

Thursday, 19 March 2026

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(9.59 am)

THE CHAIR: Yes, Ms Langdale.

MS LANGDALE: Good morning. Before I call the first witness, Dr Milton, Ms Kaur is going to read in a statement from Dr Ullal.

THE CHAIR: Yes, thank you.

Witness statement of DR KRIPA ULLAL (read)

MS KAUR: "First witness statement of Dr Kripa Ullal. "I, Dr Kripa Ullal, will say as follows: "I am a Consultant Forensic Psychiatrist. "I make this statement regarding my involvement in the care and treatment of ... VC. "I have a degree in Bachelor of Medicine and Bachelor of Surgery ... awarded in 2005 by Kasturba Medical College, India. "I am registered with the ... (GMC) and hold a full licence to practice. I am a registered member of the Royal College of Psychiatrists ... "I have been on the GMC Specialist Register for Forensic Psychiatry since 2018. I have been approved by the Secretary of State under Section 12(2) of the Mental Health Act 1983 (as amended) as having special experience in the diagnosis and treatment of mental disorders.

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summaries from previous admissions, a few psychiatric clinical letters, and Care Programme Approach records were made available to me on Systmone prison medical records on the 3 July 2023. "There was no information or handover provided to me regarding VC's mental state and presentation whilst he was detained in the custody suite at Nottingham Police Station and during his time at HMP Nottingham. The information available to me were those that were recorded within his prison records on Systmone during his stay at HMP Nottingham. "Background: "Within my role as a Consultant Forensic Psychiatrist at HMP Manchester, I provide indirect supervision to an Advanced Clinical Practitioner and a Higher Trainee in Forensic Psychiatry. These informal supervision sessions are, as and when required, to provide support and guidance regarding the care and treatment of prisoners. "I first met VC at HMP Manchester on the Regional Bed Wing on 27 June where he was admitted following his transfer. My role at HMP Manchester, as a consultant forensic psychiatrist, was to review his mental state and risk assess for any underlying mental disorder, offer medication, if it was felt appropriate, and if

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"I have worked as a Consultant Forensic Psychiatrist within a medium secure unit at Prestwich Hospital from 2018 until 2024 for Greater Manchester Mental Health NHS Foundation. I am currently employed by Greater Manchester Mental Health Foundation Trust within the division of health and justice, and work at HMP Manchester and HMP Buckley Hall. "At the time of my contact with VC, I was working as a Consultant Forensic Psychiatrist at HMP Manchester and I continue to hold this position. "This witness statement is made to assist the Nottingham Inquiry ... with the matters set out in the Rule 9 Request dated 16 January 2026. "While I have received assistance from a solicitor in drafting this statement, the contents are entirely my own. The evidence set out below reflects out my own recollection and understanding. "Source of information: "At the time of writing this statement, I have had access to VC's SystmOne prison medical records and his medical records received from the Inquiry solicitor and referred to within the index. "I have not had access to VC's primary care GP records. Some of his Nottinghamshire Healthcare NHS Foundation Trust records, which include discharge

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there was a requirement for a period of assessment and treatment in hospital, then to consider a referral to the gatekeeping hospital for detention under the Mental Health Act. "I met with VC on 3 occasions: 27 June 2023, 11 July 2023 and 15 August 2023. "Following his transfer to HMP Manchester, VC was admitted to the Regional Bed Wing where individuals who are suspected to have underlying mental illness are provided with additional support within the prison estate. The unit is supported by mental health nurses who are able to assess mental state and monitor compliance with treatment. "After a few weeks, VC was transferred to the Care and Segregation Unit, as his risk towards others was considered too high for him to be managed within the Regional Bed Wing. "I reviewed VC at HMP Manchester on 3 occasions: 27 June 2023, 11 July 2023 and 15 August 2023. Each consultation has been detailed below, which describes his presentation. "Over time, VC became less guarded and more forthcoming when discussing his psychotic experiences, which appear to have continued throughout his stay at HMP Manchester.

1 "All 3 consultations were face to face and were part
 2 of a Multidisciplinary Team review.
 3 "Prior to each review, a nursing handover was
 4 received from the Regional Bed Wing mental health nurses
 5 in the form of a recorded handover sheet.
 6 "Regarding the written material found in VC's cell
 7 at HMP Manchester I was not made aware of this at the
 8 time, hence I will not be able to comment on it within
 9 my statement.
 10 "First review on 27 June 2023:
 11 "I received an update from staff. I was advised VC
 12 was a recent transfer from HMP Nottingham. I noted that
 13 he was on a 4-officer unlock. Engagement with staff had
 14 been minimal. He denied any thoughts of self-harm, no
 15 concerns had been noted with his sleep. He was eating
 16 and drinking.
 17 "We agreed to request previous medical records to
 18 gather collateral information regarding his past
 19 psychiatric history.
 20 "VC was seen at the door. At the time of
 21 assessment, he was in a constant watch cell. Officers
 22 were unavailable to unlock the door. He presented as
 23 a tall man of slim build and of Afro-Caribbean origin.
 24 At our request, he came to the cell door to speak with
 25 us. Engagement was minimal, although he responded to

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1 "On this occasion, VC was reviewed as part of the
 2 ward round on 11 July 2023. By this time, we were aware
 3 that he liked to be referred to as 'Adam'. Handover was
 4 received from staff that there continued to be minimal
 5 engagement. He continued to deny any thoughts of
 6 self-harm and he denied experiencing any perceptual
 7 abnormalities.
 8 "VC attended the ward round with the escorting
 9 officers.
 10 "He presented with reasonable care and was dressed
 11 in prison attire. I understood that he maintained a low
 12 profile in prison. Since moving into the inpatient wing
 13 he had continued to have minimal engagement with the
 14 nursing staff.
 15 "His speech was slow in rate, volume and of normal
 16 tone. When asked a question, he took time before he
 17 responded and it was unclear whether he was experiencing
 18 any perceptual abnormalities such as voices or whether
 19 this was due to a thought disorder such as thought
 20 block. I suspected some form of thought disorder, as he
 21 was struggling to communicate effectively with us, apart
 22 from providing brief responses.
 23 "When asked, VC told me that he had been in HMP
 24 Manchester for approximately 3 weeks. He said 'yes'
 25 when asked if he was settling well. I asked him if he

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1 the questions when asked. He had no concerns that he
 2 wished to discuss with us.
 3 "When asked where he was prior to being incarcerated
 4 into prison, he stated he had no fixed abode. When
 5 asked whether he was staying with family or friends, he
 6 responded with 'no comment.' He acknowledged he had
 7 been in psychiatric hospitals in the past, and when
 8 asked about the reasons, he advised he was 'looking for
 9 aid'.
 10 "When asked if he was prescribed any medication, he
 11 responded with a 'yes' but was unable to recollect the
 12 names of the medication. He reported that the doctors
 13 seemed to think that the medications were helpful for
 14 him.
 15 "When asked if he experienced any symptoms such as
 16 hearing voices or problems with his thoughts, he
 17 responded 'no comment'.
 18 "Throughout the review he was noted to be guarded,
 19 suspicious, and was noted to be smiling incongruently.
 20 Staff advised me that he remained close to his
 21 television, watching television all day.
 22 "The plan was to continue reviewing his mental state
 23 and risk and to then consider whether referral to
 24 hospital would be appropriate.
 25 "Second review on 11 July 2023:

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1 had any difficulties with his mental health and how he
 2 felt. He responded 'same'. When asked what he meant by
 3 this, he stated 'no change'.
 4 "I reminded him that we had met briefly a few weeks
 5 ago. At the time he informed me that he had been
 6 admitted to psychiatric hospitals in the past, I asked
 7 him which hospital he had been to, and he responded
 8 'Highbury'. I asked him if this was in Nottingham and
 9 he nodded. When asked how many times he had been
 10 admitted to hospital, he stated 'a few admissions'.
 11 When I enquired about the diagnosis he had received, he
 12 stated 'psychosis'. When asked what his understanding
 13 of psychosis was, he stated 'I'm not a professional'.
 14 "I further probed into his description of psychosis
 15 and asked when he had ever heard voices. After thinking
 16 for a while he acknowledged that he was hearing voices.
 17 He said he started hearing voices in 2020, mainly male
 18 voices. He described hearing them all the time,
 19 including at the time of assessment. When I asked what
 20 happened when he started hearing voices, he stated 'got
 21 into trouble'. He told us that he was hearing these
 22 voices all day. He stated that he does recognise the
 23 male voice as the same voice, but not someone he knows.
 24 He reported that the voice he experiences is an internal
 25 voice. Upon direct questioning it was understood that

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1 the voices were commanding in nature, and were a running
2 commentary, commenting on his actions. When asked
3 whether he responded to their commands, he stated
4 'sometimes'. He then stated, 'Do what they say'. When
5 asked what he felt about these experiences, he stated
6 'gives different experiences'. When asked if he felt
7 distressed by these, he stated he used to feel stressed
8 but this has reduced since. When I asked him further
9 questions about the voices, he stated, 'Can't do certain
10 things, there are not options of how I can act'.

11 "I enquired about experiencing visual hallucinations
12 at which point I noticed that he appeared a bit
13 startled. He acknowledged that he was experiencing
14 visual hallucinations but not every day. He had not had
15 these recently. He acknowledged experiencing olfactory
16 hallucinations which were recent. He described smelling
17 things, "source was not around". When asked what he
18 meant by this, he stated: 'Smelling food when food was
19 not around'. He also experiences gustatory
20 hallucinations of having odd tastes. He was unable to
21 recall when he last experienced gustatory
22 hallucinations.

23 "VC also described experiencing thought insertion
24 and withdrawal. He reported that as time went by, he
25 started to differentiate that some of the thoughts were

1 incident leading to his arrest. He was admitted to the
2 inpatient unit at HMP Manchester with increasing
3 concerns regarding his mental health.

4 "His past psychiatric history is noted -- 4 previous
5 admissions with first contact being in May 2020.
6 Previously reported to have improvement in psychotic
7 symptoms with Aripiprazole ... and he had also been on
8 Haloperidol ... for a time. Problems with medication,
9 non-compliance in the community are documented and on
10 his last admission in 2022, a depot injection had been
11 considered.

12 "During his time in HMP Manchester, there had been
13 minimal engagement with mental health team although he
14 denied any thoughts of self-harm and denied any
15 delusional beliefs.

16 "Due to the high number of officers required to
17 unlock the door, he was seen through the hatch. He was
18 dressed in prison clothing and appeared slightly
19 unkempt. He was looking through the hatch to what was
20 happening behind me (there were officers moving around)
21 behind. His speech was quiet, monotonous and slowed.
22 When asked questions, there was a short hesitation
23 before he answered. Answers initially were short,
24 mainly 'yes' or 'no'. However, as we spoke he started
25 to engage more and answers became more detailed and

1 not his own thoughts, indicating towards thought
2 insertion. When asked about thought withdrawal, he
3 stated that this was again ongoing as he experiences
4 memory loss when asked about ideas of reference from the
5 television, he reported 'every now and then'. He was
6 unable to explain further.

7 "When I asked about how he felt about these
8 experiences, he reported that his brain had changed, and
9 he had now started processing things differently. He
10 appeared perplexed and guarded whilst talking about his
11 experiences on the day of assessment. I ended the
12 review and thanked him for being open with us.

13 "VC, towards the end of the review, was asked
14 whether he had a solicitor. He told us that he did have
15 a solicitor, and I explained that if his solicitor
16 wished to contact me, as the visiting psychiatrist,
17 I would be more than happy to speak to them.

18 "Following the ward round, we agreed to commence
19 a referral to Rampton Hospital. This needed to be via
20 the gatekeeper function at the John Howard Centre.

21 "Third review on 15 August 2023.

22 "VC was seen in segregation, there were no concerns
23 expressed from officers.

24 "The documentation confirms that he had been at HMP
25 Manchester since 20 June 2023, following a high profile

1 appropriate to the situation, and what was asked.

2 "His mood is described as good, he appeared blunted
3 in affect. He denied any thoughts to self-harm. He
4 stated that he was eating and drinking normally.

5 "VC accepted that he had been unwell in the past, he
6 admitted taking medication in the past, but stated that
7 'They said it would help but there was no effect'. He
8 stated that he had been hearing voices and that it was
9 a 'permanent problem' not stopped by medication in the
10 past. He also stated that he thought other people were
11 being harmed at times. He denied this being constant,
12 and that the people involved varied. It was unclear
13 what he meant by this, and if this was related to the
14 voices he was hearing. He did not elaborate on this
15 when asked for clarification. He just advised that this
16 was a permanent problem.

17 "When asked who might be doing this, he believed
18 that it must be someone with high technological ability
19 to be able to achieve it. He had no other thoughts on
20 this and did not identify anyone else who may be
21 involved. He accepted that he might have an illness but
22 did not seem to understand what mental illness is or
23 what effect this would have on him. He denied
24 hallucinations in other modalities.

25 "I asked about his thoughts on medication. He

1 stated that it didn't help, but agreed to trial
2 medication whilst he was here. I discussed Olanzapine,
3 (an antipsychotic medication) with him, and explained
4 side effects (EPSE), Hyper-salivation, sedation, NMS,
5 (cardiac concerns). He agreed to start Olanzapine at
6 this time.

7 He was being managed in segregation with
8 high-officer unlock. His risk to others were managed in
9 this environment at the time. There was no evidence of
10 previous self-harm, suicide, and he denied any current
11 thoughts, stating that his mood was good.

12 "My impression was one of ongoing psychotic illness
13 likely schizophrenia. My plan was for:

14 "1) for ECG and bloods ... ; ... if normal, then for
15 medication to commence; and 3), for nursing staff to
16 provide further information regarding the risks and
17 benefits of Olanzapine.

18 "VC was prescribed oral Olanzapine which is
19 antipsychotic medication in the form of oral tablets.
20 I prescribed the medication on 12 September at a dose of
21 5mg.

22 "At HMP Manchester, the medication is dispensed by
23 nursing staff to aid with compliance. VC remained
24 compliant with medication except on one occasion on
25 25 September, when he refused. However, the reason for

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1 psychotic illness, with an escalation in his risk
2 towards others. It was suspected that there was
3 an underlying psychotic disorder and hence it was felt
4 that a period of assessment and treatment under the
5 Mental Health Act would be appropriate.

6 "As per the NHS England ... document, titled 'The
7 transfer and remission of adult prisoners under the
8 Mental Health Act 1983: good practice guidance'
9 published in June 2021, transfer of a prisoner to
10 hospital should not exceed 28 days from when the
11 referral is made. However, in practice, this is rarely
12 achieved.

13 "Once the referral was made to the gatekeeping
14 hospital (through IMPACT) to consider suitability for
15 a high secure admission, the gatekeepers were required
16 to complete an assessment to consider suitability for
17 admission and the appropriate level of security. Once
18 this was completed and, in the case of VC, given his
19 status as a Cat[egory] A prisoner and the nature of the
20 then alleged offences, he was referred to Rampton High
21 Secure hospital. The High Secure hospital decides, upon
22 the date of assessment, based on their local processes
23 and the availability of the Consultant.

24 "Once VC was assessed by Dr John Milton, Consultant
25 Forensic Psychiatrist from Rampton Hospital, given the

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1 this refusal is not documented.

2 "The dose of this medication was increased to 10mg
3 on 26 September to achieve a therapeutic dose of the
4 treatment and because he continued to display psychotic
5 symptoms.

6 "As per ... records, it was reported that there was
7 slight improvement in VC's presentation since commencing
8 treatment with a reduction in the number of incidents of
9 violence within the ... Segregation Unit where he was
10 placed. However, he continued to present with psychotic
11 symptoms.

12 "Although VC did not directly comment on his
13 historical compliance with medication, he made reference
14 during the reviews, as noted previously, that the
15 medication did not help him.

16 "From VC's ... records, I have noted that he
17 declined to have blood tests on 26 September '23,
18 3 July '23, and 18 July '23.

19 "At later dates on 24 August, 1 September,
20 27 September, and 27 October, he consented to have the
21 blood tests as requested, and blood samples were
22 obtained.

23 "Following a period of assessment within the
24 Regional Bed Wing at HMP Manchester, VC's presentation
25 continued to deteriorate, which was related to his

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1 sensitivity of the case within the local area of
2 Nottingham, my understanding was that Rampton referred
3 him to Ashworth High Secure Hospital. The transfer to
4 hospital from prison depends on the availability of
5 a bed, once considered suitable for admission, and the
6 transfer date is arranged by the receiving hospital.

7 "I met with Dr Milton on 08.08.2023 within the
8 Regional Bed Wing at HMP Manchester whilst I was
9 preparing for the review of other prisoners. At the
10 meeting, I provided Dr Milton with a summary of my
11 contact with VC since his arrival at HMP Manchester.

12 "Unfortunately, I was unable to locate the report by
13 Dr Milton, as it was not stored within our prison
14 records, hence I'm unable to recollect if and when
15 I received the report.

16 "Having received and reviewed Dr Milton's report
17 from the Inquiry Solicitor on 06.02.2026, I have noted
18 that Dr Milton concurred with my opinion that VC suffers
19 from a mental illness and required a period of
20 assessment and treatment in a High Secure Hospital under
21 the Mental Health Act.

22 "A social worker assessment is part of the
23 Multidisciplinary Team assessment by a High Secure
24 hospital, and hence this was expected for VC. I was not
25 aware of when the assessment took place. I did not

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1 receive any communication from the social work team.
 2 I do not recollect contributing to the assessment.
 3 "There are no further matters that I wish to raise
 4 with the Chair of the Inquiry."

5 **MS KAUR:**

6 The statement contains the statement of truth and is
 7 signed, dated 24 February this year.

8 **THE CHAIR:** Thank you.

9 **MS LANGDALE:** May I call Dr Milton, please.

10 **DR JOHN MILTON (affirmed)**

11 **Questioned by MS LANGDALE**

12 **Q.** Dr Milton, you've prepared a statement for the Inquiry
 13 dated 13 February 2026?

14 **A.** Good morning, I did.

15 **Q.** Attached to it is the report, psychiatric assessment,
 16 that you prepared in respect of VC, dated
 17 11 August 2023?

18 **A.** Yes.

19 **Q.** Can you confirm the contents are both true and accurate
 20 at the time of you writing them?

21 **A.** I confirm, yes.

22 **Q.** Can you tell us briefly your qualifications, please?

23 **A.** So I have the standard medical and surgical degree from
 24 the University of Birmingham, I have a masters in
 25 clinical psychiatry, and most significantly, I am

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1 imprisonment, or recent community progress ..."

2 If we go to page 5, please:

3 "Most recent risk assessment of your patient,
 4 relevant clinical records of current circumstances,
 5 presentation & progress ...

6 "PNC records (if available).

7 "Copy of last CTR for all Intellectual Disorder and
 8 Autism Spectrum Disorder referrals."

9 That's what's required, and you come in on 8 August
 10 to do an assessment?

11 **A.** Yes.

12 **Q.** You assessed at HMP Manchester?

13 **A.** Yes.

14 **Q.** You tell us at paragraph 17 of your Inquiry statement
 15 that NHFT records were embargoed. What did you
 16 understand from that? Did you have access to them, or
 17 not?

18 **A.** No, at the time of my assessment I didn't. I used the
 19 word "embargoed" but other words that were used within
 20 the email exchanges were "restricted" or "locked down".

21 **Q.** So his medical records, or those medical records, locked
 22 down. What did you have access to?

23 **A.** So I was fortunate that the SystmOne records, which is
 24 a system used within the Prison Service, had actually
 25 included quite a lot of background information. So

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1 a member of the Royal College of Psychiatrists. I have
 2 a higher degree, a medical doctorate, from the
 3 University of Nottingham as well.

4 **Q.** We know, and indeed the statement that's just been read
 5 sets out, that there was a referral in respect of VC.

6 If we can go to NHFT0001214, please, from Corinne
 7 Armstrong, Advanced Clinical Practitioner. We see here
 8 a referral and request for assessment setting out past
 9 psychiatric background. We're aware, the Inquiry is
 10 aware, that some of the facts and details aren't
 11 accurate, but no doubt this was made on the information
 12 available at the time and the records available at the
 13 time?

14 **A.** Yes.

15 **Q.** Did you see this referral?

16 **A.** Yes.

17 **Q.** Referral letter, yes? We know, if we go to NHFT0001780,
 18 the Referrals to Adult Secure Inpatient Service:
 19 Guidance for Referrers document, can we go, please, to
 20 page 4 of that document, the pathway requires
 21 psychiatric reports set out there:

22 "... (no more than 3 months old) [detailing] the
 23 following: family, personal, psychosexual, psychiatric,
 24 medical, substance use, and forensic history.

25 "Circumstances & progress of hospital admission or
 18

1 I had some information about VC's psychiatric care in
 2 Nottingham, but not all the details.

3 **Q.** Did you have information from Cygnet and Arnold or
 4 hospitals, for example?

5 **A.** No, I knew he'd been admitted to those three different
 6 hospitals, Highbury Hospital on several occasions, to
 7 Calverton Hospital in Nottinghamshire and in Darlington.
 8 But I didn't have the details, I didn't see the
 9 discharge summaries.

10 There was information about the medication. There
 11 was information about what they thought the mental
 12 disorder was, but I saw no detailed information.

13 **Q.** You didn't see GP records, but you say it's not unusual
 14 not to have access to GP records.

15 **A.** Yes, in my experience that's the case.

16 **Q.** But presumably in any psychiatric assessment, the more
 17 records you have, the better?

18 **A.** Certainly true.

19 **Q.** You say at paragraph 19 you hadn't "seen the case
 20 summary, indictment or depositions relating to the
 21 alleged offences in June". You were being asked, were
 22 you, to do a risk assessment or part of that Pathways
 23 risk assessment but you didn't have any information
 24 surrounding those offences?

25 **A.** No. It's not unusual not to see the kind of information

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1 relevant to the depositions. However, the PNC, the
 2 Police National Computer printout would have been
 3 helpful, but I saw from other sources that VC did
 4 apparently have previous cautions or convictions.
 5 **Q.** So you understood what was the extent of his involvement
 6 with the police before the offences he was detained for
 7 at this point.
 8 **A.** I'd read, again in the SystmOne records sent to me by
 9 HMP Manchester in the referral information that the
 10 police had been involved on several occasions when he'd
 11 been detained under the Mental Health Act and admitted
 12 to hospital.
 13 **Q.** But you didn't know why or what the episodes --
 14 (*overspeaking*) -- --
 15 **A.** Not the details.
 16 **Q.** -- of violence may have been. No details?
 17 **A.** No.
 18 **Q.** And again, an assessment of risk, having a full and
 19 accurate set of circumstances surrounding any violent
 20 episodes previously, is highly relevant, isn't it?
 21 **A.** It would be.
 22 **Q.** Standing back from this case, as a psychiatrist, have
 23 you ever, in your practice or experience, liaised
 24 directly with the police to get their view or
 25 information about a patient or someone you've been

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1 think you'd get access to it?
 2 **A.** So I, in my training and in my brief period as a general
 3 psychiatrist, I often went to custody suites. This was
 4 before specialist section 136 suites attached to
 5 hospitals were available.
 6 So it wasn't unusual to go to a custody suite, speak
 7 to the desk sergeant, in the course of doing a Mental
 8 Health Act statement. So I would liaise with, often
 9 with the arresting officers. Things have changed. This
 10 would be back in the 1990s, early 2000s, but yes, I did
 11 have experience where I'd have assessed people in the
 12 community.
 13 **Q.** How have they changed in that respect, in terms of
 14 obtaining information?
 15 **A.** Difficult for me to say. My primary role has been as an
 16 inpatient forensic psychiatrist in a high secure
 17 hospital, so in some ways quite removed from community
 18 settings. But I do liaise with community forensic
 19 psychiatrists from time to time, but things like
 20 caseloads have increased, but in terms of inter-agency
 21 working, I couldn't say.
 22 **Q.** It sounded as though you were saying in the 1990s you
 23 could have direct conversation with custody suite
 24 officers to get information; as far as you're concerned
 25 you don't know if that could happen now, as easily?

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1 conducting an assessment of to understand the factual
 2 matrix better?
 3 **A.** In my practice at Rampton Hospital, that used to be done
 4 by my -- we had a security department, and so if there
 5 were gaps in our knowledge about an already admitted
 6 patient the security department would have liaised with
 7 the local police to try to get more information.
 8 **Q.** Is that when there's convictions?
 9 **A.** Any information. Sometimes, for example, a patient may
 10 have been referred to Prevent, because there could have
 11 been concerns about potential radicalisation or
 12 terrorist involvement. So it couldn't -- it didn't just
 13 have to be cautions and convictions; it could be a wider
 14 intelligence. But I would not do that personally. That
 15 would have been done by my colleagues in security.
 16 **Q.** Sure, but would you expect any resistance to get any
 17 information about something that didn't involve
 18 a conviction?
 19 **A.** That's not been my experience from talking to my
 20 security colleagues. There's been reasonable agency
 21 cooperation, as far as I'm aware.
 22 **Q.** Have you ever done, in your career, community
 23 assessments? So not when someone is in a secure unit,
 24 but if it's a patient in the community, if you wanted to
 25 get that kind of information from the police, do you

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1 **A.** It was through location. You were called to the local
 2 custody suite to do the Mental Health Act assessment,
 3 and inevitably you would ask the officers what the
 4 issues were. They'd probably have already been seen by
 5 a forensic medical examiner as well, but no, it's
 6 difficult for me to comment on how things are now.
 7 **Q.** So it may have been the opportunity, you're all in the
 8 same place.
 9 **A.** Exactly.
 10 **Q.** It's a person you can ask --
 11 **A.** Yes.
 12 **Q.** -- and get the information you want. And it's quite
 13 easy to see how you might want corroborating information
 14 one way or the other when you're dealing with patients;
 15 is that right?
 16 **A.** Yes.
 17 **Q.** Tell us how you see the importance of not simply relying
 18 on what the patient is telling you.
 19 **A.** So it's sometimes called informant information. So
 20 that's not in any kind of sinister -- but information
 21 for families, information from people that have spent
 22 time with either a defendant or patient. So they know
 23 them well. That's valuable information, because, as you
 24 say, you can't always -- someone who is very mentally
 25 ill may not have a very clear perception of their own

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1 problems, have no insight. So that kind of information
 2 is highly relevant.

3 **Q.** May they just not be telling you the truth? Insight is
 4 one thing and masking, we'll come to that, but sometimes
 5 they might just not be telling you the truth; they might
 6 not want to tell you the truth.

7 **A.** Yes, it's called dissimulation or fabrication of
 8 symptoms. It happens occasionally. That's one
 9 advantage of admitting someone to hospital where they
 10 have 24 hour, seven day a week observations by
 11 experienced staff. That can be an important part,
 12 particularly, you know, to rule out whether or not that
 13 is a problem. It's not my -- that's not very common.

14 **Q.** No, and I was less directing the question towards
 15 fabrication of symptomology; more fabrication of factual
 16 matrix surrounding violence, for example, which is
 17 relevant to risk.

18 **A.** Which is why having the things like the Police National
 19 Computer, PNC, account of someone's previous cautions
 20 and convictions is useful and extra information that
 21 might not be on the PNC record as well. So you're
 22 right, it would be highly relevant.

23 **Q.** Do you think psychiatrists look for information that
 24 potentially undermines the factual matrix given by
 25 a defendant or patient, or is there a tendency to accept

25

1 facts around interactions with others in the community,
 2 risk in the community, violence in the community, what
 3 other potential sources or informants, to use your
 4 terminology?

5 **A.** Family is invaluable. So family members are often the
 6 first people to have concerns about their sibling,
 7 parent, son or daughter. So often, you know, we pay
 8 strong attention to that. Again, in my -- the context
 9 of working in Rampton Hospital, we have -- that's one of
 10 the reasons we have a social care assessment by forensic
 11 social workers, sometimes the police and, as I say,
 12 through things like Prevent, and sometimes the local
 13 mental health team, they may well already be managing
 14 someone and you would spend time and going through the
 15 notes. So a multi-source approach, really, in order to
 16 get as many corroborative sources as possible.

17 **Q.** Can we have paragraph 20 of your statement on the
 18 screen, please. So it WITN0398001, page 4.

19 It's the top two paragraphs, perhaps reflecting your
 20 discipline and forensic nature of your work, but you set
 21 out at paragraph 20 why various documents, and also
 22 footage, are important, or can be helpful. Can you tell
 23 us why that is, from a psychiatrist perspective, why
 24 it's helpful to see body-worn camera footage, et cetera,
 25 in some cases?

27

1 what is reported?

2 **A.** I'm a forensic psychiatrist, so I work in a different
 3 setting to my adult mental health general psychiatric
 4 colleagues. So I have more opportunity often, and I'm
 5 more interested, particularly where there are criminal
 6 proceedings, it's very important to try to rule out
 7 whether someone is being, on the one hand of the
 8 spectrum, guarded and, on the other hand of the
 9 spectrum, deliberately misinforming you of information.

10 It could be much harder in a community setting to do
 11 that. Often I'm able to step back and have more time to
 12 seek out the information I need.

13 **Q.** Tell us what the significance of being a forensic
 14 psychiatrist is.

15 **A.** Forensic psychiatrists have a specialist training. So
 16 we deal with mentally disordered offenders, people who
 17 come before the courts. We're also trained to have
 18 extra expertise in managing risk to others, whether it
 19 be in a community setting or whether it be in specialist
 20 secure settings.

21 **Q.** You're alert to the need to fact check on key
 22 information, you just don't take things as a given.

23 **A.** Yes, it's always helpful to get at least one extra
 24 source of information.

25 **Q.** What extra sources, dealing for the moment with facts,

26

1 **A.** What we're really interested in is the defendant, their
 2 mental state at the time of their arrest, and in the
 3 early stages of their custody in the custody suite. And
 4 we have the advantage now that police officers, desk
 5 sergeants, CCTV within the police station, even within
 6 the police van in transport, often we have footage from
 7 those things. So if, for example, I'm asked to do an
 8 assessment in a murder case, say, I'm very interested in
 9 what a defendant was saying, what their actions were.
 10 Did they appear distracted and hallucinated? What were
 11 they saying in terms of eliciting thought disorder? So
 12 there's a whole range of mental state features that can
 13 come out of being able to view this kind of footage.

14 **Q.** What about interviews? Do you like to see a transcript
 15 of interview or do you like to see a video of interview
 16 where you can?

17 **A.** Both. But videos, ideally.

18 **Q.** Why?

19 **A.** I'll give you an example. I read a transcript and then
 20 saw a video clip and the defendant was facing away from
 21 the interviewers, which wouldn't have been clear on the
 22 transcript. So sometimes, again, ideally seeing video
 23 footage of an interview, not just a transcript, can be
 24 helpful.

25 **Q.** That can come down, thank you.

28

1 We see psychiatrists often referring to
 2 presentation, for example, appearance, presentation. Is
 3 viewing footage part of assessing presentation, body
 4 language, demeanour, the sorts of things you're looking
 5 at when you do have a consultation with a patient or
 6 a defendant in an assessment circumstance?
 7 **A.** Yes, you're referring to the mental state examination
 8 which is a sort of standard part of our training. So
 9 appearance and behaviour are the first things that you
 10 notice. So yes, absolutely. That is an important part
 11 of the assessment. Sorry, I forgot the first part of
 12 the question.
 13 **Q.** No, you've answered what I was interested in. Thank
 14 you.
 15 In terms of courts, you referred to court, do you do
 16 reports for court, criminal proceedings as well?
 17 **A.** Yes.
 18 **Q.** So you have experience of that?
 19 **A.** Yes.
 20 **Q.** You refer in your statement to an email that you sent to
 21 Janet Dale and Dr Ullal. If we can go, please, to the
 22 notes, NGPF0003167, page 55.
 23 Page 55, so it's NGPF0003167. It's your email on 9
 24 August, Dr Milton.
 25 **A.** Yes.

29

1 **A.** The latter. Yes, I did know what I wanted to say, and
 2 I don't think it compromised my assessment, but it was
 3 unusual.
 4 **Q.** Were you given a reason for that?
 5 **A.** No.
 6 **Q.** If we go over to the next page, 56, please, you say at
 7 the top:
 8 "Things are contained clinically for now ie he said
 9 he was not suicidal and the two recent restraints seem
 10 to be the first since his reception".
 11 There had been an escalation, hadn't there, of
 12 assaults and events which is why he'd been moved to
 13 segregation; is that right?
 14 **A.** Yes, I think he was moved to segregation on 21 July from
 15 healthcare --
 16 **Q.** That's right.
 17 **A.** -- because of those concerns and, in fact, he'd, in an
 18 unprovoked way, assaulted an officer on 5 August and on
 19 the morning of my arrival the officers told me that he
 20 was uncooperative with the segregation protocol, and
 21 they advised me not to see him in a room, and they
 22 weren't prepared to bring him out of his cell. So yes,
 23 I had to see him through the hatch.
 24 **Q.** So he really was being guarded by people at this point,
 25 wasn't he --

31

1 **Q.** "Dear Janet, sorry I couldn't speak to you today.
 2 I spoke to Dr Ullal who happened to be there."
 3 You set out:
 4 "I'm sure you won't be surprised to hear VC does
 5 need admission to hospital, clearly to high security.
 6 He is psychotic but managed in segregation. On no
 7 medication."
 8 You say:
 9 "It was a limited assessment as:
 10 "a) I still haven't had any of the previous
 11 inpatient notes, PNC or the prosecution case summary so
 12 far (although I can see the latter being delayed);
 13 "b) As I wasn't allowed to bring in any of my
 14 prepared notes."
 15 What was that about?
 16 **A.** When I arrived at Manchester prison with my prepared
 17 notes, I wasn't allowed to bring them in. Unusual.
 18 **Q.** What sort of content do prepared notes have?
 19 **A.** It had the background information that I wanted to take
 20 VC through, if I had the opportunity.
 21 **Q.** I mean, most professionals we have our notes, we're
 22 ready, we're prepared. When that was taken away, or you
 23 couldn't take it in, did that affect what happened next
 24 for you, or had you committed what you'd written down to
 25 memory and knew what you wanted to say, or ...

30

1 **A.** Yes --
 2 **Q.** -- when you saw him?
 3 **A.** -- by the environment as well as the officers.
 4 **Q.** That can come down. We know, of course, he was in
 5 custody between 13 and 17 June. He was at Nottingham
 6 Prison 17 to 20 June and moved to Her Majesty's Prison
 7 Manchester on 20 June. And it was 12 July the referral
 8 to Rampton that we've just looked at, and you see him,
 9 of course, on 8 August?
 10 In terms of mental state examination, of course by
 11 the time you saw him and even Dr Ullal, he'd been in the
 12 prison system, hadn't he, for a while by then, and then
 13 into segregation: how is that likely to affect mental
 14 state? Is it going to have an impact on mental state,
 15 for example comparing how he may have appeared 13 to 17
 16 June, and how he was after being detained, and finally
 17 in segregation when you saw him?
 18 **A.** From the chronology that I'm aware of, so I didn't know
 19 until I saw Dr McSweeney's report that he saw him on
 20 10 July in the legal visit suite, so clearly VC was able
 21 to be escorted over there and he had a 90-minute
 22 interview. But things deteriorated in terms of his
 23 risk. So by the time I saw him, yes you're right:
 24 things had deteriorated.
 25 So his initial period, the first, say, four weeks

32

1 seem to have been relatively settled. It really was
2 from 21 July that his mental state deteriorated and his
3 risk increased, and I think Dr Ullal's assessment in the
4 ward round on 11 July, which we've heard in her
5 statement, summarises the extent of his what appeared to
6 be psychotic symptomology.

7 **Q.** You tell us in your statement to the Inquiry you were:
8 "... shown some of VC's letters which I thought was
9 useful in helping to understand [his] ... inner world
10 and mental state".

11 But you were "unable to fully read them within the
12 prison" or at the time; is that right?

13 **A.** It was as I was leaving they said, "Would you be
14 interested in seeing these letters?" And given that
15 he'd been very guarded with me, it seemed, from what I'd
16 briefly saw, I said yes, and so they were scanned and
17 sent to me the following day.

18 **Q.** I'm going to take you to an Inquiry legal team's summary
19 of some of that material, but clearly the more material
20 you had from him directly, indeed for any psychiatrist,
21 particularly forensic psychiatrist, the better, to
22 understand what he was saying.

23 **A.** Yes.

24 **Q.** Can we go, then, to your report, please, and to page 2
25 of your report. It might help people if we have it in

33

1 **A.** Yes, I've read that custody record and I've seen the
2 assessments by the liaison and diversion practitioners,
3 and I think their main concern was that there were not
4 thoughts of self-harm and suicide, and that he was
5 eating and drinking. But because he seemed guarded,
6 they weren't able to elicit other features. But yeah,
7 I've not read a description that he appeared to be
8 responding to unseen stimuli which usually indicates
9 auditory or visual hallucinations.

10 **Q.** If you go to paragraph 10 of your report, please, which
11 is page 3, you see you were not allowed to take in any
12 of your notes or pre-prepared questions and you "had to
13 examine [VC] ... through his segregation cell door
14 window ... due to increased risk to others."

15 Have you had to do that before?

16 **A.** Yes.

17 **Q.** How does that work? It's literally a conversation with
18 him just the other side of it?

19 **A.** Yes, and there are prisoners in the two adjacent cells
20 with their windows open so potentially confidential
21 discussions could be shared. So sometimes it's
22 inappropriate.

23 **Q.** Paragraph 17, please. You say there:

24 "There do not appear to be temperamental issues,
25 conduct or emotional problems in childhood or

35

1 front of them at the same time. NHFT0002546. Page 2.

2 Indeed, you set out then at paragraph 5:

3 "... there had been increasing concerns relating to
4 [his] ... mental health, based on his previous
5 psychiatric contact and his presentation within the
6 prison."

7 You refer at paragraph 7, as you have now, to the
8 material that you had.

9 We have heard evidence, the Inquiry, from those who
10 saw VC in custody, and there wasn't an issue recorded
11 anywhere about him responding to unseen stimuli, not in
12 custody at all. But by the time Dr Ullal sees him,
13 that's what she sees, doesn't she? There's a difference
14 there. What, if anything, is the significance of the
15 fact that that was not the case when he was in custody,
16 that that wasn't observed?

17 **A.** When you say in custody, do you refer to the 13th to
18 17th June --

19 **Q.** Yes --

20 **A.** -- police custody in Nottingham.

21 **Q.** -- yes, in all the Mental Health Act assessments nobody
22 saw him responding to unseen stimuli or appearing to
23 hear voices --

24 **A.** Yes.

25 **Q.** -- or something of that nature.

34

1 adolescence, or any markers of callous or unempathic
2 traits ..."

3 First of all, the childhood history and the like
4 would not be known to you. I'm not contradicting that
5 but you did not have evidence of that either way, you
6 did subsequently with reports to the social worker, but
7 from your perspective it's what you have seen at that
8 point that leads you to say that; is that fair?

9 **A.** Sometimes it's important to put in the negatives,
10 because again, my colleagues in an admission setting
11 would be interested to know what this person's
12 development was like, and we know that childhood and
13 adolescence, cruelty to animals, setting fires, bullying
14 other children, those can sometimes be markers
15 associated with psychopathy and more difficult to manage
16 personality traits. But yes, I put that in because I'd
17 not read that, not that it didn't exist.

18 **Q.** And there's certainly not evidence of that before the
19 Inquiry thus far. But "unempathic". Unempathic traits
20 we do see when victims or offences are discussed with
21 him by community psychiatrists, that he does not engage
22 with impact on victims or those he's intimidated or
23 student, holding them in a neck lock, feelings of others
24 in circumstances.

25 Indeed, you'll be aware, I don't know if you saw the

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1 note but it's been widely supported, a Dr Seedat made
2 the observation when he was discussing earlier offending
3 with him in 2020, it may be he can end up killing
4 someone effectively, you know, trying to explore
5 insight, what he understood about the impact of his
6 behaviours on others, to which VC said "It won't happen,
7 it won't happen again, anything like that".

8 So we don't see any evidence of empathy discussing
9 impact on victims. Would you expect that or not? Is
10 that something you wouldn't expect to see, or would you
11 want to see that?

12 **A.** Something that could be related to what might be
13 received as limited empathy could be sometimes what's
14 described as a blunting of affect, and I think we've
15 read that in several of the psychiatric assessments and
16 this can be a feature of schizophrenia where people
17 don't have much modulation of their emotions and it can
18 sometimes present as if they appear uncaring or they
19 don't have much emotional reactivity to topics that you
20 would expect them to have. So it could well be a facet
21 of schizophrenia still, and not necessarily just someone
22 who developmentally, has grown up with these traits that
23 are described as unempathic.

24 **Q.** So how do you assess the baseline? How do you find the
25 baseline?

37

1 **Q.** But the illness sometimes may be less to the fore and it
2 could be simply exacerbating tendencies or aspects of
3 personality?

4 **A.** That's possible.

5 **Q.** To understand which, is it necessary to have a really
6 full and accurate history?

7 **A.** Yes, and in fact that is often the purpose of an
8 inpatient assessment, because it allows a very sort
9 of -- building up a picture of very detailed
10 developmental history. Not just of someone's
11 personality traits and what's called their pre-morbid
12 personality, but all other kind of developmental risk
13 factors, you know, birth injury, developmental
14 milestones. So in a way, an inpatient assessment
15 provides that.

16 **Q.** You say at paragraph 21 of your report:

17 "I have not read accounts that [VC] held any extreme
18 political or religious fundamentalist views".

19 I think elsewhere you say:

20 "Nothing to suggest he had any extreme views or
21 opinions."

22 Can we just have a look at some of the documents,
23 that he refers to. I think you got and were interested
24 in reading a typed letter, weren't you, in detail, that
25 he had written.

39

1 **A.** Again, family informant would be the best. Sometimes
2 someone who has been under the care of child and
3 adolescent mental health services and could have been
4 described. But yes, sometimes a detailed history from
5 a family member, usually a mother, would be very useful
6 information in terms of what they were like in their
7 childhood and adolescent and growing up.

8 **Q.** Because what's driven by the illness and what's driven
9 by the man, these are difficult areas to separate,
10 aren't they?

11 **A.** Yes, again sometimes, you know, people, for example,
12 people with autism spectrum disorder have a diagnosis
13 later in life, and you go back and talk to parents and
14 they'll say, "Oh, actually they never showed much
15 emotion as children" and, you know, "We were worried
16 about them".

17 So it can sometimes be something that has been
18 a sort of lifelong characteristic part of their
19 personality, almost. But it can also be part of an
20 illness. You're right, it's important to establish
21 a baseline, whether it was there developmentally or, you
22 know, for example, someone who has had a warm and
23 friendly persona and then is completely different once
24 they develop psychotic symptoms, that would be more
25 indicative of an illness.

38

1 If we can go to that first, if we can go to
2 INQY0000003, page 23. This is the document you saw,
3 over six pages, he sets out effectively what he thought
4 had happened to him and what persisted for a few months.
5 I'll give people time to scan that. *(Pause)*

6 It continues on page 24. The first paragraph:
7 "... voices ... narrating what was happening".

8 I think we can move to page 25, top paragraph:

9 "This was my introduction to the technology some
10 call neural remote monitoring, others synthetic
11 telepathy, voice2skull, silent sound, and so on."

12 We see a lot of stuff researched around this
13 electronic harassment, mind scroll and the like.

14 If we could go, please, to the same INQ reference
15 number, page 13, actually, can we start at page 12,
16 please. There were a number of zip files that he had
17 sent to his family members with lots and lots of
18 material within it. This bott.pdf three-page document
19 you'll see there refers to a:

20 "Complaint to the FBI of Satellite Surveillance and
21 Remote Neural monitoring ...

22 "Citing a laser three dimensional body
23 analyzer/scanning unit."

24 Letter refers to "equipment in the possession of the
25 writer".

40

1 If you go to the next page:
 2 "This is NOT a conspiracy theory it's a real life
 3 situation and the public needs to know ... It is also
 4 how the Aaron Alexis Washington Navy Yard shooter was
 5 driven to commit his crimes."

6 We see it continues:

7 "This is the exact activity reported by Aaron Alexis
 8 prior to his Washington Navy Yard shooting."

9 So links to mind control make this happen,
 10 effectively. So where does that come, on the balance of
 11 extreme views? I mean, is this an extreme belief?

12 **A.** There's obviously lots of conspiratorial material
 13 available on the Internet. I wasn't aware of this zip
 14 file at the time of my assessment or writing my report.

15 **Q.** Did you get this document from the Inquiry?

16 **A.** Yes.

17 **Q.** So you have now. That's helpful to know.

18 **A.** Yes.

19 **Q.** So you've seen the wider range, and then I'll ask you
 20 openly, what do you say, seeing that now, that level of
 21 material?

22 **A.** My understanding, obviously without asking VC directly,
 23 is that he was trying -- he talked widely about an
 24 entity that was controlling him. I think that he's
 25 trying to make sense of his mental illness experiences,

41

1 the phone analysis, which is INQY0000001. It begins
 2 page 1, but in fact I'm interested, please, in 6 and 7.
 3 So this is phone material. Again, you wouldn't have had
 4 access to any of this.

5 **A.** No.

6 **Q.** So a couple of things. If we go to page 7 first, we
 7 see, on page 7, "Files relating to terrorism or
 8 shootings", and he has a report, public inquiry into
 9 shootings on Dunblane, and there are images of weapons.
 10 We won't go through them all. This is the type of
 11 material that's there.

12 On page 6, interestingly, a research paper on
 13 "Psychosis: A History of the Concept", and mental health
 14 documents, copy of GDPR Regs and "other documents
 15 relating to police powers".

16 So he is looking at shootings and material like
 17 that. So where does -- you mentioned Prevent earlier,
 18 but where's the overlap there, potentially, with looking
 19 at those sorts of things?

20 **A.** Yes. It doesn't change my fundamental view that he was
 21 a man presenting with psychosis, on the basis of the
 22 symptoms. But I would want to know for how long he'd
 23 had these views. If this was something that he'd been
 24 reading about for years and years, that may well be that
 25 he'd had an interest in these things independent --

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1 why his brain had been altered. Why he was being
 2 controlled, making -- being made to think things, and
 3 this was his source material that he went to. So, you
 4 know, I use the word "pathoplastic" in my report.
 5 Sometimes it's difficult to know which comes first,
 6 whether it's someone's background interest, you know, is
 7 it writing code as a programmer that therefore
 8 influences the way their symptoms evolve? Or whether
 9 it's, you know, going right back, he takes an interest
 10 in these things because he's got a longstanding sort of
 11 conspiratorial nature? It's difficult to know. But
 12 that's the long answer.

13 The short answer is my understanding is that he was
 14 trying to make sense of his psychotic symptoms, and this
 15 was -- he was therefore led to this -- he found allies
 16 in reading this sort of material.

17 **Q.** But is the belief you're being illegally monitored by
 18 the state in a broad conspiracy involving health
 19 services, police, judiciary, et cetera, an extreme view?
 20 It's just the point you say it doesn't look like there's
 21 extreme views -- these are extreme views, aren't they?

22 **A.** Yes.

23 **Q.** And they link to violent acts described here.

24 **A.** Yes.

25 **Q.** And if that comes down, please, if we can have look at

42

1 **Q.** First?

2 **A.** Yes. So the chronology would be important to me as
 3 opposed to whether or not he became interested in these
 4 things as a consequence of becoming ill.

5 **Q.** If we can just go to one document -- can we go to an
 6 EMAS document? Six zeros 2. So EMAS0000002, page 1.

7 This is a document dated May 2020. I think you
 8 referred to an incident around 2019, but if you look,
 9 this is when he is taken by an ambulance for chest
 10 pains, "Developed L[eft] sided chest pain[s] at rest",
 11 and there's a query underneath:

12 "... acute behavioural disturbance mental health,
 13 c[omplaining]/o[f] chest pain and hearing mumbling."

14 That's the letter incident I'm going to refer to.

15 **A.** Yes.

16 **Q.** And if we go over that page, to page 2 at the bottom:

17 "P[atien]t admits to having mental health problems
 18 in past but would not say what. Not currently medicated
 19 for anything on questioning."

20 So it appears right that he presented with those
 21 symptoms. Leaving aside that mind control was not the
 22 reason for those symptoms, can we think about
 23 possibilities. One of the things he told Dr Mervis was
 24 that when he was 28 he had had one experience with
 25 cannabis which had such an effect on him he felt that

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1 his arm was going to drop off, and that he could die,
 2 effectively. It was a very strong reaction to cannabis
 3 that was described Dr Mervis, who we'll hear from.
 4 For early episodes can it be induced by drugs, an
 5 early episode event?
 6 **A.** Sorry, Dr Mervis, what was his role?
 7 **Q.** When he spoke to VC, he had mentioned that he'd used
 8 cannabis once and that it had had a considerable effect
 9 on him when he was 28.
 10 **A.** Sorry, I meant was Dr Mervis a psychiatrist or
 11 a physician who saw him --
 12 **Q.** No, a psychiatrist later on --
 13 **A.** Oh right.
 14 **Q.** -- who VC told that. Because you'll have seen, there's
 15 no lifestyle reporting of drug use that the Inquiry has
 16 heard, not from flatmates or anyone else, but he himself
 17 describes, in an assessment, that he had one experience,
 18 that it was a really bad experience for him.
 19 So I'm just questioning the admission that we've
 20 seen, and the letter and the story of how he felt, he
 21 was anxious and it was a huge reaction.
 22 What, if anything, would you say about that? He did
 23 discuss that with you, didn't he, or did you only learn
 24 that from the letter?
 25 **A.** I only learnt that from the letter.

45

1 **Q.** "Guarded" is something we see a lot in notes,
 2 psychiatric notes in particular. Is withholding
 3 information a different way of saying the same thing, or
 4 sometimes not telling the truth? Or is it important
 5 that you use "guarded"? Why is it that that's the
 6 phrase that's used when you think someone has more to
 7 say and they're not giving it you?
 8 **A.** So "guarded" in their mental health or psychiatric sense
 9 is usually referring to someone who is suspicious, who
 10 may fear what they say will have an effect on their
 11 detention, for example. But --
 12 **Q.** So be against their interests?
 13 **A.** Yes.
 14 **Q.** So they don't tell you something because they think it's
 15 better for them if they don't tell you. So that
 16 involves some reasoning, doesn't it, as well?
 17 **A.** I think in VC's case, as we may come on to, from what
 18 he'd described and what I'd read, he was having
 19 experiences, auditory hallucinations, telling him not to
 20 disclose information to health professionals. So that
 21 may have been an additional motive.
 22 **Q.** It's difficult to know, isn't it? I mean, how can one
 23 know?
 24 **A.** It is difficult to know how much weight to give to
 25 information given by someone in his position, yes.

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1 **Q.** So you may not be able to say anything about that, then?
 2 **A.** No. It sounds as if he was sensitive to the effects of
 3 cannabis.
 4 **Q.** Chair, I wonder if that's a good moment for the morning
 5 break?
 6 **THE CHAIR:** Yes, thank you. We'll take a break now, I think
 7 until 11.30. Thank you.
 8 **(11.11 am)**
 9 **(A short break).**
 10 **(11.30 am)**
 11 **THE CHAIR:** Yes, Ms Langdale.
 12 **MS LANGDALE:** If we can go back to the report, please. So
 13 NHFT0002546, page 15, paragraph 100.
 14 You explain to VC the purpose of your assessment:
 15 "... clinicians in the prison were concerned about
 16 his mental health and he may need assessment in
 17 hospital. [You] ... asked for his view on this and
 18 whether he thought of himself as mentally ill. He said
 19 he thought he would benefit from an inpatient
 20 assessment. As to any illness he responded 'it's up to
 21 you to determine that'.
 22 What did you make of that response? Was that lucid,
 23 clear?
 24 **A.** Guarded. I think he was deliberately not offering
 25 a view, and I'd seen that in the notes before.

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1 **Q.** If we go to page 16. Sorry, we're going to stay with
 2 the report, if we can. So NHFT0002546, page 16,
 3 paragraph 104, you asked VC:
 4 "... if he thought he was a risk to others. He said
 5 he was not ... I noted the alleged offences (or violence
 6 to others) but he said he preferred not to discuss this
 7 and the limited confidentiality of the interview setting
 8 led me to take this no further."
 9 That's because people could hear you, effectively?
 10 **A.** Yes.
 11 **Q.** What would you have asked -- if people weren't listening
 12 to you, what would have been relevant to follow up with
 13 on that?
 14 **A.** In the same way that in paragraph 101 I'd asked him why
 15 he'd assaulted the prison officer on 5 August. I was
 16 interested to know whether there was a link between what
 17 might be perceived as symptoms and his behaviour, in
 18 particular his risk-related behaviour. Because that
 19 would have given more weight -- ultimately my assessment
 20 was whether he needed admission to high secure hospital.
 21 So I was looking to see whether there was a link between
 22 what he regarded as -- what I would regard as symptoms,
 23 and his behaviour.
 24 **Q.** And what did he say about the prison officer, for
 25 assaulting them?

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1 A. I'll read from paragraph --
 2 "After a pause, he said 'it's not that I want to
 3 conflict ... but I'm hearing things ... a dialogue ...
 4 that I don't like'. I tried to clarify this with
 5 difficulty but I formed a view that he was describing
 6 hearing voices, referred to as 'dialogue'."
 7 Q. And again, moving back to the point, how do you separate
 8 the illness and the man, the Inquiry's seen evidence --
 9 lots of people have seen evidence now -- of footage of
 10 one of his student flatmates, after that flatmate
 11 telling him in no uncertain terms he ought to clean the
 12 bathroom up, of VC holding the flatmate in a headlock,
 13 and preventing him and another flatmate from leaving.
 14 On one view that describes, or that scene, is
 15 someone being angry and upset by being confronted and
 16 sworn at, in that case, and behaving in that way.
 17 So moving back to the point about personality,
 18 temperament, triggers, is it necessary to look at
 19 triggers in different settings before arriving at
 20 a conclusion: the voice telling you to do things is
 21 responsible for all, as it were?
 22 A. Yes. Because I was, you know, essentially doing
 23 a Mental Health Act assessment for admission to hospital
 24 I was on high alert for whether he had symptoms that
 25 predisposed to risk to others, violence. But really you

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1 factors. But it can be very difficult with short
 2 admissions.
 3 So my preference would be, for example when patients
 4 are on section 3, if they have a longer admission, it's
 5 often easier. And ultimately, you're looking for the
 6 patient to develop insight so that the patient
 7 themselves can recognise, what is sometimes called
 8 a relapse signature, they can recognise themselves when
 9 they might be at risk of hurting someone, for example.
 10 Q. So forensic assessments you're looking for informants --
 11 I'm going to use your phrase -- from a number of
 12 sources, you wouldn't rely on the patient alone --
 13 A. Yes.
 14 Q. -- and wouldn't rely on family alone, you'd rely on
 15 a number of sources --
 16 A. Yes.
 17 Q. -- in order to do that. So what hospitals or units do
 18 that kind of thing? Are you involved in that work now?
 19 A. It tends to be forensic hospitals where patients have --
 20 you know, patients are only kept as long as they need to
 21 be kept but they tend to have longer admissions, because
 22 often it's not just psychosis and isolation; they may
 23 have other facts -- so it's quite common for patients to
 24 have what's termed comorbid personality disorder, in
 25 addition to schizophrenia, and so sometimes, to go back

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1 could only tease those things -- certainly I didn't feel
 2 I could tease those things out in this context, and that
 3 would have been the utility of a lengthy psychiatric
 4 admission where those things could be explored more.
 5 But again I didn't feel I had enough information about
 6 his development and his, again, what's called pre-morbid
 7 personality.
 8 Q. Exactly, and previous incidents. That assessment, you
 9 say, how many days would it take an inpatient assessment
 10 to really get to the heart of somebody, if you wanted to
 11 do that? I'm not talking about this case, I mean
 12 generally, you've referred previously to the importance
 13 of an inpatient assessment, so not just one conversation
 14 but over a period of time.
 15 A. From what I've read, I didn't -- as I say, I didn't see
 16 all of the community and the Nottinghamshire Healthcare
 17 notes, but from what I'd read he'd had relatively brief
 18 admissions, and I don't know how much of this
 19 information, on a busy acute ward, had been sought. The
 20 advantage of a forensic admission, which are usually
 21 longer, is, that we have -- we can take more time over
 22 these things. We have the opportunity to interview
 23 relatives and other people that have known the patient
 24 in more detail at incidents, and try and tease out the
 25 different triggers, as you call them, or the different

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1 to your point about triggers, it can be useful to try
 2 and identify what factors might be -- the risk might be
 3 underpinned from personality factors such as
 4 impulsiveness, and what factors might be underpinned by,
 5 for example, command hallucinations.
 6 So forensic units are the ones that tend to have the
 7 longer admissions. My experience of community settings
 8 is patients tend to have relatively -- because of the
 9 pressure on beds, tend to have shorter admissions.
 10 Q. Leaving aside personality traits, is it possible to have
 11 a personality disorder alongside paranoid schizophrenia?
 12 A. Yes.
 13 Q. The defendant or patient would need to be assessed
 14 formally for that, wouldn't they, for a personality
 15 disorder?
 16 A. Yes.
 17 Q. Again, is that something in a forensic context that
 18 would be done, that would -- the reason for that or need
 19 for that would be more likely to be identified?
 20 A. It can sometimes be difficult because the psychotic
 21 symptoms can be conflated with features of someone's
 22 personality. So people with psychosis can be impulsive
 23 as well as being impulsive because of their personality
 24 problems.
 25 But yes, again, sometimes the higher secure services

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1 have the luxury of time and training to be able to do
2 those more. Because assessment of personality, there
3 are specialised, you know, standard interviews to do
4 that, and again, that can be more difficult to do on
5 a busy acute ward.

6 But you're right yes, they can stand together, and
7 have -- need different ways of assessing them.

8 **Q.** For those who are assessed on an inpatient forensic
9 assessment against that context, are they high risk
10 patients? Are those the people that normally access
11 those facilities, high risk to others? Is that why
12 they're in -- forensic, those who are forensically
13 assessed in the way you describe, how do they end up
14 being in a unit, assessed like that? It may seem
15 obvious to you but I'm trying to emphasise what's the
16 difference between forensic and those patients or
17 defendants that end up there as opposed to those who
18 stay in the community?

19 **A.** It's risk to others that primarily drives an admission
20 to a -- at least medium and then high secure. As you're
21 aware, there are tiers of forensic care. So it tends to
22 be risk to others that drives that, not risk of
23 self-harm, not -- just having any mental health that
24 puts their own health at risk.

25 So it's usually -- and again, to use a phrase that's

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1 be rare for someone to be admitted directly from the
2 community.

3 **Q.** Can you see, in your experience, it might be of
4 assistance if some people could be, to get that level of
5 understanding around their behaviour?

6 **A.** If there were enough beds, and someone -- and the
7 offences were grave, say. I think if you're talking
8 someone where they haven't committed an offence but
9 there are concerns about their behaviour, I think that
10 would be unusual. I think there would be concerns about
11 detaining someone for that reason. In fact there was
12 a tranche of new services called the Dangerous and
13 Severe Personality Disorder Service that were set up
14 after those very concerns about patients with
15 personality disorder in the community.

16 So it has been an issue before. But it would,
17 again, it would be rare, I think, for patients to be
18 admitted directly from the community for that kind of
19 assessment.

20 **Q.** You -- it's not on the screen but it doesn't matter, at
21 the end of paragraph 104 you say:

22 "Similarly I was not able to explore the usual
23 forensic-related issues such as weapon carrying (...why
24 he had a knife)."

25 Can you just expand on that for us, please? What's

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1 used for high security, someone has to be a grave and
2 immediate danger. So forensic is associated with high
3 risk to others usually as a term.

4 **Q.** So a really valuable resource in assessing and
5 understanding the risk people pose to others in the
6 community.

7 **A.** Yes.

8 **Q.** Are there enough forensic psychiatrists and assessment
9 centres?

10 **A.** There's probably a pressure on beds. So from my own
11 hospital where I was working, there was a substantial
12 waiting list for admission, which meant there were
13 delays in admitting people. So that suggests there
14 probably is a shortage of certainly high secure forensic
15 beds. I couldn't speak for low secure and medium
16 secure.

17 **Q.** Are they referrals by community psychiatrists or
18 treating teams?

19 **A.** Not usually.

20 **Q.** Where do they come from?

21 **A.** Admission to high security?

22 **Q.** Mm-hm.

23 **A.** Usually comes from prisons, in particular the cat A
24 prisons. Sometimes from medium secure hospitals where
25 patient risk has become difficult to manage. It would

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1 the significance of weapons? We know of course he had
2 a rucksack of weapons at the time of the offences.

3 **A.** It's a standard question that forensic mental health
4 professionals would ask, in terms of trying to determine
5 someone's risk and someone's motives. So if someone
6 routinely carries a knife, for example, because they
7 fear threat, they've got persecutory symptoms, that
8 would increase their risk, even if they'd never acted or
9 drawn a knife or hurt someone with it. So it's
10 a standard forensic question that we would ask.

11 **Q.** We know, on one of admissions to hospital, he had left
12 the hospital on day release and came back with a hammer
13 in his rucksack. The Inquiry is yet to hear evidence
14 about that and the level of interrogation around it. It
15 seems to me, not very much on the face of records and
16 interrogation around it. Do you think that's
17 significant or not, that a patient leaves and comes back
18 with a hammer in their rucksack?

19 **A.** It depends on what he said, why he had a hammer, but
20 that would be a concern, yes, that would be again, a red
21 flag to a forensic psychiatrist.

22 **Q.** I think in the notes it's recorded he's moved house,
23 done some DIY or something like that.

24 **A.** Ah.

25 **Q.** But that doesn't mean -- we've yet to see what was said

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1 about that, but you'd want to know about the
2 circumstances?
3 **A.** Yes.
4 **Q.** You say at paragraph 118:
5 "In terms of insight [VC] ... may have some partial
6 insight if his agreement to admission to hospital for
7 assessment, and consideration to take medication, is
8 seen as a facet of this."
9 Perhaps we should have that on screen, NHFT0002546,
10 paragraph 118. So the previous page. You see at the
11 bottom: "may have some partial insight".
12 What were you considering there?
13 **A.** I was surprised that he thought that coming to hospital
14 might be a useful prospect. I wasn't expecting him to
15 say that. However, prisoners sometimes have different
16 reasons for seeking hospital, you know, agreeing to
17 hospital admission. It may be that he just didn't like
18 the segregation environment.
19 But I did think it may indicate partial insight, in
20 particular that he may take medication.
21 **Q.** And it may indicate you want to be in a place better
22 than the one you're in?
23 **A.** Precisely.
24 **Q.** At paragraph 124, so page 18, you refer to VC's "planned
25 name change to 'Adam Mendes'", and you say "currently

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1 **Q.** Paragraph 129 you say, again can we go back to it,
2 please, same reference NHFT0002546, you said:
3 "Intoxication with an illicit substance as a cause
4 of a drug-related psychosis needs to be ruled out."
5 What were you -- well, tell me, expand on that.
6 What do you mean by that paragraph?
7 **A.** When someone presents with psychotic symptoms, it would
8 be useful to know whether it was either the underlying
9 cause or whether it was exacerbating, you know,
10 an existing psychotic illness. So for me it's part of a
11 routine to take urine drug samples, or hair samples,
12 actually. I didn't see them, that is not unusual.
13 Often they're done in prison and they're not always
14 recorded in the notes that I see.
15 So I'd made an assumption that they may have been
16 done, but it was really just to -- it's just more
17 information in terms of what might be the exacerbating
18 factors.
19 **Q.** You refer here to a cause of a psychosis. Are there
20 triggers for psychosis, leaving aside this one, this
21 clearly, you say, is one.
22 **A.** Yes.
23 **Q.** But somebody in their late twenties enduring, first it
24 was considered a first episode of psychosis, do single
25 episodes happen and people recover?

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1 unexplained to a satisfactory degree ... may have
2 pathological implications ... to avoid perceived
3 surveillance in the context of conspiratorial
4 delusions".
5 That can come down now. We also know, after
6 committing an offence at the Arvato warehouse he phoned
7 up the recruitment person and asked them to wipe the
8 files away. So on the one hand you've got perceived
9 surveillance, on another you've got covering your
10 tracks, where you are, what you've just done, if you
11 know something you've done you shouldn't have done.
12 It's very difficult, isn't it, to unpack that and
13 say what it means, this change of name, wanting records
14 to be removed from recruitment files.
15 **A.** Yes, the reference you just quoted in my report was my
16 speculation, because I didn't find an otherwise
17 satisfactory explanation.
18 **Q.** That's the difficulty, isn't it. Without full and
19 accurate history there is a danger of speculation, not
20 just from you, generally, trying to make sense of
21 circumstances when we don't have the full picture.
22 **A.** Yes.
23 **Q.** And sometimes it doesn't make sense and it's not clear
24 one way or another.
25 **A.** Yes, I'd agree.

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1 **A.** Yes.
2 **Q.** In those cases, might drugs or other single events be
3 a trigger or not? What do you see?
4 **A.** Yes, I think we know that adolescents that smoke
5 cannabis before the age of 15 are more likely or
6 predisposed to having a psychotic episode when they're
7 older. Life events, as they're sometimes called, so
8 a bereavement or other, you know, trauma can sometimes
9 be a triggering factor. And there are people who only
10 ever have one episode of psychosis. They receive
11 treatment, they may stay on what's called prophylactic
12 treatment for a couple of years, antipsychotic
13 medication, and then it's stopped and then they never
14 have another episode. And sometimes you can see factors
15 that might have been a triggering cause.
16 **Q.** And psychosis, early-episode psychosis, as opposed to
17 paranoid schizophrenia, what's the difference? What's
18 the overlap? We see what's recorded in the 2020
19 admission and of course we see what happens months later
20 and is repeated. So tell us, does one move to the
21 other?
22 **A.** Yes.
23 **Q.** Is the first diagnosis the right one then, or not?
24 **A.** So, as you'll have seen from my report, I used the
25 International Classification of Diseases ICD11, ICD10 or

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1 ICD11, there's different versions and it aids diagnostic
2 precision. So there are certain number of criteria: how
3 long have you had the symptoms? What kind of symptoms
4 have you had? There are so called first rank symptoms
5 of schizophrenia, so certain kinds of auditory
6 hallucinations, delusions, changes in thought processes.

7 So even if someone is presenting for the first time,
8 if they have that range of symptoms, you could be fairly
9 sure that the diagnosis will be schizophrenia. But
10 sometimes it's a rather vague presentation and the
11 symptoms aren't that clear and they don't quite meet the
12 diagnostic criteria. So it's sometimes left as an open
13 diagnosis: psychosis not otherwise specified. So it can
14 sometimes be difficult to tell, and it only becomes
15 apparent after several relapses that this is
16 schizophrenia.

17 **Q.** Paragraph 138, please. So just a bit further down, it's
18 on page 20, paragraph 138. You were not able to discuss
19 his mental state at the time of the allegations. Can
20 you just distinguish for us what the difficulty is
21 coming in later, trying to assess mental state from
22 weeks before, and what that does in terms of impacting
23 on accuracy?

24 **A.** So you're relying on the detailed descriptions of
25 clinical colleagues, in custody, often these things are

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1 from 1977 gave advice, informal criteria for admission
2 to high secure, what were called special hospitals,
3 Rampton, Ashworth, and Broadmoor, and there was this
4 phrase "grave and immediate danger". It wasn't always
5 that well defined. Grave is usually fairly obvious, so
6 we're talking grave offences and they're defined, the
7 indictable kind of offences that we are aware VC was
8 arrested for.

9 Immediate danger can sometimes be difficult, but in
10 my view he met the criteria because, three days before
11 I saw him, he'd assaulted a prison officer in an
12 unprovoked way, he was very unsettled on the day I saw
13 him, and the officers were very concerned about him. So
14 I felt that on both counts he therefore met the criteria
15 for high secure admission on that basis.

16 **Q.** Yes, thank you.

17 Chair, there's questions from Mr Moloney,
18 Ms Cartwright, and Mr Straw.

19 **THE CHAIR:** Yes, thank you.

20 **Questioned by MR MOLONEY**

21 **MR MOLONEY:** Good morning, Dr Milton.

22 **A.** Good morning.

23 **Q.** May I just commence by observing, is it right, that when
24 you went to see VC, you were not there to assess his
25 mental state on 13 June 2023 when the killings happened;

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1 more sketchy, and so -- and often there's chronological
2 gaps, there may not have been a mental state examination
3 for several weeks.

4 One of the useful things was Dr Ullal's very
5 detailed mental state examination on 11 July which
6 I think then triggered the referral to Rampton on 12
7 July.

8 But there were -- otherwise there were gaps, so
9 I didn't see great detail in the prison record. He was
10 only in Nottingham Prison for a brief period and then
11 again in the custody suite. So it's very difficult
12 to -- because again, from what I understand, there was
13 a gap where VC was not known to community services for
14 a few months before the June events, June 2023 events.
15 So there's a long period where we've no idea what his
16 mental state was other than perhaps information from his
17 family and his own account.

18 So it's -- it becomes speculative. It can be
19 difficult to build a picture without getting those extra
20 pieces of information.

21 **Q.** Finally from me, Dr Milton, on page 23 at paragraph 155,
22 you concluded his risk should be regarded as meeting the
23 grave and immediate danger criteria for high secure
24 admission. Can you just briefly unpack that?

25 **A.** So it's often forgotten, but Section 4 of the NHS Act

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1 you were there to determine whether or not the criteria
2 were met for transfer to a secure hospital.

3 **A.** Exactly.

4 **Q.** You've told Ms Langdale and the Chair that you didn't
5 have access to primary care records?

6 **A.** Yes.

7 **Q.** You ordinarily would have liked to have had them for
8 your assessment?

9 **A.** I said I think it's unusual to have primary care GP
10 records at this stage, but it's always helpful,
11 particularly when there's been a gap after someone is
12 discharged from services, to know whether they've been
13 to see their GP, collected medication. So yes, it would
14 have been helpful.

15 **Q.** But, as it were, the primary care records relating to
16 his treatment in hospital of his mental health
17 condition, they would have been useful, wouldn't they?

18 **A.** They would.

19 **Q.** Yeah. Can I take you to an email written by you on
20 14 August 2023, so some six days after your visit to see
21 VC, when you wrote to John Wallace, and that document is
22 NHFT0019315. I'm sorry, it's from John Milton to you --
23 sorry, from you to John Wallace, 4 August 2023, and it's
24 really the first substantive paragraph:

25 "I'm sure he could come to Rampton but I can see the

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1 politics. The NottsHC [that's Nottinghamshire
2 Healthcare] notes are 'locked down' ..."
3 You remember that is the term that you explained to
4 Ms Langdale at the start of giving your evidence as
5 well.
6 **A.** Yes.
7 **Q.** Then in parentheses:
8 "... (apparently) so I didn't see them but the
9 references to them suggest he was discharged back to his
10 GP due to non-engagement, never a good plan and likely
11 to be a criticism for the Trust to face."
12 **A.** Yes.
13 **Q.** What did you mean by "locked down" in those
14 circumstances, Dr Milton?
15 **A.** I didn't know what locked down meant. So it just meant
16 that I wasn't able to access the notes. Although I had
17 a subsequent email from the Executive Director Dr Elcock
18 and the head of information governance saying, "Oh if
19 you want to see the notes, you can."
20 **Q.** Right.
21 **A.** This was 15 August, I'd already submitted my report by
22 then.
23 **Q.** That means they were restricted and you couldn't access
24 them?
25 **A.** Yes, but it appears that if I'd wanted them, I could

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1 **A.** I think the difficulty I had was that we don't -- well,
2 I didn't know whether VC was concordant with medication
3 because he was discharged --
4 **Q.** No, I'm asking not about VC, more generally. I'm taking
5 the opportunity of you being here, Dr Milton, to ask
6 that if you were somebody dealing with a patient who had
7 had a record of violence, which was associated with
8 a period, on the face of it, was associated with mental
9 health illness, they also had a record of
10 non-concordance with medication, would those be
11 circumstances where you would be concerned about simply
12 discharging back to the GP when they weren't engaging?
13 **A.** Yes.
14 **Q.** Yeah, thank you. It's common sense, isn't it? And may
15 I take that nod as a "yes"?
16 **A.** Sorry, yes.
17 **THE CHAIR:** Sorry, yes, you have to say "yes" or "no" so
18 it's recorded. Thank you.
19 **MR MOLONEY:** Indeed, your analysis of the records that were
20 available to you, which you deal with at
21 paragraphs 36-49 of your report -- and I don't need to
22 take you to it -- but you say that they revealed that VC
23 responded well to medication when he was an inpatient?
24 **A.** Yes, but from reading his own records, he seemed to
25 imply that he may not have been giving the treating team

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1 have had them. But of course I didn't know that.
2 **Q.** But, Dr Milton, if I may say with the greatest of
3 respect, you're obviously very experienced and so whilst
4 you're here, if the Chair doesn't mind me asking this
5 question because it may be an issue further down, why is
6 it never a good plan to discharge a person back to their
7 GP for non-engagement?
8 **A.** I'm of an age, my psychiatrist training, where assertive
9 outreach was a primary concern. So I was just
10 recognising someone who'd had apparently had several
11 psychiatric admissions shouldn't be lost to follow-up.
12 Problematically, though, I don't know the current
13 procedures and policies of the Trust for how they
14 discharge people. There may well be a procedure where,
15 after a period of non-engagement, despite how hard you
16 try -- and again, I wasn't privy to that -- that may be
17 the reason that you just have to discharge people. But
18 in my experience, you would persist, because it would be
19 likely, on the basis of his relapse in condition, that
20 you would have further episodes of psychosis.
21 **Q.** May I just ask one follow-up question in relation to
22 that. Would that be particularly so when the services
23 were dealing with a patient who they were aware was
24 non-concordant with medication and there was a risk of
25 violence when they were non-concordant with medication?

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1 the information, whether he was in full remission. So
2 that's the difficulty. But yes, from the notes it
3 appears that the clinicians believed that he was
4 responding well to medication.
5 **Q.** Absolutely. Superficially that was the case at least?
6 **A.** Yes.
7 **Q.** And especially aripiprazole?
8 **A.** It appears so, yes.
9 **Q.** You deal with VC's progress in prison at
10 paragraphs 57-90 of your report. I don't propose to
11 take you there. When he first arrived at HMP
12 Manchester, he went to the hospital wing and was guarded
13 and refused to have blood tests?
14 **A.** Yes.
15 **Q.** Yeah. He was -- he'd been guarded all the time he'd
16 been in custody up to that point, and he continued to be
17 guarded in his presentation to staff and indeed you
18 remark at paragraph 66 of your report that he was seen
19 on 4 July by Dr Ullal, and you say that on 4 July 2023,
20 VC was examined by Dr Ullal, visiting consultant
21 psychiatrist to the prison. He again presented with
22 limited response in saying, "No comment" to questions,
23 and no overt psychotic symptoms were noted?
24 **A.** Yes.
25 **Q.** Yes. On 10 July -- and you've only subsequently become

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1 aware of this, then VC saw Dr McSweeney?
 2 **A.** Yes.
 3 **Q.** You weren't aware of that when you saw him on 8 August?
 4 **A.** (Witness nodded).
 5 **Q.** Dr McSweeney was a psychiatrist instructed by the
 6 defence solicitors?
 7 **A.** Yes.
 8 **Q.** We know that. Yes. On 11 July 2023, which was the next
 9 date that Dr Ullal saw VC, there was a very significant
 10 shift in VC's level of communication about his psychotic
 11 disorder, wasn't there?
 12 **A.** Yes.
 13 **Q.** He completely opened up to Dr Ullal about hearing
 14 voices?
 15 **A.** Yes.
 16 **Q.** Paragraphs 68-72 of your report detail in full what he
 17 said to Dr Ullal?
 18 **A.** (Witness nodded).
 19 **Q.** Indeed, we're grateful to Ms Kaur this morning for
 20 reading out that which was said to Dr Ullal on 11 July?
 21 **A.** Yes.
 22 **Q.** But it was a significant change in presentation on
 23 11 July, wasn't it? As you say, it was following
 24 that -- and you say this at paragraph 73 of your
 25 report -- that Dr Ullal and the prison healthcare team

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1 can all feed into their future risk for mental disorder.
 2 **Q.** Obviously those would be factors, Ms Langdale asked you
 3 about co-morbidity of paranoid schizophrenia and
 4 personality disorder, and of course one can develop, as
 5 it were, psychotic illness later in life whilst having
 6 had potentially the symptoms of a personality disorder
 7 before the onset of the psychotic illness?
 8 **A.** Yes.
 9 **Q.** Yeah. Is it right, Dr Milton, that in your experience,
 10 if I can ask you as somebody who has enormous experience
 11 in this area, that a number of studies suggest that the
 12 percentage of people suffering from a psychotic disorder
 13 who also have a co-morbid personality disorder is not
 14 insignificant, is it? It can be as much as 40% in some
 15 studies, can't it?
 16 **A.** Significant proportion, yes.
 17 **Q.** Significant proportion. And those -- is it right, as
 18 well, that some studies suggest that that combination of
 19 a psychotic disorder, psychotic illness, whether that be
 20 paranoid schizophrenia or anything, combined with
 21 a personality disorder, perhaps an unstable personality
 22 disorder or borderline personality disorder, can cause
 23 severe dysfunction with a higher homicide risk and
 24 poorer treatment adherence?
 25 **A.** That can be true of personality disorder. Usually it's

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1 concluded, as a result of that, that he should be
 2 referred for an assessment for admission to high secure
 3 hospital?
 4 **A.** Yes.
 5 **Q.** Cause and effect on that day, on 11 July?
 6 **A.** That's my reading of it, yes.
 7 **Q.** Now, Ms Langdale has asked you some questions about the
 8 relevance of background, and I don't propose to repeat
 9 them, but if she'll forgive me, if I could just
 10 supplement her questions with one or two others.
 11 You say at paragraph 17 of your report that you've
 12 not read of any reports of truanting or bullying issues
 13 in his upbringing?
 14 **A.** Yes, again, I was just including it as a negative in
 15 that I hadn't read any. But again, it's not to say that
 16 they hadn't happened, but --
 17 **Q.** Absolutely. May I just ask -- and Ms Langdale then went
 18 on to ask you about other things that you mentioned --
 19 what would the relevance of bullying be in those
 20 circumstances?
 21 **A.** So I would have been interested in whether he was the
 22 victim of bullying or if he was a bully himself.
 23 Sometimes people with those characteristics can go on to
 24 have other anti-social traits. Sometimes the victims of
 25 bullying can have underlying psychological trauma which

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1 some of the characteristics such as risk-taking
 2 behaviour, are less likely to concord with treatment.
 3 So sometimes that can put the risk of relapse from
 4 psychosis -- that can make it higher. But I couldn't
 5 quote you on whether studies show that there is a higher
 6 homicide rate for people with those characteristics.
 7 **Q.** But there can be, as it were, a more severe
 8 dysfunction --
 9 **A.** Yes.
 10 **Q.** -- in more general terms?
 11 **A.** Yes.
 12 **Q.** Yes.
 13 And would it be important to you, in, as it were,
 14 addressing the potential existence of a co-morbid
 15 personality disorder with a psychiatric disorder to have
 16 a full history of that person and their development?
 17 **A.** Yes.
 18 **Q.** Yes. Just one final topic, if I may, Dr Milton. You
 19 were shown, as Ms Langdale has asked you about, papers
 20 that were found in VC's cell when it was at the point he
 21 was transferred into segregation, wasn't it?
 22 **A.** Yes.
 23 **Q.** And may I just clarify one thing: that VC was seen by
 24 Dr Ullal on 11 July. He opened up about the psychotic
 25 symptoms he'd been facing and at that point, and 21 July

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1 onwards, that's when his behaviour really deteriorated,
2 isn't it, and he had to go into segregation.

3 **A.** Yes.

4 **Q.** And that's when the violence started that, as you just
5 explained to Ms Langdale, gave good cause for the
6 recommendation of transfer?

7 **A.** Yes.

8 **Q.** Yeah. You, at paragraph 90 of your report you refer to
9 a document, if we could possibly have a look at this,
10 please, which is NGPF0003167. When that comes on
11 screen, if we could go to page 183, please. This is one
12 of the letters that was -- or that was found in VC's
13 cell, and it reads:

14 "I wish to change solicitors since it is still the
15 initial stage of legal procedures and I find it to be in
16 the best interests of the case to make sure there are no
17 concerns regarding my legal representation. I have
18 a few concerns about the relationship with the current
19 team. The first choice was made with limited time and
20 information. I have concerns about the level of
21 communication and engagement with the team. There have
22 been what I thought to be crucial periods when the team
23 was unreachable and thus we were unable to have
24 productive discussions about some of my concerns.
25 I think that's an area that can be improved so as to not

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1 **Q.** And that's language that's then found in the previous
2 document. We know, and you won't know this, Dr Milton,
3 but we know that VC was represented by the same firm of
4 solicitors from police station all the way through to
5 disposal of his case.

6 But may I just ask you, please, to have a look at
7 whether or not you saw this document, which is the same
8 document, page 206. Thank you. This is "Email
9 a Prisoner". We can see the top left-hand -- that's my
10 fault, I don't know if we could go back to -- top
11 left-hand corner, 21 July 2023. It's the date it was
12 found, and we know of course that VC was transferred to
13 segregation at that time, wasn't he?

14 **A.** Yes.

15 **Q.** And I just want to ask if you saw this, but the identity
16 of the solicitor doesn't really matter, but it's on --
17 the message is sent on 3 July of 2023, and we see that
18 the contents of the letter, it's from a solicitor, and
19 it says:

20 "Dear [VC]

21 "Thank you for your letter."

22 Which would suggest that VC has written to the
23 solicitor.

24 **A.** Yes.

25 **Q.** "I have visit booked to see you on Wednesday 7th July at

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1 cause unnecessary difficulties. I have found a new
2 legal team and we had discussions to ensure best
3 arrangement."

4 So that was found in VC's cell. It's
5 a well-structured document, would you agree?

6 **A.** Yes.

7 **Q.** Yes. Then could we, having seen that, could we go to
8 page 259 of the same document, please. We perhaps see
9 the precursor of this. I don't know if you could make
10 that slightly larger, but keep it within the page.

11 Yeah. So this may be in preparation for that letter but
12 we see there "I wish to change solicitors since it is
13 still the initial stage of legal procedures", and that
14 carries on in much the same vein as we've just seen.
15 But if we see, there's an asterisk:

16 "and find it to be in the best interests of the case
17 to make sure there are no ..."

18 And again that's subsequently included, and then
19 a double asterisk: "and we had discussions to ensure the
20 best arrangement."

21 And then no asterisk:

22 "[But] I have reservations there might be issues
23 regarding ..."

24 Do you see that?

25 **A.** Yes.

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1 9.15am. I look forward to seeing you then."

2 Yes?

3 **A.** Yes.

4 **Q.** And, now, we don't have any --

5 **THE CHAIR:** Mr Moloney, if he hasn't seen this letter I'm
6 not sure he is the right witness to deal with this,
7 unless you're going to ask him something about the
8 letter, and the medical side of things.

9 **MR MOLONEY:** No, it was in the papers, Chair, that the
10 doctor saw. I'm just going to ask him --

11 **THE CHAIR:** Was this one in the papers as well? Did you
12 see --

13 **A.** I don't recall seeing this.

14 **MR MOLONEY:** You've seen it now.

15 **A.** Yes.

16 **Q.** It demonstrates that he was actively engaging with his
17 representation.

18 **A.** Yes.

19 **Q.** Yes, thank you. And then just two other documents
20 within that -- within that document. Page 190, please.
21 And it's at the top, and this is one of the handwritten
22 notes in the document that you saw:

23 "What happened, why happened, state of mind".
24 Do you see that as the first line?

25 "What happened, why happened, state of mind".

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1 A. Yes.
 2 Q. Then the final document, it's a different document,
 3 actually, but Ms Langdale took you to it and that is
 4 INQY0000003 and if we could go to page 25, please.
 5 This is the typed version of a manuscript document
 6 that you saw, the first two big paragraphs, the typed
 7 version and manuscript document that you saw. It's the
 8 account of, as it were -- it's a psychiatric history
 9 written by VC, if I could use that summary.
 10 The last --

11 **THE CHAIR:** Mr Moloney, is it a question rather than just
 12 running the document past the witness?

13 **MR MOLONEY:** I'm just establishing the provenance of the
 14 document.

15 **THE CHAIR:** I've seen the documents, obviously.

16 **MR MOLONEY:** It's just the last line. The last line is:

17 "The internal tremors remain, the brain pulsated,
 18 mental fatigue, memory loss, thoughts being inserted,
 19 thoughts removed ..."

20 Are they all classic symptoms of a psychotic
 21 disorder?

22 A. Yes, they are. I mentioned before, first-ranked
 23 symptoms of schizophrenia, many of those are
 24 first-ranked symptoms of schizophrenia.

25 Q. If you put those things together into a search engine,

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1 significant is it to have medical records going back
 2 several years which contain consistent accounts of
 3 hallucinations that he'd reported over that period?
 4 A. It's difficult to know if he had a relapsing and
 5 remitting pattern of psychotic symptoms as in he got
 6 better in between, or whether he had one long,
 7 continuous psychotic episode, but he was somewhat
 8 restricted in terms of the information he gave to the
 9 clinicians. But certainly from my reading of the
 10 records, it looks like he had a diagnosis of
 11 schizophrenia, symptoms of schizophrenia before the
 12 index offences. When I saw him afterwards, I believe he
 13 had symptoms of schizophrenia that led me to conclude he
 14 needed to be in hospital.

15 Slightly problematically, we don't know enough about
 16 his mental state because there are no accurate records
 17 for a lengthy period before, but you're right, I would
 18 say there was evidence that he had to draw a conclusion
 19 he had schizophrenia in the period before the index
 20 offences.

21 Q. Thank you. Going on, then, to the evidence after the
 22 index offences, in your report at paragraph 60, you
 23 record an observation of him at the reception screening
 24 interview at HMP Nottingham on 17 June 2023, so just
 25 four days after the index offence?

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1 it would come out with an answer that these were classic
 2 symptoms of psychotic disorder or paranoid
 3 schizophrenia?

4 A. Yes, it would be likely to.

5 **THE CHAIR:** Thank you.

6 Mr Straw.

7 **Questioned by MR STRAW**

8 **MR STRAW:** Good morning. I represent Celeste and Elias
 9 Calocane. You have explained to the Chair already that
 10 you were in possession of some records from before the
 11 index offences going back to 2020; is that right?

12 A. Yes.

13 Q. Did those records include descriptions of the delusions
 14 and hallucinations that VC had been suffering going back
 15 over that period?

16 A. Yes, to some degree. Based on the records that the
 17 clinicians had elicited at Highbury Hospital.

18 Q. Thank you. You set those out in your report and, for
 19 example, paragraph 38, you describe him in reporting of
 20 hearing hallucinations of his mother being raped and
 21 screaming; is that right?

22 A. That's what I read, yes.

23 Q. Now, when the question arises, VC reported symptoms
 24 consistent with schizophrenia after the index offence,
 25 if the question arises "Is he making them up?" how

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1 A. Yes.

2 Q. You say there:

3 "When asked if he had any mental problems [VC]
 4 responded 'It's not for you to know'. Overall he was
 5 described as 'guarded, poor eye contact, bizarre in his
 6 presentation, appeared mentally acutely unwell'".

7 Were you aware of the observations that he appeared
 8 mentally acutely unwell on 17 June; did that trigger any
 9 urgent psychiatric assessment?

10 A. Not that I read, and he was soon transferred to
 11 Nottingham Prison, although he did go straight into the
 12 healthcare wing -- sorry, at Manchester Prison. But we
 13 don't know what the person that wrote that meant.
 14 What -- because again, examples would have been helpful,
 15 but presumably that was an experienced person who
 16 thought he had symptoms of mental ill health. But yeah,
 17 I didn't see -- it was only really Dr Ullal's
 18 comprehensive assessment by 11 July that seemed to
 19 trigger recommendation for hospital.

20 Q. So we have, then, Dr Ullal, and then further down in
 21 your report you note, paragraph 74:

22 "On [14 July 2023] ...

23 He was reported to be alone in his cell but
 24 shouting, and later, when he was asked about that:

25 "He said ... he was shouting [in] the night 'because

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1 of the voice in his head along with his thoughts and
2 that he was trying to get rid of them".

3 Is that correct?

4 **A.** Yes.

5 **Q.** Thank you. Then going forward to paragraphs 84-88 of
6 your report, you set out in detail the notes that VC had
7 written while he was in custody, apparently on 21
8 July 2023.

9 Now, is it right that those notes were found when he
10 was moved to segregation?

11 **A.** Yes.

12 **Q.** So they weren't something that he offered up to staff,
13 or anyone like that?

14 **A.** No, I think the Manchester Prison clinician said they
15 were found rather than offered.

16 **Q.** Then I don't have time to go through them in detail, but
17 paragraph 85, please, just to pick out a few points.
18 You quote him and so I'm going to read out a little bit
19 of what he said. You said:

20 "I thought there was a team (3 members) of henchmen
21 sent to liquidate me. The voices never stopped and
22 added ideas."

23 He goes on:

24 "The voices went on in my head developing the plot."

25 Bottom of the page:

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1 auditory hallucinations, and we talk about them in the
2 second person, so he was hearing derogatory things about
3 him, but also in the third person where people were
4 talking about him and commenting on his actions. Again,
5 I think he -- he described them in his letters as
6 continuous, so that would be, I think, very distressing.

7 He didn't say that to me at interview, he talked
8 about a dialogue. I had a very brief interview with
9 him, but yes, that was -- unfortunately, I saw the
10 letters after I'd already examined him, so I wasn't then
11 able to go back and ask him in detail about them, but
12 yes, you know, the description of the hallucinations
13 would have been highly distressing, I think.

14 **Q.** Then we are going to hear from Ms Doherty later, she
15 produced a report on 22 August 2023; is it right that
16 you saw a copy of that report?

17 **A.** Yes.

18 **Q.** Did it include a description of a long phone call that
19 she'd had with Celeste Calocane about VC?

20 **A.** Yes.

21 **Q.** Can we have that up on screen, please, it's WITN0391002.

22 So here we see at 6.1, there's the description
23 Mrs Calocane spoke to Ms Doherty, and then can you go
24 over the page, please, and have a look at 6.9 right at
25 the bottom of the page. Ms Doherty states:

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1 "At this point I was no longer resigned (sic) over
2 my impending death like the night before. I started to
3 feel anguished. About half an hour later a new plot
4 started. I now started to hear vividly people screaming
5 for help in the next apartment. I recognised the
6 voices. These were not strangers, but people I knew and
7 cared about. Now they were in danger. The voices were
8 narrating what was happening. They themselves were the
9 perpetrators. I went to the apartment and knock on the
10 door. No one came to open. I then knocked the door
11 down and entered."

12 So he appears here to be describing the May 2020
13 incident. Would you agree that's broadly consistent
14 with other accounts that you had seen of him explaining
15 his hallucinations prior to the index offence?

16 **A.** It would appear so, yes.

17 **Q.** Further down that paragraph, you refer to him saying
18 that he felt like he was repeatedly dying. In terms of
19 the nature and severity of the hallucinations he was
20 reporting, what was that? How distressing did they seem
21 to be to him?

22 **A.** He had a very full range of hallucinations. So, as
23 we've already heard from Dr Ullal's account, he had
24 visual, olfactory, so smells, gustatory, tastes. But
25 I think the most distressing him for him were the

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1 "I asked if she [so that's Celeste Calocane] was
2 aware of what the voices said to [VC], Mrs Calocane
3 reported that they said different things, they would
4 laugh at him, and tell him that members of his family
5 were in danger. Mrs Calocane informed me that her son
6 was adamant that the government has put the voices in
7 his head as part of some form of technology."

8 Were you aware that Mrs Calocane had been unable to
9 see her son face-to-face, that's the next paragraph that
10 has recorded that?

11 **A.** No.

12 **Q.** That description there from VC, the voices were telling
13 him members of his family were in danger, there was some
14 form of technology putting voices in his head, was that
15 again consistent with reports you had seen in the
16 medical records of VC's hallucinations?

17 **A.** Yes.

18 **Q.** How important is, in your assessment in this context,
19 information from a close family member that corroborates
20 other evidence that you have from years before the index
21 offence, that corroborates information you've got from
22 VC himself; how valuable is that to your assessment?

23 **A.** As I gave in evidence earlier, I think developmental
24 history from -- called an informant, but in particular
25 a family member, and even more important from a mother,

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1 I think, is highly important, because it gives
 2 information about those risk factors I talked about, the
 3 developmental risk factors, it could be from pregnancy
 4 and birth through to, you know, what someone was like at
 5 school, their learning. But in particular, what the
 6 relative's views of someone's symptoms their experience
 7 might be like. As I mentioned before, sometimes
 8 relatives are the first people to spot someone's
 9 becoming ill when the individual themselves has no
 10 insight. So highly important.

11 **Q.** Thank you. I've just got three final very short
 12 questions. The first one is about being guarded. You
 13 mentioned earlier that one reason VC may have been
 14 guarded is his hallucinations told him not to disclose
 15 what he was suffering. Also at paragraph 136 of your
 16 report, you say this:

17 "Additionally he has described a belief that NHS
 18 staff, and his community care coordinators, are part of
 19 the 'plot', a further reason for him to have been
 20 reticent in accurate reporting of ongoing psychotic
 21 symptoms."

22 **A.** Yes.

23 **Q.** Now. May those factors be why he didn't report
 24 psychotic symptoms to the police between 13 and 17 June?

25 **A.** I know he was reticent to report them to healthcare
 85

1 conditions, but his symptoms have persisted. It was
 2 unlikely that he was able to take drugs there. Is that
 3 the explanation for your conclusion that a drug-related
 4 cause was unlikely or is it something else?

5 **A.** It's not impossible for prisoners to get drugs into
 6 the segregation unit in a cat A prison but it's highly
 7 unlikely.

8 So the fact that I saw him eight weeks after the
 9 June offences, and he remained psychotic, or appeared
 10 more psychotic, made me conclude that this was unlikely
 11 to be a drug-induced psychosis and more likely to be
 12 an ongoing illness.

13 **MR STRAW:** Okay, thank you very much. Those are all my
 14 questions. Thank you, Chair.

15 **THE CHAIR:** Yes, Mr Beer.

16 **Questioned by MR BEER**

17 **MR BEER:** Dr Milton, you know I ask questions on behalf of
 18 the Trust.

19 **A.** Morning.

20 **Q.** Can we look at four things, please. The first is you
 21 gave evidence, you've been asked a lot of questions
 22 about a wide range of issues outside the scope of your
 23 report.

24 **A.** Yes.

25 **Q.** Because you were performing a narrow function about
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1 staff. Whether that also applies to the police,
 2 I couldn't say. But certainly the former was true.

3 **Q.** Penultimate question, in your report you say:
 4 "...psychotic symptoms render [VC] [a] ... risk to
 5 others".

6 That's paragraph 159. Why was it you thought his
 7 psychotic symptoms rendered him a risk?

8 **A.** Within the context of my assessment, going back to grave
 9 and immediate danger, on 5 August, so three days before
 10 I saw him, it appears that the unprovoked assault on the
 11 prison officer, the punch in the face that came out of
 12 the blue, VC later said that that was as a result of
 13 a dialogue, voices. He didn't want to be violent, but
 14 that was what happened.

15 So in terms of my assessment, does he need to come
 16 to hospital because he's got a risk to others, and is
 17 that linked to violence, that was -- made me draw
 18 conclusions that's why a hospital admission should be
 19 useful. Difficult to say in the wider context, but
 20 certainly in that period when I saw him in that August,
 21 that was my conclusion, yes.

22 **Q.** Thank you. Then the last question: you also say in your
 23 report that a drug-related cause of his illness was
 24 unlikely. Paragraph 129. The explanation you give
 25 there was he's been in segregation, in category A
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1 possible transfer to a high secure unit.

2 **A.** That was my role, yes.

3 **Q.** That's perhaps natural because you're the first
 4 psychiatrist that we've heard from, so no complaint
 5 about that. But in the course of doing that, you gave
 6 evidence, quite a lot of it, about informant or
 7 corroborative evidence, yes?

8 **A.** Yes.

9 **Q.** The potential sources of such evidence, yes?

10 **A.** Yes.

11 **Q.** And its possible use and relevance to a consultant
 12 forensic psychiatrist writing a report for court
 13 purposes.

14 **A.** Yes.

15 **Q.** You also have given evidence today about what I'm going
 16 to classify as three species of interactions that
 17 psychiatrists might have with a patient or a detained
 18 person. One, in the community or as an inpatient.

19 **A.** Yes.

20 **Q.** Two, in the capacity in which you in fact saw VC, namely
 21 as a defendant in a prison looking at possible admission
 22 to the high secure estate.

23 **A.** Yes.

24 **Q.** Then three, a full forensic report for court purposes.

25 **A.** Yes.
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1 Q. Now, in relation to those three species, you said that
2 the extent and range of information needed varied across
3 the piece.

4 A. Yes.

5 Q. Can you explain firstly what you meant by that? Why did
6 the need vary across those three clarifications that
7 I have drawn?

8 A. The difficulty is, this was such a serious incident and
9 serious offence and fast-changing information that it
10 may have been difficult, in the early stages, for the
11 police and the healthcare professionals and the custody
12 suite to have the information to hand. So I don't know
13 from the notes of the 13th to 17th what information was
14 available.

15 By the time I came to see him, there was more
16 information. It was unfortunate, I think, that the
17 notes were locked down, that I couldn't rely on those.
18 But I still think I had enough information. But by the
19 time someone comes to write a medical legal report for
20 the court, usually all of the information is available.

21 So I -- in terms of those three species you
22 described, I was in the middle. So I had, I think,
23 sufficient information, probably more information than
24 the people initially after the offences, but certainly
25 probably not as much as the people coming to write the

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1 on for more assertive management. So that's more
2 common.

3 Q. Yes, that was a -- you've answered the question that I
4 was about to ask.

5 A. Yes.

6 Q. What sits in between.

7 A. Yes.

8 Q. In relation to referral to a forensic psychiatrist for
9 the purposes of potential admission to the high secure
10 estate, you said that would be "unusual, very unusual,
11 absent the commission of an offence". By "commission of
12 an offence", did you mean established by conviction to
13 have committed an offence, or might it include the
14 allegation of commission of an offence?

15 A. Allegation of. So it's not unusual for patients to be
16 admitted on remand under section 48, 49 of the Mental
17 Health Act because they need urgent treatment whilst
18 they're on remand. So they may -- the case has not yet
19 gone to court. So that is common as well.

20 Q. Thank you very much.

21 The third topic, and you've mentioned it already,
22 the locking down of the Trust records. I think you were
23 simply told that they had been locked down. Did you
24 understand that this had been a measure imposed by the
25 Trust to prevent inappropriate access to them and

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1 court reports. Does that answer the question?

2 Q. Partially. What about the stage before the index
3 offences? I.e., assessment in the community, or if
4 somebody is detained under section 2 or possibly
5 section 3. You said that that may be impacted by
6 capacity or by workload.

7 A. Yes.

8 Q. Can you explain what you meant by that?

9 A. I don't work in the community setting but I have
10 colleagues that do, and I know that caseloads are high,
11 very difficult to manage, with a limited number of
12 inpatient psychiatric beds. So that's really what I was
13 referring to, the difficulties of being a community
14 psychiatrist and a community nurse, for example, these
15 days.

16 Q. Second topic, please. You said that referral from
17 a community psychiatrist, a forensic psychiatrist, would
18 be unusual or very unusual, absent the commission of an
19 offence.

20 A. Maybe I can clarify what I meant. Referral from
21 a community psychiatrist to a high secure psychiatrist
22 would be highly unusual. In fact there are services.
23 Most cities what are termed community forensic services.
24 So there is a special team working in the community that
25 will assess the more risky patients and maybe take them

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1 prevent inappropriate disclosure of them or parts of
2 them?

3 A. That was my -- those were my private thoughts, that that
4 was the explanation, yes.

5 Q. To prevent the kind of wrongful disclosure that has
6 afflicted in fact other organisations in this case.

7 A. I think that's a reasonable supposition, yes.

8 Q. In fact -- so to prevent improper access?

9 A. Yes.

10 Q. In fact your access would have been completely proper.

11 A. Yes.

12 Q. You were subsequently told that.

13 A. Yes.

14 Q. But you'd already written your report.

15 A. Yes.

16 Q. You didn't go back and say: "Right, well give me the
17 records to see whether it alters any of my opinions."

18 Can you help us why that was?

19 A. Yes, I don't think it -- I contemplated that. It may be
20 that Ms Doherty had access to the notes. But certainly
21 I felt I had sufficient information from the prison
22 teams referral and the SystmOne prison records that also
23 reference quite a lot of the Nottinghamshire healthcare,
24 community care and inpatient care. So I felt I had
25 sufficient information. It would have been very

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1 helpful, in particular the period leading up to his
2 discharge from services, to have seen that. But no,
3 I didn't think -- even though those notes weren't
4 available, I still felt I had sufficient information to
5 draw the conclusions I did.

6 **Q.** Thank you.

7 Lastly, can I turn to the reasons why Rampton wasn't
8 a suitable destination, and instead he was transferred
9 to Ashworth. Did you have explained to you the reasons
10 for that?

11 **A.** Yes.

12 **Q.** I won't ask closed questions, I'll ask you an open
13 question. What were the reasons explained to you?

14 **A.** I had an email discussion with the executive director,
15 Dr Elcock, and I think, as well as the sensitivities,
16 I thought it -- we thought it likely that there would be
17 an inquiry, and Rampton Hospital is part of
18 Nottinghamshire Healthcare even though it's
19 geographically distant and therefore for those reasons
20 it could be inappropriate for Rampton Hospital to be
21 looking after a man where the rest of the Trust might be
22 under some kind of scrutiny or inquiry.

23 But Dr Elcock also made the point that Rampton
24 Hospital, being a teaching hospital, has medical
25 students and nursing students come from the University

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1 that you in effect didn't have when you did your report.

2 The first was your own notes, which were taken away
3 from you; the second were the locked down or restricted
4 notes; and third is, in effect, not being able to have
5 any one to one discussion or interview with VC because
6 of what had happened in the morning; is that correct?

7 So out of those three things that limited your
8 report, only one has no explanation, which is the
9 removal of your own notes.

10 **A.** Yes.

11 **THE CHAIR:** And that's not happened before, has it?

12 **A.** No.

13 **THE CHAIR:** Did you ever get any explanation for that?

14 **A.** No, but I didn't ask.

15 **THE CHAIR:** Were they returned to you before you left?

16 **A.** They were left in -- I left them in reception.

17 **THE CHAIR:** I see. Thank you.

18 Just dealing with the difference that you've told us
19 about between forensic psychiatry and I think you've
20 said community psychiatrists, we know that those who are
21 in the community or dealing with people in hospitals
22 which are not forensic but for forensic purposes have
23 to, for example, risk assess and discharge people when
24 they come to the end of their section 2 or section 3
25 admission.

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1 of Nottingham, and again because of the nature of the
2 victims she thought that that would be therefore
3 inappropriate that he came. So in the email to
4 Dr Wallace that was referenced, I used "politics" with
5 a small "p".

6 Those are the reasons that I think that senior
7 managers were discussing whether or not -- in fact there
8 was even a discussion whether a Rampton clinician should
9 go out and assess VC, or whether it should be a
10 clinician from either Broadmoor or Ashworth Hospital.
11 But yes, those were the reasons as I understood them.

12 **Q.** So the Trust had been involved in VC's pre-offence care.

13 **A.** Yes.

14 **Q.** It would be inappropriate for it then to house him in
15 its secure unit.

16 **A.** Precisely.

17 **Q.** Grace was a medical student and other medical students
18 may have been brought into contact with him if he'd been
19 sent to Rampton.

20 **A.** Yes.

21 **Q.** Thank you very much.

22 **THE CHAIR:** Thank you, Mr Beer.

23 I have a few questions.

Questioned by THE CHAIR

24 **THE CHAIR:** The first is in relation to the three things

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1 Do you think that the -- what you describe, I think,
2 as a more concentrated or more serious, if you like,
3 forensic training, would be useful to those clinicians
4 as well, in risk assessment, because you're dealing with
5 risk as a forensic psychiatrist, aren't you?

6 **A.** I don't want to be disingenuous and be unfair to my
7 community general adult colleagues in psychiatry
8 because, as you know, when people are detained under the
9 Mental Health Act one of the reasons can be for the
10 protection of others.

11 **THE CHAIR:** Yes.

12 **A.** And many of my community, psychiatric colleagues, manage
13 patients who are quite risky, and also they even manage
14 people who have been discharged on restriction orders.
15 They're not all managed by forensic teams. So there is
16 a blurring of roles, actually. And it's not common, but
17 I have seen structured risk assessments such as the
18 HCR 20 that forensic psychiatrists use. I've seen those
19 used in adult mental health as well. So it's not
20 unusual for them -- for general psychiatrists to have
21 what we might call forensic patients.

22 It can always be helpful to have more training.
23 Whether or not there's an added benefit, my concern
24 would be that it still wouldn't have the time to be able
25 to deploy some of those things because of the fast-paced

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1 nature; you only have a certain number of days, the
2 pressure to discharge people because there's more unwell
3 people to come in. So more training would be great.

4 Again, I don't want to make forensic psychiatry
5 sound like it's the be all and end all --

6 **THE CHAIR:** Well, I wasn't suggesting that --

7 **A.** No, I know --

8 **THE CHAIR:** -- but we've heard that there is this
9 distinction.

10 **A.** Yeah, we have the privilege of having patients for
11 longer and we can do more detailed assessments. We
12 probably have more psychologists working with us than
13 there would be in acute settings, so we are able to do
14 those things. We also have the advantage of the
15 retrospectroscope. We see people after terrible things
16 have happened, so risk assessment is often easier to do
17 than it can be in a community setting.

18 So to go back to your question, more training would
19 always be helpful, but my only worry would be, unless
20 caseloads change, it would be very difficult for them to
21 deploy them.

22 **THE CHAIR:** Well, if it's a question of time, and I think
23 you've said that there is a resource for referral to
24 a forensic team --

25 **A.** Yes.

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1 **A.** I think the fact that he was in segregation in
2 a category A prison. The fact that the impact the
3 commissioning team had already said they didn't think he
4 could be managed in lesser security medium-secure care.
5 So in a way it was fairly obvious, I think, that there
6 was an immediacy. The fact that the prison -- the very
7 experienced prison officers didn't feel comfortable
8 taking him out, that he had to stay in segregation, he
9 couldn't even be managed in healthcare. So I think
10 there were those concerns that something could happen at
11 any time he was unpredictable.

12 **THE CHAIR:** Well, that's the point, isn't it: the immediacy
13 doesn't have to be proved by something which has already
14 happened? It's a risk, isn't it?

15 **A.** Yes, there was a survey among psychiatrists some years
16 ago to try and define what people understood by
17 "immediate" and it varied from one day to six months.
18 There wasn't really great agreement. So it's -- it is
19 often in the eye of the beholder in terms of the
20 immediacy.

21 **THE CHAIR:** Just, finally, one other question that I wanted
22 to ask was in relation to the material that you've seen,
23 both on his phone and also encapsulated in the notes
24 that were found when he was taken out of the cell.

25 What monitoring, if any, is there of phone use and

99

1 **THE CHAIR:** -- should that, in your view, be done before
2 discharging someone who has a repeated, for example,
3 history of admission?

4 **A.** It is done, but again, the forensic team have quite
5 a high threshold for seeing people and taking them on.
6 I think there are probably local area protocols on who's
7 eligible for referral. But I guess not everyone who has
8 got a history of some kind of aggression can be
9 referred. But yes, I think it would be useful to get
10 a forensic opinion from time to time.

11 **THE CHAIR:** Just dealing with your own assessment, I think
12 you were looking at, as you said, the criteria for
13 referral to the high-security admission. I think you
14 have said that you're looking, effectively, for two
15 things: one is the grave and the other is the immediate
16 danger. In this case, VC met the criteria, because of
17 the two incidents that you knew about: one a couple of
18 days before you arrived and one on the morning of --

19 **A.** Yes.

20 **THE CHAIR:** -- when you arrived. Would he have met the
21 criteria had those not occurred?

22 **A.** I think so still, yes.

23 **THE CHAIR:** What would have meant that he was in immediate
24 danger? What would have led you to that without those
25 two incidents?

98

1 access to the Internet of patients who are sectioned
2 under section 2 and section 3, to your knowledge? The
3 phone use?

4 **A.** When I go on psychiatric wards in other roles to see
5 patients who are on section 2 to -- they have their
6 mobile phones. Unless they've been posting
7 inappropriate images or content on social media. But
8 usually patients -- it is a risk-assessed thing by the
9 team, but they have access to their phones.

10 **THE CHAIR:** If there were material such as this that we've
11 seen, would that be something which would lead to any
12 restriction on that, or whether it would be taken into
13 account in the assessment of the risk they posed? Or
14 what?

15 **A.** I should think so, yes.

16 **THE CHAIR:** So access would be more limited?

17 **A.** Yes, and it may be monitored, in whatever way checks are
18 done. So sometimes a member of the nursing staff may
19 ask to just check the content, or relatives may be asked
20 about social media content. So sometimes it's around
21 a person's vulnerability, posting inappropriate things
22 from someone who is obviously mentally unwell.

23 **THE CHAIR:** Yes, yes. But as far as what we see here, we
24 obviously have -- Prevent has certain criteria and F tag
25 has certain criteria.

100

1 A. Yes.
 2 **THE CHAIR:** But as far as we've seen, there's nothing which
 3 really limits the access to the sort of mind control,
 4 that sort of conspiracy theory; is that correct?
 5 A. That's my understanding, yes.
 6 **THE CHAIR:** Thank you.
 7 Yes, thank you. Well, I think what we'll do now is
 8 we'll stop there -- thank you for your evidence -- and
 9 we'll start again at 1.45.

10 (12.43 pm)

11 (The Short Adjournment)

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