call from the police or
 12 the Street Triage that an individual has been detained,
 13 under Section 135 or 136 of the Act. The individual
 14 will be brought in, the nurse in charge will read
 15 through the notes to ascertain relevant information
 16 about an individual prior to the admission.
 17 On admission, the nurse in charge will engage with
 18 the individual to ascertain confirmation of the reason
 19 for the detention into hospital, will engage with
 20 an individual to find out their needs, will also do
 21 a physical observations, blood pressure, alcometer,
 22 temperature and so forth, will do documentation to these
 23 effects.
 24 The nurse in charge will get touch with the -- with
 25 the social work team to organise an assessment for the

3

1 thereabouts, yeah.
 2 **Q.** The next correction, please.
 3 **A.** Point 60.
 4 **Q.** Paragraph 60?
 5 **A.** Yes.
 6 **Q.** Yes, go ahead.
 7 **A.** I have learnt in a way that will influence my practice.
 8 **Q.** Sorry, could you please repeat?
 9 **A.** I have learnt from the proceedings that it has impacted
 10 on my practice.
 11 **Q.** Thank you. Other than those two corrections, is the
 12 statement true and accurate to the best of your
 13 knowledge?
 14 **A.** Yes, it is.
 15 **Q.** So Mr Quartey you are a Registered Mental Health Nurse
 16 and at the time of your interactions with VC you were
 17 working as a Band 6 agency nurse at Highbury Hospital;
 18 is that correct?
 19 **A.** Correct.
 20 **Q.** You were working on the Redwood 1 Ward; is that correct?
 21 **A.** I was working on Cassidy Suite.
 22 **Q.** Currently you are no longer working for the
 23 Nottinghamshire Healthcare NHS Foundation Trust; is that
 24 right?
 25 **A.** Correct.

2

1 individual who has been detained.
 2 The nurse in charge will also offer hospitality to
 3 the individual who has been detained, will explain to an
 4 individual their rights under detention and help the
 5 assessment team in terms of information that has been
 6 gathered prior to the admission of an individual.
 7 **Q.** Just pausing there, when you're the nurse in charge, is
 8 there only one nurse allocated to the Cassidy Suite per
 9 shift?
 10 **A.** Okay. Usually there are two nursing staff. One is
 11 a registered nurse and the other is a healthcare
 12 assistant. On rare occasions there may be three staff,
 13 but usually there are two.
 14 **Q.** And how many beds were there on the Cassidy Suite in
 15 2022?
 16 **A.** A maximum of two.
 17 **Q.** So how many patients could be brought in at once?
 18 **A.** Maximum of two.
 19 **Q.** Maximum of two and you would be responsible for carrying
 20 out all those tasks in relation to both patients?
 21 **A.** Correct.
 22 **Q.** How long would you have to carry out those tasks? How
 23 long would you have, generally speaking? How much time
 24 would you allocate to that?
 25 **A.** For caring for the patients?

4

1 Q. From the point at which a patient is brought in up until
2 you finished doing the documentation, for example, how
3 long would you generally allocate to that?
4 A. It varies. It depends on the situation on the Cassidy
5 Suite. A patient might be brought in and the other
6 patient might be quite unsettled, so it varies. But
7 during the duration or the shifts, the task that needs
8 to be accomplished, we do our best to do that.
9 Q. So you had already told the Inquiry in your statement --
10 and again that's at WITN0275001, on page 3 at
11 paragraph 14 -- that you didn't have direct access to
12 RiO. You've now told us that you had limited access.
13 At that time, would you have been able to read through
14 the notes of a patient prior to them being admitted?
15 A. Yes.
16 Q. When you say read through the notes, do you mean the
17 progress notes?
18 A. Mainly the progress notes.
19 Q. Would you have time to look at historic Discharge
20 Summaries, or historic risk assessments, or information
21 from a time prior to what was entered almost immediately
22 before the patient was coming in?
23 A. As time will allow, yes.
24 Q. You mentioned that when a patient is coming in, you
25 would get a call from the Street Triage Team or the

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1 was received by the day staff. My involvement was only
2 to upload it onto the system. So I was not there when
3 the police arrived, nor when they left, according to
4 this document.
5 Q. I see. So you updated it and uploaded it that evening,
6 but you weren't on shift when VC arrived?
7 A. Correct.
8 Q. So then, in terms of the statement that you've provided
9 to the Inquiry, if we can look at page 7, paragraph 29.
10 My apologies, if we can start by looking at paragraph 28
11 and 29, but it's on the same page, page 7. You record
12 in your statement to the Inquiry a description of when
13 VC was brought onto the ward on 19 January, specifically
14 at paragraph 29, in the second sentence you say:
15 "On his arrival, VC was highly on edge so we were
16 trying to keep him calm ..."
17 Is it the case, then, that this description relates
18 to your second review of VC and not 19 January 2022?
19 A. Yes, you're right. This statement is in relation to my
20 involvement with VC on 28 January, not 19th.
21 Q. Thank you, Mr Quartey. Then let us look at your
22 interaction with VC on 28 January. If we can have,
23 please, NHFT0000168 back on screen at page 213. Just
24 looking at the last entry on that at page dated
25 28th January, entered by you, Mr Quartey. It says:

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1 police. So is it the case that you would primarily rely
2 on verbal handovers in gaining an understanding of the
3 patient?
4 A. Usually a telephone call. The time from when we receive
5 the call and the patient arriving also varies.
6 Sometimes it could be minutes, sometimes it could be
7 hours. Sometimes the admission could be a planned
8 admission.
9 Q. So is what you're saying that the amount of information
10 you gathered wholly dependent on the amount of time that
11 you have in any given situation?
12 A. Correct.
13 Q. So in terms of your first interaction with VC, please
14 can we have NHFT0000260 on screen. This is, as it's
15 coming up, a Section 136 monitoring form and you
16 completed that form; is that right, Mr Quartey?
17 A. On the 19th ... okay, if I could explain. The form 1 is
18 a form that is formulated by the police and handed over
19 to the nurse in charge at the time when the patient
20 arrives with the police. It can also be sent by the
21 police through an attached email. Now, this is an
22 uploaded version from that information that was handed
23 over to the nurse in charge.
24 With regards to 19 January, I did not receive this
25 form 1. I started my shift on a night shift. This form

6

1 "[VC] arrived on Cassidy accompanied by one
2 paramedic and one soldier. He ... appeared unhappy for
3 being here. ... Staff tried to engage him to cooperate
4 with admission formalities but he stood by the door and
5 stated he is only here for a [Mental Health Act
6 Assessment] and does not require to do his physical
7 observations ... [VC] declined all other interventions
8 normally done at admission. He appears guarded with
9 underlying anger and unpredictable of violence should he
10 get detained after the assessment."
11 So what types of signs were you looking for or did
12 you observe that would show that a patient might have
13 underlying anger?
14 A. Okay. Starting from he being detained and under
15 section 135, is an indication that he has been brought
16 to the Cassidy Suite against his will, because a warrant
17 was issued.
18 The second indication was his non-engagement with
19 staff. He did not even want to go to his bedroom. He
20 was quite on edge in the small communal area. We
21 offered him hospitality, he declined. Said he did not
22 cooperate with any physical observation, even the ones
23 that we might consider to be non-intrusive, like taking
24 oximeter pulse. He did not want to do anything with the
25 team at all.

8

1 Also, reading from his historical incidents, the
 2 level of aggression in involving his flatmate and the
 3 police, we were quite cautious not to escalate the
 4 situation, and to present him ready for the assessment,
 5 because if the situation escalates and it turns into
 6 violence and aggression, that may delay the Mental
 7 Health Act Assessment, which is also time bound. So
 8 we're trying to, in a way, keep him safe and calm.

9 **Q.** In terms of the words "unpredictable of violence", was
 10 that based on your own observation or information that
 11 you had gathered from VC's record?

12 **A.** Both.

13 **Q.** So at this point you were concerned that there could be
 14 further violence on the suite -- on the Cassidy Suite?

15 **A.** Yes.

16 **Q.** Did you discuss that presentation with the doctors who
 17 then came to carry out the Mental Health Act Assessment?

18 **A.** Yes, I mentioned his presentation to the assessment
 19 team, and documented it as well, so (*unclear*).

20 **Q.** Did you get any further information from the assessing
 21 team about the assaults that you had mentioned, the
 22 assaults on his flatmate?

23 **A.** I have gathered that from the RiO system already. So
 24 I didn't need to ask the assessment team.

25 **Q.** Would you seek further information from, for example,

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1 136 Suite and that's then -- I think the word you used
 2 is "cascaded" to the inpatient team; is that right?

3 **A.** Yes.

4 **Q.** So if there had been an incident of aggression or
 5 violence which had led to this admission, wouldn't it
 6 make sense to seek further information around the level
 7 of harm that was caused, potentially what had happened
 8 to the people who were assaulted, so that there could be
 9 a more full picture, a more full understanding, of the
 10 risks posed, that could be passed on to the inpatient
 11 team?

12 **A.** From the -- to seek the information from the assessment
 13 team, you mean?

14 **Q.** Whoever was going to see him, who would also have
 15 reviewed his notes and potentially will have known him,
 16 as we know when often the doctors who assess a patient
 17 at this point will have previous interactions with
 18 them --

19 **A.** Mm-hm.

20 **Q.** -- so yes.

21 **A.** With the benefit of hindsight, I'll say the more
 22 information the better.

23 **Q.** And that would be relevant as well to the documentation
 24 that you would have had to complete at that point; is
 25 that correct?

11

1 the AMHP or the doctors, in particular the doctor who
 2 would have known VC at the time who was reviewing him in
 3 order to have a fuller understanding of what had
 4 happened?

5 **A.** What happened in relation to?

6 **Q.** The assault which you mentioned. So you mentioned that
 7 you read about an assault on his flatmates. This was
 8 a note that existed. At the time there wasn't complete
 9 information around what had happened and the extent of
 10 the assault. Would you have asked for further
 11 information at that time so that you could get a clear
 12 verbal handover?

13 **A.** From the assessment team? No, I did not ask them.

14 **Q.** Do you think that it would have -- it would be good
 15 practice to ask those teams who are assessing the
 16 patient for any further information, in your position or
 17 in the position of a nurse in charge at the Cassidy
 18 Suite?

19 **A.** On this occasion, I did not see the need to, because the
 20 information regarding his level of aggression were
 21 documented by other practitioners and the assessment
 22 team might have had that information, the same
 23 information that I will be privy to.

24 **Q.** Of course, but you have told the Inquiry in your
 25 statement that you received verbal handover on the

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1 **A.** Yes, that's correct.

2 **Q.** So let's have a look, then, at the risk assessment which
 3 you updated on this date, which is NHFT0000191. As
 4 that's being pulled up, Mr Quartey, the Inquiry has
 5 heard evidence from other nurses who worked on the
 6 Cassidy Suite, and the nurses have told us that when you
 7 create a Risk and Safety Assessment for an existing
 8 patient, old information from previous risk assessments
 9 often is pre-populated within the document. Is that
 10 your experience of creating a new risk assessment?

11 **A.** Yes, that's correct.

12 **Q.** So then if we could please have side by side this
 13 version which is the one that Mr Quartey updated with
 14 the preceding version, which is NHFT0000192, and as that
 15 comes up, that was the risk assessment that was updated
 16 on 18 January by Claudia Birtles, who was VC's CCO. So
 17 looking at them side by side, just on the first page,
 18 could you specify what part you added to this risk
 19 assessment?

20 **A.** Okay, ... so the part that added is the one that starts
 21 from "[VC]" and ends on the main ward.

22 **Q.** So:

23 "He expresses and acts on hallucination experiences
 24 but lacks insight into his mental health condition.
 25 [VC] has not expressed thoughts to harm himself. He is

12

1 detained under S[ection]2 ... and stepped-up to Cassidy
2 Suite ..."

3 Then if we scroll down to the next page, please,
4 this is under the header risk Formulation "To Others".
5 Mr Quartey, did you update any part of this risk
6 formulation?

7 **A.** No, I did not.

8 **Q.** So where a patient has been brought into the Cassidy
9 Suite and part of your role is to update the risk
10 assessment, and you're aware that there had been
11 assaults, now I know that it's noted here that there was
12 an assault on the housemates, but it says here that the
13 police have so far refused to share details. Would you
14 have sought further information from the police at this
15 stage, given that there would have been police officers
16 at the Cassidy Suite?

17 **A.** I would have, but on this admission on 28 January, no
18 police officer attended the Cassidy Suite. It was
19 a paramedic and a soldier.

20 **Q.** What do you mean by "soldier"?

21 **A.** Well, it was someone in the military uniform. I did not
22 ask for their ID, but I remember that vividly because in
23 20 years of my career that's the only time I have seen
24 a patient been escorted by a soldier as well. So
25 I remember that vividly.

13

1 So any notes from 2021 or perhaps the Discharge Summary
2 from his previous admission in 2021?

3 **A.** It's possible.

4 **Q.** But it's time dependent?

5 **A.** Yes.

6 **Q.** There's no system in place that requires you to read any
7 of that information?

8 **A.** There is no procedure to say that the duration, because
9 some service users do have more frequency, so they might
10 have a voluminous historical detail. Some may not, but
11 as far as one can, time allowing, yes.

12 **Q.** But would this mean that, often when you're carrying out
13 these risk assessments in the moment, that you're
14 missing historic patterns and focusing instead on the
15 current presentation?

16 **A.** Not only current. One aspect that is very helpful at
17 least is the most recent Multi-Disciplinary Team
18 meeting. That captures a lot of information relevant to
19 the team and the service user.

20 **Q.** But in terms of finding out if there's patterns related
21 to the patient, that would require slightly more
22 engagement with their history; do you agree?

23 **A.** Yes.

24 **Q.** So then these risk assessments are capturing current
25 risk but not necessarily historic risk; is that right?

15

1 **Q.** So your evidence is that it wasn't a police officer, it
2 was a soldier?

3 **A.** Yes, and reading from the AMHP report, it suggests that
4 the police were present at the residence, but they were
5 on the background. So they were not -- he was brought
6 in by an ambulance, he was not handcuffed. There was no
7 police officer there.

8 **Q.** But you would generally ask police, where they attended
9 on the ward, for a verbal handover in regard to assaults
10 if there was one?

11 **A.** Yes, and if they were in attendance, that would be
12 helpful, yeah.

13 **Q.** We don't have to pull this up but in your statement you
14 said at paragraph 13:

15 "... if time allows, I [w]ould scroll through RiO to
16 find out information about [a patient's] health, [and]
17 their circumstances ..."

18 Given what we know about how many tasks you had to
19 complete as the nurse in charge, were there often times
20 when you updated a patient's risk assessment without
21 having the time to look through their history?

22 **A.** No, but it depends how much history I have time to look
23 into, but I will definitely look into some history.

24 **Q.** So, for example, this happened in January 2022. Would
25 you have had time to look beyond or previously to 2022?

14

1 **A.** I think historical risk is relative, because
2 three months could be historical and 10 years could be
3 historical. So -- but as much as time allows, I do
4 recognise the relevance of historical risk, and I will
5 normally read as far as I can.

6 **Q.** So just looking further at a few other documents which
7 you have worked on, if we can start by looking at
8 NHFT0000070. This will be the record of detention in
9 hospital, Mr Quartey.

10 **A.** Okay.

11 **Q.** So just starting at page 1, you completed this form and
12 did you review the medical recommendations for admission
13 when you completed this form?

14 **A.** I did, but admittedly, as many will be aware, the
15 handwritings of many doctors are hard to read, and so to
16 get a full view is to give a bit of time and wait when
17 the doctor do the documentation on RiO. Apart from
18 that, it's to have a synopsis of the outcome of the
19 mental health assessment but not every detail as written
20 on the A2 form, the medical recommendation form.

21 **Q.** That's understandable, but you agree that there would be
22 information in this assessment that's important to pull
23 out and input into the updated records, so that the
24 inpatient team can see them; is that right?

25 **A.** Correct.

16

1 Q. So very quickly if we can look at page 8. I believe
2 this is one of the assessments. Of course, as you say,
3 Mr Quartey, the handwriting is quite difficult to read.
4 I have done my best to decipher it, so I'm going to try
5 to read from almost halfway down., where it starts:

6 "[VC] continued to present ..."

7 So it's the second -- it's the sentence that
8 starts -- there we go:

9 "[VC] continued to present very suspicious and
10 paranoid. He feels mental health professionals are
11 mocking him & beliefs via 'neuro ... mapping' which he
12 thinks is a technology designed to deliberately annoy &
13 upset him. [VC] thinks he is targeted & persecuted by
14 people. The impact of his mental health difficulties
15 are now taking a toll on him as he feels he's failing
16 his courses & the University [is] ... threatening to
17 terminate his course & also planning to evict him from
18 his accommodation. [VC] remains with very poor
19 insight."

20 I appreciate you've said that sometimes the
21 handwriting is hard to read. I do agree this is hard to
22 read, but this is not information that was included
23 within the updated risk assessment, was it?

24 A. I'll say, if I could have a look at the assessment
25 again, please. *(Reads to self)*

17

1 A. Redwood 1.

2 Q. So you would expect, after you've updated the risk
3 assessment and the care plan, for the MDT at Redwood 1
4 to update them once more?

5 A. Yes, because it is essential to engage the patient when
6 formulating a care plan. In this instance, VC did not
7 want to be in the 136 for the Mental Health Act
8 Assessment. What is -- that is the main purpose of the
9 unit that I worked in. So he had been placed on
10 a Section 2, he did not want to engage that, therefore
11 it was difficult to formulate a holistic care plan
12 without his engagement.

13 Now, my experience is that sometimes you allow time
14 or change professionals that he might want to engage
15 with and when that is done, then it will be more prudent
16 to have a comprehensive care plan.

17 Q. That makes sense, of course, that the care plan will be
18 updated or should be updated after he is admitted. The
19 point, though, is that patients are assessed on the
20 136 Suite, the Mental Health Act Assessments take place
21 where a patient has been brought in forcibly, as you
22 said there. It would make sense, then, that the
23 information that's contained within the Mental Health
24 Act Assessments should be pulled through at the very
25 least into the risk assessment at that point; is that

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1 Q. Mr Quartey, without trying to focus too much on the
2 entirety of the contents, and I appreciate you say that
3 it would be difficult to track everything over, do you
4 agree that information around complex delusional beliefs
5 should have at least been tracked into VC's risk
6 assessment at the point of admission?

7 A. Yes, I'd say so.

8 Q. And similarly, you updated VC's care plan, and if we
9 want to have a look at that, that is NHFT0000199. While
10 it's coming up, Mr Quartey, again, there's an update
11 which you provided but there's nothing about the extent
12 of VC's delusional beliefs. And in terms of the
13 inpatient team or his MDT understanding what he might
14 need, it would have been important for that to have been
15 included; do you agree?

16 A. I do agree, but if I could explain, my role at the 136
17 Cassidy Suite was for the purposes of the detention
18 under Section 136. After the assessment, he was
19 detained on Section 2 and I took the initiative to
20 initiate the risk assessment and a care plan, subject to
21 review by the team that is going to formally admit him
22 on to the ward. So --

23 Q. Just if I can pause you there, who would be the team
24 formally admitting the patient on to the ward if it's
25 not the 136 team?

18

1 not right?

2 A. Yes, it is essential to update the risk assessment, but
3 if I may explain, there are two assessments that might
4 be in conflict here.

5 The first one is a Mental Health Act Assessment, in
6 the case of VC under Section 135 in the Cassidy Suite.
7 Then he was sectioned under Section 2 which is also an
8 assessment that lasts for 28 days. So my involvement
9 was more in the first one, the Mental Health Act
10 Assessment, and I took the initiative to start up the
11 second process, which is going to take 28 days, which
12 I was not involved in.

13 Q. That's clear because you understood that the inpatient
14 team should have some information around the
15 circumstances that led to his admission.

16 Those are my questions in respect of your
17 interactions with VC.

18 Chair, I have no more questions for the witness.

19 **THE CHAIR:** Thank you.

20 **MS HAIDAR:** But there may be questions.

21 **THE CHAIR:** Yes, Ms Patrick are you asking the questions?
22 Thank you.

23 **Questioned by MS PATRICK**

24 **MS PATRICK:** Good morning, Mr Quartey. My name is Angela
25 Patrick. I ask questions for those who were bereaved on

20

1 13 June.
 2 I've got two things I want to ask you about.
 3 A little bit about how VC was when you saw him on
 4 28 January.
 5 **A.** Sorry, come again.
 6 **Q.** I want to ask you about how VC appeared when you saw him
 7 on 28 January, and then I want to ask you about one note
 8 that's added to the care plan after you've seen it.
 9 Okay?
 10 So just to refresh your memory, I'll ask for the
 11 entry to be brought up so that you can see it. If we
 12 can go to NHFT0000168/213, and that should be the page
 13 which has your first entry when he arrives.
 14 Just wait for it to appear. If you scroll to the
 15 bottom, there we go, that's just to refresh your memory.
 16 Now, you've already said you knew about VC's history of
 17 violence when he arrived, didn't you?
 18 **A.** I knew to some level as to what I have read on ...
 19 **Q.** Yes, but it wasn't just that he had a history; the way
 20 he was behaving made you cautious, didn't it?
 21 **A.** Yes, it did.
 22 **Q.** You did try to engage him, didn't you?
 23 **A.** Yes, I did.
 24 **Q.** But he didn't want anything to do with you, did he?
 25 **A.** Correct.

21

1 **Q.** Sat up all night in the corridor, declining to go to
 2 bed. Did you get the impression he just really wanted
 3 to get out of there?
 4 **A.** Sorry?
 5 **Q.** Did you get the impression he just wanted to get out of
 6 there, didn't he?
 7 **A.** He didn't want to be there.
 8 **Q.** Didn't want anything to do with you, did he?
 9 **A.** No.
 10 **Q.** Right. Can we turn to another note. It's not a note
 11 you took. I'm going to take you back to the document
 12 you've just been shown, the care plan you prepared.
 13 That's NHFT0000199. I'm going to look at a note and
 14 it's not a note you added. I just want to ask you
 15 something about it. It's on page 3 if we could turn
 16 over. If we scroll to the bottom of the "Care Plan
 17 Details". If we go back to the back page, we don't need
 18 to, but just trust me, it looks like this has been added
 19 by somebody called Dave Thomas. Did you know Dave
 20 Thomas?
 21 **A.** Not that I can recall.
 22 **Q.** We can ask another witness about that but we can see
 23 this note he as couple of days later:
 24 "[VC] remains high profile in communal areas ...
 25 largely uncommunicative towards staff and peers recent

23

1 **Q.** He comes in at about ten o'clock at night. We see that,
 2 two minutes to ten, is that right, your entry?
 3 **A.** Correct.
 4 **Q.** There's no record there of any nighttime medication, is
 5 there?
 6 **A.** Sorry, garden medication?
 7 **Q.** Medication. There's no record there of any nighttime
 8 medication?
 9 **A.** At that point, no.
 10 **Q.** No. If we scroll over you can see the description of
 11 how he's behaving there. He's refusing to go into the
 12 bedrooms, isn't he?
 13 **A.** Yes, that's correct.
 14 **Q.** Standing by the door, sometimes sitting on the floor in
 15 the corridor?
 16 **A.** Correct.
 17 **Q.** If we turn down to 216, we'll see your entry the
 18 following morning. If we keep going a little bit
 19 further we see you there 7.22; can you see that?
 20 **A.** Yes, I can.
 21 **Q.** Great. We see he's actually sat on the floor all night,
 22 hasn't he?
 23 **A.** Yes, he has.
 24 **Q.** No record again of any nighttime medication?
 25 **A.** No, there's no record of that.

22

1 notes indicate that he has refused his noctemedications
 2 ..."
 3 Can I call that "nighttime medication"?
 4 **A.** Nighttime, yes.
 5 **Q.** "... refused his [nighttime medication] ... on at least
 6 one occasion."
 7 **A.** Mm-hm.
 8 **Q.** He's unsettled and high profile a couple of days later.
 9 Does that sound quite like how he was still presenting
 10 on the Cassidy Suite?
 11 **A.** On the Cassidy Suite on that night there wasn't the
 12 issue of a medication. High profile? I would describe
 13 his presentation on that night as unpredictable or
 14 violent. He was on edge. It was just a matter of
 15 something to ignite -- (*overspeaking*) -- (*unclear*).
 16 **MS PATRICK:** Okay, thank you. Thank you. I have no further
 17 questions, Mr Quartey.
 18 **THE CHAIR:** Yes. Mr Beggs.
 19 **Questioned by MR BEGGS**
 20 **MR BEGGS:** Could the witness be shown his witness statement
 21 WITN0275001 at page 11, please.
 22 Mr Quartey, can you look at the January 2022 entry
 23 that's just been expanded for you. It's a very minor
 24 point, but do you see at the end of that paragraph you
 25 say, "Details of this assault", and we know that's the

24

1 assault not on 28 January, but earlier in that month:
2 "... are unclear at this point as police have so far
3 refused to share details."

4 Do you see that?

5 **A.** Yes, I have.

6 **Q.** I think you described on this occasion a paramedic and
7 a soldier bringing in VC; is that right?

8 **A.** Correct.

9 **Q.** Are you able to help with which police officer or when
10 there was this refusal?

11 **A.** I'm --

12 **Q.** I ask because you don't describe a police officer in
13 attendance?

14 **A.** Well, the paragraph we're referring to was not
15 documented by myself.

16 **Q.** All right. So is the answer then you can't help as to
17 who might have refused?

18 **A.** That's correct.

19 **MR BEGGS:** Yes, thank you.

20 **THE CHAIR:** Yes, thank you very much. That's the end of
21 your evidence and I think we'll take, actually, the
22 midmorning break now before we go on to the next
23 witness, unless the next witness is ready.

24 I think in fact we'll take the break now. So we'll
25 start again at 11 o'clock. Thank you.

25

1 **Q.** And that is an all-male ward?

2 **A.** Yeah.

3 **Q.** Approximately how many beds do they have on that ward?

4 **A.** 16 beds.

5 **Q.** I'll start by looking at your first interaction with VC.

6 If we can have NHFT0000168, starting at page 181 on
7 screen.

8 Just focusing on the entry dated 7 September 2021.

9 You can see that this was entered by Melanie Davies, and
10 it reads:

11 "12pm - SECLUSION REVIEW - NURSES REVIEW By TL Mel
12 Davies and CTL Ella Harrison.

13 "Seclusion to continue due to risk to others."

14 Then the most relevant part after that is:

15 "Next review due - Drs review at 2pm".

16 So in terms of orienting ourselves in relation to
17 the chronology, on 7 September 2021 VC had been assessed
18 and detained under the Mental Health Act, approximately
19 five days before this review. But we can see that he
20 was still being kept on the Cassidy Suite and he hadn't
21 been admitted onto any general ward. Do you know why
22 that was, at that point?

23 **A.** I wasn't -- that he was awaiting a PICU bed, so while he
24 was on the Cassidy Suite he was just awaiting for a bed
25 to be allocated.

27

1 (10.42 am)

2 (A short break)

3 (11.00 am)

4 **MS HAIDAR:** Chair, may I please call the next witness?

5 **THE CHAIR:** Yes.

6 **MS HAIDAR:** Ella Harrison.

7 **ELLA HARRISON (affirmed)**

8 **Questioned by MS HAIDAR**

9 **THE CHAIR:** Yes, Ms Haidar.

10 **MS HAIDAR:** Ms Harrison, you've prepared a witness statement
11 for the Inquiry dated 12 November 2025; is that correct?

12 **A.** Yes, that's correct.

13 **Q.** Can you confirm that the statement is true and accurate
14 to the best of your knowledge?

15 **A.** Yeah.

16 **Q.** You are a Registered Mental Health Nurse and, at the
17 time of your interactions with VC, you were working as
18 a Band 6 Clinical Team Leader; is that right?

19 **A.** Yeah, that's correct.

20 **Q.** You were employed at Highbury Hospital by the
21 Nottinghamshire Healthcare NHS Foundation Trust?

22 **A.** Yes.

23 **Q.** You were primarily working on the Redwood 1 Ward; is
24 that right?

25 **A.** Yes, that's correct.

26

1 **Q.** We can see from this note VC was being treated in
2 seclusion. Would you have known at that time about the
3 incident that led VC to being treated in seclusion?

4 **A.** Yes, so general practice, it would have been -- you
5 would receive a handover of the past 24 hours, and then
6 the reasons that led to admission or the reasons that
7 led to seclusion.

8 **Q.** So what is your understanding of the incident that led
9 to VC being treated in seclusion around that time?

10 **A.** So the incident that would have occurred with the police
11 prior to the admission where he had to be tasered and
12 brought in by medical -- mechanical restraints.

13 **Q.** So what was your understanding at the time of what VC
14 did?

15 **A.** It would have been the risk to others, the incident that
16 happened prior to admission.

17 **Q.** So I'm asking about your knowledge of the incident
18 itself, just in terms of what actually happened?

19 **A.** I can't recall specifically what they would have handed
20 over, but they would have handed over that that -- the
21 reasons that led to seclusion.

22 **Q.** Do you know now about any details about that assault?

23 **A.** Yeah.

24 **Q.** Are you able to say what you know now about the
25 assaults?

28

1 A. Is it the one referring to the ones with his flatmates?
 2 Q. So this is 7 September 2021 and you've said that you
 3 would have received a handover about the assault on the
 4 police where he had to be tasered?
 5 A. Mm-hm.
 6 Q. Are you able to say what you know about the details of
 7 that incident?
 8 A. Just that it led -- just that he required the taser and
 9 it was deterioration of his mental state due to
 10 psychosis.
 11 Q. But at this point you're not able to say if you've read
 12 about the assault itself, what VC actually did before
 13 requiring taser?
 14 A. The aggression towards the street triage and the police.
 15 Q. Even without knowing details of the incident at the
 16 time, what would you have inferred about VC's
 17 presentation from the fact that he was being treated in
 18 seclusion and required a PICU?
 19 A. So I think it was really difficult because at that point
 20 I'd not -- I'd only just -- I would have briefly,
 21 snippet met him, because I was senior nurse overseeing
 22 the whole of the Highbury site, so I would have just
 23 gone to that seclusion room -- review at that time and
 24 it would have probably lasted five to ten minutes and
 25 all my interactions would have been at that point with

29

1 intervention is. So at this point we didn't enter the
 2 bed space, so it would have probably been a relatively
 3 short period.
 4 Q. Why didn't you enter the bed space?
 5 A. From what we've written it's due to the risk to others.
 6 So because they had entered prior -- on the previous
 7 nursing review, they'd entered and he'd received the IM
 8 haloperidol. At that point, we didn't feel it deemed
 9 necessary to enter again due to risk of others.
 10 Q. Just pausing there, at this nursing review you said the
 11 length of the review depends on what the intervention
 12 required is. On this occasion he had received
 13 intramuscular haloperidol, which is an injection of
 14 antipsychotic medication, at the previous review; is
 15 that right?
 16 A. Yeah.
 17 Q. So on this review, you're saying that VC didn't require
 18 further treatment, but then what was the point of the
 19 review?
 20 A. So you're monitoring mental state, physical health, you
 21 were offering them if they need any food, fluids,
 22 checking whether they are comfortable, if they require
 23 anything.
 24 Q. But you weren't even able to enter the room, you said?
 25 A. But you can still communicate through -- there's a hatch

31

1 VC.
 2 Q. Can I just ask that you speak up a little bit, it's
 3 a bit hard to hear you, and it's a big room, so we need
 4 the mics to pick up what you're saying.
 5 It's clear that it was a quick seclusion review, and
 6 you said that you were called over because you were the
 7 senior nurse in charge of all of Highbury at the time.
 8 Could you please just explain a bit more about why you
 9 would have been called to carry out this review.
 10 A. So when you're senior nurse you're supernumerary and
 11 you're not involved in the numbers, so as of the Cassidy
 12 Suite you only have one qualified nurse, so for
 13 a nursing review you would require two nurses to be
 14 present. So I cannot recall specifically but I assume
 15 that because I would have been supernumerary, they would
 16 have called for myself to attend for the seclusion
 17 review because nobody else would have been available.
 18 Q. I see. So at the time you took -- you undertook the
 19 nursing review and it says that the next review is
 20 a doctor's review --
 21 A. Mm-hm.
 22 Q. -- when you undertake a nursing review, you say it's
 23 very quick, you only reviewed VC, did you say, for five
 24 minutes; is that right?
 25 A. Approximately. Depending on what the planned

30

1 through the door, you can --
 2 Q. Did you communicate with VC?
 3 A. From what the notes was, I assume. I can't recall
 4 specifics. On general practice we would.
 5 Q. So the note doesn't seem -- it says, "[VC] has been
 6 observed". There's no note which records any engagement
 7 with VC; do you agree with that?
 8 A. Yeah.
 9 Q. You said you weren't able to enter the bed space. So
 10 were you actually able to review VC's mental state
 11 during this review?
 12 A. I can't recall because I wasn't the one that documented
 13 the notes, but like I say, we wouldn't -- general
 14 practice would be we would attempt to try, whether he
 15 declined and didn't want to engage with us, but I can't
 16 comment.
 17 Q. But you've said that due to the risk to others that was
 18 posed at the time, it was safer not to enter if you
 19 didn't absolutely have to?
 20 A. Yeah.
 21 Q. You were aware at the time that the treatment that VC
 22 required was intramuscular haloperidol; is that correct?
 23 A. Yeah, if he was declining oral.
 24 Q. You would have been aware that this was administered
 25 under restraint?

32

1 A. Yeah.

2 Q. So I appreciate that this is one brief interaction

3 during VC's third admission, but just in terms of your

4 memory of that, would you have remembered this the next

5 time you went on to see VC?

6 A. No, I can't recall that specific.

7 Q. When you became involved in VC's care the following

8 year, would you have looked at the RiO notes to see your

9 name -- potentially searched your name in his RiO notes

10 to see if you'd had previous interactions with him?

11 A. Yeah, we do. I do review the RiO notes.

12 Q. So you might have seen that you were involved with him

13 in 2021?

14 A. Yeah.

15 Q. You would have at least recalled, at that presentation,

16 the admission had been so serious so as to require

17 seclusion and a PICU?

18 A. Yeah.

19 Q. So in terms of the issues that VC was presenting with at

20 that point, you've said in your witness statement, and

21 we don't need to pull it up but you've said it,

22 paragraph 67, that you did understand the risks that VC

23 was posing at the time, including violence and

24 aggression, in addition to lack of insight and

25 non-concordance with medication. So that's

33

1 interventions would you consider that a patient who has

2 this history would require from a nursing perspective?

3 A. At that point, it would have just been about managing

4 his violence and aggression, keeping himself safe,

5 keeping others safe and then afterwards you would look

6 at the treatment plan; it would be a more long-plan so

7 then you would look at the medication options, whether

8 he needed any psychological therapy. It would just

9 be -- but the immediate response would be the management

10 of the violence and aggression.

11 Q. So there's two approaches when a patient is presenting

12 with high levels of aggression, you start by focusing on

13 trying to manage the risk; is that right?

14 A. Yeah, to keep himself safe and others.

15 Q. But then part of that long-term risk management would

16 require treatment; is that what you're saying?

17 A. Yes.

18 Q. You said long-term treatment?

19 A. Yes, absolutely.

20 Q. How would you address, for example, the lack of insight

21 in your practice?

22 A. Insight fluctuates from an individual. It's not binary.

23 It's usually on a spectrum. So he might lack insight in

24 some things but not others. So it would just be trying

25 to work, build a relationship, sustain a therapeutic

35

1 paragraph 67.

2 So you will have been told, based on your usual

3 practice, about VC's lack of insight, or is that

4 something you will have inferred from the circumstances?

5 A. Can you repeat that?

6 Q. Sorry, I can rephrase that more clearly. Do you think

7 you will have been told about these issues at the time

8 or was it something that you will have determined as the

9 nurse reviewing VC?

10 A. Usually you do get a handover for the seclusion review

11 about risks that the patient presents, so I would assume

12 that I would have received a handover.

13 Q. And when you're told that a patient has risks of

14 violence and aggression, lack of insight,

15 non-concordance, what would your opinion have been as to

16 the treatment this patient needed?

17 A. I think it's difficult because it does depend on the

18 specific presentation of that patient at that time, and

19 it varies from each admission, but at that point he

20 needed the PICU bed because the risk of violence and

21 aggression to others was the highest.

22 Q. Well, it's clear that he needed the PICU bed because of

23 the risk of violence and aggression, but where there are

24 these documented issues I'm asking more generally, is

25 this a patient who needs interventions? What type of

34

1 relationship with that patient in hope that they would

2 then gain insight into some of their condition. But

3 that's not necessarily always the case. Some people

4 don't always gain insight.

5 Q. So we can move on to looking at VC's fourth admission

6 which is where you had more substantive input into VC's

7 care. So this will have been around five months after

8 your first interaction with VC. At that point, VC is

9 admitted again to Highbury Hospital. And if we can

10 please have WITN0198001, that's your witness statement,

11 Ms Harrison, starting at page 12. At paragraph 69 you

12 note, just very briefly in the last sentence:

13 "I would have nursed VC from admission to

14 discharge".

15 So were you aware that this was VC's fourth

16 admission over the span of two years at that point?

17 A. Yes, I was aware.

18 Q. To be clear, when you say you would have nursed VC from

19 admission to discharge, you were part of the MDT that

20 was providing care and treatment at that stage to VC; is

21 that correct?

22 A. Yeah, that's correct.

23 Q. In terms of MDT decision-making, was it your experience

24 that decisions around treatments in respect of patients

25 like VC were shared amongst MDT colleagues?

36

1 A. Yeah, that's correct.

2 Q. So what aspects of treatment do you recall you were
3 responsible for at that time?

4 A. So specifically as a nurse in charge, or a nurse, you
5 were responsible for allocating the daily allocation for
6 patients and healthcare assistants and staff. So you
7 would be there to help support the patients, you would
8 help them with activities of daily living, so this would
9 be the food, the fluid, the administration of
10 medication, the physical health observations. You would
11 be there to provide psychological support for the
12 patients, whether that's interventions, activities, so
13 it would be dependent on the patient what they would
14 require.

15 Q. You had a role in determining the type of treatment that
16 could be suggested; is that right?

17 A. Yeah.

18 Q. So if we go to just the next page, which is page 13,
19 looking at paragraph 71, you've noted there that when VC
20 had his first Mental Health Act Assessment on
21 18 January, this was called "due to lack of engagement,
22 missed appointments, concerns over medication
23 concordance and a report that VC had assaulted a fellow
24 student/flatmate."

25 Just looking at that presentation, we can see that

37

1 had led to VC's admission:

2 "... has been home treated for 10 days, and although
3 he ... agreed to meet staff away from home in the
4 community [his] engagement has been superficial ... it
5 has been difficult for the team to assess [VC] properly.
6 [He has] disclosed ... that he felt the team ... were
7 part of [the] conspiracy plan in that they were
8 contributing to his mental health ..."

9 If we can go over to page 5, please, just to look at
10 some of the detail contained in this report. If we can
11 scroll down. I believe it might have been in the
12 paragraph above. Sorry. If we can go up a little bit
13 more. There we go. So we can see in the paragraph
14 which begins "Dr Lomas" -- my apologies, I'm losing my
15 place on the page.

16 The paragraph that begins "At the suite" and if we
17 go halfway down that paragraph and the sentence that
18 begins:

19 "[VC] did not fully engage in the assessment and
20 when asked questions he would state that this was not
21 relevant to this time now. [VC] declined ... he had
22 mental health or that he had concerns about [his] health
23 being able to read ... thoughts or that he could hear
24 voices. Dr Lomas again explained [to him] that he has
25 been seen by at least seven different professionals in

39

1 these are very much the same issues that VC had been
2 admitted for around five months ago; do you agree with
3 that?

4 A. Yeah.

5 Q. Again, you said you would have searched your name at the
6 time when you started to be involved with VC, so would
7 it have flagged up in your mind that VC was coming back
8 on the same issues at the time?

9 A. Yeah, we would -- I would generally review the past
10 history admissions.

11 Q. So you would have included part of -- part of your
12 review would have included what notes from past
13 admissions, specifically?

14 A. So I would -- usually I would review previous core
15 assessments, care plans, risk assessments, the AMHP and
16 Mental Health Act reports. And then, if time allows,
17 look at the running records.

18 Q. Would you have looked at the AMHP referral and
19 assessment from this admission?

20 A. Yeah.

21 Q. Let's have a look at that, that's NOCC0000043. So this
22 will be the AMHP referral and assessment that led to
23 VC's admission. We can see that's dated
24 28th January 2022. If we go to page 4, please, and the
25 second paragraph, we can see the short history of what

38

1 the past nine days and that five of them could not be
2 certain that he had taken his medication. ... Dr Lomas
3 stated to [VC] that he has had several periods of
4 deterioration in [in his MH] when he stops taking his
5 medication and this has resulted in some really
6 concerning behaviours holding [a] girl hostage, beating
7 a police officer significantly."

8 Then, finally, now we can actually move on to the
9 next paragraph:

10 "Dr Lomas and Dr Manzar have previous acquaintance
11 with [VC] and have seen his mental health deteriorate to
12 the point where he has caused significant harm and risk
13 to others. ... The risks to others is high, and
14 although during assessment he does not appear overly
15 psychotic they believed that he was masking his symptoms
16 and was very guarded with what he was willing to share."

17 So, ultimately, the reason that VC was admitted is
18 because the doctors assessing him had concerns about
19 VC's mental health deteriorating; is that right?

20 A. Yeah.

21 Q. Were you aware that this was because of VC repeatedly
22 refusing to take medication?

23 A. Yeah.

24 Q. In terms of the history that you had reviewed at that
25 point, you said you were aware that he had assaulted

40

1 police officers, you were aware that he had assaulted
2 his housemates. Were you aware that prior to that he
3 also had broken into his neighbours' flats and showed
4 violence and aggression on those occasions in May 2020?

5 **A.** Yeah.

6 **Q.** Do you agree then that it was well established that VC
7 posed a significant risk of harm to others when his
8 mental health was deteriorating?

9 **A.** Yeah.

10 **Q.** So we can see the picture here on admission, VC is
11 guarded, potentially masking symptoms, and said that he
12 doesn't believe he has mental health issues. From your
13 perspective, what needed to be done while he was an
14 inpatient to improve that presentation?

15 **A.** It would have been trying to build and sustain that
16 therapeutic relationship with him, although it was very
17 difficult because he did have mistrust in mental health
18 services, but we would try through other means. So it
19 would be monitoring his mental state through
20 observations.

21 **Q.** Where a patient is refusing to engage, as we'll come
22 onto VC does refuse to engage in this admission, what
23 else can be done beyond just building a therapeutic
24 relationship to make sure that a patient improves prior
25 to their discharge?

41

1 admission; is that right?

2 **A.** Yeah.

3 **Q.** So in terms of masking, there were no one-to-one
4 assessments?

5 **A.** It would have -- although I think he would have engaged
6 to the formal one-to-ones, I do believe that he would
7 have had interactions and conversations with staff
8 throughout his time on the ward. These would have been
9 informal, they might have just been in communal areas,
10 and even those would have highlighted if there was any
11 psychotic symptoms.

12 **Q.** But that wouldn't have told you anything about VC's
13 insight at that stage, would it?

14 **A.** We would always be assessing insight, so I think he'd
15 made comments within the notes that, for example, he'd
16 said to staff that he wished to get better and return to
17 his studies, which does show some level of -- that
18 comment shows some level of insight to say that,
19 although he didn't go into detail what he meant by "to
20 get better", he say he wishes to get better.

21 Same with when they was reading his section rights
22 to him, he'd also made comments about not wishing to
23 appeal his section and he was happy to continue his
24 treatment on the ward, whereas previously he had
25 appealed his section.

43

1 **A.** So we would look at other -- so we would look at --
2 observing him on observation levels and how he is
3 responding during our checks when we're checking on him
4 every -- at this point either ten minutes or hourly. So
5 we would observe him through that. We would look at
6 other means such as utilised Section 17 leave, we would
7 look at how that had gone, we would look at whether he
8 attended any activities. He was attending the gym. He
9 was also attending his studying.

10 **Q.** Would you be looking for -- what would you be looking
11 for in those reviews that you just listed?

12 **A.** In the observation reviews, whether there was any
13 abnormal perception, so whether he was responding to any
14 auditory hallucinations, any visual hallucinations,
15 because although patients can mask their symptoms when
16 you're having a one-to-one with them, it's very
17 difficult, when you are observing them, during
18 especially every ten minutes for them to continue to be
19 able to hide and mask the symptoms every ten minutes.

20 **Q.** Did you observe any psychotic symptoms in VC when you
21 were working with him during this period?

22 **A.** No.

23 **Q.** So were you focused on looking for psychotic symptoms?

24 **A.** Yeah, we would have.

25 **Q.** But VC refused all one-to-one engagement during this

42

1 **Q.** So that's very much focused on what VC wants for
2 himself, but in terms of risk management, knowing the
3 risks that existed, again, at that time what would you
4 think needed to be done so that VC could then be safely
5 discharged into the community, and avoid further risks
6 to others?

7 **A.** So we looked at medication concordance within the --
8 having him on the ward for the period of assessment. He
9 was concordant with his medication, despite that he was
10 previously non-concordant in the community, he was
11 reassuring us that he was happy to work with the
12 Community Team, continue taking the medication.

13 **Q.** Were you aware that both VC's care coordinator and his
14 community consultant were of the opinion that he needed
15 to be established on a depot at that stage?

16 **A.** Yeah.

17 **Q.** So where a patient is telling you they're happy to take
18 medication both while they're an inpatient and when
19 they're discharged, but their Community Team is telling
20 you "This patient has a history of not taking their
21 medication", what could you have done?

22 **A.** I think as the ward we'd tried several attempts and
23 several -- to encourage the injection, depot injection,
24 with VC. During the majority of his ward reviews it was
25 discussed. I think we based it on the rationale that

44

1 there's -- a few of the patients objected, so he'd
 2 stated that he didn't like the needles. We'd observed
 3 that he was concordant with the medication at the time
 4 on the ward --

5 **Q.** Would you ever challenge a patient who tells you that
 6 they are concordant and who tells you in fact we have
 7 seen in the notes that it's not true that he was ever
 8 non-concordant, by looking through the notes and putting
 9 to the patient the times when they were clearly
 10 non-concordant, from within their own record?

11 **A.** Yeah, we would have that conversation. We would
 12 challenge them. I think the difficulty would be to
 13 rationalise that decision of "We are going to enforce
 14 the depot injection upon you on the ward", when we are
 15 seeing compliance and he is working with us.

16 **Q.** Did you challenge VC at any point?

17 **A.** I can't recall specifically challenging him.

18 **Q.** Well, we'll look at some of the notes and some of the
 19 interactions you had in a moment, but you've said that
 20 you considered depot, but VC was accepting medication?

21 **A.** Mm-hm.

22 **Q.** So you found it difficult to enforce --

23 **A.** Mm-hm.

24 **Q.** -- depot at that time. But it seems from the notes that
 25 the only thing VC was accepting was medication. He

45

1 this occasion, were you?

2 **A.** I would say I would still have assessed part of his
 3 mental state. It was just to try to engage within
 4 a formal one-to-one with him, but again, like I say, he
 5 was on 10-minute checks so we would have monitored his
 6 mental -- his presentation and his behaviour during them
 7 10-minute checks. He would have been in communal areas.
 8 He spent -- sorry, some time in communal areas so we
 9 would have seen how he would have interacted with
 10 others.

11 **Q.** Do you agree, though, that nothing from this note
 12 indicates any improvement in his presentation from the
 13 point at which he was admitted?

14 **A.** There's not -- I'd say there'd been no decline in his
 15 mental state.

16 **Q.** Yes, of course there had been no decline but there also
 17 had been no full mental assessment. There had been no
 18 conversation with him around his thoughts, for example.

19 **A.** From that note, but on previous notes he was seen in
 20 ward reviews which would have been more detailed.

21 **Q.** Well, the previous -- what happened previously and what
 22 happened actually on 3 February in relation to VC's
 23 Section 17 leave was a near miss.

24 So if we could please have NHFT0018370 on screen,
 25 please. So you were saying that from VC's previous

47

1 wasn't accepting at that stage that he had a long-term
 2 mental illness, he wasn't accepting therapeutic
 3 interventions, he wasn't accepting his one-to-one
 4 sessions, and antipsychotic medication would only be one
 5 aspect of treatment for a patient like this; do you
 6 agree?

7 **A.** Yeah, but he was also, although he wasn't engaging in
 8 the formal one-to-ones, as I said, we also look at the
 9 other things that he's engaged. So he was attending the
 10 gym, he was using his Section 17, he was continuing with
 11 his studies which is -- on an acute ward to see somebody
 12 still continue with their studies would be
 13 -- *(overspeaking)* --

14 **Q.** Well, let's have a look at some of these interactions.
 15 If we can have NHFT0000168 back on screen and that will
 16 be page 233. Just looking at the second entry dated
 17 7 February 2022. This is entered by you, Ms Harrison,
 18 and this is a nursing review of VC. So this is around
 19 ten days after VC had been admitted. It says:
 20 "[VC] has been low profile on the ward ... He [is]
 21 ... spending majority of his time on his mobile phone
 22 ... appears ... quite guarded on approach. Declined 1.1
 23 with staff ... Staff to continue to try and engage to
 24 further assess mental state."
 25 So you weren't able to assess his mental state on

46

1 entries there was some form of engagement; is that what
 2 you said, or improvement?

3 **A.** He was asking about his plan going forward, about going
 4 to the gym, about --

5 **Q.** So he was given, we know he was given Section 17 leave
 6 during this admission --

7 **A.** Mm-hm.

8 **Q.** -- to go to the gym. And if we can please start on the
 9 next page or maybe the last page, if I'm not mistaken.
 10 Yes, this one. So this is a near-miss incident which
 11 was reported by one of the trainee doctors, Dr Gibson.
 12 It says:
 13 "Failure To Return From S[ection]17 leave."
 14 Under "Details":
 15 "P[atien]t VC was let out on S[ection]17 leave at
 16 14:07 with a planned time of return of [3.07] ...,
 17 despite only having 30 minutes leave prescribed. His
 18 time of return was not documented. He was reportedly
 19 seen at his accommodation by a former flatmate and this
 20 information was passed to the ward. ... VC denies this
 21 occurred. Based on leave record, it is not possible to
 22 tell if allegation was accurate."
 23 Then the note recalls that:
 24 "... VC is reported to have assaulted flatmate[s]
 25 and prevented them from leaving the flat prior to

48

1 admission."

2 This doesn't show that VC was being open with the
3 ward, does it? He was supposed to be going to the gym
4 but there were reports of seeing him at his
5 accommodation; is that right?

6 **A.** Yeah, it was an allegation made, yeah.

7 **Q.** VC denied it but his leave was revoked after this; is
8 that right?

9 **A.** Yeah.

10 **Q.** If we just go back to the first page of this email, we
11 can see that's an email from you, Ms Harrison.

12 **A.** Mm-hm.

13 **Q.** You say -- you reply to another member of VC's MDT team
14 ask, you say, "really?" And is that an emoji after the
15 word "really"?

16 **A.** Yeah.

17 **Q.** What is that emoji?

18 **A.** It was in response, I think, to the email from the
19 previous email from Keith, one of the RMNs. So I think
20 it was -- the Ward Manager was specifically asking what
21 had happened, if anyone could shed any light. And
22 I think the response wasn't answering the question that
23 the Ward Manager had asked, so I was questioning that
24 response.

25 **Q.** So you say that your response is in response to

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1 whether it was him innocently trying to arrange for him
2 to collect belongings. It's hard to say.

3 **Q.** But he was aware that he wasn't supposed to be going
4 back, wasn't he?

5 **A.** Yeah.

6 **Q.** After this, the doctor, Dr Gibson, was sufficiently
7 concerned to withdraw or to restrict VC's leave; is that
8 correct?

9 **A.** Yeah.

10 **Q.** So again, 3 February, that's earlier than the review
11 that you carried out, no improvement, in fact alarms
12 potentially raised about VC's mental state?

13 **A.** Yeah, and that would be normal practice for anyone.
14 Anyone that's absent from their leave that didn't return
15 within the specific time requirements, the leave would
16 generally be restricted. So it wasn't just because of
17 the incident with VC. That would be the case with any
18 patient that would overstay any of their leave. Their
19 leave would be restricted until further review by the
20 consultant.

21 **Q.** So we can move on to your next interaction with VC. So
22 we'll have the NHFT0000168 document back on screen,
23 please, at page 273.

24 Oh, this is the wrong page, my apologies. It will
25 be 245. 273 is indeed the last page of VC's records.

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1 Mr Kadzinga's email?

2 **A.** Yeah.

3 **Q.** So what did you mean by that, that it wasn't an accurate
4 answer?

5 **A.** So she was asking whether anyone had -- there was no
6 entry on that shift regarding his mental state, VC's,
7 before, and no documentation on the return time. So she
8 was asking the nurses on shift to -- if they knew any
9 more information or if they could shed some light, as
10 she said, to "the below".

11 **Q.** Were you concerned by the fact that VC had gone back to
12 his accommodation a couple of days after he'd been
13 admitted?

14 **A.** It was difficult, because as we said, it was an
15 allegation made. There was no -- although someone had
16 made that allegation, he was denying it.

17 **Q.** But whether or not it's an allegation or it's true, the
18 point is to be monitoring VC's mental state. There is
19 an allegation that he went back to his accommodation.
20 Would that have been concerning at the time, in terms of
21 his mental state?

22 **A.** It's difficult without knowing the context to why he
23 would have gone back. I know that he was being evicted
24 from that accommodation, so I think later on he did
25 return to collect belongings, so it was difficult to

50

1 Page 245, 14 February entered by Ms Harrison, it
2 simply says:

3 "Care Plan Updated

4 "Patient declined copy of care plan and refused to
5 engage".

6 So again, what does that tell you about VC's
7 unwillingness to accept treatment in general?

8 **A.** I think, as mentioned, it's different because he did
9 have a lot of mistrust in mental health professionals
10 and he did -- it's not uncommon for patients to,
11 particularly on acute wards, to decline copies of the
12 care plan after leave. A lot of the time, patients
13 don't agree with being on the ward, they don't agree
14 with the treatment that we're proposing because they're
15 in the most crisis state of their admission, so ...

16 **Q.** So you're saying that sometimes patients don't agree
17 because they're in the crisis state of their admission,
18 but at the same time your evidence earlier was that VC
19 wasn't displaying signs of crisis?

20 **A.** That's just in general. Within an acute ward, I'm
21 saying it's not uncommon for patients to decline a copy
22 of their care plan. But in VC's case, it was more than
23 likely that he was -- the mistrust that he had with
24 professionals, and he'd already expressed frustrations
25 about repeating himself numerous times, and about going

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1 over his care with different professionals, so --

2 **Q.** But at this stage it was more than just whether or not

3 VC was willing to accept treatment. There were risk to

4 others that were very clear, there's a pattern at this

5 stage of VC having to be admitted --

6 **A.** Mm-hm.

7 **Q.** -- when he was becoming unwell. So when he's refusing

8 to engage, there's more than just his acceptance to

9 consider; do you agree with that?

10 **A.** Yeah, but again, with the care plans, these are --

11 they're a written document. We would try other means.

12 So although they're refusing to receive or engage in

13 formally writing that care plan, it doesn't mean

14 necessarily that they weren't following the treatment

15 plan that was proposed upon that care plan.

16 **Q.** Before we go to look at the care plan and the treatment

17 plan, if I can just have the next page which is

18 page 246, on screen so we can see very briefly look at

19 the MDT review. Under "Feedback" it says:

20 "He [had] been quiet on the ward, not engaging. He

21 slammed the door in one of the nurse's face when trying

22 to do physical observations".

23 So again, that's more than just not engaging; that's

24 an active show of aggression towards treatment; would

25 you agree?

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1 sentence which begins:

2 "He accepts that his behaviour leading up to his

3 first admission was uncharacteristic ... but not prior

4 to the following episodes as the experiences never

5 reappeared."

6 It then goes on to say at the end of that paragraph,

7 or he has said to the MDT team:

8 "He said that if it wasn't for his first admission,

9 he wouldn't have been sectioned this time."

10 So this paints a picture of a patient who you know,

11 on his last admission, had seriously assaulted a police

12 officer. Again, as we said, required treatment in

13 seclusion and PICU. Had been transferred at that time

14 to a Section 3, because of his lack of -- the extent of

15 his lack of insight. Were you not concerned at that

16 stage by that disclosure that he was minimising the

17 extent of harm that he could pose to others?

18 **A.** I think it was difficult because for the admission that

19 we saw him, it was a very different presentation from

20 the previous admissions whereby it was a significant

21 decrease in his deterioration of his mental state where

22 he was presenting with the violence and aggression

23 voyage, so...

24 **Q.** But he was admitted on this occasion precisely due to

25 the issues with insight, the issue with non-concordance

55

1 **A.** Yes, but again on an acute ward this is quite a common

2 behaviour that we would be faced with.

3 **Q.** It may be common, but the build-up of the picture that

4 we're seeing is a patient who was disengaged on

5 admission and there were concerns around that

6 disengagement on admission and so far now, on

7 14 February, quite far into his admission, there's been

8 no improvement; would you agree?

9 **A.** In the building and sustaining a relationship it was

10 difficult and there was no improvement on that side.

11 **Q.** So let's look at the care plan, then, which is

12 NHFT0000198. This is the final care plan before VC is

13 discharged from his fourth admission.

14 If we can please look -- start by looking at page 4.

15 This information that we're about to look at at the top

16 of the page is entered under the heading "My views on

17 mental state". So it's an outline of VC's perspective

18 which he had given during the admission, and you've said

19 that this came from VC engaging in some ward reviews,

20 some MDTs. So let's have a look at what VC said:

21 "[VC] said he had 'one recognised episode' which was

22 the first admission and that was 'totally rational' to

23 be admitted to hospital. However he said that the

24 following ones were not rational."

25 Just skipping ahead in the interests of time to the

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1 in the community, the worries that the doctors had in

2 relation to the potential violence when he was unwell.

3 So wasn't that what needed to be treated as opposed to

4 overt psychosis?

5 **A.** I think it was difficult because I wouldn't say you

6 could treat insight, I think it's something, as you say,

7 that it might never -- he might not gain insight in

8 specific aspects of his care and treatment, so it is

9 a really difficult thing to treat --

10 **Q.** Well, you can't treat insight -- well you can treat

11 insight in some ways by intervening. VC wasn't

12 engaging, but then where a patient has no insight and is

13 non-concordant, then one of those things needs to be

14 treated; do you not agree?

15 **A.** Again, it was -- we were working with what we were

16 presented with on the ward at that time and what our

17 options were, and we went with the least restrictive

18 option of community treatment with medication.

19 **Q.** Before we get to the least restrictive option if we look

20 under "MY MEDICATION", it says:

21 "[VC] is currently compliant with ... medication".

22 And then under the next heading which says, "MY

23 VIEWS ON MEDICATION":

24 "When asked about his thoughts about taking

25 medication in the long term he said that he had already

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1 been taking it for a long time."
 2 Then we see:
 3 "[VC] said 'no' to starting a depot", which is under
 4 that.
 5 Did you believe VC when he was telling you that he
 6 had been taking his medication for a long time?
 7 **A.** From the notes, obviously we was aware that he was
 8 non-concordant with medication prior to admission, so
 9 you don't always take the information that patients say
 10 as undoubtedly true. So it would be -- but you would
 11 still document their point of view.
 12 **Q.** But you don't document the counter, do you?
 13 **A.** Not within this.
 14 **Q.** And at that point one of the major issues that led to
 15 admission was non-concordance.
 16 **A.** Mm-hm.
 17 **Q.** So it seems as though what was taken in terms of
 18 treatment was what VC was saying, but nothing in the
 19 care plan seeks to address the reasons for his
 20 admission; is that right?
 21 **A.** I don't know if it was above, I'm not sure, but on the
 22 views on the medication, it's not documented on that.
 23 That can't -- I don't know if it's on the reason for
 24 admission, which is above.
 25 **Q.** Another thing that we don't see within this care plan is

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1 long-term care on discharge when it comes to long-term
 2 issues?
 3 **A.** No, it would just be -- it would be a different -- it
 4 would be recorded as a community care plan or we would
 5 look at crisis care plan. It wouldn't be -- we would do
 6 a specific discharge care plan, usually. Likely it
 7 would be more a crisis care plan which would be separate
 8 to this care plan, which is about managing what we're
 9 presented with on the ward at that time.
 10 **Q.** Is this not a minimisation of the risks that VC was
 11 posing to others at that point, if you're just focusing
 12 on what was happening on the inpatient ward, not even
 13 taking into account that what led to this admission was
 14 an assault on his flatmates?
 15 **A.** No, because it would be documented elsewhere. I think
 16 you would expect that information that would be within
 17 the risk assessment. We try and make a care plan as
 18 personalised and individualised as we can to try --
 19 **Q.** My question -- sorry to interrupt, my question is not
 20 around documenting the risk; my question is around
 21 addressing the risk.
 22 If I understand correctly, your evidence is that
 23 while he was an inpatient you would only seek to manage
 24 risk if he was displaying risk on the ward. Is it not
 25 then a minimisation of the risks he posed if you don't

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1 anything around the extent of violence and aggression
 2 that VC had displayed when he was acutely unwell. Why
 3 is that? Why is there no reference to at least
 4 informing the patient about the extent of violence and
 5 aggression that they had displayed while psychotic?
 6 **A.** As said, this presentation on this admission was very
 7 different to the previous admissions, so if it was
 8 required we would have a management of violence and
 9 aggression care plan specifically for the ward
 10 management, and this usually would be for patients that
 11 are prescribed IM medication, but at this point he was
 12 only prescribed oral medication.
 13 **Q.** Well, that's in relation to potential violence on the
 14 ward.
 15 **A.** Mm-hm.
 16 **Q.** What I'm referring to is a clear pattern of violence and
 17 aggression when unwell. Shouldn't that be something
 18 that's planned for in the long term within the
 19 treatment?
 20 **A.** I would expect that would be more a community care plan.
 21 So this is -- the inpatient care plan would the
 22 management of the risks that we're presented with on the
 23 ward at that time.
 24 **Q.** You said that the inpatient team -- is it your evidence
 25 that the inpatient team has no role in planning for

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1 deal with his long-term pattern of posing a risk to
 2 others, which was well established at this point?
 3 **A.** I don't know if I've further documented below. I can't
 4 see if it is -- it is included below on the care plan.
 5 We normally put, without looking, I don't know if we can
 6 go back to that page at the bottom.
 7 **Q.** We can turn the previous page.
 8 **A.** Well, I think it's at the bottom of the care plan.
 9 Usually you would -- sorry, below.
 10 **Q.** So this is around the reasons for admission?
 11 **A.** Yeah.
 12 **Q.** Current presentation.
 13 **A.** I think it's near the end of the care plan, sorry.
 14 **Q.** Would you like us to turn to the last page? *(Pause)*
 15 **A.** There would be usually be a crisis or management plan.
 16 **Q.** There is a crisis plan at the end of page 5 but this
 17 again focuses on an AWOL management plan in case VC is
 18 AWOL from the ward.
 19 **A.** And the "DISTRESS PLAN" which is underneath, so within
 20 the ward, this is the -- what we would usually go by, so
 21 we would --
 22 **Q.** But this isn't a management plan in respect of the
 23 issues that VC was dealing with around his mental
 24 health, is it? This is just safety planning for the
 25 ward.

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1 A. This is the management, what we would see of violence
2 and aggression within the ward.

3 Q. But we've seen no interventions which require VC to face
4 the reality of his mental health issues during the time
5 that you were nursing VC, do we?

6 A. If it wasn't discussed in the ward reviews, I think
7 within a care plan -- he's refusing the copy of that
8 care plan, so maybe if he would have sat down and
9 actually gone through that care plan, you could have
10 looked at things in more details. But ultimately he
11 didn't have -- he didn't see this care plan so he
12 wouldn't have seen what was written on it because he
13 refused.

14 Q. And when you had interactions with him you don't
15 document that you raised any of it with him?

16 A. I hadn't personally had that interaction with him.

17 Q. So my last question for you, Ms Harrison, is this is
18 VC's fourth admission.

19 A. Mm-hm.

20 Q. You've accepted that he had a history of not taking
21 medication in the community. We've seen that there were
22 very serious concerns with VC's limited insights, his
23 complex delusional beliefs, and significantly, repeated
24 instances of violence against others. Why do you say
25 you could not have put in place a more assertive

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1 "Declined 1.1 with staff".

2 You've been through this all this morning, haven't
3 you?

4 A. *(The witness nodded)*.

5 Q. You've given evidence about observations and no
6 one-to-ones. I just want to look at another entry. If
7 we could turn over the page to 234, please, and if we
8 could scroll to the bottom, we see an entry by Fanuel
9 Shoko; is he another nurse who would be on shift?

10 A. Yes, that's right.

11 Q. It's described as a "brief 1", isn't it?

12 A. Yes.

13 Q. He agrees to a brief one-on-one because he wants to go
14 on leave, doesn't he?

15 A. Yeah.

16 Q. Can we just look at how that's described. He's giving
17 "short answers", isn't he? Can you see?

18 A. Yeah.

19 Q. Can I just go a couple of lines down, the nurse tries to
20 tell him "... that he was missing out on positive
21 therapeutic engagements with staff and peers", doesn't
22 he?

23 A. Yeah.

24 Q. Because there aren't any therapeutic engagements while
25 he's on ward, are there?

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1 discharge plan at the point of discharge?

2 A. I think as a team we'd felt that the patient -- with
3 regards to the depot injection, they had -- the patient
4 had objected. They were concordant on the ward, they
5 was absent from psychotic symptoms and they were of the
6 legal -- the least restrictive. We'd considered the
7 least restrictive option. We would then work with the
8 Community Team to look at the community plan.

9 MS HAIDAR: Thank you. Those are my questions.

10 THE CHAIR: Yes, Ms Patrick.

11 **Questioned by MS PATRICK**

12 MS PATRICK: Good morning, Ms Harrison. My name is Angela
13 Patrick. I ask questions on behalf of the families who
14 were bereaved on 13 June 2023.

15 I've got two things I want to ask you about. I want
16 to return to some of the notes about his presentation on
17 the ward and I want to ask you a little bit about depot.
18 Okay?

19 Now can we look, just so that you've got it in front
20 of you and refresh your memory, back at the RiO notes.
21 That's NHFT0000168 and it's page 233, I think we see
22 your first entry. Can you see that there?

23 A. Yeah.

24 Q. And can you see "low profile", "guarded on approach",
25 "majority of [the] ... time on his mobile phone",

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1 A. Not in terms of engaging with our activity coordinator
2 or --

3 Q. He doesn't engage with anybody really, does he?

4 A. Not on a formal basis.

5 Q. Well, not on any real basis, does he, at all?

6 Anyway, let's go to the next line. He then answers,
7 saying:

8 "... he did not want to engage as he did not agree
9 with the admission and the reasons why he is here. He
10 said that he did not believe that he had a mental health
11 issue and that he was going to engage as minimally as he
12 could, keeping out of people's way and not being
13 a management problem until he can go back to his life
14 and continue with his education."

15 Did you see that entry at the time, Ms Harrison?

16 A. At the time of when, sorry?

17 Q. At the time VC was on the ward and you were caring for
18 him?

19 A. I worked shifts, so I would have seen it on my next
20 shift.

21 Q. You would have read it?

22 A. Yeah.

23 Q. You would have known that that was exactly what he was
24 telling the nursing staff, "I'm not going to engage with
25 you, I'm going to keep my head down, I'm going to keep

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1 out of your way until you release me."
 2 That's what he was saying, wasn't it?
 3 A. That's what he said at that time.
 4 Q. You knew, and you've said this morning, that he could
 5 mask, couldn't he?
 6 A. It was documented that he could mask symptoms.
 7 Q. Here he was, we've seen it recorded previously in
 8 conversations with his care coordinator, this was VC
 9 telling you outright "I will not engage with you",
 10 wasn't he?
 11 A. As minimally as he could, yeah. I agreed.
 12 Q. He was going to do the bare minimum he had to do to be
 13 released, and he was telling you that, wasn't he?
 14 A. Again it is not uncommon for them, or for us to be
 15 presented with that. Patients are ultimately very angry
 16 that they are admitted to inpatient services, so...
 17 Q. He was telling you he did not believe he was ill. He
 18 had no insight, did he?
 19 A. At that point, but I think I've mentioned it did
 20 fluctuate throughout.
 21 Q. Okay. Wasn't this a reason to try harder, engage more,
 22 and to examine closely this stated guarding behaviour to
 23 try to understand what was actually going on with VC?
 24 A. Again, it's hard. We cannot force people to engage with
 25 what we -- the care we propose and the treatment we

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1 difficult to ...
 2 Q. You just didn't know what he was looking at, did you?
 3 A. It would be assumption he was doing his studies.
 4 Q. It was an assumption?
 5 A. Patients have mobile phones and we don't ask every
 6 patient what they're looking at.
 7 Q. Can we just look at the last page of your care plan that
 8 you've been taken to, NHFT0000198, please, and it's the
 9 last part we were looking at, that crisis plan.
 10 It's the page before, I apologise, it's the very end
 11 of the crisis plan. If we can get the bottom two parts
 12 described as distress planning, that would be great.
 13 Thank you, we can see that there.
 14 Can you see it, Ms Harrison?
 15 A. Yeah.
 16 Q. Now, you've said this is the plan for VC in the
 17 community. Whether it is, or it isn't, let's look at
 18 what it says.
 19 A. Sorry, it was the inpatient, not the plan for community.
 20 Q. Plan for inpatient intervention, okay. It says:
 21 "Primary interventions ... therapeutic activities".
 22 He wasn't accepting them, was he? There were none,
 23 were there?
 24 A. The activities on the ward, but a Section 17 utilising
 25 the gym, they're all classed as therapeutic activities.

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1 propose. We can't force them to engage in the
 2 activities.
 3 Q. But he did, I mean, we've seen the notes, you've been
 4 through them all. He kept his head down. He was on his
 5 laptop and he was on his phone. You've seen that,
 6 haven't you?
 7 A. Yeah.
 8 Q. You've said more than once this morning, continuing with
 9 his studies. Did you ask him what he was looking at on
 10 his mobile phone or his laptop?
 11 A. I can't recall specifically asking.
 12 Q. If you did, do you think you'd have recorded it?
 13 A. More than likely.
 14 Q. If it's not recorded, is it likely you didn't?
 15 A. More than likely. It might have happened in ward
 16 rounds. Sometimes things aren't captured.
 17 Q. Similarly, do you recall, did you ever say, "Can I just
 18 have a look at what you've been looking at? Can I check
 19 your history?"
 20 A. We could, but I think it's very invasive and I think a
 21 lot of time people would refuse to show us that. It's
 22 quite invasive to ask someone to show you their history
 23 of their phone and what they are actually looking at,
 24 and I think unless there is a cause for concern about
 25 any inappropriate usage of the phone, then it would be

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1 Q. Okay, let's just go through it. One on one time. He
 2 wasn't accepting one on ones, was he?
 3 A. He wasn't, no.
 4 Q. Encouraging good sleep hygiene. Were you here this
 5 morning, we'd looked at one other entry in another care
 6 plan which said he'd at least once refused nighttime
 7 medication; were you aware of that?
 8 A. Within the ward on --
 9 Q. On 2 February.
 10 A. For this admission?
 11 Q. Yes.
 12 A. I can't recall.
 13 Q. You can't recall it. Then secondary interventions,
 14 again, one on one time with staff that VC trusts. He
 15 didn't trust any of your staff, did he?
 16 A. Not that I'm aware.
 17 Q. So how was this plan going to help VC?
 18 A. As we've said, this is a distress -- this is
 19 a management plan for inpatient wards, and it just --
 20 it's really difficult, when patients aren't engaging, to
 21 come up with specific plans.
 22 Q. Okay. Can we turn to the next topic. Just very briefly
 23 on depot. You'd seen him in September on the Cassidy
 24 Suite, hadn't you?
 25 A. I cannot recall, but from --

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1 Q. But from the notes you would have done?
 2 A. Yes.
 3 Q. Can you recall that he was then being treated with
 4 intramuscular haloperidol?
 5 A. Because he was refusing the orals so that was the
 6 short-term treatment plan. Because he was refusing the
 7 oral he would receive the IM.
 8 Q. Now, just on depot, the decision to change his
 9 medication, if that was to occur, that would ultimately
 10 be for Dr Thangavelu, wouldn't it?
 11 A. Yeah, he obviously would have the ultimate say.
 12 **MS PATRICK:** Indeed. I think that's all the questions
 13 I have for you, Ms Harrison. Thank you.
 14 **THE CHAIR:** Thank you. Yes.
 15 **Questioned by MS CARTWRIGHT**
 16 **MS CARTWRIGHT:** Good afternoon, Nurse Harrison. Can I just
 17 ask you briefly as to an issue on discharge planning and
 18 then the care plan for discharge, please.
 19 Can we briefly look at your witness statement,
 20 please, WITN0198001 at page 9, please. Thank you. We
 21 can see that you detail at paragraph 47:
 22 "Discharge planning commences at the point of
 23 admission. The ward team and care co-ordinator should
 24 work collaboratively and identify any issues that may
 25 impact discharge at an early stage."

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1 A. -- for the discharge planning on Redwood 1.
 2 Q. Because can I ask you, just broadly breaking, without
 3 going to the RiOs, that hopefully you reviewed but if
 4 not I can take you to the pages, but one of the issues
 5 that seems to be a problem from getting from VC was his
 6 address of where he was going to be living when he was
 7 discharged.
 8 A. Mm-hm.
 9 Q. In fact, he was quite evasive about what the address was
 10 going to be; would you agree?
 11 A. Yeah.
 12 Q. That finally, VC did provide an address of 209
 13 Ilkeston Road. So can you assist why the ward staff
 14 didn't go with VC to look at that new accommodation as
 15 part of the discharge planning and whilst he was
 16 accessing the community on leave?
 17 A. I think it's not always necessary for -- it would depend
 18 on the circumstances and the context of that
 19 accommodation. In this sense he'd sorted that
 20 accommodation himself. He'd found that, and it was
 21 highlighted by his care coordinator that it wasn't
 22 uncommon for VC to move around. And he did not want us
 23 to be involved in that process.
 24 Q. But again, I think when it is finally provided, he
 25 shares that it is shared accommodation again. But

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1 Which seems self-explanatory, would you agree,
 2 because before you discharge any patient, but in
 3 particular a patient with mental health difficulties
 4 that poses risks to the public, there has to be a safe
 5 discharge; would you agree?
 6 A. Yeah.
 7 Q. So can you help me then understand how that works in
 8 practice when, if we look at your paragraph 35, because
 9 what you tell us -- sorry, just moving up please, to
 10 page 7. You say this:
 11 "If the patient is being discharged to the local
 12 community mental health team then they would then create
 13 their new care plan once the patient has been
 14 discharged."
 15 But would you agree that, from a continuity of care
 16 but also to ensure that there's a safe discharge, that
 17 should be being prepared before the patient is released,
 18 particularly a patient that has been on a section.
 19 A. Yeah, I think that was just highlighting the fact that
 20 within the RiO documentation the inpatient and the
 21 community care plans are two separate things. They are
 22 different, so the expectation was, once the patient was
 23 discharged, they would create a new care plan to
 24 highlight and reflect what had been discussed --
 25 Q. All right.

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1 wouldn't you agree that everyone needs to be satisfied
 2 that that address first of all exists and it's somewhere
 3 where VC does have a valid tenancy; would you agree?
 4 A. Yeah.
 5 Q. Secondly, that he reveals finally, having been evasive
 6 originally, that it is shared accommodation?
 7 A. Mm-hm.
 8 Q. Bearing in mind this admission had been in the context
 9 of an attack on his flatmates, that again, to assess
 10 risk to the public, that also needed to be known,
 11 whether other people may be at risk from VC; would you
 12 agree?
 13 A. Yeah, I think it's difficult. We have quite limited
 14 control over what accommodation is provided from
 15 an inpatient ward's perspective. It's -- we -- he
 16 didn't have any social -- he wasn't allocated a social
 17 worker. So in that sense we didn't have much control
 18 over the accommodation that he would have founded (*sic*)
 19 himself, whereas if social care, he had social care
 20 needs and social care would have been involved, then we
 21 would have been able to have that input and give our
 22 opinion and view.
 23 Q. Then again just as part of a discharge plan, was this
 24 not an opportunity where VC needed to be referred to
 25 adult social care, that he needed a social worker?

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1 A. It's quite a high threshold for social care, so he
 2 didn't have any immediate social care needs and they
 3 don't just accept referrals for accommodations. So it
 4 would have to be that they can't attend to their
 5 activities for daily living. He was a very high
 6 functioning and independent individual, so he wouldn't
 7 have got accepted for social care.

8 Q. But he was entitled to Section 117 aftercare because
 9 he'd previously been on a Section 3. That would have
 10 been for accommodation, so particularly on this
 11 admission it needed to be absolutely clear that he was
 12 being discharged appropriately to accommodation that
 13 existed; would you agree?

14 A. Yeah.

15 Q. The ward team, to ensure that there was a safe
 16 discharge, needed to make sure also that that
 17 accommodation existed?

18 A. Again, I think it's difficult. Like I say, we have --
 19 if the patient is not willing to let us into that
 20 accommodation or to go and view that accommodation, we
 21 have no control. We can't force the patient to let us
 22 go and see their home in the community.

23 MS CARTWRIGHT: Thank you. Those are my questions.

24 THE CHAIR: Yes.
 25 Mr Beggs?

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1 "The police couldn't share any further information
 2 with Claudia."
 3 Do you see that?

4 A. Yeah.

5 Q. Is it that entry that which caused you to reference the
 6 refusals in the two paragraphs I just showed you in your
 7 statement?

8 A. I believe so, yeah.

9 Q. And looking at that entry now, do you accept that what
 10 it actually says is "the police couldn't share any
 11 further information", rather than saying the "police
 12 couldn't share any information"? Do you see?

13 A. Yeah.

14 Q. And would you accept that the entry suggests an
 15 inability, "We don't have the information", rather than
 16 a refusal, "We won't share it"? Do you see that?

17 A. Yeah.

18 MR BEGGS: Thank you very much.

19 THE CHAIR: Mr Beer?

20 MR BEER: *(Off microphone - inaudible)*.

21 THE CHAIR: Right. Thank you we'll take a five-minute
 22 break. Thank you.

23 (12.11 am)
 24 (A short break)
 25 (12.15 am)

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1 **Questioned by MR BEGGS**

2 MR BEGGS: Could the witness please be shown page 17 of her
 3 statement, WITN0198001. Ms Harrison, would you look at
 4 paragraph 95, please, just at the top, and read it to
 5 yourself.

6 A. Yeah.

7 Q. Do you see you've recorded that the community care
 8 coordinator "had tried to liaise with the police who
 9 refused to give information"; do you see that?

10 A. Yeah.

11 Q. Then if we go to page 19 of the same statement, please.
 12 If you could read paragraph 107 to yourself, please.

13 A. Yeah.

14 Q. Do you see the same comment there: the police refusing
 15 to disclose information?

16 A. *(No audible answer)*.

17 Q. Could I then ask for you to be shown NHFT0000168, at
 18 page 225. And if we could look at the few paragraphs
 19 just below "Feedback". Just to orientate you, this is
 20 3 February 2022. Please take that from me. And do you
 21 see it says:
 22 "Claudia has been his care coordinator since summer
 23 2020 ... He is very guarded ..."
 24 And so forth.
 25 Then at the end of that:

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1 THE CHAIR: Yes, Mr Carr.

2 MR CARR: May I call, please, Dr Timothy Baker?

3 THE CHAIR: Yes.

4 DR TIMOTHY BAKER *(affirmed)*

5 **Questioned by MR CARR**

6 THE CHAIR: Yes.

7 MR CARR: Dr Baker, you have prepared three witness
 8 statements for the purposes of this Inquiry, haven't
 9 you?

10 A. That's correct.

11 Q. Your first two statements are both dated
 12 1 December 2025.

13 A. Yes.

14 Q. And then your third statement dated 23 March 2026.

15 A. That's correct.

16 Q. There's a correction you wish to make at paragraph 1 of
 17 each of those statements. Paragraph 1 is in the same
 18 terms, isn't it?

19 A. Yes.

20 Q. And the correction you want to make is in the
 21 penultimate sentence where it refers to performing
 22 "emergency resuscitation to two of the victims". You
 23 want to correct that to --

24 A. To one of the victims.

25 Q. Subject to that correction at paragraph 1 of each of

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1 your statements, are those statements true to your best
2 knowledge and belief?
3 **A.** Yes, they are.
4 **Q.** By profession you are a GP.
5 **A.** That's correct.
6 **Q.** And you're based at the University of Nottingham Health
7 Service, the Cripps Health Care Centre.
8 **A.** That's right.
9 **Q.** You've been the senior partner there since October 2023.
10 **A.** Yes.
11 **Q.** And that's the practice that VC was registered at from
12 September 2017.
13 **A.** That's correct.
14 **Q.** You yourself you didn't have any interactions with VC,
15 did you?
16 **A.** Not at any time, no.
17 **Q.** But what you do is you set out in your statement the
18 interactions that your practice had with VC and issues
19 in respect of primary care and mental health more
20 generally.
21 **A.** Absolutely.
22 **Q.** My questions are restricted to the issue of the role of
23 primary care and the primary care given to VC.
24 **A.** Okay, yes.
25 **Q.** If we go, please, to your second witness statement, the

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1 7 September.
2 **A.** That's correct.
3 **Q.** This is a letter, we'll go through to the final page,
4 but this is a letter from Dr Burri, so he was a doctor
5 in the EIP team. We can see, so if we go back to --
6 yes, there you can see Dr Burri. Go back to page 1. We
7 can see there's a section there setting out the
8 background, assessment.
9 If we turn over the page, it's giving detail of VC's
10 symptoms, the circumstances leading to his presentation,
11 issues to do with DVLA guidelines, and then there's
12 a section on "Mental State Examination".
13 And under "Impression", towards the bottom of the
14 page, you can see "First Episode Psychosis, likely
15 Affective Psychosis" and that paragraph is flagging
16 issues with superficial insight and likely compliance
17 issues.
18 **A.** Yes, yeah.
19 **Q.** We can see at the bottom of the heading "Plan" there's
20 a few steps which are proposed, one of which, number 2,
21 is to make a request to the GP to "keep monitoring
22 physical health"?
23 **A.** Yes, and that would be normal practice. That looks like
24 a well-structured letter. Lots of content. A very
25 clear plan both from secondary care and primary care

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1 WITN0084001 document, and if we put page 5, paragraphs
2 10 and 11, I want to start looking at the role of
3 primary care where a patient is receiving secondary
4 mental health care. What you've set out there, you
5 refer to some NICE guidance, is that the role of primary
6 care is to monitor the physical health of patients with
7 psychosis and schizophrenia?
8 **A.** Yes, that's correct.
9 **Q.** Then further down to paragraph 13 on page 6, you explain
10 that's usually done by offering an annual physical
11 health check?
12 **A.** Yes.
13 **Q.** And if we go up in this statement at page 4, and it's
14 paragraph 6 of the statement, you set out what you
15 expect to receive from secondary care in respect of your
16 patients, and that's correspondence, you say the amount
17 of information varies, but you expect to see detail on
18 diagnosis, information as to risk to self or others, and
19 ongoing treatment plans.
20 **A.** That's correct.
21 **Q.** And if we take this case, VC's case, we can see
22 an example of the kind of correspondence that you
23 receive. It's CHCA, so the Cripps healthcare document,
24 25, and this is a letter. We can see at the top it's
25 23 September 2020, yes, and it's after a clinic date of

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1 perspective.
2 **Q.** So it's quite detailed, it's not just a case of a doctor
3 sending you a letter from the doctor saying, "We've seen
4 him, please check."
5 **A.** Absolutely, yes.
6 **Q.** "Please keep an eye on physical health checks". It's
7 giving a fuller picture?
8 **A.** Absolutely.
9 **Q.** I'm not going to take you through every piece of
10 correspondence received by your practice, but we have
11 received the disclosure and there's further
12 correspondence like this, so following clinic
13 appointments, 17 December 2020, 17 February 2021, 14
14 April 2021, 15 October 2021 and 22 April 2022?
15 **A.** Yes, that's correct.
16 **Q.** They're providing updates following appointments with
17 VC?
18 **A.** Yes, I believe they enclosed copies of how his
19 medication was reviewed and titrated up over the course
20 of that time as it was prescribed by them.
21 **Q.** In addition, in June 2021 you received the summary care
22 plan from the care coordinator, Claudia Birtles?
23 **A.** That's correct.
24 **Q.** You received Discharge Summaries following periods of
25 detention, so from the Trust you received Discharge

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1 Summaries following the first two admissions and we're
 2 going to go to those in a few moments.
 3 **A.** Okay, yes. I believe we did not receive a Discharge
 4 Summary from his third admission.
 5 **Q.** Well, in the disclosure that's been provided by the
 6 practice is a Discharge Summary from both the Priory and
 7 from Cygnet?
 8 **A.** Yes, we received that after notification of the Inquiry
 9 and a request for further documentation. We did not
 10 have that at the time.
 11 **Q.** You received three AMHP reports, so reports by the
 12 Approved Mental Health Practitioners?
 13 **A.** Yes.
 14 **Q.** You received the report from Amie Staples, September
 15 2021, and we're going to look at that.
 16 **A.** Yes.
 17 **Q.** But also the reports from Roseanna Crane and from Fiona
 18 Parker for the two assessments in 2022, early 2022,
 19 prior to the fourth admission?
 20 **A.** Yes.
 21 **Q.** If we look in particular at the Amie Staples report,
 22 CHCA, so Cripps health document 22 [CHCA0000022]. So
 23 this is for the assessment 3 September, so the
 24 assessment that leads to the third admission.
 25 If we go to page 2 of this document, and looking at

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1 **Q.** Then the next paragraph a description of finding a bag
 2 of unused medication dating back to February 2021.
 3 **A.** *(The witness nodded).*
 4 **Q.** So another indication there of issues with --
 5 significant issues with non-concordance?
 6 **A.** Yes.
 7 **Q.** So we can take that down. It would be clear from this
 8 report, as well as the other bits of correspondence --
 9 as I say I'm not going to go through them all -- but
 10 there's a clear picture from what's being provided to
 11 the practice of a man who's suffering with psychosis?
 12 **A.** *(The witness nodded).*
 13 **Q.** Who is reliant on antipsychotic medication but is not
 14 concordant with it?
 15 **A.** Yes.
 16 **Q.** And violence and aggression when not medicated?
 17 **A.** I totally agree.
 18 **Q.** Now, if we go, please, to the GP running records, so
 19 it's Cripps Health document number 30, [CHCA0000030] and
 20 if we turn to page 7, it's the entry in the middle of
 21 the page, 3 September 2021. This entry follows that
 22 AMHP report we were just looking at --
 23 **A.** Yes.
 24 **Q.** -- leading to the third detention. Now, what we have in
 25 the middle of the page is a section titled "Comment"

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1 that box at the top, we can see, four lines down,
 2 reference to:
 3 "Acute psychosis in May 2020 leading to [VC]
 4 breaking into two of his neighbours homes."
 5 **A.** Yes.
 6 **Q.** Reference to the neighbour being so distressed by the
 7 behaviour she leaped out of the window.
 8 **A.** Yes.
 9 **Q.** After release, rapid deterioration after stopping his
 10 medication?
 11 **A.** Yes.
 12 **Q.** Reference also to him stopping because he believed he
 13 was a victim of a conspiracy?
 14 **A.** Yes, that's correct.
 15 **Q.** So that's a background of two admissions, issues of
 16 non-concordance, issues of lack of insight and delusion?
 17 **A.** Yes, I agree.
 18 **Q.** Then at page 3 of this document, in that first paragraph
 19 about halfway down, a description of VC attacking police
 20 officers, obtaining handcuffs, and using those as
 21 a weapon to hit the police officer?
 22 **A.** Yes.
 23 **Q.** So a description of the violence, extreme violence that
 24 VC was capable of?
 25 **A.** Indeed, yes.

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1 which reads:
 2 "SK.09.09.21: Viewed AMHP report and [VC] detained
 3 under S[ection] 2 of the MHA and remains under the
 4 [Local Mental Health Team]."
 5 **Q.** First question, who is SK?
 6 **A.** SK is the initials of Stuart Keeling, he is a specialist
 7 mental health nurse who is employed by our practice and
 8 he has many years of experience working in the hospital
 9 sector, in the police sector, as a sort of a Street
 10 Triage Psychiatric Nurse specialist, and he works for
 11 us.
 12 It's his role to review documents coming into the
 13 practice of a psychiatric or psychological nature as
 14 well as a workflow team. So although this is dated 3
 15 September, what that is telling me is that we probably
 16 didn't receive it until the morning of 9 September and
 17 then that's when he's reviewed the report, we've scanned
 18 it into his records, and from that, if there was any
 19 action points for us in primary care, such as contacting
 20 the patient, we would be -- we would then do that.
 21 **Q.** Did VC have a named GP? Did he have allocated GP?
 22 **A.** So in our practice of 44,000 patients, you are
 23 registered with the practice. There is an outdated
 24 system where you have a nominal GP, but with 20 GPs and
 25 44,000 students, or patients, it's really not

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1 practicable to have, and to work and see your nominated
 2 GP, so we're very open about that and you can see any
 3 doctor.
 4 **Q.** So those numbers, 44,000 patients, and how many GPs?
 5 **A.** Twenty.
 6 **Q.** So each GP has over 2,000 patients each?
 7 **A.** Yes. Yes, and they're not full-time GPs, probably 11
 8 whole-time GPs.
 9 **Q.** So SK has reviewed this report. You've made the point
 10 of looking for action points, but it's a very detailed
 11 report. It goes beyond action points of course, it's an
 12 assessment which leads to detention. Would you not
 13 expect a fuller note in these records detailing some of
 14 those issues that we've just gone through and summarised
 15 of VC's presentation?
 16 **A.** At that point, no. That's the point of a detailed
 17 assessment. Sometimes people are assessed and admitted
 18 overnight, sometimes they might be admissions for
 19 inpatient care for many months. So at this point,
 20 they're under the care of secondary care, they're
 21 admitted, or they're under the umbrella of the
 22 psychiatric Local Mental Health Team. And there's no
 23 action point in there for primary care, which in a case
 24 like this would usually be restricted to their physical
 25 health monitoring and medications.

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1 page.
 2 **A.** *(The witness nodded).*
 3 **Q.** But the lack of coding for violence wouldn't prevent,
 4 would it, SK, in this comment section, from detailing
 5 the summary of those important points that we've just
 6 gone through?
 7 **A.** That's correct. So medical records are primarily coded.
 8 There's lots of free text but free text is not
 9 searchable, and you could enter what you wanted in free
 10 text here and it would not be easily found by any
 11 subsequent person looking at a summary of the notes, but
 12 a coded entry would be.
 13 **Q.** Well, wouldn't it help -- so a GP who has to pick up the
 14 records for a subsequent contact or a subsequent
 15 appointment, the first thing they're going to do is to
 16 look back at previous entries.
 17 **A.** Yes.
 18 **Q.** Looking back at this entry, whilst they can see that an
 19 AMHP report has been received and viewed by SK, it
 20 doesn't tell them any of those salient points that we've
 21 been through.
 22 **A.** No, it doesn't.
 23 **Q.** If we can look at the steps taken by the practice during
 24 the period where VC was receiving secondary care we'll
 25 start with the first Discharge Summary, it's Cripps

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1 **Q.** So no actions points, but my question is this: in the
 2 AMHP report, as well as in the other documents which
 3 have been sent, there were a number of features of VC's
 4 presentation which are set out, which we've gone
 5 through: the risk of violence, issues with
 6 non-concordance, lack of insight.
 7 **A.** Yes.
 8 **Q.** Are those not issues which should be drawn out of the
 9 correspondence and set out in the GP records?
 10 **A.** They're very important points. They're not medical
 11 diagnoses, and so they can't be coded as such, and this
 12 is something we've reflected on since because a code
 13 such as "a patient may be violent when unwell", for
 14 example, would be a very useful code, I believe, to have
 15 on a medical record. Not only in the case of a crisis
 16 like this, but when someone, anyone, might be seeking
 17 the help and care of their GP or their nurse or their
 18 healthcare assistant in primary care for any reason,
 19 because we often do not know the reason for someone's
 20 attendance until they arrive.

And if we're alerted to the fact that somebody had
 predication to violence when unwell, I believe that
 would be a very good safety mechanism to have in place.

24 **Q.** So that's one point, is coding, and of course that would
 25 help with having an entry on the summary on the first

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1 healthcare document CHCA0000027. This is the Discharge
 2 Summary following VC's first admission from 25 May to
 3 17 June, as you can see on the first page.
 4 **A.** Yes.
 5 **Q.** If we go to page 4 of the document, we can see a series
 6 of action points. In the middle of the page, "Physical
 7 Health Plan, Need Identified."
 8 There's an entry, "Annual Health Check", "GP to
 9 provide", and again, that's what you've alluded to where
 10 you're dealing with a patient with psychosis.
 11 **A.** Yes.
 12 **Q.** But then towards the bottom of that page under the
 13 heading "Action for GP" it also states:
 14 "... please ensure that his medications are
 15 prescribed on his repeat prescriptions."
 16 **A.** Yes.
 17 **Q.** Do you see that? And over the page on page 5, at the
 18 top under "Medication" it states that VC is on
 19 aripiprazole "5mg", "Once Daily". "Issued As TTO",
 20 that's "to take out", isn't it, "14 Days"?
 21 **A.** That's correct, yes.
 22 **Q.** So he's been given 14 days' supply by the hospital but
 23 "Future Supply From" the GP? Do you see that?
 24 **A.** That is what it says. That is not how I interpret it.
 25 **Q.** Forgive me, you don't interpret --

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- 1 A. No, I do not interpret that as an instruction for the GP
2 to prescribe beyond 14 days.
- 3 Q. Well, go back to "Action", page 4:
4 "... please ensure that his medications are
5 prescribed on his repeat prescriptions."
6 That is under the heading "Action for GP", isn't it?
- 7 A. Yes.
- 8 Q. Then page 5, in terms of the medication, "Future supply
9 From" GP?
- 10 A. So may I explain my understanding of this document? So
11 you'll see that that's box is entitled "Mental
12 Health/Specialist Medication" under which aripiprazole
13 is clearly put. And as you say, future supply has been
14 put by the discharging doctor as GP. Underneath that is
15 another box for his vitamin D prescription. This has
16 not been written by the consultant. This is written by
17 Dr Ibrahim, "FY1", Foundation Year 1, a doctor not
18 12 months out of medical school who is writing
19 a discharge summary -- (*overspeaking*) --
- 20 Q. You may be straying slightly from -- the document is
21 clear, isn't it?
- 22 A. Yes.
- 23 Q. It's got an action point for the GP.
- 24 A. No, no it is not --
- 25 Q. "Future supply From GP".

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- 1 A. Absolutely.
- 2 Q. And on the document that we're looking at, the document
3 is clear; it might be contrary to your understanding or
4 practice --
- 5 A. Yes.
- 6 Q. -- but the document is clear that VC has been given
7 14 days' of medication and it is the GP who has
8 an action point to prescribe thereafter.
- 9 A. It would appear that way.
- 10 Q. If we look at your running records, Cripps Health
11 document CHCA0000030. And if we go to page 10, please.
12 Looking towards the bottom of the page, so we've got the
13 entries from June and July. Yes, 17 June we can see
14 that Discharge Summary is noted.
- 15 A. That's correct.
- 16 Q. And then there is nothing done by your practice between
17 receiving that and then notification of the subsequent
18 detention on 31 July. There's nothing done, is there?
- 19 A. No, there's nothing done. So 31st July, we've noted
20 that. That Discharge Summary arrived and was forwarded
21 to the duty doctor, that's correct and --
- 22 Q. That's in respect of the second admission and we're
23 going to come to that, but I'm dealing with discharge
24 from the first admission, action point for the GP, to
25 prescribe future medication after 14 days, and there is

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- 1 A. Yes.
- 2 Q. Now you might speculate that the doctor who has filled
3 this out is incorrect, but the document is a document,
4 isn't it?
- 5 A. No speculation. Nottinghamshire Area Prescribing
6 Committee is very precise and clear on the prescription
7 of specialist drugs in particular. I would, in my
8 understanding, it would be -- to sign a prescription for
9 aripiprazole, an atypical antipsychotic medication, from
10 someone two weeks out of a complex and risky admission
11 could -- would be irresponsible and unprofessional.
- 12 So what he's done and what I believe this is the
13 case, because this is the understanding in all of how
14 general practice and psychiatry works, is that a newly
15 discharged patient on a low titrating dose of
16 an atypical antipsychotic would be closely monitored,
17 would be prescribed for by specialist psychiatric team
18 and thereby titrated appropriately upon their review,
19 which is the instruction that was given to the patient
20 ascertained, reviewed and confirmed by Dr Murphy and is
21 in fact what happened.
- 22 Q. Well, we'll come to Dr Murphy in a moment because that's
23 actually after the second admission, isn't it?
- 24 A. That's correct.
- 25 Q. And I'm dealing with the first admission.

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- 1 nothing done by your practice on receipt of that --
- 2 A. No, that's right. The vitamin D is the prescription,
3 I believe, that will allude to. We would not pick up
4 a specialist psychiatric medication for a patient we had
5 not been able to assess -- (*overspeaking*) --
- 6 Q. Insofar as that document was in the view of the practice
7 confusing or wrong or something that the GP couldn't do,
8 then you could have contacted the hospital or the care
9 coordinator and say, "Hold on, we as a GP practice
10 aren't going to be responsible for this. This must be
11 some mistake." Was that done?
- 12 A. No, we didn't -- (*overspeaking*) --
- 13 Q. Should it have been done?
- 14 A. No, I don't believe so. I understand and we was
15 verified and this is common practice that specialist
16 teams review people just discharged from hospital,
17 supply that medication, regularly review that patient.
18 So I did not believe that was an action point expected
19 of primary care, and that was borne out by what happened
20 -- (*overspeaking*) --
- 21 Q. So you essentially felt safe in ignoring what was in
22 that Discharge Summary because you thought it would be
23 picked up by the -- by the Local Mental Health Team?
- 24 A. His psychiatric care was being fully looked after at
25 that point, including the prescribing

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- 1 -- (*overspeaking*) --
- 2 **Q.** So you felt safe -- that the practice would feel safe in
3 ignoring that direction?
- 4 **A.** We trusted the Trust to look after the patients in their
5 specialist care. It would be irresponsible and
6 unprofessional of us to prescribe for a patient
7 a medication like this, or for any other patient from
8 any other specialty without having been able to make our
9 own assessment of the pros, cons, safety risks and side
10 effects -- (*overspeaking*) --
- 11 **Q.** If you look --
- 12 **A.** -- of medication that we cannot assess.
- 13 **Q.** If you look above the entries from 31 July, what -- we
14 can go to the Discharge Summary from 31 July, but it
15 does the same, doesn't it --
- 16 **A.** -- (*overspeaking*) --
- 17 **Q.** -- in respect of action point for the GP and future
18 prescription, both entries on the discharge summary from
19 31 July have that for your practice?
- 20 **A.** Yes.
- 21 **Q.** Following 31 July, what we see and we can scroll up
22 a bit, is VC is sent three text messages, isn't he?
- 23 **A.** Yes.
- 24 **Q.** Asking for a review and to sort out medication?
- 25 **A.** Yes.

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- 1 discharge from hospital."
- 2 Do you say the references to medication in those
3 text messages is a reference to vitamin D, not
4 aripiprazole?
- 5 **A.** If I was seeing that patient then I would be asking
6 about both, but I would not be expecting to be
7 prescribing aripiprazole and, if so, I would send that
8 request straight back to the primary -- to the Secondary
9 Care Team.
- 10 **Q.** Are you aware that the Local Mental Health Team, they
11 ultimately took over prescribing VC's aripiprazole, but
12 that was following a failure of him to obtain medication
13 from his GP or to sort out obtaining medication from his
14 GP?
- 15 **A.** Well, the Early Intervention in Psychosis teams have
16 a mandate to look after patients for the first
17 three years from their diagnosis of their first episode
18 of psychosis, so it is common practice for their teams
19 to be prescribing for the duration of that time and only
20 when it is deemed safe --
- 21 **THE CHAIR:** Can you slow down, please.
- 22 **A.** -- appropriate to do so, take that over.
- 23 **THE CHAIR:** Can you slow down, please. People have to take
24 notes.
- 25 **THE WITNESS:** Oh, my apologies.

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- 1 **Q.** So that second discharge does trigger action that the
2 first discharge didn't?
- 3 **A.** That's true.
- 4 **Q.** The action following the second discharge, that should
5 have been taken following the first discharge, shouldn't
6 it?
- 7 **A.** For the prescription of vitamin D, yes. Except that
8 vitamin D is usually bought over the counter from
9 a pharmacy and doesn't require a prescription.
- 10 **Q.** So do you say those text messages, the three text
11 messages, those were to sort out prescriptions of
12 vitamin D, nothing to do with aripiprazole?
- 13 **A.** We also like to review all admissions and discharges
14 from hospital and give patients a chance to reflect on
15 those and pick up any primary care roles that would be
16 involved and in this one, as you correctly ascertained,
17 the vitamin D prescription was something that we would
18 wish to continue as well as getting his physical health
19 checks started.
- 20 **Q.** That doesn't quite answer my question. The text
21 messages from August onwards, 3 August:
22 "... book a routine telephone [appointment] for a
23 review & sort medication."
24 6 August: "... to discuss your medication ..."
25 10 August: "... review with a GP following your

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- 1 **THE CHAIR:** Thank you.
- 2 Yes.
- 3 **MR CARR:** So you never prescribe aripiprazole to EIP
4 patients?
- 5 **A.** We do when we are asked to and there is a discussion
6 about shared care, they're usually under regular review,
7 and they have been at that point deemed safe and it's
8 appropriate to pick up routine prescribing, usually on
9 a case-by-case individual patient basis.
- 10 **Q.** If we look at the appointment with Dr Murphy, it starts
11 on page 9 and goes into page 10, so it follows those
12 series of text messages following the second discharge.
- 13 **A.** Yes.
- 14 **Q.** It's a telephone review.
- 15 We have heard evidence from Dr Murphy on this, but
16 if we look at what is set out really from the start of
17 page 10, two points: one, VC says at the top, page 10:
18 "He has been started on aripiprazole (currently
19 receiving from the CMHT) ..."
- 20 And then if we look down at the bottom under "Plan":
21 "Has adequate supply of aripiprazole. I have
22 advised [patient] that when he begins to run low he must
23 [come to] us - [patient] understands."
24 Now, this is obviously more than 14 days after
25 discharge from the second admission, isn't it?

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1 A. Yes.

2 Q. So by this date, VC would have run out of the TTO supply
3 of --

4 A. That's right.

5 Q. -- of medication?

6 A. That's correct.

7 Q. Now, we know from the RiO records that the Local Mental
8 Health Team did, as I say, agree to take over
9 prescribing to VC, but we don't see in your records, do
10 we, any steps taken by your practice to verify that?

11 A. No, no, absolutely, that's a specialist medication under
12 specialist care and control, that's correct.

13 Q. We don't see any steps subsequently confirming the
14 position, so in respect of that plan, either with VC or
15 with the Local Mental Health Team?

16 A. That's correct.

17 Q. Why is that? Is it just something that, as far as
18 you're concerned, the GP practice has nothing to do
19 with?

20 A. We would not be prescribing that medication.

21 Q. Not in terms of prescribing; in terms of clarifying who
22 is prescribed -- you have confirmed that you do
23 prescribe in certain circumstances, haven't you?

24 A. Yes.

25 Q. I am asking why have you not taken steps to clarify,

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1 Q. No lack of clarity, is there?

2 A. So your question to me was: did I need to seek further
3 clarification? In my mind, in my experience, in my
4 professional opinion, no clarification was required
5 because I've seen it in practice for over 25 years that
6 the secondary care services usually pick up the baton
7 and do those assessments, and make those prescriptions.
8 So my reading of that Discharge Summary, to me, is
9 clear, that our job is to make sure his physical health
10 and physical prescriptions are looked after and
11 secondary care is entirely charged with the more
12 specialist medication, as is also clear in the RCGP and
13 NICE guidance that you referred to earlier.

14 Q. So you can ignore what's clearly set out in the
15 Discharge Summary because as far as you're concerned
16 it's wrong, no need to go back and clarify it with
17 anyone?

18 A. That is my understanding.

19 Q. If we look at the physical health check, so going up to
20 the entry on 17 August, page 9 of this document. Yes.
21 It's in the middle of the page, the entry above the one
22 we were looking at, we can see Dr Murphy has sent a text
23 message to VC asking him to make an appointment for
24 blood pressure, weight and height. No response to that,
25 was there?

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1 following this, who was responsible for prescribing
2 medication to VC, because the direction from the
3 hospital on two occasions, two Discharge Summaries, is
4 for you to do it. Why haven't you taken steps to
5 clarify whose responsibility it is?

6 A. So there is a lack of clarity in those Discharge
7 Summaries, but I think as I've clearly explained, there
8 are good and strong and responsible and professional
9 reasons why we do not pick up this prescription, and my
10 interpretation of this, not being personally involved,
11 is that this is our practice, and I am confident, having
12 worked for 25 years and been working closely with the
13 psychiatric services, this is the way that discharges
14 work. And it has been in all my clinical experience.

15 I feel confident, as was borne out, that he was
16 under close review and prescriptions were being provided
17 for him at that time, and they were in the best
18 position, knowing the patient, being able to assess him
19 on a regular basis, to do all the checks about
20 compliance, about side effects.

21 Q. On the discharge document you say the discharge document
22 isn't clear. I can put it back up, if needed, but the
23 document is entirely clear. It says, "GP is
24 responsible"; your evidence is that it's wrong?

25 A. Mm. I agree. We've not been -- (*overspeaking*) --

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1 A. No.

2 Q. If we look at page 8, there's an entry 22 April 2021,
3 offered an appointment. VC didn't show up, did he?

4 A. That's true.

5 Q. Page 7, 2 July 2021, he was asked to book an
6 appointment. He didn't, did he?

7 A. No, he did not, no. These are opt-in offers of physical
8 health monitoring. They're not mandatory.

9 Q. Page 5, 4 November 2021. Asked to make an appointment
10 for blood tests and ECG. He didn't respond, did he?

11 A. No, he did not.

12 Q. All of those offers and all that period of
13 non-engagement with your practice, that's while VC was
14 under the EIP team, so under secondary care?

15 A. Yes.

16 Q. It does not appear that his non-engagement with physical
17 health checks was ever flagged back to the Trust, who
18 delegated that role to you, was it?

19 A. That's true, that's true. These are often
20 a difficult-to-engage group of patients, and for that
21 reason as well there's a Trust-employed healthcare
22 assistant who also has a role of reviewing and offering
23 physical health checks to all patients with severe
24 mental illness both in our practice and across
25 Nottinghamshire, within the Trust.

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1 Q. In your second statement so the WITN0084001 document,
2 page 8, at paragraph 17b, you refer to the fact that you
3 don't "have a policy for raising, reporting, referring
4 or escalating ... non-engagement with physical health
5 ... [to] others, such as secondary health services."

6 Why not?

7 A. Yes, so physical health, as with all of us, not only
8 psychiatric patients, really falls to ourselves. It is
9 up to me, you, and everybody, including these patients,
10 to opt in if they wish, and there is an offer. It's
11 a serious offer because we know that amongst the
12 patients with serious mental illness, heart disease is
13 twice as common, lung disease as four times as common,
14 diabetes is six times as common, and often the
15 medication they take also increases their risk of
16 physical disease. And so we feel it's very important.
17 But it is also our responsibility to follow that up. So
18 -- (*overspeaking*) --

19 Q. I understand the point of responsibility. My question
20 specifically -- (*overspeaking*) --

21 A. -- escalated to secondary care.

22 Q. My question specifically is about sharing information in
23 respect of a vulnerable patient with others who are
24 involved in his care. You don't need a policy, do you,
25 to understand the importance of going back to the Trust

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1 A. Absolutely I do, yes.

2 Q. If we look at the discharge letter that you received
3 from the EIP team, it's Cripps Health document
4 [CHCA0000013].

5 Now, Dr Baker, Ms Heath and others from the EIP team
6 have accepted in evidence that this letter was
7 inadequate. Okay? And part of Ms Heath's evidence was
8 that she expected other documents would be sent with
9 this discharge letter such as core assessment, risk
10 assessment, care plans.

11 A. Right.

12 Q. Would you expect to receive documents like that on
13 a discharge letter?

14 A. I would expect a discussion. I would expect a very
15 clear plan, and agreement, for ongoing monitoring,
16 reasons to refer back into services, some instructions
17 as to what to do, especially regarding non-compliance
18 and non-engagement, because these are very difficult
19 patients to look after and, by the very definition of
20 the condition they have, are associated with a lack of
21 insight which makes them very difficult to engage and
22 for medication to continue.

23 Q. So you'd expect a discussion, so you'd expect someone to
24 pick up the phone, is that what you're describing?

25 A. At the very least. Usually a Multi-Disciplinary Team

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1 and saying, "Look, this patient you're caring for, we're
2 responsible for physical health healthcare but we tried
3 to contact him, he's not engaging with us, he has all
4 these physical health risks, we can't get him along, we
5 don't know what the best way of engaging him is, FYI
6 we're letting you know."

7 You don't have a policy to tell you do that, do you?

8 A. No, we don't have a policy.

9 Q. Would that be sensible to do?

10 A. It's -- I do see it as our responsibility rather than
11 theirs. It is highlighting the non-engagement, that's
12 very true.

13 Q. Is it something that should have been done in VC's case?

14 A. I do not know of anywhere that has a policy of
15 escalating non-engagement with physical health to
16 secondary care. It's often more important with physical
17 health problems, in fact, than psychiatric ones. But it
18 is a worthy idea.

19 Q. Can we move on to the issue of discharge of VC from
20 secondary care back to primary care. That's a decision
21 that primary care had no involvement in, did they?

22 A. No, that's correct.

23 Q. Do you think GPs should be involved in MDT meetings at
24 secondary care where there is a proposal to discharge
25 a non-engaging patient?

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1 meeting and a direct discussion with the consultant
2 team.

3 Q. Right, and in answer to my question, would you expect
4 the documents that I've just outlined, that Ms Heath
5 referred to, core assessment, risk assessment, care
6 plan, would you expect those documents to come up on
7 discharge?

8 A. I would.

9 Q. Should steps have been taken by your practice on
10 receiving this discharge letter without those documents
11 which you would expect to get in touch with the Trust
12 and say, "Where is the core assessment? Where is the
13 risk assessment? Where's the care plan? And why hasn't
14 the consultant given me a call to speak to me, because
15 that's what we'd usually expect"?

16 A. Yeah, I think that's fair comment. The most --

17 Q. That should have been done and it wasn't?

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

19 I agree that could have been done.

20 Q. That letter says nothing, does it, as to who was going
21 to be responsible for prescribing medication to VC?

22 A. No.

23 Q. It says nothing about what medication he was on or what
24 dosage.

25 A. No, not at all.

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- 1 Q. What would you ascertain from this letter, and what
2 would people in your practice ascertain as to VC's
3 condition, risk or management going forward?
4 A. In truth it's very difficult to know. There's very
5 little information in that. I would add that in
6 a university practice, the commonest reason for being
7 unable to contact a patient is that they're no longer
8 here. They've finished their course. They've gone back
9 to their home country or their original city of origin,
10 and they are no longer with us, even though they may
11 still be registered with us. That's by far the most
12 common reason for non-engagement.
13 Obviously their --
14 Q. Was there any basis for considering that VC had gone to
15 a different country or had left Nottingham?
16 A. Well, we see it all the time. He's finished his course,
17 not been engaged with his course for a long, long time.
18 Q. That doesn't answer my question. Was there any basis to
19 consider that VC had left --
20 A. There was no evidence to suggest that; no evidence to
21 suggest that was not the case, either.
22 Q. What was the understanding of the practice as to how VC
23 was going to receive his medication following this
24 discharge?
25 A. There was no information to go on in regard of that.

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- 1 Q. Yes, and so in answer to my question --
2 A. -- (*overspeaking*) -- (*Unclear*).
3 Q. -- what would the understanding be as to how VC was
4 going to be receiving his medication following this
5 discharge? Is your answer: he wasn't?
6 A. He wasn't. Yes, yes.
7 Q. In your second statement, paragraph 7, this is on
8 page 4, you make the point that in primary care the
9 expectation is or you "would expect a patient to be
10 discharged from secondary mental health care only when
11 and if it was considered safe and appropriate to do so."
12 A. Yes.
13 Q. In the same statement you go on, page 8, paragraph 18,
14 to say -- or referring to:
15 "Discharges from secondary care are considered to be
16 specialist decisions based on careful review of
17 diagnosis, risk and safety."
18 A. Yes.
19 Q. Now, neither in the discharge letter from Ms Heath or in
20 any of the correspondence you receive, or your practice
21 received, is there any suggestion that the discharge was
22 based on any assessment of safety.
23 A. No.
24 Q. Simply that he'd disengaged.
25 A. That's correct.

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- 1 Q. No.
2 A. He was never prescribed his medication, he's been under
3 secondary care, he's -- it looks as though he's
4 disengaged with secondary care and there's no
5 information in that -- (*overspeaking*) --
6 Q. Yes, well we've looked at the AMHP report, haven't we,
7 and we know there was a whole series of letters that
8 were sent to you and, as you describe, they set out his
9 medication being increased. The Local Mental Health
10 Team was dealing with prescription but they have
11 discharged him.
12 A. Yes.
13 Q. So what is your understanding as to how he is going to
14 be medicated following discharge? Did you believe that
15 the Local Mental Health Team were going to continue
16 doing it despite discharging him?
17 A. The only way that primary care could pick up prescribing
18 would be for him to engage with us instead, and for us
19 to make that risk assessment check with his dose, and
20 responsibly and professionally prescribe for him.
21 He hasn't been contacted or been contactable at this
22 point in time by a team going out with responsibility to
23 look for him and look after him. And so there's very
24 little we can -- are able to do as a general practice to
25 press that any further.

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- 1 Q. Is it your view that someone lacking insight,
2 non-concordant, known to be violent when not medicated,
3 is it your view that that is the kind of patient who
4 should not be discharged to primary care --
5 A. That is my --
6 Q. -- on the grounds of non-engagement.
7 A. Yes, that is my view.
8 Q. The two references in your statement I've just taken you
9 to, obviously sets out your understanding of good
10 practice and that discharges should be safe, but in
11 terms of primary care, would you not need to allow, so
12 once a patient has been discharged back for you, would
13 you not need to allow for the fact that secondary care
14 may have got it wrong? You can't simply assume that
15 every discharge has been done by the book and includes
16 a safe assessment, can you, in reality?
17 A. Yes, I think in reality, general practice is very, very
18 busy doing general practice and primary care, and we put
19 a lot of trust in our specialist colleagues in all
20 specialties to do their job, and to ensure that when
21 they discharge someone, it is safe, and with clear
22 instructions for us non-specialists to pick up the
23 baton, which was not done here.
24 Q. The bottom of page 10 into page 11 of this witness
25 statement, it's paragraphs 26 and 27, you describe

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1 circumstances in which primary care will or can
2 challenge a discharge decision where there's a clear and
3 present danger beyond the ability of primary care to
4 manage.

5 **A.** Yes.

6 **Q.** But the suggestion appears to be that primary care had
7 no concerns on this occasion, but in light of the
8 documentation that you'd received and that we looked at
9 at the beginning of your evidence, there were grounds
10 for concern, weren't there, about primary care being
11 able to manage VC?

12 **A.** Clearly. He was, yes, very unpredictable, non-compliant
13 when unwell. Yes.

14 **Q.** Wouldn't this have been a good moment for the practice
15 to carry out an assessment of all those documents with
16 the different AMHP reports, the correspondence from the
17 doctors, over the years, and to pull together the themes
18 and determine some kind of plan to manage him on
19 a primary care basis?

20 **A.** Are you referring to the time of that last letter
21 -- (*overspeaking*) --

22 **Q.** Yes, following the discharge.

23 **A.** Yes.

24 **Q.** Up until then you've described how members of staff will
25 look at correspondence, will note action points for the

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1 document. What it's identifying, so it's the paragraph
2 in the middle of the page starting "General practice
3 which is part of wider primary care". If you go down
4 about halfway into that paragraph and you've quoted from
5 this in your statement, it says:

6 "Primary care also has a duty to provide physical
7 health care including offering screening, to those
8 people with [serious enduring mental illness] such as
9 schizophrenia."

10 So that's the point you've already given evidence
11 on. And then the next sentence:

12 "However, there is no clear direction as to who
13 should manage people with stable [serious and enduring
14 mental illness] who no longer require the expertise of
15 specialist secondary care services. Many of these
16 people are being discharged into primary care with no
17 planning or support."

18 **A.** Yes.

19 **Q.** So what it's highlighting there is a lack of clarity,
20 really, as to the management of patients who are stable
21 and who have been discharged from secondary care because
22 they are stable?

23 **A.** Yes.

24 **Q.** VC was in a different category, wasn't he, because he
25 wasn't being discharged because he was stable --

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1 GP --

2 **A.** Yes.

3 **Q.** -- but really leave managing mental health symptoms to
4 secondary care. But at the point of discharge,
5 secondary care are passing the patient back to you, so
6 doesn't there need to be a bit of a taking stock of:
7 okay, let's try and get a measure of this patient and
8 figure out what's been going on over the last few years?

9 **A.** I think in reality, you know, a practice of our size
10 will receive hundreds if not thousands of letters every
11 week and a letter of a specialist -- from any specialist
12 discharging a patient would have been looked at, would
13 have been work flowed, may have been viewed by one of
14 the clinician team, and I don't think the doctor would
15 have been joined for someone to do additional work to
16 trawl through AMHP reports, hospital inpatient
17 records -- well, we don't have hospital inpatient
18 records, we have no access to RiO, but at that point to
19 refresh and review every single patient and every single
20 discharge. So I believe, no, I don't have a good
21 suggestion. I don't think we have the resources within
22 general practice to review all that information on the
23 receipt of a discharge letter of that type.

24 **Q.** Shall we look at the Royal College guidance as well. So
25 that's WITN0227002, and I want to look at page 2 of this

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1 **A.** Absolutely.

2 **Q.** -- he was being discharged for non-engagement. Is it
3 your view that there needs to be really better guidance
4 and a clearer policy as to the role of primary care --

5 **A.** I think --

6 **Q.** -- both for stable SMI and for unstable SMI?

7 **A.** Yes, I would absolutely agree with you. This is the
8 Royal College of General Practitioners report and
9 I think that's very fair comment, yes.

10 **Q.** Following discharge, did your practice consider that VC
11 was under your care for his mental health?

12 **A.** We would -- no, I would say with his diagnosis, we would
13 clearly see his physical health was an offer that we
14 were -- we have a duty of care to him to offer that, but
15 with a diagnosis such as paranoid schizophrenia, my view
16 is that that is an enduring, serious and enduring mental
17 illness that probably requires ongoing secondary care.
18 So I would never put him in this category of being
19 stable, as he was not assessed to be.

20 **Q.** So if his mental health wasn't the responsibility of
21 primary care, is the reality that following discharge,
22 his mental health was just going to go unmanaged and
23 untreated?

24 **A.** Yes.

25 **Q.** If we look at the running records again of Cripps

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1 Health, so it's Cripps Health document 30 [CHCA0000030]
2 and if we go to page 4, we can see towards the top of
3 the page, 22 September, it is noted receipt of the
4 discharge letter, it is three entries down, and then
5 what we see above that are two text messages sent to VC;
6 do you see that, 28 September, 29 September?

7 **A.** Yes.

8 **Q.** Then on to the next page, page 3, or the previous page,
9 rather, page 3 and at the bottom of that page we'll see
10 three more attempts at text message, so 30 September,
11 11 November, 21 November, and VC didn't respond to any
12 of those, did he?

13 **A.** No, he did not.

14 **Q.** Then the next entry is in respect of a phone call made 1
15 March 2023 by Ms Bailey.

16 **A.** Yes.

17 **Q.** Now, this is entered in your records and it says, "GP
18 surgery Cripps Health Centre", but who was Ms Bailey?

19 **A.** So that's interesting. Sam Bailey is an employee of the
20 Mental Health Trust. She is a healthcare assistant and
21 she has access to RiO, but she also has access to our
22 clinical system, and her role is to help with the
23 physical health monitoring of all the patients on
24 medication and having serious and enduring mental
25 illness. In addition to our offer.

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1 attempts to contact by text message have been
2 unsuccessful, you accept there should have been an
3 effort to phone VC?

4 **A.** I think a phone call is a really good way of contacting
5 people. It's still an opt-in offer of physical health
6 monitoring which he can decline, he has every right to
7 do that, but I do agree different methods of
8 communication are a good --

9 **Q.** Is there a point you would get to, as primary care,
10 where you think: well, this patient has been discharged
11 to us by secondary care for not engaging. He's not
12 engaging with us. He appears to be out in the community
13 unmedicated. We don't know what's going on. Something
14 needs to be done. We're going to refer this back to EIP
15 or contact AMHP and call for a Mental Health Act
16 Assessment? Would you ever get to that stage, or do you
17 just take the view: well, not our responsibility if he's
18 been discharged?

19 **A.** I don't think a view is taken. I think the job in --
20 the role in primary care is I arrive in the morning and
21 I have 30 or 40 patients to see who have made an
22 appointment. Clearly VC was not making appointments.
23 He was not engaging. I don't have resource to chase
24 people who are not looking or not wanting to see
25 a doctor or health physician, I'm a 100 per cent busy

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1 So she's employed by the Trust and, as you correctly
2 say, she called the same telephone number, the LMHT hold
3 for him on 1 March 2023, made contact and I think
4 there's a verbatim report that she offered him physical
5 health checks for which he declined.

6 **Q.** Yes. So the management post discharge, putting aside
7 Ms Bailey is not one of your employees, the management
8 post discharge of VC, was limited, essentially, to
9 sending five text messages?

10 **A.** Yes.

11 **Q.** Why not try to call him as Ms Bailey had?

12 **A.** Yes. So all of our patients are asked what is their
13 preferred method of communication, be it a call, a text
14 message, email, or letter? And as probably wouldn't
15 surprise people, the most common and popular method is
16 by text message. That was his preference. But we have
17 reflected upon this and we've sent him lots of text
18 messages that he had not replied to and sometimes that's
19 because of personal preference, but we -- our
20 reflections are and our practice now is that we use
21 multi-modes of communication. So we would try to phone,
22 we would try to email as well as just
23 -- *(overspeaking)* --

24 **Q.** So you accept here that, particularly in circumstances
25 where there's been a discharge with little detail,

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1 looking after the people who do.

2 So I don't think a view is taken either way, in
3 truth. It doesn't come up.

4 **Q.** So there wouldn't be a point at which --

5 **A.** So I don't think any point would be arrived at because
6 there's no point in time where that would be double
7 checked.

8 **Q.** The final issue I want to deal with with you is in
9 respect of information sharing, and there's a number of
10 different aspects to it.

11 Firstly, you've explained in your statement -- and
12 I'm not going to it -- but you've explained that because
13 VC transferred from a GP practice in Wales --

14 **A.** Yes.

15 **Q.** -- there was limited information about him which was
16 shared with your practice, and that's different where
17 a patient transfers from an English GP practice?

18 **A.** Yes, yes.

19 **Q.** Is that problematic, not having access to full records
20 when you're receiving a patient from Wales or who
21 resided in Wales?

22 **A.** It's not unusual for us. 25% of our new patients who
23 will arrive in Nottingham University will be from
24 overseas, and there's no record at all. So Wales,
25 sometimes from Scotland as well, back in 2023 it would

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1 not be unusual for us not to receive any record.
 2 **Q.** The Inquiry has now obtained those records from Wales,
 3 the full set of GP records, and you've seen them?
 4 **A.** I've seen them now, yes.
 5 **Q.** That wouldn't make any difference or would it make any
 6 difference to the way VC was managed, there's no entries
 7 in mental health -- (*overspeaking*) --
 8 **A.** No, there's no entries on mental health, no.
 9 **Q.** So would it have made a difference?
 10 **A.** It would have made no difference.
 11 **Q.** But in any event, do you consider there would be any
 12 merit in improving the system between Welsh GP practices
 13 and English ones so that you do get full records?
 14 **A.** That would be very useful, yes.
 15 **Q.** Now, so far as information sharing with the Trust, and
 16 you've made reference to the fact that Ms Bailey can
 17 make entries in your records?
 18 **A.** Yes.
 19 **Q.** Does the Trust have access to RiO records of its
 20 patients? Sorry, does the GP practice have access to
 21 the Trust's RiO records for its patients?
 22 **A.** No.
 23 **Q.** Is there any integration of RiO records into --
 24 **A.** No.
 25 **Q.** Is that something which would improve your ability to

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1 **A.** If you went to A&E, as my patient last night, I would
 2 know this morning that you'd been there, and I've a
 3 discharge summary. So emergency departments have this
 4 all sorted out. That's just not -- it's not the case in
 5 psychiatric care.
 6 **Q.** So there would be improvements then if you could
 7 access --
 8 **A.** Absolutely, absolutely.
 9 **Q.** Information sharing with the police. In what
 10 circumstances, if any, would you contact the police for
 11 information about a patient?
 12 **A.** I can't think of a time when that's happened.
 13 **Q.** AMHP reports. We've seen that you received three AMHP
 14 reports in respect of assessments of VC. The first two
 15 from May 2020 you didn't receive. Those AMHP reports,
 16 and you will have seen them in the documents you were
 17 sent for the Inquiry --
 18 **A.** That's right.
 19 **Q.** -- so "GP practice no registered or unknown".
 20 **A.** (*The witness nodded*).
 21 **Q.** How would the AMHP go about finding who a patient is
 22 registered with?
 23 **A.** Usually they ask the patient, or they ask the next of
 24 kin who may know the answer to that question. But
 25 I don't know.

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1 care for your patients?
 2 **A.** I've thought long and hard about this, and I don't
 3 believe it would. RiO has a lot of information, I don't
 4 know how much, but I don't know how or when I would be
 5 able to assimilate that information usefully or how
 6 useful it would ultimately be.
 7 I think the role of letters, clinical letters, being
 8 as clear as the ones we've looked at this morning,
 9 stating a clear diagnosis, summary, action points, is a
 10 far more effective, when done well, method of
 11 communication to us in primary care, than to have access
 12 to RiO notes.
 13 **Q.** Well, there's two points, aren't there? Firstly, one of
 14 the issues raised in your statement is the fact that
 15 Discharge Summaries can be sent weeks after the event,
 16 and if you had the ability to go and look at RiO you
 17 would know when the patient had been discharged and
 18 you'd be able to see that much more swiftly.
 19 **A.** Yes. That's true.
 20 **Q.** Even with the letter we looked at from Dr Burri, we saw
 21 that the clinic was 7 September, but the letter wasn't
 22 drafted until 23 September and date stamped received by
 23 your practice, 29 September. If you had access to RiO
 24 you could just go and look at the notes of that clinic,
 25 couldn't you?

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1 **Q.** Finally this: Covid vaccinations. Your GP records, the
 2 records from your practice, document VC receiving Covid
 3 vaccinations on 14 July 2021 and 13 December 2021.
 4 **A.** Yes.
 5 **Q.** Your statement explains that although there are entries
 6 made in the GP records, it doesn't mean that those
 7 vaccinations were carried out on your premises.
 8 **A.** That's right. We'd make a record of vaccinations for
 9 the medical record, and in fact one of those was one of
 10 the hospital Covid vaccination clinics, I believe; the
 11 other one was at Forest Recreation Ground which was
 12 a pop-up mass vaccination centre within Nottingham, set
 13 up for purpose.
 14 **Q.** Your documents don't record, do they, any needle phobia
 15 by VC?
 16 **A.** No.
 17 **MR CARR:** Thank you, Chair. Those are my questions for this
 18 witness.
 19 **THE CHAIR:** Thank you. No questions from me. How long --
 20 well, you've got five minutes. Is there going to be
 21 anything from you? Right. Well, we'll just take your
 22 questions, Ms Cartwright then, before we break.
 23 **Questioned by MS CARTWRIGHT**
 24 **MS CARTWRIGHT:** Good afternoon.
 25 Could I briefly go to your witness statement, the

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1 WITN0084002, please. It's paragraph 79 of that first
2 statement, please. Sorry, I've not got a page number,
3 I do apologise. Paragraph 79, please.

4 Thank you very much.

5 Essentially you've encapsulated:

6 "The view of the Practice that significant relapsing
7 and remitting conditions known to involve risk and
8 unpredictability such as paranoid schizophrenia remain
9 under Secondary Care."

10 And obviously that's not just your view; you're
11 saying it's a considered view of the GP practice; is
12 that correct?

13 **A.** Yeah, that's correct.

14 **Q.** Now, obviously it's been dealt with in your evidence
15 already with Mr Carr, that in September 2022, that's
16 just what happened. The secondary mental health
17 discharged VC back to the care of primary care to the GP
18 in that discharge letter, and there's many reasons that
19 have already been explained that I don't want to go over
20 as to how that discharge letter was seriously deficient.
21 But essentially that's what they had done, and that
22 letter was reviewed by the member that you've
23 essentially commissioned, Mr Keeling, whose got mental
24 health experience, who then reviewed that letter when it
25 came in. And so what I want to ask you, please, is when

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1 doing should be saying, "What on earth are you doing
2 discharging this risky patient to us in a GP practice?"
3 Would you agree?

4 **A.** I think with 44,000 patients and many letters like this
5 discharging patients all the time, that wasn't done
6 because of the pressure on primary care, and our trust
7 in specialties to make those decisions.

8 **Q.** Then can I ask you about your systems internally because
9 certainly the diagnosis of paranoid schizophrenia is
10 flagged and in bold in your GP records.

11 **A.** Yes.

12 **Q.** So was there not a practice or a system you had to pick
13 up patients that were under your care? Because
14 essentially that's what VC was at the time he carried
15 out this attack. The only care he was under was the
16 care of a GP, with the responsibilities that you have to
17 provide essentially then, you're responsible for
18 provision of his comprehensive care, because he's under
19 no other treating team.

20 **A.** Well, he's not engaging with any healthcare
21 professionals, is he, at that point, apart from that one
22 call from the healthcare assistant.

23 So we have a duty of care, yes; he has been
24 discharged to our care, yes. He could be anywhere at
25 this point, of course, and he's not engaging.

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1 that happened, why was the practice not immediately
2 escalating this as a serious incident, as a matter that
3 required a meeting as a matter of urgency to understand
4 how it was that secondary care were exactly doing that
5 for a risky patient?

6 **A.** I think when that letter came in with as little
7 information on it as was there, all the dots would not
8 have been put together to form a picture. I think that
9 letter, which didn't go into diagnosis, just purely on
10 the basis of that letter, didn't flick the switch to
11 enable that to happen. So it didn't activate any
12 process there whereby that was reviewed. And the
13 assumption is that secondary care make serious decisions
14 like this with the responsibility that they're given to
15 do so, and that isn't our decision, but I accept that
16 was not done.

17 **Q.** No. And you say that didn't flick the switch, but
18 certainly from what you did have from the various
19 discharges and you'd already identified, he had an
20 entitlement to three years of being under the EIP, and
21 so here we have VC who is not two years into that period
22 of responsibility of the EIP again, where it's not
23 flagged.

24 **A.** No.

25 **Q.** Essentially what the GP, do you agree, should have been

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1 **Q.** No, no, I appreciate that.

2 **A.** There's really not a lot of action we can take other
3 than trying to contact him to engage him.

4 **Q.** Well, then, let's go back to September 2022 and what you
5 could have done, because you say at no point did the
6 practice take on the responsibility for prescribing
7 aripiprazole, which you've described as an atypical
8 antipsychotic which needed secondary services to do so.

9 So that was not going to be happening for this
10 patient straight away. Why wasn't a safeguarding alert
11 issued that with the state of affairs had been imposed
12 upon you there was a neglect to the patient in the
13 community who was not receiving his antipsychotic
14 medication?

15 **A.** I don't think we have a system for that. I think those
16 were entrusted to secondary care because of the nature
17 of this medication. I think if it was working the other
18 way, if he'd been discharged with a letter saying he's
19 coming into the community and he requires medication so
20 there was an action point for us to pick up the
21 prescription pad and make an assessment and take on
22 responsibility for that prescription, that would be
23 different. That would have been triggered by such
24 a letter. But as we've seen, there was no instruction
25 in there and so it was that omission, I think, that

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1 perhaps meant that nothing did happen as a result of
2 that letter --

3 **Q.** So is it your evidence --

4 **A.** -- other than a call to action.

5 **Q.** -- that there was a gross failure for that discharge
6 letter not to reference the continuing of
7 a responsibility for the prescriptions of aripiprazole
8 had been passed to the GP?

9 **A.** I think that's a serious omission, yes.

10 **Q.** Then can you just help me then if we do look in the GP
11 summaries, because certainly for medication it does
12 suggest that aripiprazole was still current.

13 CHCA0000030, page 1. Because it does, under
14 "Medication" we still do have as a prescription for VC,
15 aripiprazole, 10 milligrams, "Two To Be Taken As
16 A Single Dose daily".

17 So can you just help clarify: did that mean that the
18 practice had the ability to still issue prescriptions
19 for aripiprazole for VC?

20 **A.** So the reason we put that on is the safety issue. If
21 someone is being prescribed aripiprazole, for example,
22 and there are many other examples of medication, and
23 they may come to me for something entirely unrelated,
24 a physical health problem, for instance, and I wanted to
25 prescribe them a medication for that physical health

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1 just how risky he was.

2 **A.** Yes, that wasn't done, was it? And I can think of other
3 patients and the CQC have looked at all of our patients
4 who have the same condition in a detailed report where
5 we have had those discussions.

6 And on a few occasions we've said, "No, this patient
7 isn't right for discharge", but importantly with other
8 patients sometimes we have a radar, we may have
9 a relative, we may have a husband or a wife. With VC
10 there was no early warning system, was there? And so
11 that was more cause of concern and no evidence of clear
12 and present danger that we alluded to earlier.

13 **Q.** Just, finally, on the same page in the records, please,
14 I don't want to take any time, I've essentially used up
15 my time, but I think you may be incorrect about not
16 knowing about the discharge from the Priory, certainly
17 the running records suggest you were aware of his
18 admission but also the discharge is in the running
19 chronology.

20 Can I just finish with this one because on page 1
21 again we can see that someone's extracted the times when
22 VC was detained in hospital, we've got three,
23 essentially, in the "Active problems" but then under
24 "Minor past" we've got the other admission on 25 May.

25 Those summaries don't reference VC, the fact that

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1 problem, it would be essential information for me to
2 know that they're on a medicine like this in case there
3 was an interaction between the two medications.

4 So this is on the medication screen because we have
5 clocked that he has been prescribed this and is assumed
6 to be taking it, so that there is appropriate safety
7 warnings flash up on our system should there be any
8 interaction or allergy or other condition that we needed
9 to know, prescient to any physical health conditions
10 that we may be seeing him for.

11 **Q.** So really that's just a flag to make sure, as you said,
12 there's no contraindication for other medication --

13 **A.** Yes.

14 **Q.** -- but certainly that is not suggesting in any way that
15 the GP practice at any point issued those prescriptions?

16 **A.** That's correct. That's correct.

17 **THE CHAIR:** Right.

18 **MS CARTWRIGHT:** Then can I just pick up another thing that
19 could have been done? You said you didn't consider
20 safeguarding, but again would you agree that, one, there
21 could have been or should have been a multi-agency
22 meeting to say: "We weren't involved in this discharge,
23 what on earth is going on for this risky patient?"
24 Because what the GP practice did have is all those AMHP
25 assessments and the discharges from hospital that showed

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1 he'd had a Section 3 admission and again, when there's
2 been a Section 3, something else that you could have
3 done, would you agree, is urgently contact the local
4 authority and social care saying, "We've had a patient
5 discharged to him, VC, who's had a Section 3. He now
6 urgently needs an adult social worker from adult social
7 care, he's got these ongoing obligations and duties that
8 he's entitled to free of charge under Section 3", that's
9 something else that could have urgently been done to
10 ensure that the risk was being managed in
11 September 2022; would you agree?

12 **A.** We had no role in that at all, it's a good point but
13 it's looked after by secondary care at the point of
14 discharge and often we do not know at the point of
15 discharge or we only find out a long time later. So
16 it's a good point, but it's not something that as a GP
17 in 25 years I've ever been involved in or asked to do.
18 But in my psychiatric practice before I became a GP,
19 that was a common part of the discharge planning
20 programme.

21 **Q.** So is it your evidence that the GP practice would never,
22 with a patient who's been on a section 3, be using that
23 as signposting to where the relevant individuals with
24 statutory duties should be discharging them?

25 **A.** They certainly should, and it's a good point of

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1 signposting. I think, in fact, in the Discharge Summary
 2 there is a section on Section 117 and it says, "not
 3 done" or "ineligible" or something, doesn't it? But
 4 I do not see that role as the GP to do, but as
 5 signposting that is a very good point.

6 **THE CHAIR:** Thank you. We'll take a break now until 2.25.
 7 Thank you.

8 (1.25 pm)

(The short adjournment)

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