IN THE MATTER OF AN INQUIRY

UNDER THE INQUIRIES ACT 2005

THE NOTTINGHAM INQUIRY

CLOSING STATEMENT ON BEHALF OF GARY CARTER

(A) INTRODUCTION

1. This Closing Statement is aimed predominantly at Issue 4 of the Inquiry's Terms of Reference, namely: "*Review the understanding, assessment and management of the risk of VC to others and his risk of offending between 2019 and 13 June 2023, to identify and address any issues with regard to decisions, actions or omissions of agencies, professional bodies or individuals relevant to the treatment of VC, and the management of his risk to others including whether the relevant guidance was followed appropriately. (**Understanding, assessment and management of risk**)*". Section D of this Statement deals with Issue 8 ("*Provide Recommendations to ensure lessons are learned and prevent similar attacks in the future. (**Recommendations**)*").

2. Mr Carter was employed by Nottinghamshire Healthcare NHS Foundation Trust ("**NHFT**") as a Band 6 community psychiatric nurse ("**CPN**") within the NHFT's Early Intervention in Psychosis ("**EIP**") service, based in City South, between 1 September 2020 and 30 April 2025.[1] He was allocated as the care co-ordinator ("**CCO**") for Valdo Calocane ("**VC**") on 28 April 2022. The decision to allocate VC to Mr Carter and transfer him away from his previous CCO, Claudia Birtles (who was appointed as VC's CCO on or around 26 June 2020[2] shortly after his referral to the EIP service) was made in Mr Carter's absence. Mr Carter was VC's CCO until his discharge from the EIP service on 23 September 2022, although other staff were covering Mr Carter from 25 August 2022, when Mr Carter had to take leave unexpectedly. Mr Carter was on leave at the time that the decision was taken to discharge VC from the EIP Service.

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[1] Carter [WITN0368001/3-4] §§6-10.
[2] [NHFT0000168/53].

3. During his four months as VC's CCO, Mr Carter repeatedly attempted to establish a therapeutic rapport with VC but failed to do so. He regularly telephoned and texted VC, but only managed to have two brief face-to-face interactions with him as his CCO, both of which only lasted a couple of minutes, due to VC's unwillingness to engage with Mr Carter. Mr Carter also offered and attempted to visit what he understood to be VC's home address on two occasions[3] – notwithstanding the fact that the City South EIP Team ("**the EIP Team**") had risk assessed that visits should be at their base at the Stonebridge Centre only – but either did not receive an answer or was told that VC did not live at the address. The absence of a therapeutic relationship with VC, along with the events and issues addressed in these submissions, hindered Mr Carter's ability to provide VC with any meaningful, longer-term EIP intervention work.[4]

4. Mr Carter has sought to assist the Inquiry and all those affected by the events underpinning it by giving candid, open and reflective evidence on the role that he and others played in VC's care, and in what he observed of others, and the systems that he found himself playing a role in at the material time. This Closing Statement seeks to assist the Chair in respect of Issue 4 by focussing on, first, a chronological exploration of what Mr Carter submits are the critical factual events during his tenure as VC's CCO, before coming on to consider Mr Carter's experience of the relevant systemic issues that the Inquiry will need to consider.

(B) THE KEY FACTUAL EVENTS CONCERNING MR CARTER AS VC'S CCO

The Decision to Re-Allocate VC from Ms Birtles to Mr Carter on 28 April 2022

5. VC was first contacted by Ms Birtles on behalf of the EIP service on or around 26 June 2020, having been discharged from his first admission to a hospital as a psychiatric inpatient and having received initial support from the Community Resolution and Home Treatment (CRHT) Team (known as the "**Crisis Team**"). From that date onwards, for the best part of two years, Ms Birtles was VC's CCO. Despite instances and periods of VC disengaging, Ms Birtles had built a rapport and therapeutic relationship with VC and had supported him through three further inpatient admissions and in relation to three interactions with the police owing to violence.

6. **The decision to transfer VC to Mr Carter should not have been made without an adequate consultation with Mr Carter**, who was on leave on the date of the decision

[3] 27 June 2022 [INQY0000024] and 4 August 2022 [NHFT0000168/270].
[4] As summarised in the NHFT's EIP Pathway overview at [NHFT0023114].

(28 April 2022). That decision was as important as any decision to accept a patient on to the EIP pathway, to refer to them to another service, or to discharge them: it directly concerned the future of VC's care and the ability for that care to be delivered by the person in the best position to provide it.

7. Instead, Mr Carter was presented VC's case as a "*fait accompli*"[5] on the basis that he was the only male CCO in the EIP Team.[6] That was done at a time when his caseload was consistently above the limit of "*no more than 15*" patients[7] that was set out in the then applicable (second) edition of the EIP Standards[8] ("**the EIP Standards**"), but also consisted of some of the EIP Team's more complex patients, "*who presented a greater risk of violence or inappropriate behaviour*" and of "*aggression*".[9]

8. As the Inquiry heard from a number of witnesses and sources, patient acuity was critical to understanding the 'correct' level of patients for any one CCO[10] and, in Mr Carter's case, should have resulted in him having fewer patients to ensure that he had adequate time to devote to engaging them and responding to their needs and risks.[11] Instead, Mr Carter was consistently forced to catch up with his work and record

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[5] Carter [WITN0368001/43] §§186-188 and [NHFT0004880/6]. This was not disputed by either NHFT or CTI, and no evidence has been submitted to the Inquiry, nor given to the Inquiry orally, in support of there being any form of conversation with Mr Carter to gain his consent or approval of being allocated VC, nor any assessment of the propriety of doing so (i.e. by reference to caseloads and consequential risks).

[6] Carter [WITN0368001/9: 41-43] at §35 and §180 to 184; Birtles [NHFT0004906/10], [WITN0348001/149-151] §§454-459; Parsonage [WITN0317001/61-62] §235; Heath [NHFT0004872/22] §5.113, [INQT0000071/116] §20 to [INQT0000071/117] §6; Robinson [WITN0315001/34] §100, [INQT0000071/28] §12 to [INQT0000071/29] §9. In respect of the evidence that an additional reason was the need to try a different CCO given VC's disengagement, the Inquiry will wish to consider the contemporaneous evidence that indicates that Ms Robinson, and by inference others, did not consider that a new CCO would change VC's engagement levels: [NHFT0018181].

[7] NHS Level 2 Report [NHFT0000451/22] §68; Appendix 14 to Mr Carter Investigation Report [NHFT0004919]. All of the supervision records before 13 June 2023 that have been provided show Mr Carter having a caseload of more than 15: see 19 January 2022 [NHFT0019622/2]; 24 February 2022 [NHFT0019617/1]; 23 March 2022 [NHFT0019628/1]; 27 April 2022 [NHFT0019618/1]; 27 May 2022 [NHFT0019629/1]; 27 June 2022 [NHFT0019624/1]; 27 July 2022 [NHFT0004909/1]; 26 October 2022 [NHFT0019631/1]; 24 November 2022 [NHFT0019630/1]; 22 December 2022 [NHFT0019620/1]. See also: Carter [WITN0368001/8] §§29-31 and [WITN0368001/9] §§34-35; Robinson [NHFT0004872/39]; Lloyd [WITN0357001/128] §355. Although Sharon Heath gave evidence that high caseloads may reflect the presence of a high student population that was not present in Nottingham over summer, she correctly acknowledged that she could not say whether this was applicable to Mr Carter [WITN0292001/28] §78. There is no evidence that Mr Carter's caseloads had a high number of students and this point should be disregarded. It also contradicts the evidence as to Mr Carter having a substantial number of difficult or risky patients, addressed below.

[8] [NHSE0002298/19] §109.

[9] [NHFT0000451/22] §68. See also Carter [WITN0368001/7-8] §28; [WITN0368001/44] §188; [INQT0000070/99] §5 to [INQT0000070/100] §10; Robinson [WITN0315001/34] §100; Heath [INQT0000071/118] §25 to [INQT0000071/119] §16; Lloyd [WITN0357001/128] §355.

[10] See also the Theemis Report [NHNB0018966/217-218].

[11] NHFT expected CCOs to have at a minimum of three clinical contacts with patients per day: [NHFT0021455]. If only the minimum could be achieved, that would be 15 clinical contacts per week. With a higher patient caseload, that can result in only having 1 or less clinical contacts per patient per week.

keeping outside of his contracted hours.[12] This was not Mr Carter looking for a "*distraction*",[13] but him caring about his job and his determination to "*give what the job demands*".[14]

9. The NHFT expected CCOs to have a minimum of three clinical contacts with patients per day.[15] If only the minimum could be achieved, that would be 15 clinical contacts per five working days, i.e. having contact with each patient once per working week. With a higher patient caseload, and particularly with a more complex caseload, the ability of a nurse to see all of their patients within a working week is swiftly compromised.

10. Although Mr Carter's second supervisor, Sharon Heath, told the Inquiry that Mr Carter never formally raised the issue of his caseload with her, the evidence indicates that, first, Ms Heath was aware of his objectively high caseload,[16] second, that the problem of high caseloads was known to staff at a managerial level from the time of Mr Carter joining the EIP Team,[17] and, third, that the issue was not limited to Mr Carter but applied to other CCOs.[18] It was, moreover, incumbent on managers and supervisors, rather than on Mr Carter and his CCO colleagues, to take proactive steps to ensure that their staff had manageable caseloads and that the EIP service as a whole was operating in accordance with the EIP Standards.

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[12] Carter [WITN0368001/9] §32, [NHFT0004882/4], [NHFT0004880/10]; Heath [WITN0292001/22] §63; Robinson [INQT0000071/14] §24 to [INQT0000071/16] §4, [INQT0000071/17] §§11–14, and Carter-Stone Supervision Record 27 July 2022 [NHFT0004909].

[13] [INQT0000071/16] §§10-24.

[14] Carter-Stone Supervision Record 27 July 2022 [NHFT0004909]. In light of that contemporaneous evidence, the Inquiry is invited to dismiss the off-hand suggestion by Ms Robinson that Mr Carter was working hard as a "*distraction*" ([INQT0000071/16] §§10-24): there is no other nor contemporaneous evidence to support this, and it is inconsistent with the timing of Mr Carter's warnings in respect of the same, which preceded matters in his personal life arising.

[15] [NHFT0021455]. This guidance accords with Mr Carter's broad experience, although he had not been trained or provided with any guidance on the frequency and length of meetings with patients: see §48-50 of his witness statement at [WITN0368001/12-13]. Mr Carter's reference to an "*informal*" approach to such matters was echoed by the evidence of Robinson [WITN0315001/7-8] §21 and Parsonage [WITN0317001/11] §39.

[16] Carter [WITN0368001/8-10] §§31-37, including in respect of the whiteboard in the City South office that listed patients and was used for discussions in MDTs; Robinson [NHFT0004872/39] §5.303. All of the supervision records before 13 June 2023 that have been provided show Mr Carter having a caseload of more than 15: see 19 January 2022 [NHFT0019622/2]; 24 February 2022 [NHFT0019617/1]; 23 March 2022 [NHFT0019628/1]; 27 April 2022 [NHFT0019618/1]; 27 May 2022 [NHFT0019629/1]; 27 June 2022 [NHFT0019624/1]; 27 July 2022 [NHFT0004909/1]; 26 October 2022 [NHFT0019631/1]; 24 November 2022 [NHFT0019630/1]; 22 December 2022 [NHFT0019620/1].

[17] [WITN0368001/7-8] §27-28

[18] Abigail Parsonage [WITN0317001/7] §21, Adele Pinder [WITN0396001/16] §52 and [WITN0396001/56] §182; Claudia Birtles [WITN0348001/162] §491(vii); Emma Robinson [INQT0000071/16] §25 to [INQT0000071/17] §10; Sharon Heath [WITN0292001/28] §78. Dr Lloyd also made the same observation about medical staff beyond CCOs [WITN0357001/140] §398, [INQT0000073/102] §10 to [INQT0000073/103] §12.

11. An adequate consultation with Mr Carter about taking on VC as an additional patient would have considered, *inter alia*: Mr Carter's existing caseload; whether Mr Carter was best placed to act as VC's CCO; a full and frank conversation with Mr Carter about the difficulties and risks that VC as a patient presented; and, in the event it was deemed appropriate to transfer VC to him, to consider whether any of Mr Carter's existing patients or other responsibilities (including EIP initial assessments for patients who had been newly referred to the service) should be transferred to others to accommodate this increase in his workload.

12. Such a consultation may well have resulted in: Mr Carter not being allocated VC; his caseload and responsibilities being adjusted to give him sufficient time; or being allocated VC along with another CPN – as had been the intended plan (as recorded in VC's RIO notes as the outcome of the MDT meeting on 28 April 2022).[19] The Inquiry received no adequate explanation as to why that plan was never actioned. Mr Carter submits that there is sufficient evidence for the Inquiry to infer that this was due to: the absence of another male CCO;[20] no other CCO volunteering to take on an additional patient alongside Mr Carter; and the staffing issues within the EIP Team (discussed in Section C below).

The Lack of Any or Any Adequate Handover Given to Mr Carter

13. The Inquiry heard that, **following the decision to transfer the role of CCO to Mr Carter, there should have been a full handover from Ms Birtles**,[21] but that this did not take place.[22] There is no evidence of any policy, guidance, or training that would have made clear to Ms Birtles that she needed to conduct a handover prior to relinquishing her responsibilities as CCO, and Ms Heath's evidence was that it was merely "*recommended*".[23]

14. In her evidence, Ms Birtles relied upon the fact that VC was "*familiar*" to the other members of the EIP Team[24] and that Mr Carter had attended an appointment with VC to accompany Ms Birtles.[25] She did, however, accept that Mr Carter's knowledge and

[19] [NHFT0000168/266].
[20] Bearing in mind, for example, that Ms Parsonage had the most regular contact with VC after Ms Birtles: see the RIO notes [NHFT0000168] and Carter [WITN0368001/41-42] §180.
[21] Robinson [INQT0000071/29] §25 to [INQT0000071/30] §6, [INQT0000071/30] §§7-12; Lloyd (re her understanding) [WITN0357001/115] §320.
[22] Birtles [INQT0000068/31] §6 to [INQT0000068/32] §13.
[23] [NHFT0004872/22] §5.115.
[24] [INQT0000068/31] §§6-19.
[25] [WITN0348001/150-151] §459.

understanding of VC would be limited to "*what he'd gleaned or ascertained by virtue of working in the same place and being at MDTs*".[26]

15. Whilst the Inquiry heard evidence that VC was discussed regularly at EIP Multi-Disciplinary Team ("**MDT**") meetings,[27] which occurred weekly on Thursday mornings,[28] it would not be reasonable nor fair to assume that all the information shared in those meetings had been digested, analysed and memorised by Mr Carter – or, indeed, any other member of the EIP Team – as if he or others had been VC's CCO at the material time. Whilst Mr Carter carefully listened to his colleagues' discussion of their patients, and contributed to the same, he was not doing so in his capacity as VC's CCO. His priority in terms of risk assessment and care planning was, entirely appropriately, on his own patients, particularly given his high caseload. In any event, a detailed review of the references within VC's RIO records to discussions held in the MDT meetings prior to 28 April 2022 demonstrates that they concerned VC's disengagement only, and not any other substantive issues.[29]

16. For the same reason, the Inquiry should exercise extreme caution in attributing knowledge and awareness to Mr Carter from his peripheral involvement in VC's care prior to 28 April 2022. In oral evidence, Mr Carter was asked a number of questions in relation to events prior to 28 April 2022 and, in particular, he was questioned on the proprietary and accuracy of wording in RIO notes that he did not author, and the appropriate response in terms of VC's care and risk.[30] In circumstances where he was neither author of the RIO notes nor in any way the decision maker for VC's care at those times – and his interactions with VC effectively amounted to cover or support for colleagues – it would not be appropriate nor fair to impute knowledge or responsibility to Mr Carter for those matters.

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[26] [INQT0000068/32] §§10-13.

[27] Carter [INQT0000070/85] §§2-22, [INQT0000070/21] §24 to [INQT0000070/-23] §3; Birtles [WITN0348001/42] §122; Burri [WITN0337001/27] §66; Lloyd [WITN0357001/81] §229, [WITN0357001/116] §323, [WITN0357001/132] §370, [INQT0000073/107] §§9-17, [INQT0000074/13] §§17-24, [INQT0000074/38] §§15-21, [INQT0000074/53] §§2-6; Robinson [WITN0315001/31] §95; Pinder [WITN0396001/46] §146 and [WITN0396001/54] §173. Heath stated this in her written evidence [WITN0292001/23-24] §66-67, but clarified in her oral evidence that VC's case was not discussed in detail at MDT meetings (this includes during the time that Ms Birtles was VC's CCO) [INQT0000071/96] §§3-5.

[28] Carter [WITN0368001/11] §41; Birtles [WITN0348001/148] §451; Robinson [WITN0315001/29] §90; Pinder [WITN0396001/16] §53; Bayer [WITN0385001/10] §35.

[29] [NHFT0019593/4]; [NHFT0019594/3]; [NHFT0000168/202]; [NHFT0000168/203].

[30] See, for example, [INQT0000070/5] §§4-23; [INQT0000070/14] §21 to [INQT0000070/15] §1; [INQT0000070/16] §9 to [INQT0000070/17] §15, which concerned Birtles' RIO Record entry of 31 August 2021 [NHFT0000168/162] and [INQT0000070/9] §§20-22, concerning the care plan in place at the time of the 31 August 2021 visit.

17. Notably, Mr Carter was not employed by the NHFT at the time that VC was first referred to the EIP service in or around June 2020 and would therefore not have been privy to initial discussions as to the reasons for his referral, his presentation, his behaviours, nor the detailed discussions in respect of VC's first three arrests by the police or his first two inpatient admissions. There is no evidence to suggest that Mr Carter was ever given more detail about those historical matters.

18. It would not have been reasonable for anyone to expect Mr Carter, given his excessive caseload and lack of available time, to spend what would have been at least a full day going through and absorbing the entirety of VC's RIO records,[31] and to draw conclusions as to VC's current presentation and risks from those records. Moreover, such an exercise would always have given an incomplete picture given that RIO records would never capture the entirety of Ms Birtles's interactions with VC, nor her knowledge of him as an individual, including behaviours, traits, and potential giveaways as to his concordance and mental health.

19. Ultimately, upon his allocation as VC's CCO on 29 April 2022, in the previous year Mr Carter had only one substantive interaction with VC: accompanying Ms Birtles to VC's home on 31 August 2021, when VC was described as "*floridly psychotic*".[32] That description of VC's mental state is relevant both to Mr Carter's understanding and perception of VC, and to the fact that no meaningful rapport-building could have taken place during this visit. Before that, Mr Carter's only other substantive interaction with VC was when he visited him with Ms Birtles on 15 September 2020, two weeks after joining the EIP Team.[33] Other interactions with VC were extremely limited and, in the year prior to becoming VC's CCO, were limited to two instances of medication drop-off/collection.[34] That cannot, fairly, be described as any or any meaningful basis on which Mr Carter should have been capable of gleaning information as to VC's attributes, behaviours, traits, or risks.

20. As such, as Mr Carter said,[35] prior to taking on VC as a patient, what Mr Carter knew of him was: "*… that he wasn't an easy patient from brief conversations… with* [Ms Birtles]

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[31] Carter [INQT0000069/88] §1 to [INQT0000069/89] §8 and [INQT0000070/69] §1 to [INQT0000070/70] §25. Note that Dr Burri gave evidence to similar effect in respect of 3 months' worth of notes: [INQT0000066/26] §§2-12 and [INQT0000066/36] §§17-25.
[32] [NHFT0000168/161-162]; Birtles [WITN0348001/150] §459.
[33] [NHFT0000168/134].
[34] 26 October 2020 [NHFT0000168/135]; 6 November 2020 [NHFT0000168/136]; 6 August 2021 [NHFT0000168/157]; 12 April 2022 telephone call only [NHFT0000168/264]; 20 April 2022 [NHFT0000168/265].
[35] [NHFT0004882/7].

and other members of the team e.g. [Ms Parsonage]. *I knew that there were doubts about his concordance. He was very elusive. He didn't turn up for appointments. He was difficult to maintain contact with. He was difficult to assess because he would only give you so much time*". He did not have the detailed knowledge of VC that Ms Birtles had.

21. As a consequence, Mr Carter was not aware of – or otherwise did not have an acute understanding of – the following matters and their impact on VC's risk, concordance and his short- and long-term treatment and care:

    a. The details and significance of VC's first two arrests by the police on 24 May 2020;[36]

    b. The details of how VC presented in the three Mental Health Act 1983 Assessments ("**MHAAs**") conducted prior to the 3 September 2021 assessment;[37]

    c. The details of how VC presented during all four of his inpatient admissions,[38] beyond a general awareness that VC was compliant and concordant during those stays;

    d. The contact between Dr Seedat and VC's brother, Elias, particularly in relation to text messages that Elias had shared with Dr Seedat;[39]

    e. The reasons why a Community Treatment Order ("**CTO**") had not been made[40] following it being advocated for by Ms Birtles and Dr Lloyd during VC's third[41] and fourth admission;[42]

    f. How VC's care plans had changed over time;

    g. That VC's medication had changed over time;

    h. In respect of VC's application to the First-Tier Tribunal for his discharge (during his third inpatient admission), the detail of VC's application, Ms

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[36] [NGPF0000068] and [NGPF0000082]; [INQT0000070/94] §§1-7.
[37] 24 May 2020 [NOCC0000044], 25 May 2020 [NOCC0000045], 14 July 2020 [NOCC0000046]. The 3 September 2021 assessment is at [NOCC0000050].
[38] 25 May 2020-17 June 2020; 14 July 2020-31 July 2020; 3 September 2021-22 October 2021; 28 January 2022-24 February 2022.
[39] [NHFT0000168/20-21].
[40] [WITN0368001/87] §354-357.
[41] [WITN0348005].
[42] [NHFT0019152], [NHFT0000168/237-240], [NHFT0000168/250].

Birtles' evidence to the FTT, nor the content of the FTT's judgment dismissing VC's application;[43]

i. Whether particular forms of contact or types of approach had been more or less successful in engaging VC.

22. None of those matters appeared in VC's most recent risk assessment[44] nor his summary and care plan (which was last updated on 14 February 2022, when VC was an inpatient)[45] at the time of the handover to Mr Carter. Mr Carter accepted in his evidence that he, too, failed to update the plans during his four months of acting as VC's CCO,[46] but the relevance of Ms Birtles's failure to do so at the time of a transition to a new CCO was critical.

23. In the absence of any informed handover process, Mr Carter had to – and did – rely on those documents as being reflective of VC's current risk levels and behaviours. While Mr Carter acknowledged in oral evidence that he did not ask Ms Birtles for further information about VC,[47] he had no reason to believe that those documents did not represent Ms Birtles' complete view as to VC's risk and concordance issues, notwithstanding that the Care Plan required updating. He cannot be criticised for asking for something when he did not know it was missing in the first place. The content of those documents is, therefore, a critical yardstick by which Mr Carter's actions must be measured. They informed Mr Carter that:

a. VC was taking Aripiprazole consistently, he had previously stopped "*a different medication*", and "*he now identifies the medication as having some effect and would not discontinue it again in future*";[48]

b. VC had "*the capacity to understand, retain and weigh information provided to make an informed choice about his care and management of mental health condition, including prescribed medication*";[49]

c. VC had "*Poor engagement with services. Suspected non-concordance with medication, increasing risk of relapse. No insight into MH condition*";[50]

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[43] [CYGN0000056].
[44] Dated 28 February 2022 [NHFT0000190].
[45] [NHFT0000198].
[46] [WITN0368001/47] §201, [INQT0000070/74] §§1-24.
[47] [INQT0000070/27] §§10-22.
[48] [NHFT0000198/1].
[49] [NHFT0000198/4].
[50] [NHFT0000190/1].

d. *"Historically when unwell he has forced entry into his neighbours houses under the influence of his psychotic experiences, he has had four admissions to hospital in the last 2 years."*;[51] and

e. *"Risks to others – Male, diagnosis of paranoid schizophrenia, appears to experience persecutory delusional beliefs that thoughts can be influenced and controlled by computer systems specifically developed to interfere with the mind. Hx of violence and aggress when detained (significant assault on police officers), violence and aggression towards housemates and refused to let them leave property, poor insight, does not agree that he has been unwell over the last 12 months. Poor engagement with community services, history of non-concordance with medication"*.[52]

24. It is also relevant to acknowledge that the two substantive engagements that Mr Carter had with VC prior to becoming his CCO were two remarkably different interactions, which demonstrated to Mr Carter how differently VC could present when he was and was not in the grip of psychosis. During the 15 September 2020 meeting, Mr Carter met VC for the first time and observed that he *"seemed pleasant and sociable… though he was clearly a man of few words"*.[53] Ms Birtles considered that he *"presented as mentally stable"*[54] but that *"he was occupied with his groceries and did not want to sit down and speak"*.[55] Upon leaving the appointment, both Mr Carter and Ms Birtles agreed that VC *"had been agreeable and that we had no major concerns"*,[56] notwithstanding VC's limited engagement.

25. By contrast, Ms Birtles described VC's presentation at the 31 August 2021 meeting as *"floridly psychotic"*[57] and stated that she had never seen him present like that or appear that *"unwell and angry before"*.[58] This was the first time that she had confirmation that VC was not taking his medication, as opposed to just a suspicion that that was the case,[59] and she felt unsafe continuing with the assessment in VC's home,[60] notwithstanding that she considered there was *"no evidence of any aggression"*.[61] Although Mr Carter did not know VC well, he recalled his appearance at the

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[51] [NHFT0000190/4].
[52] [NHFT0000190/5].
[53] [WITN0368001/27-28] §§118-121.
[54] [WITN0348001/77] §225.
[55] [WITN0348001/76-77] §224.
[56] [INQT0000069/91] §§7-9.
[57] Birtles [WITN0348001/150] §459.
[58] [WITN0348001/108] §325.
[59] [WITN0348001/157-158] §484, [WITN0348001/140-141] §425-427, [INQT0000067/91] §21 to [INQT0000067/92] §4.
[60] [WITN0348001/107-108] §324.
[61] [NHFT0000194/2].

September 2020 visit and thought "*he looked different* [and] *sounded different*",[62] that he "*seemed very, very unwell*", and "*appeared to be on the verge of a major breakdown*".[63]

26. Having had those two experiences of VC, it was entirely reasonable for Mr Carter – particularly given the limited handover and training that he had – to understand VC's presentation between 29 April 2022 and 25 August 2022 as being closer to that in September 2020, i.e. one of a lower risk.

The Lack of Any Meaningful Attempt to Help Mr Carter Engage with VC

27. Ms Birtles gave evidence to the Inquiry that she felt that the therapeutic relationship she had with VC had been adversely affected by her giving evidence to the First Tier Tribunal (Mental Health)[64] to the effect that VC should remain an inpatient for longer during his third admission and that he would benefit from receiving medication by depot.[65] The evidence also demonstrates that, prior to 28 April 2022, Ms Birtles considered VC's engagement to be "*very superficial*" and that he was "*very guarded and probably quite disillusioned with* [mental health] *services so he shares very little*".[66] Given that starting point, it was obvious that any new CCO would face issues in engaging with VC, and that they may be disadvantaged in doing so given the lack of knowledge of, and history with, VC.

28. There is no contemporaneous evidence to demonstrate that Ms Birtles and others in the EIP Team thought that transfer to another CCO was likely to improve VC's engagement (as has been stated in the witness evidence given to the Inquiry). On the contrary, emails exchanged between Emma Robinson, Claudia Birtles and Dr Tuhina Lloyd on 10 January 2022 indicate that they had "*discussed looking at a different CCO*" but Ms Robinson said "*I don't think that will change engagement with services, but happy to discuss*",[67] and no change to VC's CCO was made at that point, nor after the third inpatient admission and FTT proceedings.

29. However, assuming that there was a legitimate belief that VC's care and engagement could be improved by transferring him to Mr Carter, Ms Birtles was left with no doubt about the unlikeliness of that following her decision to inform VC of the change in CCO by text message. On 3 May 2022, she messaged VC to say: "*Gary Carter (the other*

[62] [INQT0000070/4] §25 to [INQT0000070/5] §3.
[63] [WITN0368001/36-37] §§157-161.
[64] [CYGN0000056]; [TCLT0000748/11-12].
[65] [WITN0348001/118] §§357-358.
[66] See e-mail to Eleanor Turner, Emma Robinson and Tuhina Lloyd on 26 April 2022 [NHFT0018168].
[67] [NHFT0018181].

nurse in our team) will be taking over as your care coordinator". VC replied: "*You should move someone else. Since you've been looking at my case since the beginning it's not really convenient having to build a rapport all over again*".[68]

30. At this stage, it should have been obvious that moving VC to a new CCO warranted re-appraisal in light of VC's response. Although the evidence indicates that Ms Birtles was concerned about the risks to her given her pregnancy,[69] it may have been possible for Ms Birtles to remain involved in VC's care, whether only at the Stonebridge Centre, or only in the background (including by way of telephone and other digital communications with VC) for the remainder of her pregnancy. **Simply dismissing VC's concern and saying that she was "*really sorry*",[70] and without conveying VC's reaction to Mr Carter (or indeed to anyone else, or placing it on VC's RIO records), was a critical missed opportunity to re-engage with VC**.

31. Regardless of her role in VC's care going forward, Ms Birtles could and should have facilitated a proper transition of VC's care from her to Mr Carter. Apart from a handover with Mr Carter (addressed above), Ms Birtles could and should have informed VC of the decision to transfer him to a different CCO in person and with Mr Carter present, so that VC and Mr Carter could be re-acquainted, and so that VC was given an opportunity to address any concerns about a new CCO in person. There was no good reason for Ms Birtles not to do this, particularly given her appointment with VC at the Stonebridge Centre on 29 April 2022.[71] Mr Carter should have been given prior warning of, and been invited to, that appointment or, alternatively, another appointment set up to facilitate that interaction between VC and Mr Carter.

32. The responsibility for taking those steps did not lie solely with Ms Birtles, but also with those with managerial responsibilities for the EIP Team and for VC's care: as with a handover, Ms Heath gave evidence that a joint visit to see a patient was only "*recommended*",[72] and there is no evidence of (i) any policy, guidance, or training in respect of the standard processes for a transfer of a patient between CCOs, nor (ii) Ms Heath making clear to Ms Birtles at the 28 April 2022 meeting that such an approach

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[68] [INQY0000007/2].
[69] Birtles [NHFT0017809/2], [NHFT0004707/2], [NHFT0004872/57], [INQT0000068/30] §18 to [INQT0000068/31] §5; Heath [NHFT0004905/23].
[70] [INQY0000007/2].
[71] [NHFT0000168/266-267].
[72] [NHFT0004872/22].

should have been taken in VC's case. Those in supervisory positions should have ensured that those transitional actions took place.

33. The net effect of the above matters was that Mr Carter was, on 29 April 2022, told he would be taking on VC's case as a '*fait accompli*', in circumstances where:

    a. He already had an excessive and complex case load,

    b. He was placed in an impossible starting position for his relationship and engagement with VC,

    c. There was no proper transition between CCOs,

    d. Ms Birtles was aware that VC was particularly reluctant to move to a new CCO,[73]

    e. He was not given all of the risk-relevant information; and

    f. In circumstances where patients' clinical staff should be changed as little as possible.[74]

34. As a consequence, although Mr Carter wanted to show VC "*to a private room and* [have] *a conversation with him*" and ask him "*how he was doing; how he was feeling; what he felt his mental state was like at the moment; whether he was happy or sad; has he got any concerns; anything I can do to help; does he need any advice? All the kinds of questions that might get him to open up*", he was never able to do that with VC, which Mr Carter attributed to the fact that VC had "*developed a working relationship with* [Ms Birtles] *and although he didn't want to engage with mental health services (and he didn't at any time) at least he would engage reasonably well with* [Ms Birtles] *because he knew her from the start…*", [75] and that "*he couldn't quite get his head around me stepping in. I'm not sure that he fully accepted that I had replaced* [Ms Birtles]…".[76]

VC's Subsequent Disengagement

35. **The impact of the above matters on VC's willingness to engage with Mr Carter from 29 April 2022 onwards is immediately apparent from a review of VC's RIO records.** On the two occasions that Mr Carter was able to see VC in person (13 May 2022 and 27 May 2022, both of which were scheduled fortnightly visits to pick up his

[73] [INQY0000007/2].
[74] [WITN0357001/11] §31.
[75] [NHFT0004880/17].
[76] [NHFT0004882/20].

medications), VC would not engage in conversation with Mr Carter, thereby eliminating any opportunity to build a therapeutic relationship or to conduct any informed mental state assessment.[77] It is unclear whether VC's expectations in respect of engagement had been affected by the agreement by Dr Lloyd to facilitate VC's wish to "*keep his contact with* [EIP] *as low key as possible*".[78]

36. Notwithstanding those circumstances, Mr Carter did take steps to keep VC engaged by texting him regularly and in a colloquial and friendly manner,[79] to encourage him to attend the Stonebridge Centre to collect his medication, and later telephoning him and offering to deliver his medication to him.[80]

37. In the week beginning 18 July 2022, Mr Carter was on annual leave. Acting as cover for Mr Carter, Abigail Parsonage exchanged text messages with VC regarding him collecting his medication, and VC told her that he would be out of the country until "*around October*".[81] On 27 July 2022, having attempted to contact VC repeatedly without success, Mr Carter was told by his mother that VC was, in fact, in Nottingham.[82] Over the next few weeks, until 25 August 2022 when Mr Carter unexpectedly was required to take carer's leave, Mr Carter tried to telephone VC,[83] had again contacted VC's mother,[84] tried cold-calling VC at his address,[85] asked the EIP's Admin Team to send VC a letter,[86] and discussed VC with colleagues, both informally[87] and at MDTs,[88] the latter being the main way in which Mr Carter and his

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[77] RIO record of these encounters: [NHFT0000168/267]. Carter [WITN0368001/50-52] §§215-225, [TCLT0000750/17-18], [INQT0000070/25] §12 to [INQT0000070/26] §7, [INQT0000070/37] §§9-12, [INQT0000070/40] §§2-7, [INQT0000070/83] §§11-21; Birtles [NHFT0004872/58]; Lloyd [WITN0357001/119] §330.
[78] [NHFT0000168/263].
[79] [INQY0000024].
[80] [INQY0000024]; [NHFT0000168/269-270].
[81] [INQY0000007/4]; [NHFT0000168/268-269].
[82] [NHFT0000168/269].
[83] [NHFT0000168/269].
[84] [NHFT0000168/269].
[85] [NHFT0000168/270].
[86] [NHFT0017920]; [NHFT0000122]; [NHFT0000168/270]. The Inquiry will note that the letter was sent by Administrative staff, not Mr Carter personally. The Administrative staff sent the letter to VC's 15 Madison Court address. It is assumed that they did so in light of the recent (9 August 2022) processing of VC's request for his medical records, which gave 15 Madison Court as his address. VC's request was dated 21 February 2022 [WITN0163002] (see also the RIO entry of 21 February 2022 at 10:33 [NHFT0000168/254-255]). 15 Madison Court was identified by Ms Birtles as being a "*different*" address [NHFT0000168/270]. Although it was put to Mr Carter in his oral evidence that he ought to have known that this was an address that VC had been evicted from [INQT0000070/43] §5 to [INQT0000070/44] §6, Ms Birtles was VC's CCO at the material time and ought to have been the one that identified this. The issue of VC being evicted from this address was not explained to Mr Carter, given the absence of a comprehensive handover.
[87] Carter [WITN0368001/63] §271, [NHFT0004882/26-27], [NHFT0004882/8]; Birtles [WITN0348001/42] §122; Burri [WITN0337001/28] §69; Parsonage [WITN0317001/8] §28.
[88] [NHFT0000168/270]. See also the references at footnote 26 (paragraph 15) above.

colleagues raised concerns about patients so that the discussion benefited from the entirety of the EIP Team (rather than through one-to-one supervisions).[89]

38. As Mr Carter described in evidence to the Inquiry, he faced a difficult balance between trying to be open and available to VC, and not being overly assertive such that he contributed to VC's belief that he felt "*persecuted*" and caused him to disengage entirely. That balance was particularly difficult to get right in circumstances where he did not have, in contrast to a more assertive programme and because of his high caseload, the time and resource to regularly track down VC's whereabouts and state of mind, notwithstanding that that was what he wanted to do.[90] That is particularly relevant in the absence of a CTO, and the precarious influence that Mr Carter had over whether VC continued to attend for his medication.[91] This conundrum was recognised in the Theemis Report[92] and by a number of witnesses, including: Ms Birtles;[93] Ms Robinson;[94] Dr Lloyd;[95] Ms Pinder;[96] and Ms Parsonage.[97]

39. No one in the EIP Team had suggested an alternative or better approach when Ms Birtles was VC's CCO, and did not do so in the weekly MDTs when Mr Carter was his CCO, notwithstanding that Mr Carter always discussed all his patients at every MDT meeting. During the period that Mr Carter was VC's CCO, leaving aside periods when Mr Carter was on leave,[98] there were 15 MDT meetings where VC would have been discussed.

40. The Inquiry must, therefore, ask itself why Mr Carter ought to have determined a 'better' path of care or intervention in circumstances where more senior staff, including VC's consultant psychiatrist, had not done so. Those individuals were present at the MDT meetings regularly, and Dr Lloyd had been scheduled to see VC on a number of occasions when he did not attend. She told the Inquiry that, in those circumstances, it was her practice to review a patient's RIO notes "*in order to establish*

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[89] [NHFT0004905/21]; Carter [WITN0368001/11] §41, [WITN0368001/6] §21, [WITN0368001/21] §88; Birtles [WITN0348001/8] §24; Lloyd [WITN0357001 /45] §126, [WITN0357001/81] §231; Heath [WITN0292001/11] §31, [INQT0000071/82] §§11-18; Robinson [WITN0315001/40] §117, [WITN0315001/37] §109, [INQT0000071/13] §§13-16; Parsonage [WITN0317001/8] §28.
[90] [NHFT0004711/2]; [TCLT0000750/19].
[91] [WITN0368001/51] §219.
[92] [NHNB0018966/201].
[93] [WITN0348001/77] §225, [WITN0348001/145] §§440-442, [INQT0000067/53] §5 to [INQT0000067/54] §8.
[94] [WITN0315001/38] §112.
[95] [WITN0357001/120] §334.
[96] [WITN0396001/49] §160.
[97] [WITN0317001/10] §37.
[98] Excluding Thursday 21 July 2022 and from 25 August 2022 onwards.

when they had last been seen and whether there were any recent concerns about their mental health or immediate risk of harm to themselves or to others".[99] As Ms Robinson put it: "*Critical decisions were made as a team: difficult matters were escalated to me; I in turn could escalate them to senior managers. We did not make decisions in isolation*"[100] Extreme caution must be taken in retrospectively allocating blame to one individual, without having adequate consideration for how teams and systems operated, and the adequacy of any checks and balances on decision-making.

41. **In conclusion, Mr Carter was candid in his evidence to the Inquiry that he accepted that he could have done more to seek out and/or engage with VC over the period 29 April 2022 – 25 August 2022.[101] Rather than simply rest on those concessions, it is vital that the Inquiry ask itself why it was that Mr Carter found himself in that position, in the absence of any evidence that Mr Carter was in some way deliberately disregarding his obligations (on the contrary, the evidence demonstrates he was exceptionally committed, such that he did additional work outside of his working hours and while on leave).**

42. In answering that question, the Inquiry will no doubt have regard to the systemic issues that it has been investigating. However, specifically in relation to Mr Carter, it is important and fair to acknowledge:

    a. First, the difficult position that Mr Carter was placed in from the outset, both in terms of what he was not informed of and the limitations on his ability to build a rapport and therapeutic relationship with VC;

    b. Second, the limitations on Mr Carter's time due to his excessive caseload and the general function and structure of the EIP Team;

    c. Third, the absence of detailed policies, guidance or training on the difficult areas of VC's care and seeking to engage with VC (see further in paragraphs 61-62, below);

    d. Fourth, the fact that no other EIP Team member, including more experienced managerial staff and VC's consultant psychiatrist, formed the view that an alternative approach should be taken to VC's care; and

[99] [NHFT0019589/6].
[100] [WITN0315001/17] §46.
[101] [INQT0000070/49] §§5-14, [INQT0000070/48] §§14-24, [INQT0000070/55] §§14-19, [INQT0000070/73] §25 to [INQT0000070/74] §24, [INQT0000070/86] §§12-22, [INQT0000070/100] §21 to [INQT0000070/101] §10.

e. Fifth, that Mr Carter followed the spirit if not the letter of the EIP "Merged Do Not Attends (DNAs)" Policy at §7.2[102] - in circumstances where he and other EIP Team members were not trained on it, and were only "*made aware of it*"[103] - by calling VC and his mother, sending a letter to VC, cold-calling at VC's address, and giving consideration to contacting the police to report VC as a missing person.

Mr Carter's Leave from 25 August 2022 and the Decision to Discharge VC on 22 September 2022

43. When Mr Carter unexpectedly took carer's leave on 25 August 2022, he did not know how long his leave would be. Despite being on leave, Mr Carter had a telephone conversation with VC's mother on 31 August 2022, who informed him that she had not had face to face contact with VC "*for many months*" and that he had not been at an address she had tried to visit recently. Mr Carter gave VC's mother an address that the EIP Team had recently been provided with (as a consequence of VC applying for a copy of his medical records on 21 February 2022[104] and providing a different address to that recorded on his NHFT records, although the EIP Team were not informed of this until 9 August 2022[105]) and recorded in RIO that he felt it appropriate "*to go out and see* [VC] *to determine his mental state and general wellbeing*".[106]

44. Mr Carter was unable to attempt to visit VC at this address before the latter's discharge from EIP, owing to his ongoing leave, although it is unlikely that VC resided there.[107] As set out below, that action was specifically noted by his colleagues in his absence in early September 2022,[108] yet there is no evidence as to why this was not followed up by anyone in Mr Carter's absence.

45. Between 25 August and 23 September 2022, five MDT meetings took place in Mr Carter's absence. The only reference to what may have been discussed in those meetings concerning VC comes from a brief RIO note from Ms Heath (see paragraph 47, below) and two brief references to VC within emails sent by Ms Parsonage to the

[102] [NHFT0004725].
[103] Carter [WITN0368001/5] §20, [WITN0368001/21] §87; Parsonage [INQT0000069/50] §§4-15; Robinson [INQT0000071/52] §17 to [INQT0000071/55] §22; Lloyd [WITN0357001/11] §33, [INQT0000074/35] §9 to [INQT0000074/36] §21.
[104] [WITN0163002]. See footnote 86 above in relation to the inaccuracy of this address.
[105] [NHFT0018055].
[106] [NHFT0000168/270].
[107] See footnote 86 above in relation to the inaccuracy of this address.
[108] [NHFT0018394].

other CCOs and to Ms Heath and Ms Robinson to arrange cover for Mr Carter's patients during his leave:

a. 8 September 2022: "*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*";[109] and

b. 16 September 2022: "*Gary's caseload 19/09… VC – discuss Tuesday discharge*".[110]

46. The decision to discharge VC was taken at the following Thursday MDT meeting, on 22 September 2022. There is no record of that meeting.

47. Within VC's RIO records, Ms Heath noted that the reasoning for the decision was "*as no contact has been made with Valdo for a period of time despite attempts to make contact and having done cold calls, decision made within the team to discharge back to GP due to non engagement with view for GP to refer back to services in the future if needed*",[111] although Ms Heath has also stated that she does not believe she was at the relevant meeting, but assumes she assisted with the follow-up actions.[112] Most witnesses have stated that they either cannot recall whether they were at that meeting, or that they were not there, though it appears that Dr Lloyd, Ms Parsonage, and Frances Doughty were present.[113]

48. The Inquiry is invited to dismiss Dr Lloyd's suggestion – made for the first time in the afternoon session of her oral evidence, and contrary to her signed witness statement – that Mr Carter had determined, at some point prior to him taking leave on 25 August 2022 – that VC should be discharged from the EIP, and that she was only ever responsible for taking "*administrative*" action in "*rubber stamping*" that decision.[114] That suggestion was contrary to the contemporaneous evidence (see the RIO note referenced at paragraph 43, above, and the emails referenced in paragraph 45, above) and to her witness statement in which she proffers an explanation of why it "*was decided to discharge VC from the service as non-engaging patient*", namely that "*we reached a point where it became very clear that VC was actively and intentionally disengaging with services and his medication… There was no further intervention that we could offer as a team.*"[115]

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[109] [NHFT0018394].
[110] [NHFT0019091/2].
[111] [NHFT0000168/270-271].
[112] [WITN0292001/15-16] §42-43.
[113] Lloyd [WITN0357001/125] §347; Parsonage [WITN0317001/55] §209; Bayer [WITN0385001/21] §74.
[114] [INQT0000074/72] §1 to [INQT0000074/73] §3.
[115] [WITN0357001/125] §§348-349.

49. As set out at paragraph 43 above, the last note made by Mr Carter on VC's RIO records indicated that, having spoken to VC's mother, he thought that a face-to-face visit with VC was required. The subsequent e-mails, limited as they are, suggest that Ms Parsonage identified that RIO entry as being significant, and that it was used to discuss the next steps in respect of VC's care. Those emails also contradict any suggestion that the team were all under the impression that the decision to discharge VC had been taken and was settled, if not yet 'rubber stamped', and their oral evidence to the Inquiry – all given prior to Dr Lloyd's oral evidence and, therefore, before this new suggestion had been made – was consistent with those contemporaneous emails, and indicated that the discharge decision was, as per the RIO records, made on 22 September 2022.

50. It is correct that, in an earlier RIO reference dated 4 August 2022, Mr Carter set out that he had been unsuccessful in attempting to cold-call at VC's address, and had been told "*that no one of that name lived there*" and that VC had "*a history of giving false addresses*".[116] Faced with that dilemma, and an extended period of disengagement by VC – including VC falsely stating to EIP professionals that he had left the country – Mr Carter recorded that he would "*take this situation back to Dr Lloyd and Emma* [Robinson] *on Monday. To consider – discharge to GP? report as a missing person?*".[117] Even leaving aside the clinical, professional and potentially legal obligations on different members of the EIP Team, the terms of that entry itself indicate that the EIP Team did not operate on the assumption that Mr Carter as a CCO would single-handedly make the determination as to what steps would be taken in relation to VC's case.

51. It is undoubtedly the case that all members of the EIP Team, including Mr Carter but also those in more senior positions and with more psychiatric qualifications, were, in the absence of a more assertive offering (as discussed at paragraphs 66-71 below), at a loss as to how to provide their services to VC in the face of his persistently limited engagement (and, for some periods, disengagement) and therefore considered what steps could and should be taken, including his potential discharge.

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[116] [NHFT0000168/270].
[117] [NHFT0000168/270].

52. There is no evidence that any of the supervising EIP staff, or Dr Lloyd as the consultant psychiatrist, discouraged or disapproved of the consideration of VC's discharge on the basis of non-engagement.[118] On the contrary, there is evidence that:

    a. This approach was taken in relation to VC at least four months prior to Mr Carter assuming the role of VC's CCO, and was endorsed or instigated by Dr Lloyd and senior managers:

        i. In an email on 10 January 2022 to Ms Birtles, Ms Robinson stated that "*we may need to consider discharge, we know he can become unwell and has had admissions but he is not engaging at all… I know we discussed looking at a different CCO but I don't think that will change engagement with the services…*";[119]

        ii. On 17 January 2022 Dr Lloyd also stated, following VC missing an appointment with her that "*Consideration will need to be given to discharge as Valdo has essentially disengaged…*";[120]

        iii. Ms Heath gave evidence that there were references to considering VC's discharge when she joined the team in January 2022;[121]

        iv. Ms Parsonage also told the Inquiry that she was "*fairly confident*" that discharge had been discussed from February 2022;[122] and

    b. Senior staff were themselves under pressure to discharge high-risk, non-engaging patients.[123] That pressure is relevant regardless of whether the e-mail evidencing it (see footnote 123) concerned EIP patients or "*high risk AO* [Assertive Outreach]" patients (and is arguably more concerning in respect of

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[118] There is no evidence to suggest that Mr Carter personally had a practice of suggesting that patients should be discharged on the basis of their non-engagement at the material time. Mr Carter's evidence on the reduction in his caseload from 24 to approximately 12-13 patients following advice from Ms Heath to "*refer people on if at all possible*" ([WITN0368001/8] §31 and [INQT0000070/102] §13 to [INQT0000070/103] §9) was interpreted by CTI as Mr Carter having "*discharged quite a number to the GP around this time*" ([INQT0000074/57] §§21-25). Mr Carter's supervision records demonstrate that he had 19 patients on his caseload as at 22 December 2022 ([NHFT0019620]). The next supervision record that has been disclosed, dated 29 June 2023, shows a caseload of 11 ([NHFT0019625]). It is unclear why supervision records for the intervening period have not been disclosed, in circumstances where monthly supervisions took place, with the exception of February 2023. Accordingly, it is not known when in 2023 the discharges took place, but the evidence demonstrates that it was not "*at the material time*". The Inquiry did not receive evidence on the basis upon which those individual patients were discharged.

[119] [NHFT0018181].

[120] [NHFT0000168/203].

[121] [WITN0292001/24] §67.

[122] [INQT0000069/49] §§5-7, [INQT0000069/60] §§10-17, [INQT0000069/54] §23 to [INQT0000069/55] §11.

[123] [WITN0206043].

the latter), being reflective of the culture and thinking at senior levels in relation to non-engagement.

53. Accordingly, although NHFT's EIP policy has now changed to state explicitly that patients should not be discharged on the basis of non-engagement alone,[124] the evidence is clear that that was not the understood position at the material time.

54. Mr Carter was also firm in his evidence to the Inquiry that he could not understand the decision to discharge VC and did not agree with it, given that the EIP Team "*should have seriously considered reporting him to the police as a missing person*" further to VC's mother reporting that VC was not at the address she had for him, and given that he "*would expect the CCO's views to be sought*".[125] To Mr Carter, the breakdown in face to face communication with VC's mother represented a significant development that warranted reappraisal of the approach to VC's disengagement, and it ought to have done to all other members of the EIP Team.

55. Thus, even if Mr Carter and/or the EIP Team had, somehow, made a collective, advanced determination that VC should be discharged (which is disputed), it would not have been appropriate to follow that plan blindly with wilful disregard for the new information that VC's mother had provided. When that point was put to Dr Lloyd, she gave conflicting evidence as to whether or not she was aware of the note of that telephone call on 31 August 2022, [126] and said that she had not reviewed the updated RIO Records (which contained Mr Carter's recorded decision to visit VC to assess his mental state and wellbeing) prior to the 22 September 2022 MDT meeting, on the basis that the decision to discharge VC had already been made, but not yet rubber stamped.[127] Her decision to ignore the main repository of information pertaining to a patient, particularly in the absence of their CCO, is inexcusable. It also stands in contrast to her evidence to the Inquiry that she would "*consult the records of EIP patients often enough to maintain medical oversight…* [and] *would typically review a patient's records … before more detailed case discussions in MDT meetings…*".[128]

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[124] [WITN0317002/17].
[125] [WITN0368001/70] §§300-302.
[126] [INQT0000074/97] §§6-20 ("*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 [INQT0000074/106] §§1-2 ("*I don't think I was aware of this particular entry from the 31st*").
[127] [INQT0000074/103] §17 to [INQT0000074/106] §17.
[128] [WITN0357001/20] §57.

56. Dr Lloyd's attempt to attribute blame and responsibility to Mr Carter for making the determination as to VC's discharge not only raised significant issues as to her reliability and credibility as a witness but ought, in Mr Carter's submission, to cause the Inquiry significant concern as to her understanding of her responsibilities as the consultant that was ultimately responsible for VC's care and for oversight of the EIP Team.

57. Irrespective of whether the Inquiry determines that Dr Lloyd was a responsible clinician under the Mental Health Act 1983 ("**the MHA 1983**") (on the basis that VC was, at that point in time, "*liable to be detained*" in accordance with Part II of the MHA 1983)[129], she remained responsible for VC's treatment, as her witness statement correctly acknowledged: "*The community consultant psychiatrist was responsible for the direct medical management of all patients within their individual caseload but also had oversight of all patients within the EIP service*".[130] Her experience and qualifications entitle her to assume the burden of that responsibility, and no amount of team input or discussion in respect of the decision making could alter that.

58. Dr Lloyd relied on the fact that she had only had one appointment with VC six months prior (on 14 March 2022),[131] and that she only spent 1.5 days (i.e. 12 hours) per week with the EIP Team.[132] Those matters are clearly relevant to the standard of care that Dr Lloyd could realistically deliver, as well as her ability to oversee her patients, and ought to have been something that the NHFT was aware of. They did not, however, entitle her to derogate from, or delegate, her clinical and professional responsibilities to a community psychiatric nurse with insufficient qualifications to make those determinations. The Inquiry should instead accept Mr Carter's evidence – which he was not challenged on – as being reflective of the appropriate and accurate position, i.e. that he had "*never discharged anybody in my career. It's not my job. Responsible Consultants discharge people. I can put my view forward, but ultimately it's other people who discharge*".[133]

59. Dr Lloyd's refusal to accept those points in evidence,[134] and her assertions that she did nothing more than "*rubber stamp*" a CPN's decision to discharge a patient, indicates

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[129] Section 34(1) of the MHA 1983.
[130] [WITN0357001/20] §56.
[131] [INQT0000074/96] §§6-23.
[132] [INQT0000073/102] §§5-14; [INQT0000073/110] §§13-24; [WITN0357001/140] §398.
[133] [WITN0368001/16] §67; [NHFT0004880/5]; [TCLT0000750/32].
[134] [INQT0000074/58] §25 to [INQT0000074/59] §17; [INQT0000074/79] §§5-24; [INQT0000074/80] §24 to [INQT0000074/83] §19; [INQT0000074/103] §17 to [INQT0000074/109] §4.

that her misunderstanding of her clinical and professional obligations was ongoing as late as May 2026 and is, therefore, an area that is ripe for a recommendation by the Inquiry.

(C) MR CARTER'S EXPERIENCE OF SYSTEMIC ISSUES WITHIN THE EIP TEAM AND THE NHFT

60. While Mr Carter recognises that his experiences only form part of the factual picture that the Inquiry is considering when it comes to the systemic issues within the NHFT, they are nonetheless important.

    a. First, those matters are extremely significant context that must be considered in any fair assessment of his actions.

    b. Second, Mr Carter has given his evidence on these issues as he experienced them in an entirely candid manner. It is also relevant that he is entirely independent from the NHFT, having resigned from his role as he felt he could not trust the NHFT[135] and, having raised the preventability of the 13 June 2023 killings within the NHFT and received a firmly negative response, felt that if he did not resign he "*would be forced to just toe NHFT's line about what happened and wouldn't be able to express my own feelings about the tragedy*".[136] He was similarly candid in a staff feedback session being undertaken as part of the CQC review, telling his interviewers that he felt that systemic failure led to the events in June 2023.[137] His independence should cause the Inquiry to place significant weight on his evidence.

    c. Third, his evidence on the relevant systemic issues was broadly reflected in, or endorsed by, other witnesses within the EIP Team.

Training

61. When Mr Carter joined NHFT in September 2020, he had spent the best part of fifteen years working in nursing homes.[138] He initially joined as an agency worker on a six month contract, but then took up a permanent position. Between then and him leaving NHFT in April 2025, he did not receive formal training on: completing clinical

[135] [WITN0368001/85] §344, §§346-347.
[136] [WITN0368001/85] §345; see also [INQT0000070/77] §1 to [INQT0000070/78] §13.
[137] [CQCM0010338/7].
[138] [WITN0368002].

records,[139] on handling non-concordance,[140] patient disengagement,[141] or formal training on how to complete risk assessments in respect of risks to others.[142] He had seen the EIP Operational Policy[143] and the DNA policy dated September 2021,[144] although he did not feel "*familiar*" with either of those documents and did not remember looking at them regularly, and instead discussed those issues with colleagues.[145]

62. As the CQC noted in its Special Review Report, other patients who had disengaged from the City South EIP Team had been "*followed up… in a variety of ways, such as by text, email, telephone calls and home visits, which had led in most cases to the patients re-engaging with services*",[146] which was the same approach that Mr Carter and the rest of the EIP Team took in their attempts to try and re-engage VC. However, ultimately, "*the EIP team did not have specific guidance within the standard operating procedures about how to manage patients who had disengaged from services. There were no frameworks in place about what should happen if a patient missed a certain number of appointments, and what steps care co-ordinators should follow depending on the number of appointments missed*".[147] In those circumstances, given his lack of adequate training, guidance and any alternative direction from more senior members of the team, there was no basis nor reason for Mr Carter to consider an alternative approach.

Staffing Levels and Caseloads

63. The City South EIP Team was understaffed throughout the four years that Mr Carter worked there.[148] Indeed, Mr Carter was initially hired as an agency worker to help with the absence of staff.[149] When Mr Carter initially joined NHFT as a CPN, Ms Robinson made clear to him that his caseload would likely be over the recommended limit of 15, as he would be the only male CPN (and because other staff members

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[139] [WITN0368001/17] §§72-73.
[140] [WITN0368001/6] §§19-21. See also Parsonage [WITN0317001/5] §14; Pinder [WITN0396001/11] §39 and Bayer [WITN0385001/6] §22.
[141] [WITN0368001/6] §20. See also Birtles [WITN0348001/12] §38; Lloyd [WITN0357001/11] §33; Parsonage [WITN0317001/6] §17; Pinder [WITN0396001/10] §32; and Bayer [WITN0385001/8] §29.
[142] Carter [WITN0368001/24] §§99-101, [INQT0000069/80] §1 to [INQT0000069/82] §16; Birtles [WITN0348001/37] §106; Robinson [WITN0315001/24] §69; Heath [WITN0292001/4] §10; Pinder [WITN0396001/29] §98 and [WITN0396001/34-35] §§113-115.
[143] [CQCM0009938].
[144] [NHFT0004725].
[145] [WITN0368001/4] §13 and [WITN0368001/21] §87.
[146] [CQCM0016518/27].
[147] Ibid.
[148] Carter [WITN0368001/89] §366, [TCLT0000750/39].
[149] [WITN0368001/4] §9.

already had caseloads of over 15).[150] That prediction materialised within the first month of him joining and at one point, not long after Mr Carter began in the EIP Team, he was the only CPN for a period of 2-3 weeks.[151] On any view, that situation was unsatisfactory and created risks for patients, the public, and staff. The chronic understaffing of the EIP Team had direct repercussions on the caseloads of CCOs and their ability to do their best for patients, and to deliver any form of "*assertive*" approach following the termination of the assertive outreach program within NHFT.

64. Mr Carter's caseload was consistently above the limit of "*no more than 15*" patients[152] that was set out in the EIP Standards.[153] His patients also consisted of some of the EIP Team's more complex patients, "*who presented a greater risk of violence or inappropriate behaviour*" and of "*aggression*".[154] The EIP Standards specified that there should be systems in place to monitor staff members' caseloads and to ensure that they do not exceed 15.[155] Thus, the suggestions made by Ms Robinson and Ms Heath that Mr Carter did not specifically complain to them about his caseload[156] misses the point entirely: it was incumbent upon them and other managerial staff within NHFT not to rely on individuals who were willing to be team players and to take a heavy caseload to bear the burden and, instead, to take steps to ensure that staff levels were adequate and caseloads were manageable, by reference not just to the EIP Standards but to patient complexity. The clear outcome of not doing so would not be limited to staff

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[150] [WITN0368001/7-8] §28. Evidence of other CCOs having high and demanding caseloads includes: Parsonage [WITN0317001/7] §21; Pinder [WITN0396001/16] §52, [WITN0396001/56] §182; Birtles [WITN0348001/162] §491; Robinson [INQT0000071/16] §5 to [INQT0000071/17] §10; and Heath [WITN0292001/28] §78. Dr Lloyd also made the same observation about medical staff beyond CCOs [WITN0357001/140] §398 and [INQT0000073/102] §10 to [INQT0000073/103] §12.

[151] Carter [WITN0368001/7-8] §§27-30, [NHFT0004711/1].

[152] NHS Level 2 Report [NHFT0000451/22] §68; Appendix 14 to Mr Carter Investigation Report [NHFT0004919]. All of the supervision records before 13 June 2023 that have been provided show Mr Carter having a caseload of more than 15: see 19 January 2022 [NHFT0019622/2]; 24 February 2022 [NHFT0019617/1]; 23 March 2022 [NHFT0019628/1]; 27 April 2022 [NHFT0019618/1]; 27 May 2022 [NHFT0019629/1]; 27 June 2022 [NHFT0019624/1]; 27 July 2022 [NHFT0004909/1]; 26 October 2022 [NHFT0019631/1]; 24 November 2022 [NHFT0019630/1]; 22 December 2022 [NHFT0019620/1]. See also: Carter [WITN0368001/8] §§29-31 and [WITN0368001/9] §§34-35; Lloyd [WITN0357001/128] §355. Although Sharon Heath gave evidence that high caseloads may reflect the presence of a high student population that was not present in Nottingham over summer, she correctly acknowledged that she could not say whether this was applicable to Mr Carter [WITN0292001/28] §78. There is no evidence that Mr Carter's caseloads had a high number of students and this point should be disregarded. It also contradicts the evidence as to Mr Carter having a substantial number of difficult or risky patients, addressed below.

[153] [NHSE0002298/19] §109.

[154] [NHFT0000451/22] §68. See also Carter [WITN0368001/7-8] §28; [WITN0368001/44] §188; [INQT0000070/99] §5 to [INQT0000070/100] §10; Robinson WITN0315001/34] §100; Heath [INQT0000071/118] §25 to [INQT0000071/119] §16; Lloyd [WITN0357001/128] §355.

[155] [NHSE0002298/19] §109.

[156] Robinson [INQT0000071/17] §11 to [INQT0000071/18] §10; Heath [WITN0292001/27-28] §§76-79, [INQT0000071/119] §25 to [INQT0000071/120] §23. Though, note the more equivocal evidence given by Ms Robinson in her NHFT Interview, as summarised at [NHFT0004872/39] §5.303: "*ER stated that GC had not complained about his caseload, though he had sometimes raised the fact that he had high numbers of patients on his caseload*".

burnout, but would including preventing staff from being able to deliver meaningful and sufficiently regular care to each of their patients.[157]

65. Similarly, the decision to allocate VC to two CCOs would have doubled the amount of time that was available to seek out and interact with VC. Given VC's known issues with disengagement, that second CCO could either have been Ms Birtles for continuity of care or, if that was deemed too risky due to her pregnancy, Ms Parsonage, who had had the most contact with VC second to Ms Birtles (and who recognised, in her evidence to the Inquiry, that this would have been a helpful approach).[158] No clear answer was ever given to the Inquiry as to why a second CCO was not appointed.

The Limitations of the EIP Service and the Service Gap

66. Both the intended nature of the EIP Team, and the caseload that Mr Carter had, meant it was not remotely realistic to expect him to track down disengaged and evasive patients. He simply did not have time to do so, as much as he might have wanted to. The best he could do with the time and resources available to him was to try to reach out to VC in different ways to encourage engagement, and to monitor medication concordance from afar.

67. The EIP Team were dispensing VC's medication precisely because that was a realistic measure they could take when concerned about concordance (rather than the default position of his GP dispensing it). Doing so meant that they knew when it was due and whether it had been collected.[159] But there was no expectation, nor would it have been possible, to routinely check VC's medication blister pack, nor ensure that he swallowed his medication in front of them daily.[160] As such, Mr Carter did what the EIP service expected (and was designed to do).

68. While the NHFT's EIP Policy recommended "*An assertive approach to engagement to reduce the risk of service users being lost to services and potentially experiencing a longer duration of untreated psychosis*",[161] there was no guidance on what that approach looked like or, more importantly, how it was going to be provided given the extremely high patient to staff ratio and consequent caseloads. It is unclear whether NHFT considered

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[157] Emma Robinson and Sharon Heath ultimately accepted this; see, respectively [INQT0000071/72] §§4-8 and [INQT0000071/118] §25 to [INQT0000071/119] §16.
[158] Parsonage [WITN0317001/57] §218, [WITN0317001/61] §235.
[159] Parsonage [WITN0317001/4] §13; Bayer [WITN0385001/5] §18; Birtles [WITN0348001/8] §24, [INQT0000067/73] §22 to [INQT0000067/74] §24; Burri [INQT0000066/48] §23 to [INQT0000066/49] §10.
[160] Carter [INQT0000070/37] §20 to [INQT0000070/38] §22; Birtles [WITN0348001/76] §224; Parsonage [WITN0317001/33] §129; Pinder [WITN0396001/47] §151 and [WITN0396001/49] §160.
[161] [CQCM0009938/7].

the EIP service to be capable of providing "*intensive case management for people with psychosis or schizophrenia who are likely to disengage from treatment or services*" (as per NICE guidance);[162] on any realistic view, as it was set up at the material time it plainly could not. As the Theemis Report put it: "*The policy is disconnected with the reality of what is possible to deliver within the constraints of service budget and resources*".[163]

69. The issue in VC's case is that, as the CQC's Special Review Report concluded, it is clear that he needed a level of community care, supervision, and engagement attempts that was beyond what the EIP Team was set up for, and staffed to provide.[164] Without an Assertive Outreach team specifically designed to deal with patients with the kind of disengagement and characteristics and beliefs that VC presented with, the mental health services within NHFT could never adequately supervise and care for VC. Mr Carter and the EIP Team could act as no more than an occasional check-in, and regularly felt the frustration and impact on them as professionals of being at a loss as to how to provide the care that VC needed.

70. The Inquiry heard from several NHFT witnesses as to the inability or inappropriateness of other services or teams within the Trust to provide the kind of care and service that VC needed:

    a. The local mental health team was even less resourced than the EIP Team and catered for all types of mental health conditions, and therefore did not have the specialised resource that individuals with psychosis and schizophrenia required;[165]

    b. A referral to the Community Forensic Team was considered to be inappropriate on the basis that VC would not meet the referral criteria.[166] It was clear that the CCOs were not familiar with how to seek out forensic input on

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[162] [NICE0000019/28] §1.5.1.2.
[163] [NHNB0018966/200].
[164] [CQCM0016518/31].
[165] Lloyd [WITN0357001/24] §75(ii), [WITN0357001/127] §352, [WITN0357001/136] §385; Robinson [WITN0315001/14] §38.
[166] As set out in the witness statement of Dr Mark Taylor at [WITN0388001/21-22], paragraph 69: "*a) They will have an identifiable mental disorder; b) They will present with a significant probability of serious harm in that the individual's behaviour has or could lead to life threatening injury or irreversible harm to others. Patients typically have a history of GBH, fire setting, stalking, and/or sexual violence, with a suspected link between the mental disorder and significant risk of serious harm. c) There should be a suspected link between the mental disorder and significant risk of serious harm. d) Specialist forensic management is required. The specialist work undertaken may include providing education and therapy on issues such as impulse control, problem solving and building healthy structures and routines. Specialist work may involve directing the individual to a relevant inpatient or criminal justice service. e) Patients should have the potential to benefit from the treatment/assessment provided through active engagement with the team. Where this is not the case the referring agency will be contacted, and a plan will be shared in regard to future management or discharge.*"

their cases and there was a lack of links between the two teams for that type of cross-team working;[167]

c. While the Crisis Team provided a more hands-on approach to care for a few days at a time when VC was particularly admission-vulnerable,[168] they did not have the capacity to do this on an ongoing basis as they were also understaffed and at capacity[169] (and, like EIP, their service was not intended to operate in this way, with the Crisis Team being a short-term, intensive monitoring service).[170] Moreover, Mr Carter and other City South EIP staff had been advised by Ms Robinson in January 2022 of the "*massive shortages in inpatient areas*". Ms Robinson also "*requested staff to be mindful when contacting colleagues in crisis teams/and management and there doesn't seem to be any capacity*";[171] and

d. Seeking a MHAA would require "*clear evidence of deteriorating mental health*",[172] but the EIP Team only had evidence that VC did not wish to engage with services and, based on their collective knowledge and experience of making referrals to the Crisis Team for a MHAA, they considered that this would not meet the threshold that a MHAA and/or detention under the MHA 1983 was warranted.[173] Dr Lloyd, as the most qualified member of the EIP Team was firm in that view.[174]

71. Similarly, there was no organisation or service outside of the NHFT that could fill that gap. Notwithstanding that Mr Carter gave evidence that he accepted that he and the other members of the EIP Team ought to have contacted the police before discharging VC,[175] it is relevant to the Inquiry's consideration of this systemic issue that it heard consistent evidence from the EIP Team that the police would only conduct a welfare check if there was "*imminent risk to life or limb*" based on their view that they "*had neither the resources nor the expertise to carry out these checks on patients with mental health*

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[167] Carter [WITN0368001/26] §109 and [WITN0368001/91] §372; Birtles [WITN0348001/39] §112; Lloyd [WITN0357001/43] §§121-123; Parsonage [INQT0000069/5] §21 to [INQT0000069/6] §8 and [WITN0317001/73] §286; Pinder [WITN0396001/30] §101; Heath [WITN0292001/31] §89.

[168] Lloyd [WITN0357001/137] §386; Birtles [INQT0000067/87] §17 to [INQT0000067/89] §9; Parsonage [INQT0000069/13] §§21-25.

[169] Carter [WITN0368001/6] §23, [WITN0368001/16] §64, [WITN0368001/25] §106, [WITN0368001/72-73] §304(iv).

[170] Lloyd [WITN0357001/107] §296, [WITN0357001/13] §39(i), [INQT0000074/109] §§13-19.

[171] [NHFT0000544/4].

[172] Lloyd [WITN0357001/81] §231.

[173] Lloyd [WITN0357001/81] §231, [WITN0357001/103] §284, [WITN0357001/107] §296, [WITN0357001/126] §§350-351, [WITN0357001/134] §§376-381, [WITN0357001/139] §396, [INQT0000074/33] §19 to [INQT0000074/34] §14; Carter [WITN0368001/72-73] §304(iii)-(iv); Bayer [WITN0385001/25] §95.

[174] Ibid.

[175] [WITN0368001/70-71] §302.

difficulties", and that they could not report VC as a missing person in circumstances where he was making contact with the EIP Team and his family, albeit on an irregular and disengaged basis.[176] Although introduced after the date of VC's discharge, the Inquiry will wish to consider the broader evidence from witnesses on the impact of the 'Right Care, Right Person' national partnership agreement,[177] introduced in 2023, and whether that approach was feasible given the absence of a service within all NHS Trusts that was able to take an assertive approach to tracking down and engaging patients.

Documentation within EIP: Risk Assessments; Summary and Care Plans; Relapse Prevention Plans and RIO Records

72. As set out earlier in this statement, at the time that Mr Carter became VC's CCO on 29 April 2022, VC's key documentation had last been updated as follows:

    a. **Risk assessment**: on 28 February 2022, following VC's discharge from hospital;[178]

    b. **Summary and care plan**: on 14 February 2022, while VC was still an inpatient;[179]

    c. **Relapse prevention plan:** 18 January 2021;[180]

    d. **Mental health clustering tool**: 9 August 2021.[181]

73. Mr Carter updated the clustering tool, [182] but not the remaining documents. He was frank in his evidence to the Inquiry that he had not done so, but that he had read, reviewed and digested those documents when he took over VC's case,[183] and intended to update the documents comprehensively with the input of VC once he had the opportunity to do so.

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[176] Carter [WITN0368001/63] §269, [WITN0368001/90-91] §371, [INQT0000070/55] §§21-25; Lloyd [WITN0357001/127] §§353-354, [WITN0357001/142] §404, [INQT0000074/52] §20 to [INQT0000074/54] §5, [INQT0000074/69] §16 to [INQT0000074/70] §9, [NHFT0019589/15]; Robinson [NHFT0004872/127]; Parsonage [WITN0317001/56] §212.
[177] [NHNB0000318/9].
[178] [NHFT0000190].
[179] [NHFT0000198].
[180] [NHFT0000270].
[181] [NHFT0000180].
[182] [NHFT0000179]. Mr Carter was questioned about the accuracy of his scoring of VC, and it was put to him that he had filled this in incorrectly based on VC's historical presentation, in circumstances where the questions specifically asked Mr Carter to fill in the form in respect of VC's "*most severe occurrence in the previous two weeks*". [INQT0000070/49] §15 to [INQT0000070/51] §23.
[183] [WITN0368001/47] §200, [WITN0368001/82] §335, [NHFT0004882/15-17], [NHFT0004882/27].

Risk Assessment

74. As Mr Carter told the Inquiry, he had "*extremely limited contact*" with VC and thought it did not make sense to change the risk assessment immediately upon becoming VC's CCO, particularly since he was yet to have a substantive meeting with VC and, therefore, he did not have "*any basis on which to update his risk assessment…* [which] *already reflected his problems with non-concordance and poor engagement*".[184]

75. The evidence received by the Inquiry demonstrates that Mr Carter was not alone in his approach to conducting and documenting those assessments and plans, and that there were systemic issues relating to risk assessment in the EIP Team:

    a. Ms Birtles and Dr Burri also gave evidence that they would consider and review risk assessments without necessarily updating them – particularly if they did not consider a patient's risks to have altered;[185]

    b. The evidence demonstrates that the EIP Team did not have formal training on how to complete these risk assessments in respect of the risks to others;[186]

    c. Nor did the team have training on the content of relevant NICE guidelines, which recommended that risk assessments be carried out "*with the service user*";[187]

    d. The CQC's Special Review found that many service users "*did not have an updated crisis or risk plan*" and that "[h]*ow well staff assessed and managed risk… varied*", as did "*the approach to risk assessment*";[188] and

    e. The Theemis Report found that VC's risk assessments (authored by individuals other than Mr Carter) did not indicate a "*dynamic approach to risk assessment and management*" and read "*as a list of previous violent behaviour rather than a true formulation and therefore does not demonstrate active risk control or understanding of the impact in change of effectiveness of protective factors*".[189]

Care Plan

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[184] [WITN0368001/47] §201, [WITN0368001/67-68] §289, [WITN0368001/77] §319, [WITN0368001/82], §335.
[185] [WITN0348001/47] §136, [WITN0348001/71] §210; Burri [WITN0337001/32] §79.
[186] Carter [WITN0368001/24] §§99-101, [INQT0000069/80] §1 to [INQT0000069/82] §16; Birtles [WITN0348001/37] §106; Robinson [WITN0315001/24] §69; Heath [WITN0292001/4] §10; Pinder [WITN0396001/29] §98 and [WITN0396001/34-35] §§113-115.
[187] [NICE0000025/26] at §1.2.10.
[188] [CQCM0016517/46].
[189] [NHNB0018966/12].

76. While Mr Carter wanted to update VC's care plan off the back of a meeting with VC, so that the documentation would be comprehensive, he did accept that he ought to have updated the care plan so that it no longer suggested that VC was an inpatient, and that he would have done this when he got the opportunity to do so.[190]

77. The same criticism can and should be made of VC's CCO at the time of his discharge from hospital, Ms Birtles.[191] Had Ms Birtles updated VC's care plan at that time, when VC was engaging with her even if on a shallow basis, it ought to have specified the means by which the EIP Team could re-engage with VC and/or contact him. There was no way for Mr Carter to extract that information from VC once he had disengaged, at the point of his transfer to Mr Carter.

78. Again, the evidence received by the Inquiry demonstrates that the issues with care plans were systemic across the EIP Team:

    a. A number of witnesses gave evidence that the expectation within the EIP Team was that care plans should be completed in collaboration with, and with input from, the patient, rather than in a patient's absence;[192]

    b. The EIP Policy specified that patients "*should always be central participants*" in the care planning process,[193] and the 2018 DNA Policy stipulated that "*As soon as practicable, individual care plans should be developed alongside the patient…*";[194]

    c. NICE Guidelines also recommended that a care plan be written "*in collaboration with the service user as soon as possible following assessment*";[195]

    d. The notes created by Dr Ahmed and Dr Dracass for their contribution to the CQC Special Review observed that "*Inpatient care plans are populated with previous information and often not updated accurately with personalised information…*";[196] and

    e. The Theemis Report found that the care plans for VC authored by individuals other than Mr Carter:

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[190] [WITN0368001/47] §201, [WITN0368001/82] §335, [INQT0000070/74] §§17-18.
[191] Heath [WITN0292001/25] §§70-71; Carter [INQT0000070/74] §§7-18; Birtles [WITN0348001/99] §298, [WITN0348001/143] §434.
[192] Carter [WITN0368001/14] §§54-57; Birtles [WITN0348001/48] §139, Lloyd [WITN0357001/23] §69, [WITN0357001/66] §189; Burri [WITN0337001/13] §30; Heath [WITN0292001/7] §18; Pinder [WITN0396001/4] §14, [WITN0396001/21] §71, [WITN0396001/24] §78.
[193] [CQCM0009938/10].
[194] [NHFT0000417/5] §4.1.
[195] [WITN0320022/13] §1.3.3.5.
[196] [CQCM0016210/7].

i. Placed "*significant emphasis on VC accessing his own coping strategies*";[197]

ii. "*did not include active management plans for known hazards*";[198]

iii. Did not have "*active plans for the management of his non-concordance, his poor engagement and potential for violence when his mental health deteriorated*" and, therefore, "*it is hard to consider that the care plans fully captured VC's needs or served to manage risk to himself and others*";[199] and

iv. That subsequent versions of the care plans were "*largely the same*".[200]

79. Accordingly, although Ms Heath told the Inquiry in her witness statement that "*It is usual practice to update all documents by the care coordinator when having any new patient even if transferred from a different care coordinator and also on a change of a patient's presentation and after discussions within MDTs of any new plans of care*",[201] there is no evidence to indicate that staff were told of this expectation, or had indeed adopted this as their usual practice, nor that those documents were being completed to an adequate standard when they were updated. It will be for the Inquiry to consider whether that is attributable to staff workloads and/or training, or any other factors.

RIO Records

80. Mr Carter has accepted that his notes were not as detailed as they could have been.[202] However, in the absence of any training or guidance on those matters following his recruitment in September 2020,[203] and without anyone raising this issue with him prior to the events of June 2023, he could not be expected to have known different or to have taken any corrective action.[204]

81. The lack of any adequate administrative support or recognised system for note-keeping in respect of MDT meetings at the material time demonstrates that record keeping was certainly not a strong point of the EIP Team as a whole. Moreover, in the absence of any opportunities to meaningfully engage with VC, there is no proper basis

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[197] [NHNB0018966/146].
[198] [NHNB0018966/166].
[199] [NHNB0018966/166].
[200] [NHNB0018966/146].
[201] [WITN0292001/23] §65.
[202] [INQT0000069/99] §§8-18, [INQT0000070/73] §§13-24.
[203] [WITN0368001/17] §§72-73.
[204] Carter [WITN0368001/83] §§337-339; [INQT0000070/73] §§13-24; Heath [WITN0292001/20] §§57-58, [INQT0000071/107] §23 to [INQT0000071/108] §18.

on which it could be contended that Mr Carter's style of note-taking had an impact on how VC's care and treatment was delivered.

(D) RECOMMENDATIONS

82. Mr Carter's witness statement at paragraphs 365-372[205] sets out his views on recommendations that the Inquiry may wish to consider making. Those views remain relevant following the evidence that the Inquiry has heard, and Mr Carter maintains them. In summary, Mr Carter invites the Inquiry to consider recommendations that address:

    a. Sufficient levels of staffing and staff diversity in the EIP Team (paragraphs 366-368);

    b. The emphasis that is routinely placed on the 'least restrictive option' principle in mental health services, including in relation to what community patients consent to, and how that needs to be balanced against the risk to others (paragraph 369);

    c. Limited inpatient beds in mental health wards (paragraph 370);

    d. Inter-agency working, particularly in relation to mental health services and the police (paragraph 371);

    e. The interactions and inter-workings between the EIP Team and the Community Forensic Team (paragraph 372).

83. In light of paragraphs 56-59 above, Mr Carter also invites the Inquiry to consider a recommendation that ensures there is clarity in respect of staff roles and who carries the ultimate responsibility for a patient's care, and any critical decision making in relation thereto (including in respect of handovers where a patient's care is transferred to someone new).

(E) CONCLUDING REMARKS

84. Mr Carter, in a similar vein to a number of other professional witnesses, has told the Inquiry that neither he nor other members of the EIP Team "*ever anticipated that [VC]*

[205] [WITN0368001/89-91].

was capable of killing someone",[206] but that "*it was only a matter of time before he would have a breakdown again*",[207] and that there was a risk that VC could be aggressive and violent.

85. Irrespective of the precise situations that could or could not be foreseen, Mr Carter is clear in his mind that more could have been done and that the service that he and others in the EIP Team delivered could and should have been better. While the team was no doubt staffed by individuals with good intentions, the systems that they worked in hampered those good intentions. In doing so, they let down VC and all the individuals affected by the sad events on 13 June 2023. Mr Carter has spent a long time reflecting on those matters, and has done his best to assist this Inquiry in its exploration of all relevant matters. He hopes that the Inquiry will bring about meaningful changes and improvements in the provision of mental health services in this country.

86. As the Inquiry begins to draw to a close, Mr Carter once again wishes to express his support and condolences to all those who have lost loved ones as a consequence of the events on 13 June 2023, and those whose lives have been affected and changed. He wishes to express his unreserved apology for his mistakes and the part that they played in this tragedy.

SCARLETT MILLIGAN

39 Essex Chambers

NATASHA DAVIES

Bates Wells

[206] [WITN0368001/84] §342.
[207] [WITN0368001/88] §362.