Wednesday, 6 May 2026

(2.00 pm)

MS LANGDALE: Thank you. Can we have NHFT0000168 page64, please, on the screen. Dr Lloyd, this is 16 July 2020, "72 hour review". And we see under "Patient comments", page 64, third paragraph down:

"Dr Seedat observed there seems to be no insight or remorse and ... the danger is that this will happen again and perhaps [VC] will end up killing someone. [VC] ... responds by saying 'it will not happen again'."

Did you see this in the notes?

A. Yes, I did.

Q. Do you agree with it, what he said?

A. So when I read this in the notes, having also read in detail the events that had led up to both the first and second admissions, I felt that his comment here had to be put into context, and I understand that Dr Seedat does go on and put it into context.

What he is saying is that VC's behaviour, ie, attempting to kick down the door, the unintended consequence of this was that the student jumped out of the window and that, should he do it again, it could be that she jumps out of a higher window or something else happens and he ends up killing someone; not that he has clear intent, planning, you know, any kind of

premeditated wish to kill someone --

Q. But his actions could result in killing someone.

A. That's right, yes, it could.

Q. S you agreed with that when you read it?

A. Absolutely.

Q. And if we see, if we go, please, to NHFT0000222, you see the Discharge Summary. It repeats what's in the note that's coming off the screen, the diagnosis -- primary diagnosis of schizophrenia.

So if we go, please, to page 2: "Primary Diagnosis Paranoid Schizophrenia" at this time.

Dr Burri was the one who conducted further examinations, wasn't it, in respect of VC, rather than yourself soon after?

A. That's right.

Q. But whether -- he described, he thought two consecutive episodes of psychosis or a psychotic disorder. But the treatment would have been the same, from what you were saying before: antipsychotic medication in conjunction with psychological therapies; is that right?

A. That's correct, yes.

Q. I don't want to get hung up on a diagnosis. The treatment was the same at the time.

A. Yes.

Q. Psychoeducation and relapse prevention work should have

been going on in the community, shouldn't it?

A. It should, yes.

Q. Why wasn't it?

A. I'm not certain why it wasn't started immediately but I do believe that Claudia Birtles did a good piece of psychoeducation work and relapse prevention early warning signals with VC in January 2021.

Q. Well, I don't mind us jumping to that, if you like, it's NHFT0000168, page 145. And this is the Relapse Prevention Plan, page 145. And so VC started to complete card sorting exercises for the plan. Let's have a look at the bottom of it.

"If [VC] were to become unwell again he would like people not to be overly judgemental.

"He would like to avoid hospital, use least restrictive practice (increase contact with care team/[Crisis Team] ...) and speak with the family on his behalf.

"[VC] would like to remain on Aripiprazole as he has been on this since the start".

It's hardly a Relapse Prevention Plan that, is it?

Whatever he's been asked to do, that's simply a "I just want to get on with my own thing", isn't it?

A. This looks like an advanced statement actually, rather than an actual Relapse Prevention Plan, yes, I agree.

It looks as though these are VC's wishes in terms of what he would like to see in event of a further relapse.

Q. And they look like very rehearsed in terms of Mental Health Act language and terminology, "not to be overly judgmental", "least restrictive practice"; do you agree?

A. Yes.

Q. Do many of your patients say: "I'd like you to use the least restrictive practice"?

A. No, they don't.

Q. Have you ever heard that?

A. Not that I can recall, no.

Q. And you've had how many patients?

A. Over the years?

Q. Yes.

A. Gosh, thousands.

Q. Do many say: "I don't want you to be overly judgmental"?

A. That depends. It depends on the sort of education and the eloquence of a patient. So yes, occasionally, that has been said.

Q. Where criminal acts have been committed there's a requirement to be judgemental, isn't it, even within mental health services and developing a therapeutic relationship with the patient, to recognise behaviour that falls under criminal law. Do you agree or not?

A. I think we would do everything in our capacity to

prevent further criminal behaviour, yes. It's not something that we would endorse, no.

Q. Can we have that down, please, and NHFT0000202, page 1. We're going back to 2020, 1 September. The Summary Care Plan sets out summary formulation at the beginning. The formulation doesn't actually, it's agreed, set out risk, risk management, anything of that kind.

If we go to the bottom of the page it doesn't include the primary -- the schizophrenia diagnosis. And if we go to page 3, please, we see "Actions" listed:

"Regular contact with Care Coordinator."

How often VC has contact, et cetera.

"Services to build therapeutic relationships ..."

And under "Actions", further down:

"Ongoing monitoring of mood, mental state and behaviours

"Continue to explore and develop coping strategies that might prove effective ..."

And the responsible people are named as yourself and Claudia Birtles.

In terms of Claudia Birtles we're agreed, she wasn't doing detailed relapse prevention planning work with him or risk assessment management plans, was she, with you?

A. Sorry, could you repeat the question?

Q. She wasn't preparing risk assessment management plans

with you and she wasn't preparing either Relapse Prevention Plans or anything of that kind.

A. Not with me, no. I wasn't directly involved in VC's care at this time. I think I've mentioned before that Dr Burri was the doctor that was working with him directly, and so my involvement was more indirect in terms of supervising him and providing expertise to the MDT.

Q. Well, we see in the top box where it says:

"Completing psychoeducation and relapse prevention planning ..."

Neither is happening. Dr Burri goes and does one of the mental state examinations, and he is a trainee, isn't he? He's an ST5 or ST6.

A. He was an ST5 at the time.

Q. So he's an ST5. So he does his mental state examination in accordance with his level of skill. You aren't doing the mental state examinations at all, are you?

A. Not at this stage, no.

Q. Didn't you think in this patient that would be wise: that you should do one?

A. VC at this stage is not really different to most of the patients on our caseload. So there is nothing particularly unusual or unique about VC's presentation at this stage.

Our trainees, particularly our higher trainees, have to be able to work relatively independently and autonomously. We follow clear college guidelines on these issues, and they have certain competences that they must meet. The supervision level is indirect.

Q. His name is not on the care plan though, is it, Dr Burri?

A. I don't know why it's not on the care plan --

Q. Are they sometimes -- are ST5s on the care plan named?

A. Yes.

Q. Why is your name -- you see, it's not clear what your role or responsibility was, listening to you. What were you expected to do?

A. My role here is having oversight as the community consultant working in the team, it's having oversight.

Q. So are you responsible, for example, for the review of his antipsychotic medication --

A. No.

Q. -- or discussion around that? Who is responsible for that in the community?

A. Dr Burri would be at this stage because VC is on his caseload.

Q. Did he ever discuss his medication with you, his treatment, what he needed, whether it needed to be adjusted or anything like that?

A. Yes, he did in supervision sessions. Each time an adjustment was made, we did talk about that.

Q. What about the elephant in the room, the one that you knew, that he wasn't taking it anyway?

A. I didn't know this at this stage.

Q. We discussed this morning how readily apparent, and went through a number of notes with Claudia Birtles referring to the fact he said he had 28 days, when she knew it was 14 days medication and the like. He's constantly saying things that are very capable of disproof, if you look a few pages before or afterwards. Are you saying when you spoke to Dr Burri around this time you hadn't done that exercise to see --

A. I hadn't specifically looked through the notes at this stage, no, because Dr Burri was essentially leading medically and was working alongside Claudia Birtles. So, no, I wouldn't have looked at the notes specifically at this stage.

Q. When did you look at the notes and assess for yourself he was not taking medication as he should?

A. So the only time that I knew that he hadn't was when Dr Burri handed VC's case directly over to me, which was at the end of his placement with us.

Q. When was that?

A. That would have been 31 July 2021. So this is all in

2020, I'm guessing. And that's when I would have had the handover, I would have gone back and read in a bit more detail about VC's presentation.

Q. So the care plan stays the same, very little update. So in 2021, then, in accordance with this care plan, what were you doing around Relapse Prevention Plans or monitoring mood, mental state and behaviours of VC because that's what it suggests you're doing, and it's the same plan later on?

A. So the first time VC is booked in to see me is on 9 August 2021. There's a clinic appointment. That's --

Q. We know you don't have that. We've got all the did not attends; we can deal with that. What did you actively do? Can we just confine ourselves to that?

A. There was very little that I actively did because I hadn't had the opportunity to --

Q. So it's nothing, just nothing.

A. -- to see him.

Q. No relapse prevention plan -- just to cut through this, we've got a lot of documents to go, if we actually look at what the care plan says you're doing, is the answer "Didn't do any of that", either in 2020 because you didn't expect yourself to do it, but 2021 likewise?

A. I didn't expect myself to be doing any of those actions at this point and I don't know why my name is there.

Q. In 2021, when you'd taken over from Dr Burri, is it the same: you didn't expect or believe you were responsible for risk assessment on a regular basis, monitoring of mood, mental state and behaviours?

A. Those actions, carrying out a level 2 risk assessment on a regular basis, the fortnightly monitoring of mood, mental state and behaviours and coping mechanisms, are all roles that the care coordinator performs. So the formal level 2 risk assessment forms are done by the care coordinator; the fortnightly monitoring of mood, mental state and behaviours is the role of the care coordinator; and exploring and developing coping strategies is also her role. If VC had agreed to have CBTp, cognitive behavioural therapy for psychosis, then the work around developing coping strategies would have been done much more intensively by our team psychologist.

Q. That places a lot of responsibility on the care coordinator, doesn't it --

A. That's right.

Q. -- and none of yourself? There's nothing.

A. Absolutely, yes, and that's why they have a capped caseload of 15 -- or they're supposed to -- because they have an extremely broad, overarching role. They are the lead clinician --

Q. We've got the point of her role, thank you.

A. -- in this case.

Q. Annual Care Programme Approach, those reviews, were you involved in those?

A. Yes.

Q. We understand the initial care plan is done by the care coordinator in collaboration with the patient.

A. *(The witness nodded)*.

Q. What about the Care Programme Approach reviews? Did you look at these?

A. Yes, so the CPA, the Care Programme Approach reviews are done annually, and I understand in this occasion, in 2021, the review was done before I took -- *(overspeaking)* --

Q. So you never did one of those reviews?

A. No.

Q. Just so we're clear. Okay.

A. No, so I wasn't involved because it happened the month before. My first appointment with him was 9 August, which he didn't attend.

Q. In terms of risk assessment, are you saying that was delegated to the care coordinator?

A. No --

Q. -- the level of --

A. -- they carry out the formal risk assessment form which

is in RiO but what we always do is we discuss risk in a lot of detail in the MDT --

Q. Why aren't those meetings recorded? It's easy enough these days, just record them, press a button, or got your medical secretary to take a note -- *(overspeaking)* --

A. I've already answered that question.

Q. But it's very convenient, isn't it, to say it was discussed because we see no documentation between you and Claudia Birtles about risk assessment or forms or whatever you needed to complete?

A. I can't change that. It's something that wasn't just done, it wasn't just our team, it was across the Local Mental Health Teams. I can't really say much more.

Q. That's because it wasn't done, was it?

A. That --

Q. Risk assessment wasn't done in accordance with that care plan at all?

A. Risk assessment was done regularly and there was a very clear understanding of risk by Claudia Birtles, and myself, but only based on the information that was available to us.

Q. There was risk about -- risk to Claudia Birtles, wasn't there? There was a risk management discussion between you and her about her no longer being VC's carer and

people going in pairs. So there was risk assessment for her.
A. No.
Q. You didn't have that discussion with her?
A. That wasn't done by me. That was a risk assessment done by Emma Robinson with Claudia Birtles at the time because Claudia was pregnant.
Q. Did you know about that? Were you part of that risk assessment?
A. I wasn't part of that risk assessment. They're usually done between a clinician and their line manager.
Q. So that risk assessment took place -- we've seen notes of that -- but there wasn't a risk assessment of VC's risk to neighbours those around him or in the light of the events that had happened in 2020 or 2021 was there: the risk to the public and other people?
A. I know that those risks are listed in the level 2 form, but I think unfortunately -- unfortunately, the detailed risk discussions that we had, no, because they were part of an MDT discussion. They were not recorded. It does not mean that they didn't happen. And we had an understanding of the risk to the public and I had a clear understanding of risk, as I knew it, and that's something that I've documented in my witness statement.
Q. Let's move on now to the documents, NHFT0017810, page 2.

This is Dr Seedat emailing you. From what you said earlier, there's no conversations, you just email each other and he lets you know that he's surprised in November 2020 VC tries to contact him. So we see at page 2. His email at the bottom, and yours at the top. Four days later:

"... it looks like the team have been making a concerted effort to visit and follow [him] up .... patient has not been engaging ... CPN Gary Carter has now seen him. As you can imagine patients with psychosis can sometimes behave in quite erratic ways ..."

Were you interested to know why he was looking or wanted to speak to Dr Seedat?
A. Absolutely, and so as soon as I've sent this email, I make sure that VC's review is brought forward so that Dr Burri accesses him much sooner than he otherwise would have so that we can learn why it is that he wanted to see Dr Seedat.
Q. And if we look, please, at NHFT0017810, page 1, contrary to what you said a moment ago, Dr Lloyd from Gary Carter, 9 November:

"... 28 days of meds out ... said he had about 10 left? Needless to say I kept the new meds and will liaise with Claudia about going out and again."

So Gary Carter doesn't email often, from what we've looked at, does he?
A. No, he doesn't.
Q. And he's emailed you querying medication, VC's medication, what's left, what's going on, against this backdrop. Did that make you ask further questions or wonder why he was doing that?
A. I knew there had been a period where he hadn't engaged and I think I must have assumed that because they hadn't been able to see him for that period that the medication ... I'm not sure. Yes. I don't remember this email but yes, I can see that he said that.
Q. So he's worried about medication at this time. And if we go -- *(overspeaking)* --
A. He said that there's about ten left, yes.
Q. If we go to NHFT0000168, page 138 please. This is 10 November Bilal Burri note, and the plan, at the bottom:

"Close monitoring in the community by [the care coordinator] ..."

So what did you think was required for close monitoring?
A. The most that we could offer was weekly at this stage.
Q. So in your discussions about risks and generally, did you think you needed to escalate this or get a Mental

Health Act Assessment or do something to reflect that you couldn't possibly closely monitor according to what was -- *(overspeaking)* --
A. I don't think he would have met threshold for a Mental Health Act Assessment whatsoever at this stage. There is -- there is nothing to suggest here that there is an increase in risk to either himself or others or a deterioration in his self-care.

So no, he wouldn't meet threshold, and I think the other difficulty is that he's not in immediate crisis, he's come forward, he's been very open with the team, he's told us for the first time that he hasn't been completely honest with the inpatient team.
Q. "Very open with the team". With all you know now, let alone what you should have known then, are you actually suggesting he was being open with the team?
A. I think he was being more open than he had been.
Q. Well, that's not -- you asserted he was being open with the team; he wasn't, was he?
A. He was telling us that he's continuing to have symptoms, which is something that we didn't know.
Q. And he wanted to be more open, arguably, with Dr Burri or Dr Seedat, saying what in fact had happened: that he'd been hearing voices and --
A. Yes.

Q. -- just said he hadn't to get out of hospital. And when he tried to do that, I think he gets a response "Couldn't it have waited till a Thursday?" from Dr Burri, and Dr Seedat phones him and says "It's not my job, it's back to you."

Do you think this lack of continuity of personal care impacted here?

A. Possibly. I think often patients will form a strong relationship with a clinician very, very early on in their patient journey, and it looked to me that VC had quite a lot of rapport with Dr Seedat, because I know that this isn't the only time that he's gone and asked for Dr Seedat. I think it happens again consequently.

So he keeps going back, wanting to talk to the doctor that he'd originally formed that relationship with. So yes, I think continuity of care can certainly be an issue, and I think we know that, particularly with all of the separate teams, it is very difficult.

Q. Can we that have CQCM0016518, page 33, please. In fact page 34. This is the CQC report page 34, third paragraph.

"Despite the evidence that VC was symptomatic on the treatment prescribed and had been admitted to hospital on multiple occasions over a short period, there was no change in the approach to treatment. NICE guidelines

are clear that people with schizophrenia whose illness has not responded adequately to treatment, should have their diagnosis and treatment reviewed to ensure it is at an adequate dosage and for the correct duration."

We know that between 2 February 2021 and 13 April 2021, he is not reviewed by a nurse or assessed by a doctor. Six weeks, 2 Feb to 15 March, six weeks he is not seen by anyone. What would you say about that?

A. From the 2nd of February --

Q. And 15 March 2021.

A. That's six weeks.

Q. Yeah. And he sees Dr Burri's on 15 March for a memory test and his next face-to-face review is on 13 April 2021, four weeks after the memory test.

A. I'm not certain in why over that six weeks he wasn't seen by anybody. The care plan would have suggested it should have been fortnightly at that stage.

Q. But it wasn't, was it?

A. No, but I don't know why.

Q. So whose responsibility is that? If you can't do it yourself and you've delegated it to Dr Burri, whose responsibility is it to make sure it happens in appropriate times?

A. Dr Burri would only see VC as and when required, and it's usually our nursing staff, the care coordinators,

who book in appointments for doctors to see patients. That's how it works in all of the Early Intervention teams, and also in the LMHT, so I'm not sure --

Q. -- *(overspeaking)* -- I'm beginning to wonder what the psychiatrist does, if you don't mind me asking, Dr Lloyd. So they're responsible for knowing when these doctors' assessments need to be conducted. They're the ones assessing for signs of psychosis, are they, as well, even though they're not doctors, when they go out to these visits -- *(overspeaking)* --

A. They do the monitoring --

Q. They're monitoring medication --

A. -- yes.

Q. Well, that's assessment, monitoring, telling you when it should happen?

A. Yes, they do. They book in the medical appointments. It's not something that I necessarily agreed with, I'll be perfectly honest with you, and I did email both the administrative staff and also my line manager to say that I wasn't particularly happy that appointments were being booked in for the medical staff by care coordinators as often, you know --

Q. As was required, by the sounds of it.

A. But I --

Q. But you didn't like that many?

A. But I got a response back saying that's what happens. That's the usual practice. And I have copies of those emails, if you need to see them.

Q. May 2021. Were you aware that VC had gone to Thames House in London? You didn't hear anything about that. It would have been helpful to know what he was thinking about going down there and asking him about it.

A. I didn't know about that, no.

Q. Did you know in July that he had assaulted one of his flatmates that he subsequently became fixated on and tried to follow?

A. No.

Q. We've mentioned earlier stalking and being fixated on people; it's very troubling, isn't it, when those offences arise?

A. That's right.

Q. If we can have NHFT0000168 page 157, please. This is the appointment date, 9 August 2021, when he doesn't attend the appointment. See at the bottom of 157. "Did not attend ... at noon." The penultimate box:

"... did not attend his clinic at noon today. ... CPN feels he might be relapsing so she will book ... for a home visit."

With your ST6. Why was it that you wouldn't do a rearranged appointment as the consultant?

A. I was aware that I only had one home visit slot and, unfortunately, it was booked with another patient that needed to be seen just as urgently. However, Dr Sasidharan, Sasitha, had just started, had taken over from Dr Burri --

Q. So she was quite new in the role, was she, to psychiatry?

A. But she's an ST6 so she was six months away from becoming a consultant herself.

Q. Let's look at page 159, what she finds. So somebody again new to VC, meets him, and we get this report at paragraph 4, "he has been doing fine. "Reported ... he is compliant with his medications ... no side effects."

The bottom paragraph, Mental state examination:

"... voices ... become faint ... no longer distressed ... not ... responding to unseen stimuli. ... happy to follow medical advice. [And] Is willing to continue to take medication.

"Impression: His mental health has remained stable."

No challenging or probing there of medication when he says at the top, line 3, "Compliant with his medications and no side effects reported". At the very least it would require to have a look at where he keeps his medication, what he's got there, testing it out, having a conversation about that. There's no probe

whatsoever, is there?

A. It doesn't look like she checked his medication, no.

Q. Would you have checked? Would you have asked more about that, given the background and your CPN thought he was relapsing?

A. Yes, probably.

Q. Probably or definitely? It's fundamental, isn't it?

A. Yes, I would have checked.

Q. So somebody, relatively inexperienced to you, does that assessment and all looks well at the conclusion of that, and that's not the case: it wasn't well, was it?

A. I don't think it was no. I can't remember specifically what the next appointment showed.

Q. The next appointment with you, page 163, the bottom box, you were due to be attending with a second doctor. If we go over the page, he didn't answer the door, no response. This was when events led to the Mental Health Act warrant and the assault on the police officer.

A. Right.

Q. So things weren't well. Moving forward at 167, please. If we can look under "Scene", third paragraph:

"Officers went to restrain him and he seriously and repeatedly assaulted the male officer particularly."

Have you ever watched the body-worn video footage of this event?

A. No.

Q. So what do you rely on in understanding what happened at that event?

A. I rely on the medical notes and the description of what's happened. I rely on any further information brought to me by the care coordinator that she may have gleaned in her dealings with VC. And, usually, after a Mental Health Act Assessment like this, there's a long period of inpatient assessment and there are detailed notes about somebody's mental state, risk, all available in those notes. But, unfortunately in this case, he went into a private hospital and we weren't able to access those notes.

Q. But you could see he'd seriously assaulted a police officer?

A. Yes.

Q. You haven't seen it since, to see that there was a degree of planning when he takes his glasses off, puts them on the windowsill?

A. No.

Q. Indicates he doesn't want to hurt female police officers, but he'd like the male officer to take him out of the room. Yet you comment in your statement at paragraph 255:

"... very likely [he] acted in self-defence: he

perceived himself to be under attack from the police and [needed] to fight for his life."

A. Yes, so the reason for that was that both Claudia Birtles and I had a conversation about this particular event, a detailed conversation. I'd also seen Ben Lomas' -- Dr Ben Lomas' entry in the notes and what we concluded from this, and certainly what Claudia said to me at the time, was that this was a man who was floridly psychotic. She had seen him, I think, just prior to this Mental Health Act Assessment with Gary Carter, and had felt that he was extremely unwell. He had a strong belief that there was a conspiracy against him, that a group of people, comprising MI5, the police, the Government and mental health services, were all conspiring against him and they were -- and that we were using some kind of technology --

Q. We've got that. So 31 August, that meeting --

A. Yes, so he was extremely frightened. And then a group of people, including the police, forced entry into his property, the very group of people that he is incredibly paranoid about, and, you know, I could see that that would feel really threatening and provoking.

Q. Dr Manzar was there, wasn't he? Dr Manzar who he already knew, Dr Lomas, Amie Staples, so mental health professionals, not just the police, and afterwards he

described it as poor judgement from himself, didn't he? Anyway, you've commented as to what you think likely happened in that moment.

A. I, having spoken to his care coordinator, having had a detailed discussion with her, having thought about his kind of perceived thinking, how VC might have felt, given those fixed, strong delusional beliefs and having individuals who formed part of that belief walking into his property against his will. Now, obviously I wasn't there, I haven't seen the video footage so I made a comment based on the knowledge that I did have.

Q. Might it have been better to view the best evidence before you did?

A. I didn't even know video footage existed.

Q. Can we have NHFT0018143, page 1, please. This is an email from Claudia Birtles to you. VC on this detention, is applying to a tribunal for his release. Ms Birtles says to you:

"VC has a tribunal next Thursday. I'm going to suggest consideration of a depot, hope that's okay. This was a consideration after his last admission however Dr Seedat gave him the benefit of the doubt and agreed to continue with orals."

Your ST6 responds:

"I do agree with depot, especially him having no

insight."

Did you see the email?

A. I saw -- I definitely saw Claudia's email.

Q. Did you not respond to it, then?

A. It was sent to me, VC, yeah. *(Read to self)*.

I probably had a conversation with her after it, rather than actually do an email response. I'm only in the office above, and Claudia often came in and spoke to me face-to-face.

Q. But you agreed with it, you agreed with the depot?

A. Absolutely, yes.

Q. Indeed you do a report for the tribunal. If we can have CYGN0000011, page 3. Page 3 you set out a diagnosis.

Sorry, that can come down. Different person, sorry.

A. Oh, okay.

Q. Don't worry.

Did you read the tribunal ruling?

A. I don't think I ever saw the tribunal ruling.

Q. Were you interested to read the ruling, knowing he'd made an application?

A. Yes.

Q. So why didn't you read it?

A. I don't think I ever received the ruling at all but I did receive verbal information back from Claudia.

Q. What did you understand it had been? Perhaps we can

have CYGN0000056, page 3. We see there:

"If discharged, we would be very concerned about [VC's] own safety and that of others: he hears voices, gains access to others' property and behaves in a way perceived as threatening to others. He has been violent towards others. When he's unwell the risk are serious."

Did you agree with that?

A. Yes, the risks could be significant when he's unwell.

Q. "Could be" is not the same as when he's unwell the risks are serious. Not could be serious: are serious?

A. The only time they have been serious, from what I believe, is the attack on the police, the two police officers. I've already told you about my views of him kicking the door down and what I believe the risks to have been at that time but I think, certainly on this occasion, just going to his third admission, yes, the attack sounded very serious.

Q. If you go to page 5, please, (iii) at the top:

"[VC's] delusions are sufficiently severe and distressing so as to cause him to seriously assault a police officer and require physical restraint. This is the second time his illness has resulted in someone else suffering a significant injury."

So that's the same as the woman jumping out of the flat.

Paragraph 13:

"Unequivocal evidence [further down the page] the risks to others when [VC] is unwell are high, relapse occurs rapidly and is difficult to manage. These risks eventuated very recently and it is important that they are minimised so far as is reasonable before [VC] is discharged into the community."

You should have read that, shouldn't you?

A. I should have received it yes, and I don't know why I didn't. It may be because I wasn't involved in the particular tribunal and --

Q. The findings are: when he is unwell, high relapse occurs rapidly and he is difficult to manage.

A. That may be true for the second admission but we know now, don't we, that actually it's possibly not true for the lead-up to the third because he apparently stopped his medication in October but I guess the tribunal would not have known that.

Q. Say that again.

A. So in October 2020, when VC apparently stopped taking his medication --

Q. So he tells Dr Blackwood, yes. So much earlier on in his illness.

A. Yes, there's been a nine-month period leading up to September 2021 when he actually relapses. So there's

a long period of him not taking medication, and not relapsing immediately.
Q. But you don't know, do you, about Sebastian --
A. I don't know that.
Q. -- the events with Sebastian in July 2021. He assaults him. You don't know about how he's following him; you don't know about why he goes to Thames House, why he's there. So what's your assumption that there's no difficulties or complications arising from his mental health at that time?
A. But my understanding is all of those events occur either mid or later in 2021, rather than early on. But yes, at the time I wouldn't have known that.
Q. It's guesswork for you, isn't it, because you never saw him and you only had the records, which we've got in front of us?
A. Yes, yeah.
Q. So can we have a look, please, 168, page 195. This is after his discharge. We see at the top of the page, 195, 25 October, Claudia Birtles, underneath "Note":
"[VC] wasn't sure of exactly how many tablets he was discharged with but believes it was possibly a 28-day supply [and Claudia Birtles] yet to receive the discharge summary."
If we go to PAGR0000029, page 3. We know from

page 3 of the summary he was discharged to his new flat with 14 days' medication so very self-evidently and immediately telling a lie about the amount of medication he had to Claudia Birtles. Did you detect that at the time?
A. I don't think the Discharge Summary was available to us at that time.
Q. Well, it won't have been soon thereafter, will it? Soon enough if you wanted to see what he said. Did you detect that at any time?
A. I honestly don't remember seeing this Discharge Summary.
Q. You saw what Claudia Birtles had said about the medication. Did you suggest to her, "Well, look, given we wanted a depot, it hasn't happened, let's move on, double check, treble check this medication"?
A. My intention at this time was to try and see him and to have a very frank conversation with him about depot medication, and that was very much the plan at this stage: that there was a conversation with him where we made it really clear that we felt he needed to be on depot.
Q. If we look at 198, please, at the bottom, NHFT0000168 page 198, 15 November, he doesn't attend the appointment with you. So NHFT0000168, page 198. Doesn't attend his appointment, at the bottom of the page. You say in your

statement you didn't have any concerns about him not attending this as he'd been seen by Claudia Birtles earlier.
It's not the same, is it, being seen by the care coordinator and being seen by you as the psychiatrist, the Consultant Psychiatrist?
A. I think it's unfortunate that he didn't attend but the reason that I make this comment is because the DNA policy for the Trust is really clear that, if a patient doesn't attend, you know, we need to try and assess or get some idea of the level of risk and, as part of that assessment of the level of risk, it's about whether a patient has been seen by somebody else, another clinician in the team; how they were at the time; was there any evidence of relapse; was there any evidence, signs and symptoms of psychosis? And whilst ideally I would have seen him because I wanted to have this conversation about depot, I felt at least he has been seen and there are no immediate risks to self or others highlighted.
Q. At page 199, please, at the top, 19 November, Claudia sees him, Claudia Birtles. 199, top box:
"[VC] said he'd missed a couple of doses of aripiprazole, later failing to collect them last week. Been taking 10 milligrams since the admission. Aware he

needs to take 20 milligrams."
So clear, not taking his medication as required, and we see if we have the rest of the page illuminated in one box, we see, please, that 29 November he didn't attend. 6 December, third missed appointment with you, and medication due on 14 December.
So you've had three missed appointments at this time, haven't you, in this period, when you say you want to speak to him about depot?
A. Yes.
Q. And you know he's not taking the medication, and you're sufficiently concerned to want to raise forcing medication through depot?
A. That's what I wanted to do at this stage, definitely.
Q. So what did you do at that point when he hadn't come for three times?
A. I was starting to feel this isn't good, however patients who are in the community, who are voluntary, cannot be compelled to attend appointments or indeed to take their medication, and that is unfortunately the position that we find ourselves in.
Q. So you thought there was nothing you could do at that point?
A. We didn't have powers at this point to do a lot more, until he actually met clear threshold for a Mental

Health Act Assessment. They are essentially the only powers that a Community Team has in the community unless a patient is on a CTO.

Q. He wasn't taking the treatment that was necessary for his mental disorder.

A. No.

Q. You knew that.

A. Yes.

Q. So why not trigger a Mental Health Act Assessment -- *(overspeaking)* -- and detention under Section 3 for treatment?

A. Because he would not meet threshold for a Mental Health Act Assessment. It is very clear, you know, the Mental Health Act has principles of least restriction, it has Codes of Practice. Now, as far as VC is concerned what we would have to show was clear evidence of deteriorating mental health and a clear risk of harm to self or others.

And whilst --

Q. You had the tribunal findings: rapid relapse, risk to others. You had the evidence.

A. That is not enough evidence. That's historic evidence of things that have happened historically. The evidence that we'd need to be showing here is that there is a current risk, at that time, of hallucinations,

delusions, or thought disorder, that there is also some kind of risk, some kind of escalation of risk to self or others, and that could be thoughts or comments around self-harm, thoughts or comments of harm to others, escalating violence. That could even be a third-party report.

So for example, if Mum had contacted us at that time and said, "Look, I've had numerous phone calls with him" -- which I know she had during this period. Celeste Calocane had said, "I'm really worried, I think VC's mental health is deteriorating for these reasons", we could have taken that to the AMHP because there are thresholds that need to be met, even in terms of calling a Mental Health Act Assessment.

Q. Can we look at, please, at NHFT0000417, page 7, and this is the relevant policy in place at the time around not attending, DNAs. We see at the top:

"Actions to be taken by the clinical lead to understand and mitigate risks may include the following:

"Where risks are identified".

If we go down to the third bullet point:

"Contact will be made with the patients GP on the day of the missed appointment.

"Consideration will be given to an urgent home visit

"Making contact with known relatives/carers,

neighbours and friends where appropriate.

"Consideration will be given to arranging a Mental Health Act Assessment.

"The Police may be contacted to request a welfare visit

"Other services such as the Crisis Team or the Assertive Outreach Team may be asked to continue trying to contact the patient out of hours."

So it continues. After the three successive DNAs, did you trigger any of these responses?

A. This is not the policy that that we were using at the time, the one that --

Q. It says "Policy Trustwide" on page 1, not that we need to turn to it, but it doesn't suggest it's not for the EIP.

A. No, no, it's not that it's not for EIP, but I think there may have been another policy that we were using at the time --

Q. Which was what?

A. -- I think unfortunately the policies get changed. If you look in my -- the one I refer to repeatedly in my statement, that's the policy that --

Q. Just tell me what you did -- *(overspeaking)* --

A. Essentially --

Q. Whatever the policy said, what did you do?

A. -- what we do as part of --

Q. No, what did you do after three DNAs by him? What did you trigger or do?

A. After three DNAs, we then take it back to the Multi-Disciplinary Team and we talk through what are the options, what can we do to engage this man at this stage? Are there --

Q. What did you do?

A. -- are there any options at this stage? And I think at this point we decided that we would really try to enlist the help of Celeste, with whom he had a good relationship, with whom --

Q. So what did you do?

A. So there was a conversation. So Claudia spoke to Celeste, and said, "We really need some help here, we need to try to get VC to come to his appointments so that Dr Lloyd can have a conversation with him", and she does that on our behalf.

I think VC's response to that is that he's been extremely busy with his university work. He's had a lot of deadlines and he's really struggling at the moment.

Q. Let's just see what his response, let's stick to the point you were making. NHFT0000168, page 201, please. This is a note of 16 December 2021:

"[VC] was very confrontational and ... angry

throughout the call.

"... [asked] why had I tried to make contact with him via his mum. [And] ... went on to say ... under no circumstances could I have any contact with his mum as it was 'stressing her out' ... totally unnecessary ... he was contactable by his own number."

She went on to explain that there's a concern about lack of contact from VC:

"[VC] has missed 3 appointments with Dr Lloyd, and had not replied to ... text messages since November. [VC] did not agree with this and told me that he was 'cutting his contact off completely' and I was never to speak with her again."

So that response to go via his mother didn't work, did it? He didn't want her having information and he didn't want to speak to Claudia either.

So can we go to NHFT0000168, page 202, please. 10 January, we are into 2022 now, and another missed appointment. Didn't attend your 12 noon appointment.

".... the 4th appointment he has missed ... One home visit by me. He has also disengaged from his CPN Claudia. We do not know if he is taking his medication. We will discuss next steps at MDT ..."

So don't know if he's taking his medication, you know there are attendant risks, he's not engaging with

Claudia or you. Can we have, please, NHFT0018181, page 1. That's 10 January, the "Did not attend" for you, and on 10 January Emma Robinson sends an email to Claudia Birtles. So NHFT0018181, page 1.

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

"I don't know what more you can do"? Did you agree with that? There was nothing more that Claudia Birtles could do?

A. I think we went on to have further discussions at MDT shortly around that time because both Emma Robinson felt that we had become quite stuck at this stage. There just didn't seem to be a way forward and obviously Claudia had been trying. She just wasn't sure how much longer she could keep trying so I think we did have a further discussion --

Q. If we go to NHFT0000168, page 203, 17 January. Fourth box down:

"Will discuss ... at MDT ... Thursday. Consideration will need to be given to discharge as [VC]

has essentially disengaged and we have not been able to monitor him."

This is your edit, isn't it? Above it says your edit.

A. And that may be following an MDT discussion.

Q. "Perhaps a conversation with his mum and course tutors to see if there are any concerns currently will be prudent before considering discharge."

A. And what I'd hoped was that maybe if we'd spoken to Mum and she'd had any new information, or the course tutor, it might give us that sort of third-party information that we need.

Q. You got some third-party information on 18 January?

A. Yes, we did unfortunately, yes.

Q. Yes, so in a completely different direction from the University, concerning an assault by VC on his flatmate.

A. That's right.

Q. And the police were called out, yes?

A. Yes.

Q. If we can go, please, to NHFT0018114 page 1. 18 January. We also see Emma Robinson raising to you:

"Adele has just been to see me about the above patient ... has raised concerns about going to see him in terms of risk towards others, I think also in light of the incident over the weekend locking students in his

accommodation. I know the last contact was a while ago but I worried for the safety of the staff if they went to see him, I have asked Adele to start have conversations with the AMHPs with regards to a [Mental Health Act] assessment ..."

So you -- I don't see a response there but did you get that email?

A. I must have got it because I think a Mental Health Act Assessment is immediately triggered.

Q. So after that incident, it looks as though discharge was deflected by that incident and concerns for staff and a Mental Health Act Assessment; is that right?

A. We had -- we clearly had definite grounds at that point to call a Mental Health Act Assessment, yes.

Q. What had changed?

A. What had changed --

Q. Yes.

A. -- was that there had been an act of clear aggression towards a student, which is very concerning, and hence -- yes.

Q. We know an assessment was set up, 19 January. We'll be hearing from Dr Mike Skelton about that. We know after that assessment, 21 January, he was still in the community and was missing medication and a further assessment and detention arose, didn't it?

A. Yes.
Q. Had you followed that: that, in effect, on 19 January he was discharged back into the community? Did you look at that at the time?
A. I did.
Q. What did you make of that decision?
A. I could see it was a difficult decision because, essentially, reading through the notes at that time, the assessing team were not able to find any evidence of psychosis and, without that, it becomes really tricky to, again, have grounds for a Mental Health Act Assessment and, secondly, you have to go for the least restrictive option and I believe that VC was saying at that time that he would be happy to take medication and have follow-up from the Crisis Team. And so they used that as a testing out period.

Now, whilst it wasn't ideal, you know, we are limited by the constraints of the Mental Health Act, which is law.

Q. NHFT0000168, page 225, please. The fourth admission, 3 February 2022. Claudia Birtles attends this ward review -- Dr Thangavelu, Dr Gibson. If we go to page 226, we see at paragraph 2:

"[VC] said his thoughts are normal. Denies people interfering with them. Denies having thoughts that

people are trying to harm him."

Three paragraphs down, he was asked about having a depot. So four paragraphs down, please, from where it's currently highlighted:

"He was then asked about having a depot form of medication, and he would prefer not to have a depot. It was explained that the Community Team thought it would be beneficial to have one however he said that he didn't like needles and would prefer to continue with tablets."

Did you know he'd said that?

A. Yes.
Q. Did you know whether he didn't like needles?
A. I didn't know that at that point, no.
Q. Did you know he'd had Covid vaccines, blood tests and never been raised?
A. No, so I wouldn't have seen this at the time but I think I did see it when I read the notes, just prior to my next appointment.
Q. NHFT0018527, please, page 1, is an email from you, Dr Lloyd, to Dr Thangavelu. You say:

"As you know, this will be his fourth admission. He is essentially becoming a revolving door. Can we please consider a depot for him and possibly a CTO so that we don't end up back at square one with poor engagement and concordance at discharge. I appreciate the situation

isn't straightforward and he manages to conceal his symptoms well, however his insight remains very poor according to Claudia, we really need a robust plan at the point of discharge."

So you were supporting a depot and a Community Treatment Order.

A. Yes, and I had a conversation very shortly after this with Dr Thangavelu over the phone.
Q. If we have, you'll tell us about that, please, NHFT0019152, page 1. So when did you have the conversation with him?
A. I can't give you the exact date but it would have been very soon after I sent this email. It was followed up with a phone call and a discussion about how challenging it had become for the Community Team to see VC, to get him to engage in any kind of treatment plan, whether that be medication, CBT --
Q. How long was that conversation with him?
A. I don't think it was extremely, you know, it wasn't a detailed conversation but it was a --
Q. You made your position clear that it --
A. Yes, absolutely and, you know, I made a plea that could this really be given some serious consideration at this point because, otherwise, I just didn't know the way forward.

Q. If there had been a CTO, who would have been administering the depot in the community: one of your team?
A. It would have been one of my team.
Q. You or can the coordinator do it?
A. No --
Q. Can nurses do it?
A. -- it would have been one of the nursing staff.
Q. Is there a greater expense attached to depot medication, compared with other medication? Are costs a consideration here or not?
A. I don't think so.
Q. Not as far as you're aware?
A. No.
Q. It's not something that isn't authorised -- you've given depots, have you, to other people?
A. Many a time.
Q. Many a time. So would you know now, for example, how many people in the team are having -- patients under the EIP team would be having depots?
A. I couldn't tell you off the top of my head but --
Q. We can probably get the information?
A. Yeah, we have a -- yeah, a -- *(overspeaking)* --
Q. So this wasn't a cultural outlier to suggest this, this was a perfectly typical of patients that weren't taking

medication?
A. Typical of patients that are non-concordant, yes.
Q. If we go, please, to NHFT0000168, page 239. This is the ward review, 10 February 2022, when Dr Thangavelu discusses the depot option, paragraph 6:
"VC said no, said he was satisfied with the medications as it is. He's been on it for a while. When it's changed in the past he'd experienced side effects."
Again, there doesn't seem to be, on that record, does there, a challenge about anything and everything he says about medication? He's not confronted at any time with untruths he's told about them. Do you agree with that: you don't see that anywhere?
A. I don't see that it's -- there's a sort of an assertive, you know, kind of stance taken about VC needing to start a depot.
I think there is a difficulty here which Dr Thangavelu did explain to me on the phone, which is that, during this admission, he had not really seen any appreciable evidence of VC having psychotic symptoms and, as such, it made it difficult for him to change the Section 2 to a Section 3.
Q. I'm not going to argue about the capacity of the law. Let me move on please to --

A. But there's an important point that I just want to make. And without the Section 3, a CTO can't be put in place.
Q. No, I understand that but you could have put a Section 3 in place to get a treatment regime established. He hadn't had consistent medication at this point for a long while, had he? Understanding what worked well was going to take time to find out and could have justified an extensive detention to work out the treatment?
A. He felt that he could not justify -- that there weren't grounds to move to a Section 3. That's what he told me --
Q. He'll give that evidence. We can hear from him, no doubt.
A. Okay.
Q. But can we co, please, to NHFT0000168, page 250, please. Is Mrs Sue Middleton one of the nurses in your team?
A. No.
Q. No. Because it looks as though, if we go to 250 and 251, "In-Reach to facilitate early discharge", she attends VC's review, fourth admission. So we go to the top, please, 251. So this is Crisis at the meeting:
"... 4th admission in the past 2 years and thoughts of Community Team are he would be better placed on a depot and CTO as risk to others increase when [he] is

unwell."
Had you liaised at all with Crisis? You clearly had the same views about this, did you liaise with them to make a united position on that?
A. Not that I can remember.
Q. Because it looks as though Claudia Birtles is present at some point, this in reach is happening at others, and if both organisations were saying, "We can't manage it", that was significant, wasn't it?
A. Yes.
Q. Can we go, please, to NHFT0000168, page 263. This is your meeting. You finally meet VC on 14 March 2022. And we see your notes in the bottom box. And VC told you that he hadn't missed any medication. That's in the first paragraph. In fact it was clear by that time that he hadn't been taking medication, wasn't it, over time?
A. Yes.
Q. Did you probe or challenge him on that and say, "You clearly haven't and this has caused your problems," or anything like that?
A. I said to him that we had concerns that he had missed medication, but I think what he said very specifically was that in the lead-up to that fourth admission he had been well, and he seemed really quite angry about that fourth Mental Health Act Assessment. And he felt that

it had been completely unnecessary because the altercation that had taken place had not been driven whatsoever by psychosis.
Q. And again, did you see independent evidence about that? We know there was a video, a phone video of it.
A. I hadn't -- I didn't know there was a phone video of it and I wouldn't have known. I guess you don't know what you don't know. -- *(overspeaking)* --
Q. But you know you can't take what he says at face value about --
A. I accept that it's very difficult but what I realised at this stage was that we had absolutely no powers to get him to come to appointments. We had no powers to get him to take his treatment, that he had said to the inpatient team he felt persecuted by us.
I was worried, because I know that Celeste Calocane had also felt that that fourth admission had perhaps not been necessary. I don't think she'd seen any evidence in the lead-up to the fourth admission of any psychosis.
So it became really difficult to know how to manage this situation where he could almost immediately disengage again unless we at least tried to work on his -- essentially he was telling us: "This is what I'm prepared to do. I'm only, you know, willing to work with you. These are my needs."

And I just didn't want that immediate disengagement.
Q. At this meeting, you needed to dig deeper and consider other signs of relapse, didn't you? There had been numerous examples of him masking, concealing symptoms. You were getting straightforward exchange here.
A. There was 20 minutes' follow-up here, and in that time you're not, you know, it's just not possible to start doing relapse signature work or start digging significantly deeper. What I concentrated on here was the events leading up to that fourth admission because that was something that would be informing risk, that future risk. So I needed to understand, you know, was that fourth admission, was it driven by psychosis or was it just an altercation like VC was saying?
Now I just wanted to try and under -- try and get his perspective on it. I'd already seen a conversation between the victim and Dr Gibson in the notes.
Q. And you were aware of the screams in the night, in the middle of the night being heard from his room?
A. So I'd heard about the screams in the night, but apart from that --
Q. Just pausing there, that's significant, isn't it? His flatmates are saying screaming in the night. Interesting you see it in the same statement we went to before, shouting?

A. Yes, so I'd read that, that there had been screams in the night, but beyond that, the discussion again didn't really highlight the seriousness at all of that particular incident.
Q. Did you rely on Claudia Birtles to liaise with Ellie Turner from the University? You didn't speak to the University yourself about what was happening to the other students at the time while these assessments were going on or anything like that?
A. I believe that Claudia was in touch with Ellie Turner, that that liaison was going on, yes.
Q. Were you aware that he'd returned to the University and gave a false name when questioned who he was visiting? That's in the notes as well, isn't it, and emails?
A. I can't remember. I possibly knew about that, yes.
Q. Very troubling, isn't it, that he's gone back and given a false name?
A. It's unusual behaviour, yes. And that was actually during his admission, if I remember correctly.
Q. If we go, please, to NHFT0000168, page 267. Bottom of the page, doesn't attend an appointment with you. Yes? See 13 June.
A. Yes.
Q. So how many appointments has he missed with you by now?
A. I think somewhere in the region of nine.

Q. It's a lot of missed appointments, isn't it?
A. Mm-hm, it is.
Q. Are some of those not recorded? I don't think they're all recorded in the notes.
A. So there are five in between his third and fourth admission. There's two when I take over his care. There's a further one which I think, to be fair, he'd gone into hospital that time, that he'd missed the very, very first one. There's this one in June and there's another one in August. So I don't I- can't remember the exact number. I think I worked out that in total there'd been somewhere between ten and 11.
Q. If we go, please, to NHFT0000168, page 270, 4 August, Gary Carter, who we've heard evidence from, knocks on the door. He's actually knocking at an address where he's told VC doesn't live. He says at the top:
"... [he] will take [it] ... back to Dr Lloyd and Emma on Monday.
"To consider
"discharge to GP?
"report as a missing person?"
Then on 9 August:
"[VC] has requested access to his notes."
And then it's appreciated that the address for that is the Madison Court address.

Were you aware at the time, as was apparent in the notes, that was the very property he'd had to leave in January so he couldn't possibly be living at Madison Court?
A. No, I wasn't aware. I think because VC had had so many addresses at that stage, it was almost impossible to keep on top of it all. There were repeated changes of address from what I can understand, and on several occasions we had turned up to the wrong address purely because we just couldn't keep on top of this constant address change.
Q. 18 August 2022, Gary Carter:
"[VC] has applied for access to ... [the] notes. ... not contacted me after being sent an invite to do so."
It goes without saying, if you don't know the address the invite is not going to be received and responded to, is it?
A. No.
Q. Telephone conversation with VC's mother. Hasn't seen him "for many months". "... attempted to go and see him but ... was not at the address."
In these circumstances, the police should have been notified, shouldn't they? The police should have been asked to locate him. You knew he'd attacked, seriously

attacked, a police officer.
A. So we had a conversation specifically about this in our MDT, and we talked about police involvement. And the options open to us at the time were two. One was missing person, to report him as a missing person, and the other one was to ask for a police welfare check.
Q. What about the third one: using your initiative and saying: "This patient, we are concerned about. He's not taking his medication. He's had four admissions. He's attacked a police officer. We know he's caused harm to students. We want to know where he is. Can you help us find him?"
Do you think they'd say no, if you put it like that, as a Consultant Psychiatrist sufficiently concerned about where he was?
A. We have had numerous conversations historically with the police, and asked for help in circumstances where quite risky patients have disappeared and we haven't been able to find them, and the response has been that it is not police duty to be finding patients with mental health issues, that this is the responsibility of Health and Social Care Services. That has been an issue over and over again. And I think, when you are faced with that repeatedly, you actually reach a stage where you think: you know what, is it even worth going down that line yet

again?
So we'd been asking repeatedly for welfare checks, can we have help? And I think, you know, the police themselves are struggling resource-wise, and maybe they can't help.
Q. The very next day of course, after your discharge, they'd issued a warrant, hadn't they, in relation to --
A. Yes, well we didn't know about that.
Q. Would you ordinarily know about that, if they'd issued warrants?
A. No.
Q. But in this case, even without knowing about the warrant, had you contacted first, at the time you were having the MDT. If we can have, please, NHFT0000168, page 271 on the screen, as I'd indicated before, he had committed this offence; they were interested in him, even if you had other experiences.
A. We didn't know they were interested in him.
Q. But if you didn't, you should have discharged your responsibility in asking them to find him, shouldn't you? And then it was a matter for them. You didn't discharge your responsibility; instead, you discharged him to the community, to a GP.
So let's look at the discussion within the MDT.
"... no contact has been made with [VC] ..."

It's the top box:
"... for a period of time despite attempts to make contact and having done cold calls, decision made within the team to discharge back to the GP due to non engagement with view for GP to refer back to services in the future if needed."
Now it's understood neither care coordinator were present at that meeting. Can you --
A. However, the actual decision to discharge, I have a very clear and distinct memory, took place well before this meeting and it took place when Gary Carter was present because, in fact, it was when he raises -- it was shortly after -- I don't think it was exactly at the time -- but he raises, "Bring to the MDT a discussion about discharge versus the police being missing".
I don't think it took place exactly when he said that but it was certainly some time in August.
Q. He raised two options, then: discharge or contacting the police?
A. That's what he raised. But we actually talked through much more than two options. We did talk about the two options. We mentioned -- you know, we had a discussion about missing person but we realised that, actually, VC wasn't missing. He'd had conversations with Mum, there'd been a conversation with his sister and no

concerns had been raised that he'd requested his notes. So we knew he wasn't actually missing --
Q. They hadn't seen him. They hadn't seen him, so how could they raise concerns? The people living in and around him were the people who were likely to know if there were concerns, wherever he was.
A. But his sister had had a conversation with him over the phone and in previous years --
Q. So that you as a psychiatrist and you thought at this point there wasn't a problem?
A. I hadn't seen him, no, at this point.
Q. You'd seen him in March, hadn't you? You'd seen his records?
A. I'd seen him in March. So in March he was well. He had just come out of hospital after a period of treatment where medication would have been administered to him and watched. So he was well at that point in March. I had no concerns immediately at that point about his mental health. Yes, there were historic concerns but, certainly at that point, there was nothing to suggest that he was psychotic or indeed -- *(overspeaking)* --
Q. If you accepted everything he said to you. The only way you can conclude that is to accept everything you've written down in that box?
A. But from a mental state examination there was nothing to

suggest that he was psychotic. He was not responding to hallucinations; he was not thought disordered. He'd just had a solid period of treatment, robust treatment, on the ward. I wouldn't have expected him to be unwell at that point.

Q. This meeting, this MDT -- I don't need any more information about it, thank you, just who was present. Who was present?

A. This MDT where I remember the discussion about discharge?

Q. Yes, the one that's recorded here.

A. Yes, so --

Q. 23 September.

A. I don't know who was present on the 23 September specifically.

Q. What's the minimum you'd have in an MDT?

A. I don't think there was a minimum number, specifically. Again, I think usually there would be someone that is a team leader or comes from a management background. There'd usually be some sort of medical representation.

Q. Is the pressure from a management background to discharge patients? We know that Gary Carter discharged quite number to the GP around this time. Is it an advantage to the service to just take people off the books, if you're not seeing them and doing very much?

Is it better for you not to have had them on there at all?

A. No, I wouldn't have said so, no.

Q. Which is worse for the service: if a patient does something while they're actively being cared for within the service or when they've been discharged and sometime later? Which would you regard as a worse reflection?

A. It's not something that I've specifically reflected on. It's not something that I would even think about. As far as I'm concerned, in this situation here, we had tried over a nine-month period to engage VC, and we'd failed. We'd failed to engage him. We had not been able to see him as often as we'd wanted. I certainly hadn't been able to. We had not been able to get him to accept his treatment. We had no powers to compel him to come to appointments. We had no powers to enforce treatment without a CTO.

Q. So you felt redundant, you couldn't do anything else?

A. We felt absolutely redundant. Gary --

Q. Can I just remind you, we need to be mindful of the time, we have to break shortly. NHFT0000123, page 1, please, and this is the discharge letter to the GP and it's signed by Sharon Heath. Why doesn't it have your name as the Consultant Psychiatrist responsible?

A. Because discharge summaries usually come from the care

coordinator, and I don't know why Sharon signed it in this case. I think the response -- the consultant responsible is an interesting word because, at the end of the day, I'm a community consultant working with a team. I'm not someone with ultimate or sole responsibility. It's not as though --

Q. The person with authority or power, if you choose to use it?

A. I have authority and power, so does the team leader, so does the clinical lead. The care coordinators have all of the knowledge. They do, as you can see, the vast majority of the work. The leadership across the team is shared and distributed. We have pharmacists that provide pharmacological leadership; we have psychologists that provide psychological leadership. So it's not as if I am the only one person here that has all of the responsibility.

Q. "Pooled GP list", what does that mean?

A. I don't know.

Q. Because there isn't a named GP, is there? There isn't a connection with a named human being out there?

A. No, that's --

Q. There's no description of why the decision's taken, no rationale --

A. No.

Q. -- no safety plan, no management plan?

A. No, it's not a good Discharge Summary at all.

Q. It's appalling. It's not a Discharge Summary at all, it's a "I've washed my hands away"?

A. No, it's not a discharge summary at all, I completely agree with that.

Q. It's not sent to the family?

A. No.

Q. It could have been sent to the family, couldn't it?

A. Yes.

Q. Even though you couldn't give, you thought, information directly from him about his health, you could have sent that to the family and should have done?

A. Yes, I think all of that information should have gone out. I spoke to Sharon Heath about it but this was much later on down the line because I hadn't seen it -- hadn't seen this at the time, and I think her response was that all of that information should have been attached with this letter but, for some sort of -- I think some kind of administrative failure, had led to just this covering letter going out. That was her response.

Q. Last question from me, please, NHFT0004820, page 3. You said this morning that you'd been instructed not to discuss events with colleagues.

A. That's right.
Q. This is an email 27 February 2025 to Claudia Birtles and Sharon Heath:
"... I have been asked to answer a set of questions in relation to a complaint made against the Trust by the victims of VC's family. Given my very limited involvement with him I would appreciate meeting up so we can tackle some of these questions together and formulate a response? Could we find a time fairly soon to do this, please."
So it looked like you did have conversations subsequent --
A. Yes.
Q. -- and had you forgotten that this morning when I asked you about that?
A. This was at a point where everything was out in the public domain. So we were then told "It is okay to now have those discussions". So initially, in 2023 and 2024, before things were in the public domain, we could not but then, afterwards, those conversations were taking place.
Q. The Inquiry has a statement from Stephen McGowan -- Chair, the reference number WITN0319001, so we'll upload that later -- In relation to audits of early intervention psychosis programmes.

You, I don't think, at Nottingham, have ever had a peer review, have you, across the service?
A. An audit across the service?
Q. A peer review. Peer reviews: members of the review team encouraged to share recommendations from their own services and experience with others. Have you had that within Nottingham?
A. I don't think so I've not come across a peer review being done within our Trust.
Q. Do you think that would be helpful to have a review from another Trust elsewhere --
A. Yes, yes of course.
Q. -- to share --
A. Absolutely, yes.
MS LANGDALE: Chair, those are my questions. It may be a good time for the break before others ask the rest of the questions.
THE CHAIR: I think we'll take a relatively short break so if we take a break until -- if we start again at 3.45. Thank you.
(3.28 pm)
(A short break)
(3.44 pm)
THE CHAIR: Mr Moloney.
Questioned by MR MOLONEY

MR MOLONEY: Good afternoon, Dr Lloyd.
A. Good afternoon.
Q. The last document Ms Langdale took you to was a document NHFT0004820, and I'd like to go to that, if I could. It was an email from February that you explained the significance of to Ms Langdale in your questions. And if I could, please, I'd like to go to the last page of that -- well, page 5 out of 6, please.
And to set the context for these emails, that this is to you, and it's from a lady by the name of Anna Hiley, and it's about the investigation. And we can see halfway down the page:
"In preparing our response, I and an external psychiatrist ... will be interviewing the staff who were involved in specific aspects of [VC's] care."
Then in the next paragraph:
"We will provide in advance the questions pertinent for yourself that I and Dr Read will be seeking to respond to ..."
So this is essentially an email to you, saying that they intended to interview you, and that they would send the questions that were pertinent to you in advance so you could consider them.
If we go up to page 4, you say that -- you say thank you to Anna, and you say you'd:

"... really appreciate early access to the notes so that [you] have ample time to ...read through all the notes again and prepare for this interview. It has been some time since I did this. ... I only work 2.5 days ... so my [prep] ... time is very limited .... I look forward to hearing from you ..."
We go up and we see that Theresa Dorey is sending you the notes, and you say:
"Thank you for that," and then if we go up to page 3 Katie Crookes checks you have access to the notes, and further up then you say -- and this is on page 3 and this is from you to Claudia Birtles and Sharon Heath:
"Good morning Claudia/Sharon. I have been asked to answer a set of questions in relation to a complaint made against the Trust by the ... ['family of VC's victims', it should be]. Given my very limited involvement with him I would appreciate meeting up so that we can tackle some of these questions together and formulate a response? Could we find a time fairly soon to do this please. Many thanks, Tuhina".
Then we see that Sharon Heath says -- gives her dates of availability: Tuesday 11th, Thursday 13th. You say "unfortunately [you're] ... on leave that week. Don't worry [you'll] ... meet Claudia and use the notes to put a response together. Let me know if there's

anything you want to add with regard to the discharge letter, process and contact with family?"

And then Sharon Heath says that she could meet the following week, and then you organise the potential Teams meeting.

Now isn't that just exactly what Gary Carter said, that he wanted everybody to be on the same page?

A. It was really important here for me to get both Claudia and Sharon's views, because many of the questions that had been put to me were not things that I had been directly involved with.

For example, the discharge letter question, I wouldn't have written the discharge letter; it would have come from Sharon Heath. So it was really important to have her input with regard to that question.

And I must have read through all the questions and realised that there were several questions where Claudia, as lead clinician, would have had a lot more understanding and knowledge than myself.

So yes, absolutely. I think we always work as a team, and that's how Early Intervention in Psychosis teams work. It's all about team working, team decision-making, so everything we do is team oriented. So in answering many of the questions which, when in relation to the team, yes, of course I will ask for

their opinion on many of the answers so that I make sure I give the best and most accurate answer, and it's not just based on what I think or believe.

Q. But these were questions directed to you that were pertinent to you, as it said, and --

A. They were not pertinent to me. I read through them and many of those questions, and I can't remember exactly what they are off -- immediately, but I'm happy to, if anyone has got a copy of those, we can look through them and I can show you exactly how they're not specifically pertinent to me; they're things that maybe the Trust believed I should be able to fully answer myself but in actual fact when I looked at the questions, there was very clear evidence that both Claudia and Sharon would be able to help immensely in terms of their involvement in those questions.

Q. But the questions were to be asked of you. Surely your answer, if these were -- if you weren't able to answer, is to say, "Well, that question should be asked of Sharon or it should be asked of Claudia", rather than you giving an answer which was a collective answer?

A. I was told very clearly that these questions needed to be answered by myself, that there was a recognition that I may not have been the person leading specifically in relation to this, but I was told that I needed to give

an answer. And this happens quite a lot in complaints, and various scenarios where questions are put to me by a patient or a family, but actually, it's not pertinent to me; it's what the family may think is pertinent to me. There is a difference.

Q. So when you said, "Given my very limited involvement with him I would appreciate meeting up so we can tackle some of these questions together and formulate a response", was that meaning that the response would not be -- would simply be that they would feed in and you would give any response that was from you?

A. Could you repeat that question?

Q. Was the response to come from you or from the collective who met to discuss the questions?

A. The response would predominantly be from me, but I would have used their knowledge, which for specific questions it was really important for them to have an input.

Q. If you disagreed with them, would you have still maintained your position?

A. Which is?

Q. Whatever position you were taking, that whatever you thought.

A. Not if it wasn't something that I had enough knowledge about. I would have to defer that knowledge to them. That's why I'm asking them, because I wouldn't have

necessarily known the answer.

Q. And so is it your evidence that you did not say to Gary Carter: "We need to all make sure we're on the same page here"?

A. And when, apparently, did I say this to Gary Carter?

Q. In a car, I believe. He gave evidence that you were all in a car after a meeting and you said, "We all need to be on the same page here."

A. After a meeting where?

Q. Or car park --

A. In a car park?

Q. In a car park.

A. It was in a car park. Do we have any more information beyond that? Do we have a date for the meeting or minutes that I attended this meeting?

Q. Did you not remember if you had said that to Gary Carter? Would you not remember if you'd said that to Gary Carter, Dr Lloyd?

A. I don't recall saying that to Gary Carter, which is why I'm asking for clarification.

Q. Right. If you'd said something like that to Gary Carter in the early days, is it something you would remember or not, ordinarily?

A. I would not have said anything to Gary Carter in the early days because right at that initial stage,

particularly in 2023, we were told very clearly not to be talking about the case to anybody.
Q. By 2023 --
A. No, by 2020 -- it was in 20 --
Q. No, I'm talking about -- I'm sorry, I'm moving on. I do apologise. That's my fault.
A. Oh, sorry, I'm sorry.
Q. By 2023, before discharge, Ms Robinson gave evidence that EIP had "lost VC yesterday". Did you see that evidence?
A. I was travelling but I do believe I saw -- I briefly read a transcript. So yes, I saw -- I think I did see that, yes.
Q. And you've answered questions by Ms Langdale today --
A. Yes.
Q. -- about how essentially you didn't know what to do with VC by the time it came to discharge.
A. By the time it came to discharge, yes, we were struggling to find him. It had become incredibly difficult. He had become very skilled, by this stage, at avoiding services.
Q. Given that, given that he was very skilled and it was very difficult to find him, why didn't you contact the police to see if they could find him?
A. Because we knew from previous experience that every time

we have contacted the police asking for help, when there hasn't been clear and imminent risk to life or limb, and that's what we're quoted: there should be clear imminent risk to life or limb otherwise it is not their responsibility to be getting involved in cases relating to mental health issues; that it is the duty of the mental health team or social care.
Q. Right.
A. And that's been a repeated response from the police.
Q. Now one of the addresses he gave was 209 Ilkeston Road, wasn't it? Do you remember that?
A. I can't remember any of the addresses off the top of my head, but yes, if you say that was an address, I will accept that.
Q. Have you ever been told that the police assessed that house as being linked to drug dealing?
A. No, I didn't know that.
Q. And that there were reports of a firearm, a black handgun being seen there on 26 July 2022?
A. I didn't know that.
Q. If you'd contacted the police when considering discharge when you couldn't find him, and you had been told that, would you have been very concerned about VC associating himself with that address?
A. Possibly, yes. It depends whether he was directly

involved in the drug dealing.
Q. Can we please look at the document WITN0163002. Now, this is -- do you remember VC asking for disclosure of his medical records after the fourth admission?
A. This was shortly after the fourth admission?
Q. Fourth admission, yes. Well, this document was in fact August 2022, but the date on it is actually 21 February 2022 and it may be it's taken time. Gary -- it's in the RiO as August but --
A. Yes, I remember VC requesting his notes, yes.
Q. Do you see the address, 15 Madison Court?
A. I do see that, yes.
Q. Did you see as well that he appears to have scrubbed out "209"?
A. No, I can't -- I'm not sure what he's scrubbed out but I can see a scribbling.
Q. I'd like to ask you about discharge, if I may, please.
You were asked about the importance of the care coordinator's views by Ms Langdale.
A. Yes, it is important.
Q. Yes. But you accept that Gary Carter was not present at the meeting where he was discharged.
A. As I've explained --
Q. No, you said of course that you thought he'd had a meeting with Gary Carter before then, yes?

A. The discharge decision was taken before that final date. What I remember of that final meeting was that it was administrative. I can't remember any detail except it felt like a rubber stamping because, in an MDT meeting, it's the care coordinator that brings cases for discussion. Now, Gary Carter wasn't there, so I -- you know, I cannot understand who would have brought one of his cases for discussion. It doesn't quite compute with me. It's very odd.
The decision to discharge, as far as I can remember, had been taken some time in August. Gary had come into the room and he had said, "I have done everything that I possibly can now. I've completely run out of all ideas". And I specifically have a clear and distinct memory of him saying that and having a discussion about the options: what else can we do? Should we think about Crisis? Mental Health Act admission? Should we think about police? And that's when there was the discussion about asking for either a welfare check or missing person, both of which we decided not to go for, for the reasons that I have put in my statement, and that at that point we felt that there was no other option, really, apart from discharge.
I do not believe that the meeting on the 22nd was a decision-making meeting; I think it was

a rubber-stamping of discharge because I have no recollection of any kind of decision being made on that day.

Q. You'd previously agitated for VC to be given a depot, hadn't you --

A. Yes.

Q. -- by an email to Dr Thangavelu. You discharged him without any depot, didn't you?

A. Yes, because we had no choice but to do so. We had run out of options. There was nothing else at that stage that we felt we could do. We had lost him. We didn't know where he was; his family didn't know where he was.

We had lost him, we had reached that position where, after nine months of trying, we felt that there was nothing else that our small team could do. We didn't have the skillset of an Assertive Outreach Team, we didn't have the ability to track and trace someone who was changing addresses rapidly, who was potentially not even in the county.

Q. So that was it.

A. So we had reached that position where we didn't know what more we could do. And under those circumstances, what are the options?

Q. Can I just ask you about annual job planning, very quickly. Does annual job planning take place with the

Clinical Director?

A. Yes.

Q. Are hours and workload discussed?

A. Is what discussed.

Q. Are hours and workload discovered at the annual job planning?

A. It is discussed, yes.

Q. It's a formal process that, isn't it, the annual job planning?

A. It's a formal process.

Q. If you had an unsafe service, should it be escalated to the Medical Director or the Chief Executive?

A. I didn't feel that service was unsafe?

MR MOLONEY: Thank you very much, Dr Lloyd.

THE CHAIR: Yes, Ms Cartwright.

Questioned by MS CARTWRIGHT

MS CARTWRIGHT: Good afternoon, Dr Lloyd. I ask questions on behalf of the survivors.

Now, Dr Lloyd, you've told the Inquiry today that there was a known issue regarding documenting the MDTs and I think you've said that it had been raised repeatedly through the consultant route?

A. No, I don't think I'd said that.

Q. All right, well, let me be clear. So we've got no records of the MDTs?

A. That's correct.

Q. So you're saying that wasn't known within the Trust: that there was no one taking notes of the MDTs?

A. So, as far as I was aware, the MDT meetings were not being recorded across a number of teams across the Trust. There was no administrative support to do that.

Q. That's what I understood your evidence to be but can I just be clear then, because you referenced something that was raised repeatedly by the consultants that was being escalated within the Trust? Can I be clear what you were speaking about then?

A. That wasn't the MDTs. I think that was to do with caseload, I believe.

Q. All right.

A. Yes, so it was the fact that all of us had extremely inflated caseloads for the amount of hours that we were working and that's something that's been raised numerous times in consultant meetings and forums.

Q. Now, you didn't detail that within your witness statement to the Inquiry. Why not?

A. So what I mentioned in the witness statement was that the three sessions that I had, the 12 hours that I had allocated to EIP, didn't feel sufficient at all.

Q. Well, that's something quite different to you saying all of the consultants were raising with the Trust the

workload. That's very different: that's an issue of patient safety, it's an issue of clinical governance, and you've given evidence as if this is a relevant factor that was well known in the Trust. So why did you not include it in your witness statement?

A. My witness statement was very much guided by the questions that were put to me.

Q. So if you had relevant evidence that wasn't covered by a question, you decided to leave it out of your statement?

A. I don't believe that this is an issue just for our Trust. I think that psychiatry is chronically underfunded nationally. That's my understanding. So I think this is a well-known fact across psychiatric services and I wasn't specifically asked about my views on services locally or nationally. I was purely asked a series of questions to help the Inquiry to come to their conclusions regarding this case. You know, I'm not sure that what you're asking was necessarily relevant, specifically to VC.

Q. All right, but you're essentially saying there's a document trail that exists where the Trusts were being notified about issue as to workload of the consultants in this team?

A. It wasn't just this team; I'm talking about consultants

across adult mental health.
Q. All right, well, let's just deal with the MDT, then. So you knew that the MDTs were not being recorded.
A. That's right.
Q. And so you essentially said to Ms Langdale, "Well, there's nothing more to say on it," but actually, you do have something more to say on it because you have your own professional obligations in respect of recording; would you agree?
A. So I raised it with the team --
Q. No, that's not the question.
A. So, okay --
Q. You had professional obligations, governed by the General Medical Council, in respect of recording keeping and ensuring that you record your relevant decision-making and actions, and even more so when you're attending MDTs, when you know they are not being documented and you're party to them, even more so this raises the obligation on you personally and professionally to document your involvement in the MDT; would you agree?
A. I think, if I'm expected to document every single decision that's made in the MDT, that's all I would have time to do. It just wouldn't be possible. There are somewhere in the region of, you know, sort of 25-35, 40

patients that are discussed. It's just -- it just would not be possible for me to do that level of documentation. It would be impossible. That's all I would do in my 12 hours.
Q. Well, you are the responsible clinician, the community consultant --
A. I'm not the responsible clinician, no. That is a legal term.
Q. Well, you are VC's consultant --
A. I'm the community consultant, correct.
Q. But you were VC's consultant?
A. Yes, I am -- was.
Q. Well, you were supervising Dr Burri as your ST5.
A. Yes.
Q. And I'll come on to deal with that, but after he then left and handed VC back over to you from July of 2021, you were VC's community consultant, yes?
A. Yes.
Q. And so in terms of MDT where VC is being discussed and decisions being made about him and his care and his medical provision, you had an obligation to make formal recordings of your work, that were accurate, contemporaneous, and legible. They may have been brief but you had a requirement yourself to make those notes; would you agree?

And the guidance makes clear that you have to record decisions made and actions agreed, and therefore, even if other people weren't doing notes of the MDT, you personally should have been making notes.
A. The decisions that were being made were not unilateral decisions being made by me. They were team decisions. And the team member that has clearly been identified as being responsible for recording in the MDT notes is the care coordinator; and so it is their role, primarily, as lead clinician, to be recording in the notes, not mine. I am one member of the team inputting and giving my opinion at times when needed. There are many other opinions coming from people --
Q. But a central member of the team --
A. I'm not a central member of the team --
Q. You are a consultant psychiatrist. There were no other consultant psychiatrists contributing to those MDTs.
A. There wasn't, but I'm not necessarily the central member; I'm not making unilateral decisions. These are joint team decisions. The care coordinator is bringing the case for discussion. It is their responsibility, as far as I'm concerned, to be recording, and that's what I've been told: that that is their role, it's their duty, it was what I was told at the beginning. We should have had administrative support, we didn't have

it, but as consultant, I would not have the time or ability in 12 hours to be making those detailed recordings.
Q. So then when there were, as you've told us on a number of occasions you reviewed VC's notes and noting that the care coordinators were not documenting the MDTs, what did you do to flag to them then, if you say it wasn't your responsibility, "There are no notes of these important MDTs"?
A. That's when I flagged it to the team leader and said, "This isn't happening. We really need to have administrative support," and she said, "No, that's just something that we can't get. That resource is not available to us. This is not just our team, this is across many teams within the Trust."
And when I spoke to my peer group I found out actually that was in fact the case.
And so it wasn't just me that wasn't, you know, sort of flagging this up specifically; there were other consultants in the Trust that were in exactly the same position, and, you know, it's not -- it's a shared responsibility, isn't it? It's not down to me to make huge changes to what's going on across the Trust.
Q. I'm going to suggest to you, in fact what you're trying to do is limit your responsibility and the leadership

you should have had as a consultant for VC's care, and for VC's decision to be discharged -- most aptly typified by the fact that you didn't even bother to draft the discharge letter handing over continuity of care to the GP when there was no care coordinator involved in that meeting; would you agree?

A. The decision to discharge VC was made well before that meeting when Gary Carter was present. It was made in August. He was present, and he should have drafted the letter, as all the other care coordinators do. Whenever there is a -- whenever there is a discharge meeting where a patient, family, GP are all invited to clinic, and I'm there and it's my clinic, I always draft the discharge letter on every occasion.

On this occasion there wasn't that meeting because VC was not present. It was an MDT discussion, and for that reason I didn't draft the letter, because it was an MDT discussion and it should have been the care coordinator who brought the case, and in any case, even when I do the discharge letter in clinic, there is also a second letter that goes out from the care coordinator. So there's usually two letters that the GP receives.

Q. Let's just look, because essentially, your evidence today that the decision to discharge was made before the September MDT is, I think, I'm going to suggest you've

changed it because you've now realised, in the correction you made, that Gary Carter wasn't in the MDT.

So can we look at what you did say, please, in your witness statement, WITN0357001 at page 125.

So paragraph 347 on page 125. Thank you.

"I was present at this ..."

Sorry, 23 September you deal with the discharge, but you say:

"I was present at this MDT, from memory ..."

So this is the MDT of 22 November:

"... Emma Robinson ... Gary Carter (CCO), Abigail Parsonage ... Adele Pinder ... Frances Doughty ... and Paul Williams ... were all in attendance. There were other team members in attendance as well but I am unable to recall exactly who they were.

"It was decided to discharge VC from the service as a non-engaging patient. Despite a nine-month period of trying to engage him in the community from October 2021 to September 2022 we reached a point where it became very clear that VC was actively and intentionally disengaging with services and his medication [and so on]."

You don't say in your witness statement there, "We made the decision before then in August," and I'm going to suggest that's the evidence you're now giving because

you've realised there was no care coordinator in that MDT.

A. That's not correct. I have written very clearly my recall, my memory of the meeting. The only thing that I have got wrong here is the date, and the reason for that is whilst I have clear memories of events and meetings, it's not always very easy to remember dates in detail. And what I'd done, I'd gone to the notes when I was writing my statement, and I'd looked at -- I'd used dates in the notes as anchors. And so when I'd seen that Sharon Heath had written in the notes that the discharge decision had been made on 22nd September, I'd attached my memory of what had happened to the 22nd September, thinking that must have been the date when we had this conversation. And so essentially, yes, I'd made a mistake with the date here, but everything else I've written, including the fact that I was certain that Gary was present, which I was, was because he had been present.

Q. It's for the Chair to make of your evidence what she wishes to make.

A. Mm. That's absolutely fine.

Q. Now then we know Gary Carter wasn't there.

A. He wasn't.

Q. And we also know the previous care coordinator wasn't

involved. So back to the question that you avoided before: why, therefore, did you not write the discharge letter providing the continuity of care back to the GP? You're discharging VC, as his consultant, from secondary mental health services back to the GP. Why did you not write it?

A. Because I assumed that it would be written by Gary Carter as soon as he returned, which was actually the week after, because that's what the care coordinators always do. And if that's their role and responsibility, I think it's --

Q. I'm going to suggest to you it's continuity of care again. Good medical practice makes clear as well you have your responsibilities again contained in good medical practice, that where continuity of care is being passed between teams, you have your responsibility to ensure that responsibility for safe patient transfer between teams. So you had a role, a significant role to play here, where you have a psychotic schizophrenia, a patient who was non-engaged, not complying with medication. If ever there was a discharge letter that needed to be carefully crafted, it was this one, and you should have written it, including your rationale for why you were discharging VC from secondary mental health?

A. If that's your view ...

Q. Well, then can we look at your notes, because I'm going to suggest this again shows your poor note keeping and recordkeeping. So let's just look at two examples of when VC failed to attend and how your note keeping is non-compliant with the policies that applied at the time regarding do not attend. Can we look in the RIO, please, NHFT0000168, and I'm going to suggest that these entries really do show that, despite the complex picture for VC, just the level of care and attention you were giving to VC's case, page 267, please, your entry for 13th June.

Bottom of the page, we've got 13 June. Over the page, please:

"Medication aripiprazole, [VC] did not attending his 10 am appointment, CPN to reschedule."

Now, in terms of the Trust's policy, perhaps we'll just look at another example. 269, please, 1 August. Again, your note for 1 August:

"Aripiprazole, [VC] did not attend his 11 am appointment. Another will be arranged by his CPN."

Now, would you agree that this was an opportunity, when you were making recordings, to actually do what you should have done in accordance with the policy, which would be to have documented calls to GP, calls to family, your risk assessment at that time, in light of

his non-attendance.

A. So as I've explained to you, we follow the Trust policy with all of our DNAs, and in any one clinic there could be a number of DNAs, you know, particularly with psychotic patients. Sometimes it can be anything up to 50 per cent. And I think, if each time I'm almost cutting and pasting, you know --

Q. Well, it's not cut and pasting.

A. Well, it almost is, isn't it? It's like discussion with the CPN who is in the room, "Have you got any concerns?" I have looked back at the notes and I have found that there is nothing in the last few entries which are to of concern, and then the next steps are that the CPN will now contact the patient by phone, and that could be immediately or a bit later in the week, if we've identified no concerns. It would be -- you know, what would be really helpful here is, if there had been DNAs, there was almost like something that we could tick really quickly to say, "These things are done", there's essentially like a checklist for us. That would have been helpful because, essentially, each time we would just be saying the same thing in terms of repeating what we're doing, as far as the Trust DNA policy is concerned, and that's what we follow.

Q. So did you call VC's family?

A. I didn't but the CPN, the care coordinator who was with me in the room, often she'll call immediately while --

Q. Well, again, the purpose of records and documenting it is then it shows it's been done?

A. Yes, and she does document it. So if you look at the next entry, "Phone call to [VC]", 3 August.

Q. That's not what the policy required on the day, that a patient does not attend. It's "Contact the GP" and, bearing in mind you've got a slot now in your busy schedule where the patient has not turned up, the policy --

A. We may have a slot but, actually, what we're doing in that lots is me and the CPN are having a discussion, we're looking through the notes, we're having a discussion. That slot actually gets used up making sure that all the actions from the DNA policy are followed -- *(overspeaking)* --

Q. There is no evidence of that and, most significantly, there is no evidence of what you were required to do when VC did not attend, which is the risk assessment, a documented risk assessment.

A. It's not a risk assessment, actually. It says "level of risk" in the DNA policy that we follow, the one that you will find that I have referenced. It says the level of risk and I don't know which DNA policy you are looking

at --

Q. I'm looking at the one that was in place from September 2021 --

A. I think there might have been two in place.

Q. There was one before but, again, that had requirements, but the one you were required to follow, NHFT0004725, please. So is it your evidence you were following an earlier iteration of the policy and not following the policy that was, in fact, the promulgated policy for the Trust at the relevant time?

A. I was following the policy that I had --

Q. Well, let's look at this one. So this is the Trust version, 7 September 2021. Is it your evidence to this Inquiry that you were failing to follow the Trust's relevant policy in 2021/2022?

A. So this was a new policy, wasn't it?

Q. No, this is the policy, version date September 2021. It's the live policy for your relative involvement. So is it your evidence you were failing to follow the Trust policy?

A. No, I believe I was following the right policy and I believe it's one that I have referenced in my ... in my statement, so if we can put that up -- *(overspeaking)* --

Q. Well, let's look at the other policy then NHFT0000417.

A. I'm happy to look at the one -- I'm happy to look at the date on the one that we have in ...
Q. So this is the earlier policy, I think one you reference. Is it this policy you are saying you were following?
A. I can't tell you from looking at the front.
Q. Well, perhaps then let's just go to page 7, which would show what you should be doing when a patient doesn't turn up. Was it this policy you were following?
A. So actions will be taken by the clinical lead, which wouldn't be me. I'm not the lead clinician. I mean, I don't think it was this policy but I'm just looking at it now. "The clinical lead must make repeated efforts to contact the patient via telephone", yeah, "on the day of the missed appointment", which they do, which is the care coordinator.
Q. Let's just leave aside the content. I just want to try and crystallise what you were following --
A. I can't -- I don't think it is this one. There is another one which I have referenced.
Q. Then let's just look then, please, back to the September 2021, which is the 4725, please, NHFT0004725, and go to page 7, please. So were you following this policy?
A. Yes, that's right, "Immediate assessment of the patient's level of risk".

Q. Yes, so --
A. So "level of risk" is not a risk assessment:
"In an outpatient clinic setting, an assessment of the patient's level of risk may not necessarily require the oversight of the full MDT and must be conducted by a member of medical staff or another practitioner."
And that's what is conducted between myself and Claudia Birtles:
"The requirement for either a full MDT risk assessment ..."
So that's the full MDT risk:
"... or a risk assessment undertaken by an individual member of staff will depend on ..."
So they're asking us to look at a level of risk --
Q. Yes, and that's what I'm asking you about.
A. And that's what we do and so --
Q. And that's what I'm suggesting to you. So it doesn't have to be a formal document as in the risk assessments that were -- but you needed to document, in your notes, in your clinical entry, your assessment of risk, which is a risk assessment, and that's what was needed and required. And there's no evidence anywhere that you would at any occasion consider that for VC and you've certainly not documented it. And so I'm going to suggest that you now say you did that.

A. We always did that, for every patient.
Q. Well, there's no evidence of that whatsoever.
THE CHAIR: Ms Cartwright, ultimately I have to make a decision about this and you're over time now by a long way.
MS CARTWRIGHT: No. Well, I'll leave the other point.
THE CHAIR: Thank you.
Yes, Mr Straw.

Questioned by MR STRAW

MR STRAW: Dr Lloyd, I represent VC's family.
It's right, isn't it, that you quickly after the June 2023 attacks realised that you'd made a serious error by discharging VC into the community to his GP?
That's right, isn't it?
A. No, it's not right.
Q. And since then, your evidence has been aimed at covering your back rather than telling the truth; that's right, isn't it?
A. That's not correct.
Q. Well, let's look at a few examples. You said earlier on that Celeste Calocane felt the fourth admission had not been necessary; do you remember that?
A. That had been told to me by Claudia Birtles after the fourth admission, and I had also read in the notes that Celeste Calocane had felt that he hadn't been unwell,

and that that admission should not have taken place. I specifically remember reading that at the time.
Q. Okay, well let's look at the notes, please, up on screen: NOCC0000043. And we can see this is 28 January 2022 AMHP report by Fiona Parker. Can we go to page 4 of that, please.
We see at the top telephone call from Celeste:
"Unaware of situation and a little exasperated ..."
And then:
"... noted his belief in conspiracy theories. Does not object to admission if we think he needs this."
A. Okay.
Q. That was her view, wasn't it? She didn't anywhere suggest --
A. She didn't sound like she objected, no, but I certainly got the impression from some of the excerpts in the notes that she hadn't felt that he was unwell in the lead-up to the admission or indeed after he'd been admitted, when in the past she'd been really quite assertive in coming forward whenever she had any concerns. Even conversations on the phone, when his voice had sounded a little bit unusual, she would ring up and say, "He doesn't say sound right."
Whereas on this occasion she'd had a number of phone calls with VC in the lead-up to the admission, and

hadn't really raised any concerns and had, in a telephone conversation and a ward round, suggested that she just hadn't felt that he'd been unwell this time.

Q. Hadn't raised any concerns. That's your evidence.

A. Not -- certainly not as far as I'm aware in the lead-up to this admission.

Q. Okay --

A. I wasn't aware if she had.

Q. Can we have RiOs, the NHFT0000168 document, page 223. There's an entry 2 February there in the middle of the page, telephone call to "mother (Celeste ...)":

"She explained [VC] seemed normal to his parents, until they heard about [the] incident."

Then she talked about talking to him on the phone, and I'll come back to that.

"Celeste was worried about him. She thinks he is scared of mental health services and feels persecuted by them."

So on the face of the RiO notes you had read she was expressing concerns, wasn't he?

A. She's saying he's frightened of mental health services, he feels persecuted by them, which would explain why he had disengaged and why he had missed all the points with me, yes.

Q. Well, it was an indication that he was relapsing into paranoid delusions, wasn't it?

A. She didn't suggest that at all. She was worried about him.

THE CHAIR: She's not a psychiatrist.

A. No, of course she's not, but I'm just saying that she's saying he's "scared of mental health services and feels persecuted by them." That doesn't suggest that she feels he's been particularly unwell.

MR STRAW: Let's take another example. Earlier on you discussed your reasons for discharge, and you referred to the August 2022 phone calls referring to Celeste, the mum, and also the sister. And you said no concerns had been raised. Do you remember that?

A. That's what I was told by the care coordinator, yes.

Q. But that's misleading, isn't it. There was -- at no point did they say they weren't concerned about him.

A. Right.

Q. Rather, what they did say, and we've seen the note earlier, was that Celeste had had no face-to-face contact with VC for many months. Do you remember that note?

A. I remember that note but I also recall that there'd been a conversation with -- with sister, and I said -- I specifically asked Gary: "When you spoke to

Mum and when you asked about sister, were any concerns raised?" And he said "No, she didn't raise any concerns on this occasion at all and in fact she seemed" -- and these are Gary's words -- "she'd seemed a little bit irritated by me contacting her."

Q. You've mentioned couple of times there significant pieces of evidence about things you say Celeste said, which we don't see on the medical notes at all.

A. Such as?

Q. Well, the one you just mentioned?

A. Just that one, yes.

Q. Irritated, that's not on the notes, was it?

A. That's not but that was communicated to me by Gary after because I specifically asked "Did Celeste express any concerns?" And the response was, "No". But there had been a conversation with sister, but no, no concerns had been expressed.

Q. I suggest the reason it's not on the notes was because it wasn't ever said. That's right, isn't it?

A. What was never said?

Q. Your evidence just now about Gary Carter saying, well, Celeste was irritated, she didn't raise any concerns. That was never said, was it?

A. That was said.

Q. Okay, so I've just referred you to the point about

Celeste not having face-to-face contact for many months. It was obvious from an early stage, wasn't it, that face-to-face assessments of VC were important because he masked his symptoms?

A. Yes, it was important, yes.

Q. So it was significant, wasn't it, that Celeste hadn't had face-to-face contact with him for many months?

A. That was significant. It was significant that we haven't been able to see VC for a number of months.

Q. You were aware as well, weren't you, that VC had withdrawn consent for the medical team to share any information about him with Celeste towards the end of 2021?

A. That's correct.

Q. So she really wasn't in a position to express a view about his mental state, was she, in those circumstances?

A. Because she hadn't seen him.

Q. She hadn't seen him, she wasn't being given any information from the medical services about him, she just didn't have a basis to properly understand what his mental state was?

A. At that stage, unfortunately, we didn't either because we hadn't been able to see him.

Q. But I'm asking about Celeste and you placing weight on, as you say, no concerns having been raised. I suggest,

in all of this contact, because of all of these reasons, you were just wrong to place any weight on the fact that she had been phoned up and she said, "I haven't had face-to-face contact with him for many months", and that was it?

A. But there had been a telephone call with sister and also, on 31 August, I understand that Celeste had a conversation with VC. So I think there were two conversations with him on the phone and, whilst I accept they weren't face-to-face, I think because she knew -- I got the sense that she knew him well because, previously when she'd had telephone conversations with him, even the tone of his voice she was able to pick up that there was something wrong because she called us and said, "He sounded really different on the phone, I'm very worried".

So, you know, I'm not saying that it's easy to ascertain concern over the telephone but, if there had been something that she'd picked up, surely she would have told us.

Q. Two other examples: in your witness statement you discuss the University, you discuss VC's university. So paragraph 143 you refer to your meeting with VC on 14 March 2022, and you say:

"I noted that VC was on track and coping well with

his degree."

Do you remember that?

A. He told me that.

Q. Well, what you say in your witness statement is:

"I noted VC was on track and coping well with his degree."

That's what you say, isn't it?

A. Yes, if that's what I've written, yes.

Q. Again, it's not true, is it?

A. I did later find out that he had decided not to pursue the Masters and had decided to go for a lesser degree. But he was on track with that and he achieved a good 2:1, that's my understanding. So it wasn't that he wasn't on track. He didn't perhaps get the Masters that he'd wanted originally but he still gained a university degree, which is of -- you know, mechanical engineering is incredibly tough and he is a man with mental health issues who manages to gain a 2:1 in a really tough subject. I think that's --

Q. Where did you get that information from?

A. -- I think that's pretty impressive.

Q. Yes, he got the 2:1 based on his marks up until early 2020, didn't he? Not on what happened afterwards? That's right, isn't it?

A. Yes, I guess it's up to 2020, yes.

Q. Can we have the RiO back on screen, please. It's NHFT0000168, page 210. The NHFT0000168 document, sorry. Page 210. So top of the screen here, 24 January 2022, an entry from Ms Birtles:

"[VC] does appear to be struggling with his studies. Feedback from course leader indicates that [VC] has failed to complete a whole module and has been submitting exams too late."

We saw a similar note from Dr Manzar's 28 January 2022 assessment, which noted that VC was failing in his courses and the University is threatening to terminate his course. Now, when you say he was on track: again, that wasn't true, was it?

A. When did I actually say that? What was the date?

Q. Sorry, when did you say he's on track?

A. Mm.

Q. You just said it.

A. No, as in you brought it up; it was in my statement. Do we have a date for that? Can we get that up?

Q. Just a moment ago, when you were responding to me about his university course, you said you thought he was on track.

A. It's what I had written in my statement, apparently.

Q. That's what you said to me in oral evidence, in your sworn oral evidence a few moments ago.

MS LANGDALE: It's March 2022.

A. Okay, March 2022. Thank you. And was he back on track in March 2022? I'm not sure. Perhaps he was. Certainly that's probably what he told me.

MR STRAW: Okay, and final --

A. I'm not sure -- I'm really not sure what the question is here. At the time he told me he was back on track, and that's what I'd noted down, after my appointment. Is that the question?

Q. Well, I think we've been through this in enough detail.

A. I think we have, haven't we.

Q. Last question, last area. You noted earlier that the decision to discharge had been made in August 2022 and the decision had been made on the basis that Mr Carter came up to you and indicated that --

A. He didn't come up to me. He came to the team meeting and brought up with all of us that he had done everything that he possibly could, and we needed to consider either reporting VC as a missing person to the police or discharge, and we went on to have a discussion about a number of options.

Q. So you had done all you could, there's nothing more you could do, and so the decision was made to discharge him.

A. The decision was made to discharge because at that point in time we had no powers in the community. We didn't

have any powers to compel him to attend appointments, we didn't have any powers to compel him to take his treatment. We'd tried for a nine-month period to do so. It's a team that essentially was not capable or resourced to manage someone like VC who was actively and deliberately disengaging, changing addresses, telling us he was abroad, us not being able to find him --

Q. You'd done all you could?

A. -- *(overspeaking)* -- Mum didn't know -- we felt that we had done everything we could at that stage and we didn't know what other options there were.

Q. Sure. Can we have the RiOs back on screen, please, page 270. In the bottom of the page now, please.

So it's 31 August, the end of August, so after you'd made the decision to discharge, on your evidence just now, after you'd come to the point when you thought you'd done all you could, you couldn't do anything else:

"Telephone conversation with Celeste ...

"[She'd] ... not seen [VC] face to face for many months but she had a telephone conversation with him in the last week. Celeste attempted to go and see [VC] but he was not at the address she was familiar with.

"I feel [so this is Gary Carter] in the circumstances I will arrange a visit with a colleague to go out and see [VC] to determine his mental state and

general wellbeing."

A. That should have happened as soon as we got the new address, and in fact that was on the 9 August when we got the new address, and so as soon as we got that, there would have been a suggestion that Gary go and visit VC at that new address. So I don't know why it's taken another three weeks for Gary to decide at that point that he will go and do a home visit, when we've had the address for a significant length of time.

Q. This contradicts your evidence, doesn't it, you gave just now?

A. Which evidence?

Q. Let me finish. This contradicts your evidence that you gave just now --

A. Which is.

Q. -- that --

A. Gary had done everything that he can.

THE CHAIR: Just listen to the question.

A. Okay.

MR STRAW: This contradicts your evidence that you gave just now which was that you decided to discharge him in August 2022 because you as the team felt that you had done all you could for him. And I suggest this contradicts that because it shows that Mr Carter considered there was more that could be done.

A. At the end of the day, if Mr Carter comes along and says to us "I've done everything that I can" then we have to take him at his word. If he then decides that there's more he feels he can do, it's -- it's -- yes, I don't know. It's very odd. The timeline does not make sense to me there.

MR STRAW: Thank you very much.

THE CHAIR: Thank you. Yes.

Yes, Ms Milligan.

Questioned by MS MILLIGAN

MS MILLIGAN: *(Unclear)* very brief lines of questioning, I'm conscious of the time.

Dr Lloyd, I ask questions on behalf of Gary Carter.

Can I start with the issue of discharge that you've just been discussing with Mr Straw.

A. Yes.

Q. If I could have please the RiO notes, the NHFT0000168 document. Just while they're loading, you gave evidence that, at some time in August, there was a decision to discharge that was subsequently rubber stamped. So the first entry on this page is being entry by Mr Carter, 4 August, and I believe this is the one you were referring to earlier, saying it was some time after this entry that -- forgive me. You need the page number. It's 270, it will come up in just one moment and it's

the first entry at the top of that screen. You say at some point after this entry, that's when the decision was made in MDT to discharge VC; is that right?

A. That's definitely what I believe because my recollection is distinct and clear of Gary bringing the case to the meeting for discussion and the discussion taking place of discharge and I think versus reporting him to the police. And, in fact, I think Gary says that it's something that we need to consider and I don't think it happened on the -- I don't think it happened around 4 August, I think it happened later, this --

Q. You say it was in August, sometime in August?

A. I think it was in August but I can't tell you exactly when it was.

Q. All right, if we look down the page, just for your reference, we heard that Gary went off unexpectedly on carer's leave from 25 August 2022 but there's a reference here on 31 August, at the bottom of the page, to Gary nonetheless taking a telephone call from Celeste -- you've just been through this with Mr Straw, Celeste reporting:

"She has not seen [VC] face to face for many months but she had a telephone conversation with him ... attempted to go and see [VC] but he was not at the address ..."

Then the final line:

"I feel in the circumstances I will arrange a visit with a colleague to go out and see him to determine his mental state and general wellbeing."

So my question is: even if -- and it's an if -- there had been a decision to discharge VC that was yet to be "rubber stamped", in your words, this was a material change that warranted consideration by the team, wasn't it?

A. Say that again. What was a material change?

Q. VC's mother calling up and, in essence, expressing concerns and VC's care coordinator saying, "In the circumstances, I need to go out and visit him"? That was a material change to whatever may have been discussed earlier in August.

A. I think earlier in August, as soon as we got the new address --

Q. Forgive me, I don't mean to be rude but we're tight on time. That's not the question. I'm saying that if it is the case that a decision has been made to discharge VC, and it's an if, but let's proceed on that basis, by 31 August, there was a material change and it warranted you and the other members of the EIP team to look again and say, "Actually, before we rubber stamp this, is this the right decision?" That's right, isn't it?

A. I don't think I was aware of this particular entry from the 31st.

Q. You didn't look at the RiO notes prior to the MDT -- *(overspeaking)* -- meeting to discharge VC.

A. No, because I thought the discharge had actually -- the discharge decision had been taken. So no.

If I believed at that he's actually been discharged already, it seems odd to then go back and look at the notes.

Q. So even if it's yet to be rubber stamped, it's your evidence that you don't need to look at the RiO notes?

A. If all we're doing is a process of administration, yes, this person has been discharged, but Gary hasn't got round doing the paperwork then yes, I wouldn't necessarily go back and specifically look at the notes because, as far as I'm concerned, that discharge decision has taken place.

Q. Could I take you to another document, please, NHFT0018512. And this is an email, you're not copied in it, just to be clear.

A. Oh right.

Q. But this is from Ms Parsonage dated 8 September:

"Hi all,

"Looked at Gary's patients here's what we've got over the next few weeks ..."

We see below the big redaction.

"VC ... gary has put this on rio 'I feel in the circumstances I will arrange a visit with a colleague to go out and see [VC] to determine his mental state and general wellbeing.' Discuss MDT".

So the team, the broader team certainly didn't think he'd been discharged, they're referring to VC as a patient that needed to be discussed at MDT.

So he hadn't been discharged at this point, had he?

A. But as far as I'm concerned, the decision to discharge had been taken. It's just he hadn't been discharged. We had the conversation. But it doesn't look as though the paperwork was done.

I honestly I don't know, but I can tell you for a fact that I remember that meeting specifically, and it may be that we had the discussion but then a decision was taken after that not to discharge him. I haven't -- I really don't know but I know what I remember. And I remember Gary specifically coming into the room and saying, "I have done everything that I can," and us talking -- the whole team talking about all the options.

And if you look at Gary's witness statement, again, in there he states that he comes in to the MDT, and he believes it's in August, and he says, "I have done everything that I can."

And it's at that point where we go through all the options and discharge becomes something very prominent. And it is there in his witness statement because I read it, because I was questioning: this is odd, the timeline doesn't look right. And when I looked at Gary's statement and I actually saw those words.

Q. All right, one more document, please. Just building on this. NHFT0018292. This is a week later, 16 September '22.

It's another cover email so there's been an MDT to discuss what Gary had written on VC's RiO records. A week later Ms Parsonage again emailing round:

"Here is the cover for next week."

If I could just pop down, later down that at page, please. It may be on the next page, forgive me. There we go, we see one of Gary's patients:

"VC -- discuss Tuesday discharge".

So there were discussions, weren't there, in MDT in September about VC, and those culminated in the decision on 23 September 2022 to discharge VC. That didn't take place at an earlier date. You are simply wrong about that.

A. "discuss Tuesday discharge". Well, we don't have MDTs on a Tuesday.

Q. That's not the question I'm putting to you. I think

I've put it, and --
THE CHAIR: Yes, thank you.
A. All right.
THE CHAIR: We've got the point.
MS MILLIGAN: Thank you.
THE CHAIR: Yes. Ms Patry, do you want to raise anything?

Questioned by MS PATRY

MS PATRY: Thank you, Dr Lloyd, I ask questions on behalf of the University of Nottingham's.
A. Okay.
Q. Three very short topics.
A. Sure.
Q. At paragraph 160 of your statement which I can turn up if it's helpful. WITN0357001, page 56. You seem to -- I'll give you a moment to look at it.

Can you just cast your eye over paragraph 160. You appeared to suggest that you considered the incident at the University on 15 January, the assault on the family, had not been triggered by psychosis. Do you see that, where you've written that?
A. Yes.
Q. Now, the University's position is that it was never told that and the question I have for you is: did you at any stage inform the University of that or instruct anyone else, including Claudia Birtles, to tell the University

that?
A. The reason why I have considered that it wasn't driven by psychosis was because --
Q. Sorry, forgive me. I have five minutes. It's not about why you reached that conclusion. Did you ever inform the University of that conclusion or instruct anyone else to inform the University of that conclusion?
A. That I didn't think it was driven by --
Q. Driven by psychosis.
A. I would have expected that the individuals that carried out the Mental Health Act Assessment who have written that down, the ward that couldn't find any psychosis would have had liaison with the University --
THE CHAIR: You were asked a specific question as to whether you didn't -- *(overspeaking)* --
A. No, I didn't because it wasn't something that I had any first-hand knowledge of. It was just something that I'd picked up from the notes.
MS PATRY: I am very grateful for that answer.

The second question I want to ask you is about, at the time of the Mental Health Act Assessment that took place around 19th January. The relevant AMHP report -- again, I can turn it up but I don't have much time -- reports that the advice from the psychiatrist was to tell the University to keep VC stable, given that he had

not been detained immediately. Would you like to see that?
A. Sure.
Q. It's NGPF0003312, and we are looking at the bottom of page 5 and top of page 6. Page 5, going over to 6.

Sorry, I can't see the page very clearly, "Discussion with Ellie, [University] Mental Health":

"Ellie ... advised there was ambiguity re [VC] residence at Raleigh Park, meaning that he may not be allowed to go back through disciplinary procedures ... Dr Skelton provided some input to Ellie, advising that a community plan is the least restrictive option ..."

I'm not going to read it all but the very last part of it:

"... it was emphasised [by Dr Skelton] that stability for [VC] was important to the community plan being successful."

So that's what the psychiatrist had advised and that's what was contained in the AMHP report. The question I have for you, Dr Lloyd, is: do you agree, given your knowledge of VC at this relevant time -- this is January 2022 -- do you agree that it was important for VC to remain as stable as possible in order for the community plan to be successful?
A. Yes.

Q. Thank you. Then finally, please, in a number of places in your witness statement you seem to suggest that the University mental health services didn't inform you of any incidents during the relevant period. I'm going to ask if you could please look at paragraph 283. That's back at WITN0357001 at page 103.

So if I can situate you in time here, because it's a very long statement, you're addressing the period December 2021 here, and you can see that if you scroll back up but in the interests of time please take it from me that you're talking about a period December 2021 here.
A. Mm-hm.
Q. You appeared to be saying, right at the bottom of that paragraph:

"The University Mental Health Advisory Service had not shared any concerns regarding VC at this time."

If I can just ask you this question. The University was wholly unaware that VC had committed an assault on PC Pritchard; it was wholly unaware that he'd been admitted to hospital after that assault; and in fact, we can't see that there was any communication between mental health services and the University at all until January 2022.

So what I want to know is: what incident or concern

do you say should have been communicated by the Mental Health Advisory Service during that period?
A. I think I was just suggesting that, if there had been an incident or anything untoward, that we perhaps might have heard from the University. It was no more than that.
Q. All right so it's not a suggestion that we failed to do anything?
A. Not at all, no.
Q. Given that the NHS held the risk in relation to VC, do you accept that you or your team should have told the University, or arranged for the University to be told, about all the issues which took place between September 2021 and 15 January 2022? So that's the assault, that's the admission, and that's the -- we've heard extensive evidence on it today, that's all the failures that your team had in either engaging VC or treating him during the relevant period. Wasn't that something that you and your team needed to tell the University?
A. I think, in retrospect, yes, that ought to have happened. We ought to have said at that point, when we found that he'd completely disengaged, I think he was seeing Claudia right up to sort of December, but yes, after that, there was a disengagement, and yes, there

should have been better communication with the University -- *(overspeaking)* --
Q. Were there any barriers to communication between your team in the University?
A. I don't think so and I don't know why, you know. I also take responsibility. I don't know why there wasn't that communication. That should have happened.
MS PATRY: I'm really very grateful for that answer. Thank you. Those are my questions.

Questioned by THE CHAIR

THE CHAIR: Yes, just one question, Dr Lloyd.
A. Yes.
THE CHAIR: You said at one stage when you were asked about risk, you said about the tribunal ruling. You said that you didn't think you ever saw the ruling and you were asked about it where it says that the risks were serious. I think you said the only time the risks had been serious was in relation to PC Pritchard. That's right?
A. At that point, yes, I felt that that was a very serious incident.
THE CHAIR: There's a difference, isn't there, between the risk of something happening and it actually happening?
A. Yes.
THE CHAIR: What you were being asked about there was the

assessment of the risk of something happening and they were saying there was serious risks. Do you disagree that there were serious risks rather than a serious incident?
A. Now that you frame it in that way, I can see that, yes, there are risks that are serious.
THE CHAIR: It's not how I'm framing it. I just want to know whether you were considering it in that way, about risks of things happening rather than incidents --
A. Yes.
THE CHAIR: -- which had happened.
A. We recognised that there were definite risks with VC.
THE CHAIR: Just finally in relation to what you've just gone through, in relation to your recollection that in fact VC was discharged in September, I think you told the Inquiry that it would be for the care coordinator to bring a case to the MDT; is that right?
A. That's what normally happens. The care coordinators go through their caseload and they -- if there's individuals that they feel need to be discussed and, generally speaking, I think Gary Carter always discussed -- I think he pretty much discussed all of his cases, to be fair.
THE CHAIR: The only care coordinator present that we know about on 22 September when there is this note of the

discharge was Abi Parsonage, who says she was only there for about 15 minutes. So who brought that case to the MDT?
A. That's what I don't know. That seems --
THE CHAIR: Well, I'm going to ask whether it was you.
A. No, absolutely not because I thought he'd already been discharged.
THE CHAIR: I see. Thank you.
Right, we'll finish there for today and start again tomorrow morning at 10.00.
(5.00 pm)
(The hearing adjourned until 10.00 am the following day)

I N D E X