

Thursday, 23 April 2026

1
2 (10.00 am)
3 **MS LANGDALE:** Chair. May I call, please, Dr Seedat.
4 **THE CHAIR:** Yes, please.
5 **DR FAIZAL SEEDAT (affirmed)**
6 **Questioned by MS LANGDALE**
7 **THE CHAIR:** Yes.
8 **MS LANGDALE:** Dr Seedat, you have prepared a statement for
9 the Inquiry dated 3 February 2026. Can you confirm that
10 the contents are true and accurate as far as you're
11 concerned?
12 **A.** I can confirm them, they are true and accurate.
13 **Q.** Can you tell us, please, about your qualifications and
14 your background?
15 **A.** I completed my medical school in Zambia where I was born
16 and living at the time. After completing my medical
17 school, I went into post-graduate training in Zambia,
18 and then I made the decision to write the PLAB exam,
19 which I completed in 1997, which would then allow me GMC
20 registration, and looking for work in the UK. I was
21 successful in obtaining a training psychiatry post in
22 1999 which is when I started.
23 I completed my -- in those days it used to be called
24 SHO training for three years, and subsequent to that I
25 did my -- which was in Shrewsbury, Shropshire, within

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1 assessment, formulation and management planning of the
2 patient, and I also would perform my legal duties under
3 the Mental Health Act, particularly when patients are
4 under detention.
5 **Q.** We're going to go, Dr Seedat, through a number of notes
6 and records and I'll ask you questions flowing from
7 those. Can we look firstly, please, at NHFT0000168,
8 page 2, and this is the Mental Health Act Assessment on
9 24 May and it's Dr Gandhi's note of that.
10 **A.** Yes.
11 **Q.** And when we see page 2 on the screen, we see halfway
12 down:
13 "He was oriented to time, place and person."
14 Sets out what happened:
15 "On further questioning he revealed he [could] hear
16 his mother screaming and people ... screaming telling
17 him ... his mother was being raped [etc]..."
18 Did you see that? Would you have seen this
19 summary --
20 **A.** Yes, I did.
21 **Q.** -- from the -- so you saw that before you went on to see
22 him.
23 **A.** That is correct.
24 **Q.** Can we have please NHFT0000197, page 1. This is a risk
25 assessment, Dr Seedat, conducted by Annette Palmer. And

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1 the Keele rotation, and subsequent to that I obtained
2 a post doing my registrar training for three years at
3 Nottinghamshire Healthcare NHS Foundation Trust, which
4 I completed in 2007 and, upon my completion,
5 I immediately took on a consultant post.
6 In terms of my consultant post, I initially worked
7 solely in the community for up to three years. In 2010,
8 I took on a dual role where I worked both as an
9 inpatient consultant as well as a community consultant
10 in general adult psychiatry.
11 In 2016, I relinquished my community post and became
12 a sole inpatient consultant, but at the same time also
13 taking on the role as Clinical Director for Adult Mental
14 Health Services within the Trust.
15 And 2022, I relinquished my post as a Clinical
16 Director, and since then have been working solely as an
17 inpatient consultant.
18 **Q.** For the period that the Inquiry is investigating in
19 relation to the care of VC, you were the consultant
20 involved in his care, is that right, in 2020?
21 **A.** That is correct.
22 **Q.** As the consultant, what is your responsibility? What
23 comes with that role, as it were?
24 **A.** My role as a consultant is obviously I am sort of like
25 the overarching individual that looks at the proper

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1 we see, when it comes on the screen, at page 2,
2 a description of the reason for VC's arrest on the first
3 occasion:
4 "Arrested for damaging a neighbouring flat door
5 after believing ... his mum was inside screaming and
6 being raped. [VC] did not gain entry or harm anyone but
7 he was kicking the door."
8 If we can go to page 4, please:
9 "[VC] ... a student at Nottingham University
10 studying Mechanical Engineering."
11 Sets out again:
12 "... arrested by the police for criminal damage
13 (kicked a door in of another flat). ... police were
14 called for burglary but they found [VC] who resides in
15 a group of flat[s].
16 "No history of violence or aggression."
17 This is one of a number of risk assessments that the
18 Inquiry has seen, and you will know that the CQC were
19 reviewing in their report how risk assessments were put
20 together. Would you agree, at the outset, that the way
21 information was put on risk assessments was inadequate,
22 it wasn't updated, it wasn't dynamic it wasn't in
23 realtime and not very helpful for people looking at the
24 risks?
25 **A.** I agree.

4

1 **Q.** Just so we're clear, if we go, please, to NHFT0000530,
 2 page 12, these are key findings in fact from the Theemis
 3 Report, and we see from paragraph 2:
 4 "The way in which risk was being documented and
 5 formulated was not indicative of a dynamic approach to
 6 risk assessment and management. That is to say, risk
 7 was not considered to be changeable based on the
 8 presence of known hazards and in the context of
 9 different settings. For example, VC's risk in hospital
 10 would have been different from when in the community
 11 where hazards such as non-concordance and disengagement
 12 from services may have led to new or increased risks.
 13 The risk assessment formulation section reads as a list
 14 of previous violent behaviour rather than a true
 15 formulation and therefore [did] not demonstrate active
 16 risk control or understanding of the impact in change of
 17 effectiveness of protective factors."

18 Do you agree with that?

19 **A.** My understanding is that this Theemis report was in
 20 terms of VC's whole care in the time that he was
 21 involved with Nottinghamshire Healthcare Services and
 22 I would think that, based on the assessment they made, I
 23 would concur with their findings, with the caveat that I
 24 did not read a lot of the information post -- or in fact
 25 any of the information post--- my involvement, and hence

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1 **A.** I would say that it's not a very clear-cut thing to say
 2 whether I take responsibility. I think work on the
 3 inpatient ward is delegated, responsibilities are shared
 4 between members of the MDT and it would be very
 5 difficult and in fact impossible for a consultant to be
 6 versed on every single document that is being completed.
 7 It is hoped that people completing the documents would
 8 do it in terms of in the way it's meant to be done.

9 So I think it's not simple to say that, you know,
 10 I should be taking responsibility for everyone's
 11 clinical work. That would be very difficult, in fact
 12 impossible, to do in terms of the workload and the
 13 demands that a consultant has on an inpatient ward, in
 14 my case, being the sole consultant looking after 16
 15 patients.

16 **Q.** Can we have, please, NHFT0000168, page 7. This is
 17 your -- it's a Multi-Disciplinary Team meeting and
 18 discussion, setting out, VC:

19 "New admission on the ward ... First presentation
 20 to mental health services. Requires a period of
 21 observation ... to do an assessment of his mental state
 22 and ... we will defer the 72 hour review until Thursday
 23 as he's in a state that is too chaotic for this now."

24 We see who's in attendance, Dr Seedat, yourself,
 25 Dr Ludvigsen, Dr Ibrahim and a nurse. What's the value

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1 I am not versed with the contents and details of the
 2 assessments that were made subsequent to my involvement,
 3 but I would think that these findings were based on the
 4 review of the information in the notes that were
 5 available.

6 **Q.** Well, that includes the notes when he was an inpatient
 7 with you, wasn't it?

8 **A.** That's right, yes.

9 **Q.** So you're not saying it didn't apply --

10 **A.** No.

11 **Q.** -- when he was an inpatient because we've seen documents
 12 where there's a cut and paste from an account earlier
 13 on, and actual real descriptions of events being added
 14 much later. For example, surrounding these incidents on
 15 24 May?

16 **A.** Yes.

17 **Q.** So the criticism applies there, as well, doesn't it --

18 **A.** Yes.

19 **Q.** -- that the risk assessment and risk formulation was not
 20 properly completed when he was an inpatient either?

21 **A.** Yes, within those documents, yes.

22 **Q.** Do you take responsibility for that as the consultant?
 23 You say you didn't see the risk assessments, but
 24 ultimately do you take responsibility as the consultant
 25 that that wasn't effectively undertaken?

6

1 of the Multi-Disciplinary Team meeting?

2 **A.** This meeting, the intention, the initial intention on
 3 this particular day when VC was admitted for the first
 4 time, was actually to complete a 72-hour senior review.

5 However, when the time came to complete the 72-hour
 6 senior review, it became quite evident to me based on
 7 the information from the nursing staff that VC was very
 8 unsettled on the ward, there had been attempts by VC to
 9 try and escape from the ward --

10 **Q.** Shall we put that on the screen at the same time?
 11 Page 8, that's the event:

12 "... observed walking around the ward. ... started
 13 to kick a glass door".

14 Is this the event you mean?

15 **A.** That's correct, yeah.

16 **Q.** That's at the top of page 8. Carry on.

17 **A.** He had required the team to restrain him. He had also
 18 required PRN medication, and I made the decision that
 19 based on that clinical picture, it would not be helpful,
 20 or very little would be achieved in trying to interview
 21 and assess a patient in this chaotic state.

22 And I made the decision to say that I think it would
 23 be best that we allowed VC to settle so that we can then
 24 make a proper assessment when VC maybe will be in a more
 25 stable and settled state, which I think would be --

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1 would help and be more informative than when somebody is
2 chaotic.

3 **Q.** So the purpose of having the nurse, the junior resident
4 doctors and yourself together, is to share information
5 about the patient?

6 **A.** Yes, and that's the standard people who attend. So the
7 same people attended a ward review. It happened -- this
8 was on a Tuesday. Tuesday is the day when I do ward
9 reviews, where I see patients and there will be the
10 resident doctors attending, they'll be a nurse from the
11 ward who will give what has happened on the ward; there
12 will also be other people who may be invited to attend.

13 So on this occasion VC was discussed last, at the
14 end of the ward review, because he was the new patient
15 on the ward and that would have been the only time at
16 which I would have been able to see VC if I was going to
17 complete a 72-hour senior review.

18 **Q.** Is that ward review an opportunity to share information
19 about risk, as in fact appears to have occurred if there
20 was discussion of this event, how he was behaving?

21 **A.** *(The witness nodded).*

22 **Q.** You share information between you?

23 **A.** That's correct, yes.

24 **Q.** You, on page 8, if we look at it on the screen, you had
25 a conversation with VC's mum. That was the first of

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1 symptoms of mental illness, specifically looking at
2 things like delusions, hallucinations, and also more
3 importantly to look whether there was any comments
4 around risk that VC may have mentioned within these text
5 messages.

6 **Q.** Risk to others?

7 **A.** Risk to others, risk to self, because sometimes people
8 would describe these things in communications; they may
9 not describe them vocally.

10 **Q.** So risk to himself and risk of violence to others,
11 important to see what he's saying and thinking.

12 **A.** That's correct.

13 **Q.** To see if you can bring your professional opinion to
14 bear on what that might be.

15 **A.** Yeah, and also to add to my assessment and which will
16 then aid me in terms of me formulating both his
17 potential diagnosis, if it sort of supports any of that,
18 and, in addition, also help with risk assessment, and
19 obviously that was subsequently direct clinical
20 management.

21 **Q.** Our phones tell a lot about people, don't they, what's
22 on our phones, our messaging. As a consultant, do you
23 often get information from patients' phones one way or
24 another, either from them or from people who have
25 messaged them?

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1 many conversations, wasn't it, where she was interested
2 to know what was happening, was keen to share any
3 information she had with you about her son; is that
4 right?

5 **A.** That's correct.

6 **Q.** You could ask her freely what you were interested in
7 about him as well, presumably?

8 **A.** That's correct.

9 **Q.** She told you, we see on page 8, that she had a journal,
10 or rather her son had completed a journal, of
11 communications the family were concerned about. Were
12 you interested to get that information?

13 **A.** Yes, I was.

14 **Q.** Why were you interested in it?

15 **A.** Because VC's mum had informed me that within these text
16 messages there was a lot of odd conversations that had
17 gone on, which obviously my view of that was that this
18 probably related to his mental health, and obtaining
19 those text messages or whatever had been recorded would
20 help and aid in terms of me first of all trying to
21 understand his psychiatric phenomenology in terms of
22 what symptoms and difficulties he'd been experiencing in
23 terms of his mental health, whether I can make any
24 assessments from those text messages about his state of
25 mind, and whether I can concretely identify specific

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1 **A.** *(The witness nodded).*

2 **Q.** Because it must be very useful to see that kind of
3 information.

4 **A.** We do. We do that on quite a regular basis and there
5 tends to be a common caveat that the person reporting
6 these sorts of conversations would seek that we do not
7 disclose this to the patient in view that they do not
8 want to impact on any of their relationship, or the
9 person may then stop talking to them; and some levels we
10 do respect that, and I have to balance how I then use
11 that information, because whatever information I have,
12 ultimately I have to share it with the patient,
13 particularly if I come to some sort of formulation.

14 I have to in some ways clarify to the patient why
15 I have come to that diagnosis, and I have to use their
16 symptoms, their presentation, to help them understand
17 and explain why I have come to that conclusion. Because
18 in my experience, patients will sometimes disagree, they
19 will not believe; others find it a relief that, you
20 know, there is something that helps explain what they
21 have been experiencing.

22 **Q.** So you're clear that you are able, as a psychiatrist, to
23 receive information from family members or people who
24 have relevant text information; it's just how you share
25 that with the patient that you have to be careful about,

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1 depending on --

2 **A.** Sometimes can be challenging, yes.

3 **Q.** Yes. But that wouldn't stop you. The fear of that

4 challenge wouldn't be a barrier to you taking the

5 information in the first place.

6 **A.** No, it would not. I've always somehow -- in some cases

7 I have had to present it in a way that, through my

8 investigations, I've been able to identify this and not

9 really indicating that this has come from family.

10 **Q.** When somebody is on the ward, in this case VC is an

11 inpatient and has access to a phone, would you have any

12 knowledge, or would anyone on the ward have any

13 knowledge of what he is looking at on his phone? Would

14 that be monitored in any way?

15 **A.** That would be difficult to do.

16 **Q.** So you don't routinely monitor?

17 **A.** No. Unless -- and there have been certain situations

18 where if we receive information, where say for example

19 a family member may be concerned that they are putting

20 postings on social media, which are -- potentially could

21 be damaging to the patient, it could be retaliation. We

22 would, in those situations, make a determination whether

23 the person still having their phone is a positive thing

24 or is it something we should, in view that they are

25 unwell, it would be for their safety that they don't

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1 could be quite an invasion of their privacy, and it's

2 very difficult to know where the balance stands.

3 **Q.** Well, in terms of invasion to privacy, we now know of

4 course, because VC's phones have been analysed and

5 they've been produced through a criminal trial, that he

6 was looking, for example, at mass shootings.

7 If you're assessing a patient and looking at the

8 risk of a patient, the risk to others, it's important to

9 know, isn't it, what kind of information they might be

10 viewing, what they might be being influenced by?

11 So why couldn't you ask a question in the greater

12 public interest, instead of specific privacy concerns

13 that you may have?

14 **A.** I think it is important. I guess if there was a legal

15 framework and there was clear guidance as to how and

16 when this could be used, and this was made public in

17 that patients will be subject to these sorts of --

18 **Q.** Requests --

19 **A.** Request.

20 **Q.** It's only a request you can make.

21 **A.** Yes.

22 **Q.** But you can make a request at any time: "What have you

23 been looking at?" Or delve into that to see if the

24 patient will share the information with you.

25 **A.** And yeah, routinely we do tend to do that with patients

15

1 have access to social media and hence therefore in those

2 situations we would bring in certain sanctions around

3 that --

4 **Q.** But --

5 **A.** -- for their own safety.

6 **Q.** But unless anyone in the community makes you aware of

7 that, it wouldn't be something you'd be checking. Do

8 you ever say to people "What have you been looking at on

9 your phone today? Anything that's disturbed you?" Or

10 asked those kinds of questions in a consultation?

11 **A.** No. Sometimes, and this has on occasions happened,

12 where staff may be on certain social media groups and

13 some posting may come up and they will say, "Well, this

14 was something that was posted by the patient" and this

15 will be brought to the ward, and then we will try to

16 address that in the safest way possible.

17 **Q.** In terms of being proactive about gathering information,

18 do you think psychiatrists should be more proactive in

19 this area and seek out, even if a patient chooses not to

20 tell you, just try and work out what they're spending

21 ages looking at on their phone?

22 **A.** I think it's important that we respect people's privacy.

23 I think it's very difficult to sort of fall or cross

24 those boundaries, I would say. Yes, it would be

25 a helpful thing, but at the same time also I think it

14

1 where we know they've been spending a lot of time on the

2 phone. Some patients would voice it, some patients

3 would say that they'd rather not talk about it. I guess

4 it doesn't give us any further powers to then press on

5 that. It would be difficult.

6 **Q.** We don't see anywhere -- I'll be corrected no doubt if

7 I'm wrong -- in the RiO notes or generally to anyone

8 exploring what he's looking at, what he's thinking

9 about, when he's in his room, and VC is somebody,

10 certainly as this admission continues, who chooses to be

11 in his room. He's --

12 **A.** Correct.

13 **Q.** -- in inverted commas, "no trouble", is he?

14 **A.** No.

15 **Q.** He's quietly spoken, he's polite, he appears polite,

16 he's educated, and spending a lot of time looking at

17 things, and there doesn't seem to be much discussion

18 anywhere about what he's looking at.

19 **A.** A lot of the comments that were made within the

20 observations when he was in his bedroom were things

21 around doing his university work, drawing. There was

22 little comment to say that VC was spending a lot of time

23 on his phone. And I think if he was, then I guess there

24 would have been a probe to check, you know, what was it

25 that he was spending a lot of his time on the phone for.

16

1 Q. You would expect that or would hope that would happen?

2 A. Yes.

3 Q. Can we have, please -- that can come down --
4 NHFT0000168, page 11 and this is your 72-hour review,
5 Dr Seedat. We see "MDT discussion":

6 "Dr Ludvigsen believes that [VC] has been responding
7 to unseen stimuli. He has stopped during conversation
8 and stared at the wall. When asked what he was thinking
9 about, he said capital punishment. He said that he has
10 the 'solution' although he did not say to what. Has
11 coursework deadlines and exam soon for university. ...
12 This seems to have triggered the presentation. Has been
13 stressed about university work."

14 Dr Ludvigsen gave evidence that this was a worrying
15 situation. She was worried about the fact he had said
16 "capital punishment". Were you worried about that too,
17 and what was the discussion between you about that?

18 A. Yes, that was the first time that the message around
19 capital punishment was made, and subsequent to that,
20 when I received the text messages from the brother which
21 was passed on by his mother, there was a comment made in
22 one of the text messages where VC had mentioned to his
23 brother that he had watched a video on capital
24 punishment, and he was frustrated that people were -- I
25 can't remember the exact words but I think the

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1 doors and breaking them down. ... claims this is out of
2 character. Described himself as 'some lunatic banging
3 on people's door' and people were right to be scared."

4 In your statement you referred to that as thinking
5 he had insight at that point for saying that, that he
6 was like some lunatic banging on doors; is that fair?

7 A. Yes, I think he recognised that his behaviours were not
8 in keeping with what a normal, peaceful individual,
9 would behave in. And my understanding or my conclusion
10 around that was that he had some acknowledgement about
11 his behaviours not being right, not being just in some
12 ways.

13 Q. At the bottom of the page:

14 "He says a lot of students in university are very
15 much younger than him, he is almost 30. [VC] says he
16 wants to become a better person. [VC] believes his mind
17 has become clearer since being admitted to Highbury.
18 [And you] explained [he] has had a psychotic breakdown."

19 Just dealing with that, a lot of students are
20 younger than him, was he expressing his disappointment
21 with where he was on the trajectory of life?

22 A. Yes, he was.

23 Q. These younger people were doing better, they were
24 already there, effectively, at a younger age?

25 A. I don't think he was in any way referring that they were

19

1 understanding was that they were somehow making
2 a mockery or commenting on him having watched that
3 video.

4 I had discussions with him and VC was not very
5 forthcoming with what the exact intention or purpose
6 was, but did admit that he had watched the video, and
7 this was subsequent to receiving the text messages, to
8 try and understand whether there was any intent or
9 whether there was any concern or intention about either
10 punishing someone or particularly having understood that
11 VC had formed this belief system in himself that there
12 was some sort of conspiracy going on against him and
13 there were these people who were somehow following him,
14 and I guess making a mockery of him. Which he said it
15 did frustrate him. And VC did not suggest any plans or
16 any intent of wanting to harm anyone. And he was quite
17 clear. He said that he wouldn't do that.

18 Q. We're going to go to the records for a reason because
19 I'm assuming that notes are made at the time about when
20 you were told things. I appreciate he told you at some
21 point that he was being mocked and people were following
22 him, but let's look at what you were told here, if we
23 can?

24 He says in this bottom paragraph:

25 "VC is aware he is here as he has been banging on

18

1 better. I think he felt that what he was doing is
2 something he should have been doing when --

3 Q. When he was young?

4 A. -- when he was their age. And the fact that he had --
5 he was doing this at a much older age, he obviously
6 worried about where his trajectory was in terms of
7 completing education, gaining employment, and in some
8 ways I guess mentioning his siblings as well.

9 Q. Yes, he had two very bright siblings and he was aware of
10 that, was he?

11 A. He was. He was. He was well aware that he had somehow
12 fallen back and was behind as compared to where his
13 siblings were and I think there were aspects of
14 self-esteem that he was struggling with, that he had not
15 reached that point at the age that he was.

16 Q. If we go to page 12, you explained that at the top:

17 "The most likely cause of the psychotic breakdown is
18 sleep deprivation/stress. [VC] explained he would want
19 to seek a period of being [I think that should say not
20 medicated or medication free] so that he could better
21 understand who he is".

22 Is that right?

23 A. That is correct.

24 Q. So is that something that's commonly done, not
25 medicating patients on acute admission?

20

1 **A.** When patients present for the first time, I think it's
 2 very helpful to have a period of assessment without any
 3 medication. When someone has been started on
 4 medication, particularly where it's not clear what the
 5 formulation or where the evolution of the illness will
 6 go, in view that we have a lot of patients who are
 7 admitted who become psychotic due to the influence of
 8 substances or sleep deprivation or social isolation,
 9 I see quite a number of patients who, after staying on
 10 the ward for a few days, completely recover, do not
 11 require any need for medication, and are safely
 12 discharged back into the community. And I thought it
 13 was important that I do the same with VC on this
 14 occasion.

15 And secondly, also, that I think, in my experience
 16 it sort of helps when you are convinced and when there
 17 is evidence that occurs on the ward that suggests that
 18 they become psychotic, it becomes easier to explain and
 19 I guess convince patients that, you know, this is
 20 actually what you have. I've given you this period
 21 where you're not taking any medication, you are still
 22 expressing these sorts of beliefs, these cannot be in
 23 keeping with reality, hence it is my conclusion that
 24 this is more suggestive of illness, rather than this
 25 being driven by either sleep deprivation or just social

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1 **Q.** So this would have been a door off where someone was
 2 sleeping, and he was in that toilet, was he?
 3 **A.** It could either have been whether there was somebody in
 4 the room or somebody was not in the room, so he had gone
 5 into a room which was not his and hid in the toilet.
 6 **Q.** Did you find out if someone was in the room? Because
 7 that seems relevant, doesn't it, to be in somebody
 8 else's room and see them there?
 9 **A.** Yes. So when I did become aware of this incident, I did
 10 ask for details. Unfortunately, the nurse was not able
 11 to give me details. I was also surprised that the
 12 person did not even ask VC about what was he doing in
 13 the bedroom or in the toilet. Why was he hiding? What
 14 was he hiding from? I think that was something that I
 15 would have expected someone to ask.
 16 **Q.** Well, you saw it in the RiO notes, did you, or found out
 17 pretty quickly about it. Didn't you ask? I mean,
 18 closer to events it might have been easier to get
 19 answers to those questions.
 20 **A.** Yes, when I did eventually see him on, I think it was 5
 21 June, subsequent to another incident where VC had
 22 informed one of the nursing staff that he had been
 23 hearing voices and he had directed the nurse towards
 24 a door, and VC was surprised when the door was open
 25 because it was a linen cupboard. He was, I guess,

23

1 isolation, et cetera.

2 **Q.** If we put page 13 up, please, we see the regular
 3 antipsychotic medication was stopped on 28 May. So
 4 you've prescribed him some when he comes on the 24th,
 5 then it's stopped on the 28th; is that the position?
 6 What did he have before he was stopped?
 7 **A.** It was something that was commenced by the people who
 8 did the mental health assessment, it was not something
 9 that I had started him on.
 10 **Q.** Do you know what he was on in that short period?
 11 **A.** Yes, olanzapine 5 milligrams.
 12 **Q.** Right, each day, from 24th to the 28th?
 13 **A.** Yes. It's a night medication that someone takes every
 14 night on a regular basis. And at the point that I
 15 stopped it, he had taken it for two days.
 16 **Q.** We then see, if we go to page 15, on 1 June there's an
 17 incident on the ward, isn't there? We see that recorded
 18 there.
 19 **A.** That's right.
 20 **Q.** "... he went to patient's bedroom toilet and hiding
 21 there, woke up at around 3.30 hrs and came in the
 22 communal area and [fell] asleep."
 23 Just explain, "went to a patient's toilet and hiding
 24 there". Have they got toilets in their own bedrooms?
 25 **A.** Yes.

22

1 expecting that there would be somebody in there.
 2 Having noted those two events, I made, and it just
 3 so happened that on the same day his family were also
 4 coming down from Wales, as you know, this was during the
 5 Covid period and social distancing rules were in play.
 6 I took the opportunity to use that to both explain
 7 to VC in terms of my conclusion now that, with all the
 8 symptoms and all the information I had, and the recent
 9 developments in his presentation, that this was
 10 suggestive of illness and we need to start treatment
 11 sooner rather than later rather than delay things.
 12 **Q.** In your statement, paragraph 206, you don't need to go
 13 to it, you say about that incident that in your view his
 14 behaviour was driven by active psychotic symptoms, he
 15 was feeling scared, probably fearing something, and
 16 decided to hide. That's your reasoning for him being in
 17 that toilet.
 18 **A.** Yes.
 19 **Q.** Again, without assessing the facts around it, whether
 20 there was any other patient in the room, whether there'd
 21 been an exchange of any kind, why he'd gone into the
 22 communal area and whether he'd been asked about that at
 23 the time, it's very difficult, isn't it, to say why that
 24 event occurred, beyond saying he may have been
 25 psychotic, but why it occurred?

24

1 A. Yes, I would say that, based on what his mental state
2 was even prior to coming into hospital, at the time
3 I felt that that was the only likely explanation that I
4 could find for his behaviour, adding to the auditory
5 hallucinations that he had for the first time expressed
6 that he'd been experiencing because otherwise, prior to
7 1 June, VC had mentioned that he had been settled, he
8 was okay, and not expressing or demonstrating any overt
9 psychotic symptoms.

10 Q. On this page there's also a note of you speaking to VC's
11 mother "today" and you say there, or it's recorded:

12 "I gave her a brief account of the events leading to
13 admission and also the damage to the door to a lady in
14 the next building."

15 What did you give her by way of information about
16 the events on 24 May that had led to his admission?

17 A. I had informed her, based on the information I had, I
18 told her about the attempts that VC had made to gain
19 entry into other fellow residents' properties. I said
20 that on this one occasion this lady was so scared that
21 she had to escape, and that escape was by jumping off
22 the window and in the process that she had hurt herself.

23 Q. Did you know how significantly she had hurt herself?

24 A. No, I didn't. All I knew was that she -- I did identify
25 it as a significant injury, because I later found out

25

1 to the people he thought were invading his mind".

2 A. That's correct.

3 Q. So when the woman jumped out of the window he was trying
4 to get to the flat to the person who was trying to
5 invade his mind. Is that what you -- (*overspeaking*) --

6 A. My understanding was --

7 Q. -- what you've recorded?

8 A. -- that was in reference to -- and this has also been
9 documented in the brother's text messages, and also
10 subsequently when I sort of asked him about this where
11 VC had moved from his accommodation to the accommodation
12 where the incidents had happened.

13 So he had confronted housemates at his first flat,
14 that was in relation to that; not in relation to the
15 lady who had jumped from the window.

16 Q. The lady who jumped from the window is the same
17 accommodation; it's the Brook Court accommodation --

18 A. No, this was the one before that. He was staying at
19 accommodation before Brook Court, a month prior to that.

20 Q. Well, where does he mention a month prior to that?

21 Because what this note --

22 A. It says he had moved house to a different area. So we
23 are still on the same conversation.

24 Q. Well, he says:

25 "Thinks people have been following him ... probably

27

1 that she actually had surgery.

2 Q. How much later did you find that out?

3 A. A few days later. I think it was 1 June when I received
4 an email from police officer.

5 Q. Can we go please to your ward review on 2 June which is
6 168, page 17. This is where -- this is at 4.44. You
7 referred to it earlier, Dr Seedat, where VC is telling
8 you about people following him or watching him. We see
9 that under "Patient comments".

10 A. Yes.

11 Q. So you were asking him, are you, about -- well, tell us
12 what you were asking him?

13 A. I was trying to ask him whether there were any
14 experiences he wanted to talk about that, you know, he
15 found strange or that he found concerning. And this is
16 when VC started to voice that, you know, he was being
17 followed, he was being watched. This went to the extent
18 where he had also moved house to a different area,
19 trying to get away from these individuals, which was in
20 keeping with some of the text messages that his brother
21 had shared. A lot of the symptoms had some sort of
22 similarity in terms of concepts with that.

23 Q. What he's telling you here is that he:

24 "Did not feel fear but became angry about this.

25 "This is why he went to the neighbouring flat to get

26

1 since last October."

2 This is now May 2024.

3 A. That's correct.

4 Q. So he's saying he has moved house to a different area,
5 that means since last October he has moved house; it
6 doesn't mean -- when did you think he had moved house?

7 A. He said he had moved "a few weeks ago".

8 Q. Yes, so he's in the same place as where the lady jumped
9 out of the window in May. Why are you saying -- just
10 look at the document -- that this isn't a description of
11 what happened in Brook Court when the lady jumped out of
12 the window.

13 A. So what I'm trying to say is that -- maybe it's the way
14 it's documented -- VC told me that he had been living at
15 another residence from where he had moved here -- he had
16 moved, and he had moved because he was hoping that he
17 could get away from them.

18 Q. Right.

19 A. The two incidences that happened were at the new address
20 that he had moved to.

21 Q. Yes, yes.

22 A. So this comment is not related to him wanting to go to
23 her flat to --

24 Q. This says:

25 "This is why he went to the neighbouring flat to try

28

1 to get to the people he thought were invading his mind".
 2 We know he's at Brook Court, gone to three different
 3 numbers of neighbouring flats: kicking a door when no
 4 one was in on one occasion; kicking a door in when
 5 somebody jumped out of the window and injured herself
 6 seriously; and thirdly, when somebody was present who
 7 was able to restrain him with other residents that
 8 helped him.

9 So neighbouring flats in Brook Court is where he
 10 went or tried to go into.

11 **A.** Which is correct, and the consistent descriptions or
 12 information that VC gave us about his intentions of
 13 going to those flats was because he heard a woman crying
 14 who he believed to be his mother and he wanted to
 15 investigate.

16 What I'm trying to say is that this comment about
 17 him going to the flatmate to check whether they were
 18 invading his mind, this is what happened at his previous
 19 address, not at Brook Court.

20 **Q.** We've seen what Dr Gandhi recorded, and that is the
 21 description of his mother being raped. But this is your
 22 first record of patient comments, and you don't record
 23 that comment yourself. So I'm assuming from that he
 24 didn't say that to you, otherwise we would see that
 25 there instead of this explanation? This a differing

29

1 believing that people in neighbouring flats were trying
 2 to invade his mind, and he recognised or told you that
 3 he realises he needs to ask for help if he's hearing
 4 such voices.

5 **A.** Yes.

6 **Q.** That is a different explanation than the one he gave
 7 earlier to Dr Gandhi, isn't it, and it's one that's
 8 echoed, as you treat him subsequently, that he thinks
 9 his mind is being taken over and he gets angry about it?

10 **A.** And that was also very evident in the text messages:
 11 that he thought people were trying to invade his mind
 12 and read his thoughts and his memories et cetera.

13 **Q.** That was at the heart of his illness, that that's what
 14 he thought was happening: someone taking over his mind
 15 and he was angry about it and felt it was unjust, and he
 16 was being monitored, and on occasion worrying that his
 17 family would be monitored too if he went into their
 18 house.

19 **A.** Yes.

20 **Q.** That's the essence of it.

21 **A.** At the time he did not see it as illness.

22 **Q.** Can we go please to WITN0163012, page 1, and these are
 23 emails between you and the police. And we see at the
 24 bottom:

25 "Good afternoon Doctor."

31

1 explanation, isn't it, from the one that Dr Gandhi was
 2 given?

3 **A.** Yes.

4 **Q.** So he gives you it in this 72 -- in this ward review
 5 where you're interested in what he is saying about what
 6 he has done, and he says at the bottom:

7 "[He] ... felt ashamed and weak telling anyone so
 8 I did not ask for help".

9 This is the fact that he knows something is wrong
 10 but he felt ashamed and weak telling anyone.

11 "Now realises that in order to safeguard his own
 12 safety and wellbeing and that of others he must ask for
 13 help if he finds he is hearing voices and becoming
 14 paranoid ..."

15 Yes?

16 **A.** Yes.

17 **Q.** So he's recognising he's becoming paranoid, he's hearing
 18 voices, and he's behaved in a way that's affected the
 19 wellbeing of others. That's what he's expressing there
 20 to you.

21 **A.** Yeah, I did form that inform -- that conclusion, that
 22 his behaviours were clearly affecting others and, as you
 23 will know subsequently to that, I did have a very frank
 24 conversation with him about that.

25 **Q.** So he is clearly talking about events at Brook Court,

30

1 From PC Marsden:

2 "I am the officer in the case in relation to [VC].

3 I believe he was sectioned ... after he was assessed at
 4 the Bridewell Custody Suite ... [he] kicked the door to
 5 an internal flat, several times causing the young female
 6 victim inside the flat to become extremely scared, so
 7 much so that she jumped out her first floor flat window,
 8 damaging her back in the process. The injuries
 9 sustained to the victim subsequently required
 10 an operation on her back, but she is now walking a week
 11 later [but] ... is still on a ward within the QMC."

12 You respond asking for clarification.

13 Well, do you want to tell us what you respond?

14 **A.** The usual request that I receive from the police is
 15 about whether somebody is fit for interview,
 16 particularly when there is an offence that has been
 17 committed, and in my email I ask specifically about
 18 a formal form. There is, if my memory serves me
 19 correctly, something called an M11 form which is an
 20 interview form that we or the RC will complete to inform
 21 the police whether somebody is fit for interview or not.

22 On this occasion, the police officer, PC Marsden,
 23 replied to say that an email will suffice. In
 24 hindsight, I would have probably insisted that he sends
 25 me a form so that I complete the form where there has

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1 been agreement between the inpatient consultants, or the
2 consultants in the Trust, with the police that we will
3 be supporting only fit for interview if they require any
4 formal psychiatric opinions about whether somebody
5 should be charged or whatever it is, or have
6 a psychiatric report for court purposes, they will need
7 to get through this through an independent psychiatrist,
8 or through normal processes that they would use.

9 On this occasion I read the email as PC Marsden
10 asking whether I concurred with his opinion that Valdo
11 lacked capacity at the time of committing the crime, and
12 my purpose of the email was purely to state that it was
13 not in any way -- and I was never under the impression
14 that it would be used to decide whether VC was going to
15 be charged or not charged. And that was not my
16 intention of sending that email.

17 **Q.** The police officer says:

18 "... at the time VC may not have had capacity in
19 relation to his judgement ..."

20 What did you understand that the PC was saying
21 there?

22 **A.** I understood that the PC was trying to indicate to me
23 that VC was not in his right frame of mind when
24 committing the crime, ie there was -- there was some
25 sort of illness that had a bearing on his behaviour,

33

1 He'd clearly said something to Dr Gandhi about it in
2 the Mental Health Act Assessment and he had discussed
3 later in the day that you sent this -- you sent this
4 email at 13:44, your ward review was at 16:44, but he
5 had told you in that ward review why he went to the
6 neighbouring flat. It wasn't that he didn't recollect
7 it, did he? He did recollect it.

8 **A.** There were -- there was variability in terms of -- at
9 times he would say that he didn't remember the
10 incidences, then other times he said that he did.

11 **Q.** Why didn't you say that to the police? Instead of
12 saying he had no recollection of the event, say:
13 sometimes he had no recollection and at other times he
14 did.

15 **A.** I should have said that.

16 **Q.** It is important, isn't it?

17 **A.** Yes.

18 **Q.** Why is it important?

19 **A.** Because I think then the police can make a judgement in
20 that he was well aware of the behaviours and the actions
21 that he took.

22 **Q.** Are you asked on a regular basis for this kind of
23 information from the police or a police officer in
24 a case?

25 **A.** I am, and as I said, my -- and my consistent position

35

1 which is what I was trying to confirm in my email
2 response.

3 **Q.** So you were looking at it as mental health capacity.

4 **A.** That's correct.

5 **Q.** Did you think that the police officer would be in
6 a position one way or the other to comment on that or
7 whether he'd be able to?

8 **A.** I think I tried to make it as simple as I could in terms
9 of trying to respond to his email. And --

10 **Q.** If we go to WITN0163014, page 1 -- so it's still
11 WITN0163014, page 1 -- we see your response. So what
12 was your response to him?

13 **A.** My response was basically to confirm that, one, VC was
14 on my ward, that I was looking after him. I informed
15 him about the legal status that he was under, and I said
16 to him that based on my assessment to date, that there
17 was clear symptoms and signs suggestive of an acute
18 psychotic illness, and -- based on this -- and the fact
19 that his behaviours were intricately related to his
20 belief systems, it was my view that he was not of sound
21 mind when he was unwell, when he was carrying out these
22 behaviours.

23 **Q.** You say at paragraph 3:

24 "He had no recollection of the events prior to his
25 admission ..."

34

1 now, and at this time it should have been a -- that's
2 why I'm a bit surprised that actually he did respond to
3 this email, but I did, that I make it very clear that
4 the only thing that I would be willing to offer would be
5 is whether somebody is, at that particular point in
6 time, fit for interview or not. And hence I would only
7 complete the form; I would not reply or respond to any
8 emails.

9 **Q.** Because this was a very serious matter, wasn't it?
10 Somebody had --

11 **A.** It was, yes.

12 **Q.** -- jumped out of a window.

13 **A.** Yes.

14 **Q.** Required back surgery, serious injury, and "no
15 recollection of events" and "not in touch with reality",
16 on its face is giving somebody literally a 'Get out of
17 jail free' card; you just can't go near this person.

18 **A.** I as I said, I never thought the police would use that
19 as a decision-maker whether they would charge.

20 **Q.** What were they going to do with that? "No recollection
21 of events" and "acute psychotic illness". What did you
22 think they were going to do with that?

23 **A.** I was just trying to convey what I think his mental
24 state was at the time of committing the crime.

25 **Q.** If we look, please, at NGPF0006002, this is

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1 a Nottinghamshire Police policy dealing with persons
 2 with mental health and the procedure that they have or
 3 should have. And if we can go to page 22, please:
 4 "Public interest issues:
 5 "When a person experiencing a mental disorder
 6 commits an offence, it is sometimes presumed that the
 7 offence is linked to the mental disorder. This is often
 8 not the case and the mentally disordered offender may
 9 then proceed through the Criminal Justice System. It is
 10 no more helpful or fair for people with mental ill
 11 health or learning difficulties to be 'labelled' as
 12 unfit to prosecute than it is to assume they are not fit
 13 or competent to access the criminal justice ... as
 14 victims or witnesses."
 15 Do you agree with that?
 16 **A.** Could you please take the page back and -- sorry, I was
 17 looking at the top of the document and not the bottom.
 18 **Q.** It's the bottom of page 22 and the top of page 23.
 19 Perhaps we could have them next to each other. Can you
 20 see there, "Public interest issues"?
 21 **A.** Yes.
 22 **Q.** Have a read. Would you agree with that?
 23 **A.** Yes, I do.
 24 **Q.** So it sounds from your evidence as though you've
 25 tightened up on that practice since this case, then,

37

1 his brother had carefully put together. You read the
 2 whole document.
 3 **A.** Yes, I did.
 4 **Q.** Did you give this document or email this whole document
 5 to anyone else?
 6 **A.** No, I didn't.
 7 **Q.** Why not?
 8 **A.** Because I used the summary in terms of describing what
 9 was evident within the text messages. I carefully read
 10 all the messages and highlighted all the important
 11 messages within that, within the email. And I thought
 12 that that satisfactorily captured the context and the
 13 contents of the text messages.
 14 **Q.** Your summary in the notes is a whole lot shorter than
 15 this document, isn't it?
 16 **A.** Yes, it is.
 17 **Q.** Didn't you think it was right or fair to give your
 18 colleagues a chance to read it? We've spoken about the
 19 value of the multidisciplinary team meeting, the Early
 20 Intervention Psychosis Team, others subsequently. This
 21 was a document that you could share, it was relevant to
 22 share, so why didn't you?
 23 **A.** In hindsight, maybe I should have copied the email and
 24 put it on the RiO records.
 25 **Q.** If we look at the contents then, please, we see an

39

1 that you've recognised that it's completely
 2 inappropriate for you to respond to an email like that?
 3 **A.** That's correct.
 4 **Q.** Because, firstly, the officer is not assessing capacity;
 5 and secondly, you see him much later and aren't in
 6 a position to do so anyway at the time of the offence,
 7 or in terms of accounts given for the offence, are you?
 8 **A.** I agree.
 9 **Q.** That can come down, please.
 10 We know the text messages and document from VC's
 11 family was sent to you on 28 May and you had a read of
 12 them, didn't you, on 3 June. Is that right from your
 13 statement, you looked at the text messages and material
 14 sent on 3 June?
 15 **A.** Yes, I had a read of them at the time that they were
 16 sent and then I summarised the text messages within the
 17 RiO notes so that other people who may come across his
 18 notes will know what was written in these text messages.
 19 **Q.** Who did you share the messages with, the whole messages?
 20 We're going to come to the RiO note summary but in terms
 21 of the document and perhaps if we just have it on
 22 screen, NGPF0002527 beginning at page 20. It goes
 23 backwards so that's how we have to do it page 20,
 24 please.

25 This is the document that his mother sent you and

38

1 inclusion in October 2017:
 2 "(I'm not sure this is related ... seemed worth
 3 noting)
 4 "SMS conversation about him being hacked - email
 5 account password had been [changed] he had been having
 6 DNS issues.
 7 "... feared they had access to bank accounts ...
 8 "... thought his internet connection had been
 9 rerouted as he had no connection".
 10 Again, as a one-off, that might not have seemed, it
 11 could have been a genuine situation presumably in 2017,
 12 but when you were looking at everything as a whole, were
 13 you interested in that? That that extended back to
 14 2017?
 15 **A.** Yes, yes, I did conclude that that was probably in
 16 context of the subsequent text messages that his
 17 probable difficulties dated back much later than, and
 18 I think VC did eventually confirm that he thought that
 19 things were going on from October the previous year.
 20 **Q.** This is 2017, October 2017.
 21 **A.** Yes.
 22 **Q.** So not the previous year in 2023 --
 23 **A.** Yes.
 24 **Q.** -- this is 2017, so a long time before.
 25 **A.** Yes.

40

1 Q. So that's been included, and also 31 March:
 2 "Mum facetimes him without warning. He flips out
 3 and tells her never to do that again. ... calls ... and
 4 apologises for getting angry ... explains why he didn't
 5 want to facetime, saying something along the lines of
 6 'there are strange things happening in my flat'. [And]
 7 He didn't want to go into detail."
 8 So March 2020.
 9 We see, if we go to the page before, 19, so we've
 10 got 19 and 20 on the screen, April 2020:
 11 "... he expressed concerns about ... monitoring --
 12 seemed as though a specific person in his apartment was
 13 involved. He mentioned confronting them and them
 14 denying it and acting innocently."
 15 If we go to page 18, please, so if we can have 17
 16 and 18 on the screen at the same time, if we look at 18,
 17 Dr Seedat, 15:19 on 12 April:
 18 "I thought why do I feel like this now? I know
 19 I didn't work myself into this state of mind. I was
 20 thinking about red rum not 120 minutes ago. Now not
 21 only do I not care I feel appreciation".
 22 What did you make of that text? Did that worry you?
 23 "I was thinking about red rum?"
 24 A. Yeah, at the time it didn't worry me. I -- having read
 25 the text messages, there was a lot of religious --

41

1 and tried to determine what he meant by it and what the
 2 implications were.
 3 Q. You said --
 4 A. -- (*overspeaking*) -- changed.
 5 Q. You said earlier, you discussed the capital punishment
 6 reference with him and you knew he'd watched a video or
 7 he'd watched a video about --
 8 A. I knew that from the text messages with VC -- with the
 9 brother that he had been -- he had watched a capital
 10 punishment video.
 11 Q. So you did have that conversation expressly with him.
 12 A. Yes.
 13 Q. And what was his reason for that when you discussed it
 14 with him?
 15 A. He said that he was just going through materials and he
 16 came across this video around capital punishment and he
 17 looked at it, and the frustration he felt afterwards was
 18 because the voices were then making fun of him, and that
 19 sort of upset him. He didn't really talk much about the
 20 actual intention of why he was looking at that. He said
 21 he came across it, and watched it.
 22 Q. Did you discuss the intention of watching it?
 23 A. With him?
 24 Q. Mm.
 25 A. Yes, I did.

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1 discussions, whether religion could somehow help VC
 2 solve these experiences that he'd been experiencing and
 3 I think there had been a lot of prompts and hints from
 4 his brother about praying, et cetera, and I thought that
 5 was a reference to some religious experience that --
 6 Q. What, you thought "red rum" was a reference to that?
 7 A. Yes, something -- I --
 8 Q. So you didn't know what it meant, you didn't know it
 9 spells "murder" backwards?
 10 A. I didn't, no.
 11 Q. The significance of that --
 12 A. I didn't at the time.
 13 Q. -- in films and literature. Your colleague did. When
 14 Dr Ludvigsen was asked about that, straightaway she said
 15 that was worrying in an already worrying situation.
 16 It's not a text you recreated in the RiO records, so she
 17 did not see and get that information, and it sounds as
 18 though you didn't understand that reference at the time.
 19 A. No, I didn't.
 20 Q. Is it worrying now you know what it was? "I thought why
 21 do I feel like this? I know I didn't work myself into
 22 this state of mind, I was thinking about red rum
 23 [murder] not 120 minutes ago."
 24 A. Yeah, that would have been worrying. That would have
 25 been something that I would have then discussed with him

42

1 Q. And what did you ask him and what did you ascertain?
 2 A. I asked him, you know, why did you come across this
 3 particular video? You could have, you know, there are
 4 lots of things that come up, why particular this video?
 5 And he was not able to explain it, in terms of why it
 6 came up. He said, "It just came up on my phone."
 7 Q. Did you ask him if he found it distressing or
 8 disturbing?
 9 A. I did.
 10 Q. And what was his answer to that?
 11 A. He said that he just -- it was interesting reading. He
 12 didn't say that he was in any way distressed, he was in
 13 any way fearful or anything like that.
 14 Q. Well, that's a very unemotional, blunt response to
 15 something that's vile.
 16 A. It is, and I think there was a blunting of his affect
 17 early on in his admission, which was quite evident, to
 18 a lot of things.
 19 Q. If we look at page 17, please, 14:52, 12 April:
 20 "... previous night I felt immense anguish,
 21 paranoia, anger, hatred.
 22 "Couldn't sleep, had the darkest thoughts ... could
 23 imagine.
 24 "Wanted to hurt ... permanently ..."
 25 What about that? Did you ask him about that?

44

1 A. I did. I asked him whether -- in terms of reading
2 the -- in terms of reading his texts I sort of
3 understood why he could have been thinking that, because
4 when people believe that they are being watched, being
5 tormented, being made mockery of, it could either go two
6 ways: either people will start having thoughts or
7 battles about themselves, doing things to themselves,
8 ie, removing themselves from the misery; or they would
9 have intentions around the persons that they believed
10 may be behind these belief systems. And VC was quite
11 clear to me that he had no plans or no intent to hurt
12 anyone, despite what he had said. He had said that he
13 had said this in the context of feeling frustrated and
14 angry.

15 And subsequent to that, I'm not aware that this was
16 ever mentioned again, in the time up to the time that I
17 met him.

18 Q. That's not taking a longitudinal view, is it, Dr Seedat?

19 A. I would slightly disagree with that in that I did have
20 that in my mind whenever I was assessing him. I was
21 looking out for whether there were any belief systems or
22 any experiences that would encourage him or tell him to
23 hurt other people. I regularly asked him whether he had
24 any thoughts and plans about wanting to hurt other
25 people because I was well aware that some of these

45

1 "... screamed for them to stop.

2 "Says something along the lines of he hears them as
3 clearly as my voice ..."

4 "He says he knows the voices/people wouldn't dare
5 say anything [to] mock him to his face. Pride spikes
6 dramatically. Makes a remark about harming the people
7 he's hearing (hard to tell when he's making
8 a distinction between the voices as people and just
9 voices).

10 "... talked about some of the events from two days
11 ago ...

12 "On the 18th ... watched a video about capital
13 punishment and started writing his thoughts ... and
14 [then] could ... hear voices/people laughing and
15 mocking -- seeing him write and making comments on it --
16 unclear whether they were commenting on the actual
17 content of what he was writing or just the act. He
18 associated these voices/[and] people with the
19 people/person monitoring in his last apartment [and] ...
20 got angry as he thought the person/people followed him
21 to his new home."

22 Angry, being followed, capacity for fixation; would
23 you agree?

24 A. Yes.

25 Q. Really dangerous.

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1 experiences can lead to people doing these things, and
2 I was also well aware of the incidences that had already
3 taken place, and subsequent to, on the second admission,
4 I did have a very frank conversation and I guess I laid
5 it out to him about what the potential consequences
6 could be, if this behaviour continued.

7 Q. We'll come to that later, thank you. So if we go to
8 page 14, third of the anyway down:

9 "Because I think that they are watching I know that
10 I can break their heads with my hands".

11 What did you make of that?

12 A. That is something I even summarised in my text messages
13 in terms of the RiO record.

14 Q. It's violent, isn't it, these are violent scribes?

15 A. Yes.

16 Q. If we go, please, to page 6 and 7, piecing together
17 events, there's a summary helpfully provided for you,
18 and it says:

19 "He had a dream and ... he woke up ... same Voice,
20 now outside of his head, was telling someone else next
21 door about the dream. ... screamed for them to stop.

22 "Says something along the lines ..."

23 This is page 6, please, if we can have pages 6 and

24 7.

25 So we're looking at the third paragraph:

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1 A. (*The witness nodded*).

2 Q. You're nodding but that doesn't get picked up. These
3 are dangerous expressions of violence.

4 A. -- (*overspeaking*) -- at the time, based on, in addition
5 to this, I had also taken into consideration his
6 presentation assessments that I had made, and having
7 regularly asked and questioned about risk and about any
8 intentions of harm, et cetera. And I was well aware
9 that these were potential pointers towards risk. It's
10 not that I'd ignored them. I did consider them, in
11 terms of clearly identifying whether this concern or
12 these thoughts that he had were things that he had
13 an ongoing intent, an ongoing plan, and consistently
14 during the times that he was admitted, VC denied having
15 any such experiences or thoughts at that time.

16 Q. In your practice, have you ever been sent this kind of
17 material and seen laid out for you a series of messages
18 of the kind that we're going through now?

19 A. There have been a few occasions.

20 Q. With violence expressed in the same terms? "Crush their
21 heads with my hand"?

22 A. Maybe not to that extent, but there has been text
23 messages where there has been expressions of risk to
24 both theirself and to others which -- (*overspeaking*) --

25 Q. So to be clear, did you see these as relevant to risk to

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1 others: the anger, the hatred --

2 **A.** Yes, yes.

3 **Q.** -- the paranoia?

4 **A.** Yes.

5 **Q.** So you did look at this as risk to others?

6 **A.** Yes, and it is something that is commonly assessed in

7 patients who do have psychotic experiences, because we

8 know that there is a general feeling of fear,

9 apprehension, anger, et cetera. Because they find it

10 difficult to understand, and frustrated that why is it

11 happening to them and not to someone else.

12 **Q.** And if we go, please, to page 4, the third paragraph, he

13 describes being in a shop and taking a while to choose,

14 and the security guard coming behind him, and thinking

15 he was shoplifting.

16 Page 4. Third paragraph:

17 "So I started to shout at him and to try to shame

18 him."

19 Do you see he says that?

20 **A.** Yes.

21 **Q.** He said something:

22 "So I started to shout at him and shame him."

23 Are you aware, Dr Seedat, of the work of

24 Professor Seena Fazel who conducts research into the

25 area of schizophrenia and associated risks of violence?

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1 **Q.** If we can go back to this document on the screen and go

2 to page 1, please. 23 May:

3 "Calls [his brother] to talk about faith ...

4 mentions having been to the hospital (the night before?)

5 and having an encounter with God and feeling at peace on

6 the way home."

7 23 May, we know that he did go to hospital. Did you

8 ever see before the Inquiry the reference to that or the

9 records of that?

10 **A.** I didn't see the records, but I was aware that VC had

11 attended the A&E department.

12 **Q.** Were you interested to see what that was about or to ask

13 for the records. We'll put it on the screen now so that

14 you have them. EMAS000002, pages 1 and 2 together,

15 please. Did you ask him about that?

16 **A.** I asked him "What was the reason you attended the

17 hospital" and he response was that he thought he was

18 having chest pains.

19 **Q.** If we put page 1 and 2 on there, please, indeed, we see

20 the complaint is:

21 "... chest pain ... Developed L sided Chest type.

22 "Details: ?/acute behavioural disturbance ?mental

23 health c/o chest pain and hearing mumbling."

24 If we go to page 2 at the bottom:

25 "... APPEARS ANXIOUS/UNSURE OVER SOMETHING BUT CREW

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1 **A.** I am -- I can't remember if I've specifically seen his

2 research work but I have seen and read research work

3 around violence and mental illness, including

4 schizophrenia.

5 **Q.** And in 2024 Professor Fazel conducted the first

6 qualitative study to explore the psychological processes

7 of violence and psychosis, and he found three themes

8 emerging. The first was violence as the dominant

9 response mode, in other words people who have grown up

10 with violence around them and it's second nature; the

11 third referred to violence as relieving negative

12 external stress; and the second:

13 "Violence protects against a trio of sensitivities.

14 Participants highly sensitive to disrespect, threats of

15 physical harm, and unfair treatment, whether real or

16 imagined."

17 Do you think, in your treatment of VC, that he had

18 those sensitivities?

19 **A.** I think he did, yes, he did express those.

20 (*overspeaking*) --

21 **Q.** -- (*overspeaking*) -- proud and sensitive to insult and

22 being offended, do you agree?

23 **A.** Yes, he did, at times it did come through. It was not

24 all the time. I think there was a difference when he

25 was under treatment.

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1 CANNOT ESTABLISH WHAT."

2 Then at page 3:

3 "Hyperactive [Glasgow coma scale] 14/15 with crew

4 presenting under the influence of drugs or acute mental

5 health but denies drug use hearing voices mumbling

6 erratic behaviour complaining of intermittent chest pain

7 but does not give clear [history]."

8 What do you think that event was? It was the day

9 before, obviously, he was admitted under the Mental

10 Health Act Assessment, but what would you say about that

11 event?

12 **A.** It is likely that -- and this is speculative, of

13 course -- that VC was probably getting more and more

14 anxious, and it's not uncommon that people who have

15 increased anxiety levels can present as if they were

16 having heart attack, hence I'm guessing VC's expression

17 that he was having chest pain.

18 So there was a clear distress that VC was

19 experiencing, and based on this documentation, probably

20 likely, due to the psychotic experiences he was having

21 at the time.

22 **Q.** The ambulance crew were querying under the influence of

23 drugs. Did you, in any of your conversation, ask him if

24 he'd taken illegal drugs or used them?

25 **A.** Yes.

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1 Q. What did he say to you?
 2 A. VC, as well as his family's comments, were very clear
 3 that VC did not use any substances and on the 28th we
 4 did do a urine drug screen during his first admission.
 5 It all came back negative except for benzodiazepines,
 6 which was understandable because he had received
 7 benzodiazepines prior to the EDS.
 8 Q. When you say the drugs came back negative, are you
 9 testing for illegal drugs as well, yes?
 10 A. Yes, yes. The EDS is done to test for cocaine, opiates,
 11 stimulants, et cetera, cannabis.
 12 Q. Are you aware that he subsequently, in the context of
 13 the criminal proceedings, told Dr Mirvis that he had
 14 used cannabis once, and that it had a profound effect on
 15 him. He thought his arm was dropping-off and that he
 16 was going to die. That's what he told Dr Mirvis; are
 17 you aware of that?
 18 A. No, I wasn't.
 19 Q. Do you think that's an extreme reaction?
 20 A. In terms of do you mean to the cannabis?
 21 Q. Yes, he said he took cannabis once, he said it was only
 22 once and that's what happened.
 23 A. I would think so, though in my experience I think people
 24 have had a variety of reactions when taking illicit
 25 substances. Some people are able to tolerate it, some

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1 that and he didn't tell you about such a significant
 2 experience? In other words, he was withholding it from
 3 you, wasn't he? If you asked him about illegal drugs,
 4 he chose not to tell you that.
 5 A. I guess in the point when this incident happened,
 6 I guess he mentioned it, but I don't know if he dated
 7 it, whether it was pre-or post, or was this a historical
 8 event? And yes, it would have been helpful to
 9 understand what cannabis would -- what effect it would
 10 have if he did take cannabis. I guess what he would not
 11 have confirmed was whether he had still continued using
 12 cannabis because sometimes people would use something on
 13 one occasion, and they have an ill trip or a bad trip,
 14 and they will never use it again.
 15 Q. Sure, but it's a credibility point, isn't it?
 16 A. Yes.
 17 Q. You've asked the question for a reason --
 18 A. Yes.
 19 Q. -- it's important to you --
 20 A. Yes.
 21 Q. -- and he's not told you the truth?
 22 A. That's true. He should have if he did.
 23 Q. NHFT0000168, page 21, and this is your RiO note
 24 summarising the text that we have gone through. You say
 25 at paragraph 3:

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1 people even with small amounts are unable to, but
 2 presenting with so-called physical symptoms where he was
 3 losing his arm or something is unusual.
 4 Q. I'm not suggesting he presented to hospital with that,
 5 but he described that. So that would be an unusual
 6 response to cannabis?
 7 A. I would think so, yes.
 8 Q. One that would impact you psychiatrically, potentially?
 9 A. I think it would impact in the sense that one would
 10 consider that, you know, cannabis in this case,
 11 obviously I can only comment on cannabis, probably has
 12 a detrimental effect on his brain, and we know that
 13 there is a link between cannabis use and psychosis. So
 14 it would have been something of interest, yes.
 15 Q. So if he'd told you that, would you have explored that
 16 more and wanted to understand when and how that
 17 happened?
 18 A. In terms of using cannabis?
 19 Q. Yes.
 20 A. Yes.
 21 Q. Just where he was -- because we haven't got a point in
 22 time for that, but where he was and what happened, what
 23 he described?
 24 A. Yeah, it would be important, yes.
 25 Q. Are you concerned that you asked him many times about

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1 "He says he hears voices in his head ... other times
 2 it was like someone speaking to him, outside of his
 3 head."
 4 You repeat:
 5 "... the text that he had a dream and the next day
 6 believed someone in the next room was telling his dream
 7 to others. He said that people would not mock him
 8 in person and made some remark to wanting to hurt these
 9 people he was hearing."
 10 You don't say, "Hurt these people ... permanently
 11 ..." and I don't want to be pedantic about that, but
 12 it's significant, isn't it, "hurt these people
 13 permanently"?
 14 A. Yes.
 15 Q. Why did you not include that, then, if you were not
 16 going to share the document, which I suggest should have
 17 been your primary position, because you share the risk
 18 with your colleagues; do you agree?
 19 A. Yes, I thought that that statement was enough to confirm
 20 the experiences or the thoughts he had been having about
 21 harming other people.
 22 Q. So you thought that was adequately communicated by
 23 saying he wanted to hurt these people, in other words he
 24 wants to harm people?
 25 A. Yes.

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1 Q. But the tone "permanently" and "breaking their heads
2 with my hands and having the darkest thought I could
3 have imagined", the tone of that is very chilling, isn't
4 it?
5 A. Yes, it is.
6 Q. Not just with the benefit of hindsight, it's chilling;
7 do you agree?
8 A. I agree.
9 Q. The fact that he described he felt immense anger and
10 hatred.
11 A. *(The witness nodded)*.
12 Q. That's not included there. So would you accept that's
13 not an adequate summary of the tone and nature of the
14 messages that had been sent to you by his family?
15 A. I would agree.
16 Q. Professor Fazel's work -- and this was back in 2020 and
17 looking at the case of Sweden -- demonstrated that 23%
18 of people with schizophrenia had a violent conviction in
19 Sweden. 11% of men will get a violent conviction within
20 five years of the diagnosis compared with 3% of women.
21 When you were treating VC, were you aware of that
22 association between schizophrenia and violent
23 conviction?
24 A. I wasn't aware of the exact percentages, but I was aware
25 that schizophrenia can lead to violence and convictions.

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1 A. Was doing --
2 Q. -- expressed religious beliefs and his mother was --
3 A. -- *(overspeaking)* -- the bible, was reading the Qur'an,
4 was trying to find some sort of spiritual understanding
5 to try and explain and help him cope with what he was
6 experiencing. There was quite a -- I know his brother
7 was also attempting to preach some of these or encourage
8 him to pray, believe in God, et cetera.
9 Q. This, you say:
10 "Clear evidence of auditory hallucinations 3rd
11 person, passivity and persecutory delusional beliefs.
12 This suggests more of a functional illness rather than
13 it being precipitated by stress or isolation."
14 Functional illness. You had already, at this point,
15 June 2020, considered this could be more of a functional
16 illness. You'd looked at these texts, and I think you
17 had considered he may have had it for six months by now;
18 is that right?
19 A. Probably, yes.
20 Q. So by June 2020, six months of being affected by this.
21 You also tell us in your statement:
22 "... the longer the period of untreated psychosis,
23 the poorer the [diagnosis] ..."
24 A. The poorer the outcomes.
25 Q. The poorer the outcomes, sorry. The poorer the outcome.

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1 Q. Particularly for men --
2 A. -- *(overspeaking)* -- percentage was a bit less than
3 that, and I thought it was 10-15%.
4 Q. But you knew the association and did you know it was the
5 case for younger men in particular?
6 A. Yes.
7 Q. Didn't that influence your consideration of how he
8 should be treated and managed in this period of time?
9 A. I think in all cases, it sort of informs my decision
10 making about patient's presentation as well as risk. So
11 yes, those things did factor into my decision making
12 around treatment.
13 Q. You say in the bottom in summary:
14 "Clearly shows Psychotic symptoms starting and
15 developing over time with associated behaviours around
16 increased religious pre-occupation [and] crying ..."
17 Was that a fair summary, that it was around
18 increased religious pre-occupation? We've both read the
19 same messages, so why do you say that?
20 A. I think I was trying to allude to the point that in
21 addition to the psychotic symptoms, there was a lot of
22 religious thinking, and trying to use religion as a way
23 to resolve these things, which is what I was trying to
24 convey.
25 Q. Was there? I mean, clearly his brother --

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1 A. That is what the evidence suggests, yes. This is why
2 the EIP team evolved, through that research.
3 Q. So it was really important, once you had realised
4 through the messages and generally, that this may have
5 been going on for some time, that he got the right
6 treatment quickly and effectively, wasn't it?
7 A. That's correct.
8 Q. And comprehensive assessment, given he'd managed to not
9 just live in the community, but be at university masking
10 these symptoms that he'd had for some period of time.
11 A. Yes.
12 Q. What weight did you give to the fact that he had had
13 those experiences or some kind of experiences, and been
14 able to go to university at the same time? What did
15 that make you consider, in terms of how you dealt with
16 him?
17 A. I guess in some ways it was interesting to note that
18 despite the extent of the experiences he had been
19 having, that he was managing and able to function,
20 attend to his lectures, I would presume, the fact that
21 he was making progress, he had now reached his third
22 year, he was almost completing his third year which
23 would mean that he had somehow got through his studies
24 and was getting thorough his exams and progressing going
25 forward in terms of his career. And one could make

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1 inferences that, you know, he had some sort of strong
2 resolve in terms of trying to keep the psychotic
3 symptoms at bay and, at the same time, continuing to
4 study and function and complete his studies.

5 **MS LANGDALE:** Thank you. I think that's a good time for the
6 morning break, Chair.

7 **THE CHAIR:** Yes, thank you. Yes, we'll come back again at
8 quarter to 12. Thank you.

9 (11.24 am)

10 (A short break)

11 (11.45 am)

12 **MS LANGDALE:** Dr Seedat, we were looking at your entry on
13 3 June before we broke for the break, and your summary,
14 if we have it back on the screen, please, at 168,
15 page 21.

16 So you have recorded there:

17 "... suggest[s] more of a functional illness rather
18 than it being precipitated by stress or isolation."

19 He was in hospital. Was that not the best place to
20 assess, over a longer period of time, whether indeed he
21 had that functional illness?

22 **A.** I believe that in the (*unclear*) of time that VC was
23 admitted, there was adequate levels of assessment and
24 information that was available to make an opinion and
25 view about his clinical presentation, and the likely

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1 progressed.

2 **Q.** You could have converted it to a Section 3 and had him
3 in longer.

4 **A.** I would need to have the legal framework in which to do
5 that, and I would have found it very difficult to fulfil
6 the criteria for detention under Section 3 at that point
7 in time.

8 **Q.** Was that because you thought he was cooperating with you
9 and telling you the truth? Telling you accurately about
10 his symptoms and his views on medication?

11 **A.** Well, I think it's very difficult to say otherwise.
12 I mean we have to take on board what people are saying.
13 I'm not saying that we don't in any way assess whether
14 somebody is not telling you the truth. There would be
15 other evidence which would suggest that if somebody
16 wasn't, but at the time it was my belief and opinion
17 that VC was showing improvement, his demeanour had
18 changed, he was able to recognise the symptoms and see
19 them as illness even though he was maybe disappointed in
20 terms of knowing that it was illness, as he thought that
21 he would some how fix this by some -- by himself.

22 So I believe that VC over time did develop
23 an understanding of -- understanding his symptoms as an
24 illness, the need for treatment; he had been compliant
25 with treatment, and there'd been an overall change in

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1 formulation of his difficulties equating to a diagnosis
2 of a psychotic episode.

3 **Q.** The formulation of risk needed time, didn't it? He'd
4 been sent these messages, messages where he'd expressed
5 darkest thoughts on occasions. You summarised them here
6 as saying "wanting to hurt these people he was hearing"
7 and somewhere else he's written "wants to hurt ...
8 permanently"; doesn't say expressly "people
9 permanently", but says "hurt ... permanently".

10 So you had expressions within those text messages
11 that needed serious evaluation in terms of risk to the
12 public, and himself, potentially.

13 **A.** Yeah, and I believe that in the time that he was in
14 hospital, we were able to do that. We were able to
15 observe -- monitor his behaviour; we were able to
16 monitor any events of concern on the ward. We were able
17 to monitor the response to treatment that had been
18 started. We were able to identify or ask about risks to
19 others, to himself. I feel that we did have, we did
20 make the effort, and had the time to do that.

21 I did not feel that keeping him any longer would
22 have achieved anything, and also the detention under
23 Section 2 explicitly sort of, it would have been
24 difficult to continue his detention beyond that based on
25 the presentation that he was exhibiting as time

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1 his behaviour as well. There was less vacancy, there
2 was less distance, presentation during conversations,
3 et cetera.

4 And all that, to me, suggested that VC was better
5 than when he was admitted, and we got to a point where
6 it would have been very difficult to fulfil the criteria
7 for ongoing detention.

8 **Q.** I'm not suggesting in 2020 he was viewing videos of
9 massacres; that, on the evidence we have, came later in
10 2022. But in that first admission, you had enough
11 information in his texts and the communications you'd
12 had with his family to directly explore with him
13 violence risk. We know you do it in the second
14 admission, but in the first admission that does not
15 happen, does it? You don't explore what his belief
16 system is and his views around harming others.

17 **A.** We did. I think, in view of the incidents that had
18 happened when he got admitted, which were, as I said,
19 quite aggressive and concerning, I did discuss with him.
20 In fact VC was surprised when I'd informed him what had
21 happened to the lady with the second event, and he was
22 quite surprised and I think in some ways shocked that
23 that incident had happened.

24 And I did ask him, we assessed -- tried to determine
25 his pre-morbid state, we asked collateral information

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1 from his family, whether there was any tendencies
2 towards violence. We looked at predisposing factors,
3 whether there was any evidence to suggest that there
4 were any predisposing factors, like in his early life,
5 which there wasn't.

6 So I think we did do a risk assessment. I think
7 it's not correct that we didn't. We did consider the
8 risk of harms to others because --

9 **Q.** You didn't record that anywhere, did you? You didn't
10 set that out as a risk formulation and what you had
11 considered?

12 **A.** And maybe that is one of the areas I guess we do need to
13 get better at, is to try and I guess be more explicit in
14 terms of what aspects of assessment we have made to come
15 to a certain conclusion, and that is something that I am
16 working on to try and improve in my documentation.

17 **Q.** If we go, please, to 168, page 22. This is 4 June and
18 a conversation, the first of three you have with Eleanor
19 Turner, Mental Health Liaison Officer at the University.

20 What do you communicate to her and why are you
21 speaking with someone from the University?

22 **A.** So I became aware, from VC's mother, who the linked
23 person was at the University. She first gave me an
24 email which I wrote to and, as my emails suggest,
25 bounced back without a reply. And then she confirmed

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1 fact I on many occasions spoke to VC about going home.
2 University had made me very clear, ie, Eleanor had made
3 it very clear to say there were no face-to-face
4 lectures, the lectures were all happening online. The
5 exam, whenever he takes it, whether it's the exam that's
6 coming or the re-sit, he can do that online as well. He
7 doesn't need to remain on campus to do his studies.

8 And this was put to VC on several occasions that it
9 was both the University's view and it was also our
10 suggestion that he goes and spends some time with his
11 family, particularly back to his mother, and his mother
12 was willing to have him back home, if VC so chose. And
13 VC was very adamant that he did not want to take that
14 course of action.

15 In fact, he was also made aware that his current
16 tenancy was expiring very soon, within a few days of his
17 intended discharge, and VC had plans of either remaining
18 in Nottingham or going to Birmingham where he had
19 some -- he had a period of stay and did some work there,
20 which we were not very supportive of.

21 **Q.** Can we look, please, at NHFT0018629, page 1. It's the
22 letter from you to the University, informing them of
23 VC's admission to the psychiatric ward on 25 May:

24 "It is our view that his difficulties have been
25 present for a few weeks, and feel that sleep

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1 with me to say that the address she had given me, or the
2 email address she had given, me was actually wrong, and
3 when she gave me the correct one I then made contact
4 with Eleanor, Ms Turner, and I then subsequently gave
5 her my email and my contact details, and suggest either
6 she calls me or I call her.

7 Eventually we did have a conversation, and during
8 that conversation I made it -- she was made well aware
9 that the incidences that had happened, the assessments
10 that we were making, and she stated that the University
11 will be keen to help and support him, and we discussed
12 about where VC would be discharged to, and one of the
13 discussions we had was if she could identify and find
14 out what jurisdiction or powers the University had in
15 terms of where VC returned back to in terms of
16 accommodation, whether they had any legal
17 responsibilities of about the accommodation or was this
18 something beyond their control?

19 Which is what I later found out: was this was
20 a third-party accommodation and the University had
21 nothing to do with it.

22 **Q.** But they didn't want him going back there, did they?
23 She didn't want him to be back in that accommodation.

24 **A.** I think in an ideal situation, if there was alternative
25 accommodation, that would definitely be considered. In

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1 deprivation, stress and social isolation have had a part
2 to play. We remain hopeful that he will make a good
3 recovery."

4 Dr Gandhi, in that Mental Health Act Assessment, had
5 referred to stresses from the university work on VC.

6 What were you saying here about the stresses of his
7 university degree, one way or the other?

8 **A.** Can you ask the question again?

9 **Q.** Did you think that --

10 **A.** Yes.

11 **Q.** -- completing the degree was putting stress on him?

12 **A.** Yes, I think the -- that was the only stress that VC
13 alluded to in terms of social factors. And I was well
14 aware of them, and that, is, as far as my recollection
15 is, when I was -- when I had a discussion with Eleanor,
16 where she said the University will be happy to help,
17 will continue to help and support him, that was in
18 relation to his studies. I may not have explicitly said
19 that, you know, it's important that we try and address
20 his stresses, but I made the connection that she would
21 have been well aware that obviously studies do have an
22 impact on patient's(?) wellbeing and hence the support
23 and help from the University would be a helpful thing.

24 **Q.** And you say:

25 "... it will be important [for] ... the University

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1 to take into consideration the recent difficulties he
2 has had to support him to complete his exam and the
3 academic year."

4 That was very much looking at it, you may have
5 thought, from VC's perspective. Were there other
6 factors that you might have considered there in
7 suggesting to the University they needed to support him
8 to push through, as it were?

9 **A.** I think what I did find difficult is I was very unclear
10 in terms of what the mental health unit at the
11 University was able to provide support with. My
12 understanding is that their support was more at
13 a pastoral level, and VC obviously required more support
14 than that, in terms of his mental health. This is why
15 referral to secondary care services in the community
16 was, I thought, the appropriate and correct channels, as
17 opposed to what the University mental health liaison --
18 or service team would have done in terms of supporting
19 VC.

20 What I was expecting the University would help is
21 whether they would -- there was in any way possible to
22 try and make it easier for VC to complete his studies,
23 ie, completing his third year, whether that is to defer
24 the exams, to give him more time to catch up with his
25 lectures, et cetera. Because in view of these

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1 isn't he, so you're writing this it a point when he
2 hasn't resumed medication. So you don't know yet
3 whether he's going to make a good recovery or not
4 presumably -- at all --

5 **A.** No, that's why I'm saying we are remaining hopeful,
6 rather than saying he will be well, which I think is
7 very different.

8 **Q.** Can we have, please, UNIN0000594. This is a note that
9 Ellie Turner has made and she, on 9 June:

10 "Telephone call to ward for update as planned.
11 Staff nurse reports [VC] to be improving and now
12 compliant with medication. However, [VC] is isolating
13 [him]self on ward and not engaging in any meaningful way
14 with ward staff or activities."

15 We need page 4, please. Thanks.

16 "Nurse reports [VC's] discharge is planned for next
17 week and he continues to plan to return to Nottingham
18 address before possibly moving to Birmingham despite
19 having no known links with Birmingham. I again voiced
20 my concern at risk assessment and discharge plan.
21 Requested email copy of risk assessment and left message
22 for Consultant to call me to discuss."

23 They never receive a risk assessment, and did you in
24 fact not call back and discuss risk, which is what Ellie
25 Turner was worried about; the risk that he posed?

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1 difficulties, he did tell me that he had somehow fallen
2 back a bit.

3 **Q.** And you say in this letter:

4 "We remain hopeful ... he will make a good
5 recovery."

6 You may have been hopeful but was that an accurate
7 summary of the position at that time? You thought in
8 fact he may have a functional illness, that it had been
9 going on for longer than before his apparently acute
10 presentation, and you're giving a prognosis there. Was
11 that the accurate one?

12 **A.** I think I wouldn't say that I was giving a prognosis.
13 What I was trying to say is that I'm remaining hopeful,
14 trying to imply that, you know, we will aim towards
15 getting him better so that he can continue with his
16 studies and complete those studies because that's quite
17 important to him. And I think with all patients, we do
18 need to have a sense of hope, even for those who may
19 have symptoms for longer than, you know, than when
20 treatment was first initiated.

21 And in my experience, people who have had symptoms
22 that have been untreated for longer periods and do
23 respond positively to treatment, and get on, and
24 function appropriately.

25 **Q.** Well, at this point he's on his trial of non-medication,

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1 **A.** At the time this email was written, VC was still very
2 early in in terms of his treatment. He'd only been --
3 I think this email was sent on the 9th. It had only
4 been four days since his medication was started.

5 We were still in the process of informing or
6 assessing the response to treatment, and whether there
7 would be any ongoing risk.

8 I am unclear as to why the risk assessment that was
9 requested from the nurse was sent or not sent.

10 **Q.** Can we have, please, NHFT0000168, page 23.

11 This is going back in time again now, 5 June. We
12 referred to it earlier. You see the third reference:

13 "... [VC] pacing the ward ... [heard] a noise ...
14 [VC] was asked ... what he was hearing. He said was
15 hearing a woman in distress and wanted to save her".

16 This is the linen cupboard episode you referred to
17 earlier.

18 **A.** Yes.

19 **Q.** So you knew about this --

20 **A.** Yes.

21 **Q.** -- and took the view that his psychotic symptoms had
22 returned and medication needed to be given?

23 **A.** That's correct.

24 **Q.** You chose aripiprazole at a dose of 5?

25 **A.** Yes.

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1 Q. Why at that level? That's a very low dose, isn't it?
 2 A. That's the recommended starting dose for patients on
 3 antipsychotics who have never had any psychotics before.
 4 I think in all, in general practice, is always to try
 5 and start with low doses and then increase as required
 6 per response.

7 It may appear to be a small dose, but I have seen
 8 people respond to even smaller doses than 5 milligrams.

9 Q. How long does it take to assess whether it is effective
 10 or not, normally?

11 A. It can start working within two to five days and in some
 12 cases can take up to ten to 14 days.

13 Q. Can we have page 24 from the same date. 5 June.
 14 "Discussion with [VC] and his family".

15 A. Yes.

16 Q. "[VC] gave me his valid consent to be able to discuss
 17 his difficulties with his family."

18 Can we unpack that, please. If he had not consented
 19 to sharing information with the family, would you have
 20 shared any, or not?

21 A. I think that would have made it very difficult in terms
 22 of patient-doctor confidentiality and these are regular
 23 things that we do find challenging.

24 On balance, it would be against the doctor-patient
 25 confidentiality to actually reveal information about

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1 that he did go home for short periods of time. But he
 2 hadn't lived there for long periods of time. He said
 3 that he had been doing, you know, his studies,
 4 et cetera.

5 Q. So if he wasn't living with them, they're going to have
 6 limited knowledge of his day-to-day life, aren't they,
 7 potentially; that's a matter for you to explore?

8 A. Yes.

9 Q. Family history. His father told you, if we look at the
 10 same box, that:

11 "... he was now able to recall his own father [so
 12 that's] [VC's] grandfather] did experience some mental
 13 health difficulties but was not aware of any diagnosis
 14 and does not feel that he got treatment supported by
 15 family."

16 So that's a significant piece of information you're
 17 being given, isn't it: that there's a mental health
 18 diagnosis, you're not aware of the diagnosis but
 19 symptoms in his grandfather, paternal grandfather?

20 A. Yes, and that information was considered in terms of
 21 looking at the possibility of there being some sort of
 22 genetic loading to his illness. I think what was
 23 unclear and never established was what was the mental
 24 health difficulties that grandfather experienced. It
 25 may not have been a psychosis, in which case there may

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1 a patient when they have explicitly stated, or if they
 2 had explicitly stated that they did not want information
 3 sharing. And that would have made it very difficult,
 4 and in situations like that, I tend to try and explain
 5 to the patient why this would be important particularly
 6 where families are very involved, because there's
 7 sometimes we have families who are very distant, and you
 8 have to question whether they would -- they are actually
 9 helping the patient or not and hence sharing information
 10 would be helpful or not helpful. In this situation,
 11 I think I was quite convinced that the family were very
 12 interested and connected with VC, and wanting, you know,
 13 the best for him.

14 Q. And wanting to support you?

15 A. Yes.

16 Q. We've seen what was sent to you --

17 A. In terms of -- yes. And so I was pleased that
 18 throughout the whole process I think VC never declined
 19 us sharing information with his family.

20 Q. Were you aware that he hadn't actually lived with his
 21 family for a long time? He was 30 when you saw him; did
 22 you question how long he had been living elsewhere?

23 A. I was aware that he had been at university. I was aware
 24 that he had lived in Pembrokeshire. But I was in the
 25 belief, and I think he did tell me that there were times

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1 not have been genetic loading with psychosis, but the
 2 fact that there was family history I think it was
 3 considered as an important consideration in his
 4 formulation.

5 Q. If we go to page 26, please. Of the same bundle.
 6 Multi-Disciplinary Team meeting, 8 June. Team
 7 discussion, you're there, Dr Ludvigsen, a number of
 8 other professionals listed:

9 "... [VC] seems increasingly withdrawn, need to
 10 uncover why this may be, eg is he masking psychosis or
 11 low mood or are there other reasons. Was reported to
 12 have been hearing a woman's voice screaming which staff
 13 could not hear."

14 And the plan includes at the first point:

15 "... please try to dig deeper when he declines an
 16 activity -- if anything, is really behind the refusal."

17 What did you mean, "dig deeper", there?

18 A. I was trying to convey to staff that if there was
 19 concerns around being guarded or masking symptoms, it
 20 would be helpful that staff took a more proactive view
 21 to things, in that if VC was saying something like "I'm
 22 okay" or "I don't want to do this", it would be helpful
 23 to understand why is that VC does not want to do this or
 24 what does "fine" mean?

25 And that would mean that if you spend more time with

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1 him, then there could be things that may be uncovered
 2 that would be helpful in terms of our assessments.
 3 There was, having understood his pre-morbid
 4 personality, getting collateral from his family, who
 5 confirmed that VC had become someone who liked his own
 6 space, was quiet --
 7 **Q.** Didn't have many friends? (*overspeaking*) --
 8 **A.** Did not have many friends. VC himself, in the
 9 conversations I had, made it very clear that when he
 10 came to England, due to language barrier, I think at the
 11 time probably he was speaking Portuguese and he somehow
 12 learnt English subsequently, he found it very difficult
 13 to make friends, and he said that hence a pattern had
 14 developed where he started developing or spending a lot
 15 of time by himself and he started becoming comfortable
 16 with this.
 17 **Q.** We have a statement that was sent to you I think,
 18 WITN0428001, from a witness who lived with VC in Wales
 19 in 2014, 2015. And she contacted the police and has
 20 subsequently made a statement for the Inquiry, because
 21 she was concerned about his behaviour at that time.
 22 Have you had an opportunity to read that statement?
 23 **A.** Yes, I have read it, yes.
 24 **Q.** And she sets out at paragraph 5 she would wake up during
 25 the night:

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1 ... and ... interactions with housemates."
 2 Would that have been helpful for you to know at the
 3 time, when you saw him: that in fact this is 2014 to
 4 2015, these issues have been identified in his
 5 interactions with others?
 6 **A.** I accept it would have been helpful and it would have
 7 been important to try and explore these with him to try
 8 and get an understanding in terms of what explanations
 9 he would have given in terms of the experiences that
 10 people had observed.
 11 **Q.** That can come down, thank you. Because you've spoken
 12 about pre-morbid or characteristics or personality.
 13 It's very difficult, isn't it, in a case like this, to
 14 have enough information to deal with that?
 15 **A.** Yes, and I guess in a lot of these situations obviously
 16 we can only speak to people we come in contact with, and
 17 obtaining information from the family who, one would
 18 presume, would know their loved one well, would give
 19 some sort of understanding, in terms of what this
 20 individual is like --
 21 **Q.** Yes, their experience.
 22 **A.** -- or was like. Yes.
 23 **Q.** Their experience.
 24 **A.** In terms of their interactions, their experiences of
 25 him.

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1 "... frequently wake up to the sound of someone in
 2 the kitchen, which turned out to be him. [It happened]
 3 ... several times during the same night."
 4 She could see that:
 5 "Because of the layout of the house ..."
 6 She heard:
 7 "... repetitive noises, what I would describe as
 8 screaming coming from his room. A friend who was
 9 staying ... at the time also heard these noises."
 10 And at paragraph 8:
 11 "... an incident involving food going missing from
 12 the house. One of my housemates ... asked everyone in
 13 the house about this. When she asked [VC] about it, he
 14 raised his voice and asked why she was accusing him,
 15 which I found intimidating. He then walked away and the
 16 issue was not discussed further."
 17 In terms of pre-morbid characteristics, we were
 18 talking earlier about sensitivities, sensitivities to
 19 being insulted, offended or accused. That's a distinct
 20 reaction that's being reported there, isn't it?
 21 **A.** I think it is, yes.
 22 **Q.** And if we see paragraph 14, she wanted to set out
 23 information that she thought may be relevant to mental
 24 health, describing "behaviours [she'd] ... observed,
 25 including unusual patterns of activity during the night

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1 **Q.** Mm-hm. But it's one part of experience, isn't it,
 2 particularly parental experience --
 3 **A.** Yes.
 4 **Q.** -- the relationship between parents and adult --
 5 **A.** That's correct, yes.
 6 **Q.** -- children. There's lots of other people around VC of
 7 the same age. People who live with him can give very
 8 important information about that, can't they?
 9 **A.** Yeah.
 10 **Q.** So you were relying solely at this period in the
 11 assessment with his -- from his family, who were helping
 12 you as best they could. But do you recognise there may
 13 well have been other information within his community
 14 and generally that would have been relevant to
 15 assessment?
 16 **A.** I think that's relevant in all cases. I guess the
 17 challenging debate comes in terms of how do you get
 18 access to all of these individuals and interview them,
 19 and at the same time have to maintain patient-doctor
 20 confidentiality, which makes it very tricky and
 21 difficult.
 22 **Q.** The University, you had a point of contact there with
 23 Ellie Turner. Might you have asked her? You can
 24 receive information, if you don't share it. What's the
 25 information from his tutors, from colleagues on the

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1 course? How do they find him?
 2 Would you have thought to ask for that kind of
 3 information about him?
 4 **A.** I would think that would have been -- whether they would
 5 have actually infor -- it may have informed in terms of
 6 what his behaviours were, but personality is formed
 7 around the age of 18 and it's about looking at
 8 consistent patterns of how someone reacts and responds
 9 to situations, and it's difficult to know whether they
 10 would be able to make inferences or comments on that.
 11 They may be able to give comment about certain
 12 interactions that they may have had, and that could have
 13 been helpful in terms of maybe trying to piece together
 14 what this person is really like. But it may not
 15 necessarily give a complete picture of what the person's
 16 pre-morbid personality is because there's a lot of time
 17 when I guess the individual is not in their presence.
 18 **Q.** Can we have, please, 168, page 28, 9 June. This is
 19 where discharge planning and discussion begins. If we
 20 look under "Patient comments", "Patient comments":
 21 "Dr Seedat stated ... he does not want [VC] to
 22 change, he wants the way [VC] does things to change.
 23 ... wants [VC] to come out of social isolation.
 24 Dr Seedat explained ... he is concerned how [VC] will be
 25 able to manage on his own when he is discharged from
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1 **A.** I think when it comes to accommodation, this can be
 2 quite difficult. I tend to have very little control in
 3 terms of where someone will end up in terms of
 4 accommodation. There is a level of autonomy that we
 5 need to respect. If somebody is making a capacious
 6 decision about returning to an address or
 7 an accommodation that they hold, then we have to respect
 8 that. I don't have any legal powers or any remit to
 9 dictate where people live or don't live. I can make
 10 suggestions, for example if somebody needed supported
 11 accommodation we would discuss with the individual to
 12 say, "This would be the best option and these are the
 13 reasons why," or "You would be okay if you went into
 14 independent accommodation, for example."
 15 In VC's case, he was a student, he had
 16 accommodation. I was concerned about the fact that he
 17 had such a short tenancy, ie he had a short time before
 18 which his tenancy was going to end. But at the same
 19 time VC said that he -- and I was assured that VC was
 20 aware of that situation -- and VC wasn't clear whether
 21 he was going to remain in Nottingham or he would
 22 consider going to Birmingham where he had lived before
 23 and had sought employment, as an option, because the
 24 University year was coming to an end.
 25 **Q.** Can we have, please, NHFT0000168, page 31. This is an
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1 what he is seeing on the ward ... [He] ... is
 2 disappointed he will need to take medication [that's
 3 VC]. [VC] has made a conscious effort to try and
 4 embrace his illness but its not been easy. He denies
 5 feeling depressed about his illness. He has not had
 6 thoughts about hurting himself or others."
 7 You referred to that earlier this morning. Is this
 8 the meeting where you were satisfied that he didn't have
 9 thoughts to hurt himself or others?
 10 **A.** It wasn't just this meeting. There were other
 11 conversations we had around his thoughts around wanting
 12 to hurt himself or others.
 13 **Q.** He explained that his tenancy was going to end on
 14 25 June.
 15 Did you regard it, do you regard it, as any part of
 16 your function to understand the discharge plans and how
 17 choate they are, how they're going to work or not?
 18 Because we have a situation here where VC is saying
 19 "I might go to Birmingham", and his family are obviously
 20 worried about that and don't know what he's thinking
 21 about in Birmingham. He may come out somewhere in
 22 Nottingham and go to premises where there's other
 23 concerns about why he's there.
 24 What's your role, as far as you're concerned, in
 25 this discharge planning process?
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1 occupational therapist's notes for 10 June. We see at
 2 paragraph 2:
 3 "... [VC] ... [had] politely declined to participate
 4 in any gardening and requested to sit and enjoy being
 5 outdoors."
 6 There's plenty of references to politeness when in
 7 fact what follows is complete non-engagement and not
 8 taking up the offers. But because it's done politely,
 9 doesn't cause the person making the offer presumably any
 10 immediate problem, it's not highlighted as being
 11 non-engagement, not prepared to participate in
 12 activities or presumably otherwise they wouldn't be
 13 offered, psychotherapies that you think are relevant and
 14 helpful.
 15 **A.** OT is, in terms of the OT provisions that the hospital
 16 has, is quite limited in some ways. It is not uncommon
 17 that patients may not have an interest in terms of the
 18 activities that are being given. I think VC indicated
 19 that he would be interested in activities related to the
 20 gym or physical activity. And unfortunately at the time
 21 we were unable to provide that in view of the Covid
 22 situation in order to limit the contamination of the
 23 virus from one individual to another.
 24 I think it was generally looked at, some of these
 25 activities were not of interest to VC and hence VC was
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1 not willing to engage with them. And that is not
2 uncommon with many patients, it comes similar to
3 activities like cooking, gardening, not everyone takes
4 an interest in these activities.

5 **Q.** It's recorded here:

6 "He had declined the possibility of completing some
7 exercises on the ward with OT, sharing he only wants to
8 lift weights." (As read)

9 Where a patient is having violent thoughts, would
10 you take into account their physical strength when
11 considering risk to others?

12 **A.** I think one has to look at in terms of their ability to,
13 I guess, cause some level of harm. It would be
14 automatic to say that somebody who was of small build or
15 stature will be less physically able than somebody who
16 is bigger than that.

17 **Q.** Can we have page 32, please. This is a key worker,
18 halfway down, discussing -- page 32 -- discussing
19 discharge plans.

20 "[VC] had a smile on his face and stated he was
21 feeling brilliant.

22 "... asked [VC] about his plans ... and he stated
23 ... return to his flat and then move to Birmingham when
24 his tenancy finished ... he knew Birmingham and [wanted
25 to get] back to his ... job.

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1 **Q.** If we go, please, to page 45 so 168, page 45, this is
2 a Crisis Team meeting. You're present:

3 "Dr Seedat informed [the] Crisis Team [VC] has been
4 stable on the ward."

5 Stable? There were episodes on the ward. It was
6 a short period of time, but there were at least,
7 a couple of, you described, episodes of psychotic in
8 fear, the play wrestling that Dr Ludvigsen described
9 with another patient. Was that stable, from your
10 perspective, all those features?

11 **A.** Yes, the only incident was about the play fighting which
12 was actually perpetrated by another service user rather
13 than VC himself. And I think VC made that -- saw it as
14 that, and the people who observed it also observed it as
15 that. It was not an incident to suggest there was any
16 malice or violence related to that incident.

17 **Q.** Shall we have it on the screen since you've described
18 it, page 22, NHFT0000168, page 22. And it's in the
19 bottom box. The report was "that [VC] was assaulted by
20 [the] peer".

21 Do you see at the bottom?

22 **Q.** Yes.

23 "Despite the fact that it took a couple members to
24 pull [that other person] off VC when they were both
25 lying on the floor. Another staff member ... confirmed

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1 "[Telephone call] from mother who expressed concerns
2 about ... [the] discharge plan and she stated that she
3 was hoping to speak to his [that's you, Dr Seedat]
4 tomorrow ... as he felt discharge was too early."

5 That means she, I presume, because you didn't feel
6 that discharge was too early, did you?

7 **A.** No, I didn't.

8 **Q.** But you had her concerns and you had the University
9 concerns as well, if we went to them, didn't you, from
10 Ellie Turner, about the discharge plan?

11 **A.** The concerns from the University, as I said, were
12 earlier on in terms of when treatment had just started.
13 I would think that if Ellie Turner had seen him towards
14 the end of the admission, she may have made a different
15 opinion.

16 In terms of VC's mum, I did meet with her the next
17 time and I explained to her, I think some of her
18 anxieties were some lack of understanding of how things
19 work within mental health services, and I took the
20 opportunity to explain my rationale as to why we had
21 come to this decision about why discharge was now
22 appropriate, and at the end of this conversation it was
23 my view that VC's mum was satisfied with the explanation
24 that I had given, and we were in agreement with
25 progressing with discharge.

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1 that he did not think there was anything other than play
2 fighting taking place ... no aggression."

3 So from your perspective, if we go back to page 45,
4 you informed the Crisis Team that he'd been stable on
5 the ward:

6 "Explained that this presentation is not isolated,
7 appears to be going towards an illness. Dr Seedat
8 explained that [VC] and [the] family have not taken the
9 news very well."

10 "Appeared to be going towards an illness". This was
11 an assessment period. You were still unclear, weren't
12 you, at least on the face of this document, why not keep
13 him in, assess him more thoroughly and establish what
14 was in fact established later in July?

15 **A.** I think what I meant by saying it appears to be unclear
16 is what the psychosis was related to, and this -- at
17 this juncture, I had not made any formal diagnosis.
18 I had made a collective -- I had used the collective
19 term which is what psychosis is, and described it as
20 a first psychotic episode, and time will tell whether
21 this would evolve into a different sort of psychotic
22 diagnosis that we have. It could be mood related, it
23 could be schizophrenia related, et cetera, and at this
24 point it was difficult for me to make that conclusive
25 decision, and he didn't --

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1 Q. Is there a limit -- sorry --
 2 A. It didn't have to be that he needed to remain on the
 3 ward to complete that assessment, could have continued
 4 within the community and as more evidence comes about,
 5 a more definitive diagnosis could be made whether this
 6 was more in keeping with schizophrenia or mood disorder,
 7 which is what we tend to mostly consider ourselves with,
 8 because they have prognostic implications in terms of
 9 outcomes. And time would help us decide that.
 10 Q. Is there any time limit on what's described as a "first
 11 episode of psychosis" --
 12 A. -- (*overspeaking*) --
 13 Q. -- because this had been going on for a long time,
 14 hadn't it, on your assessment?
 15 A. I mean "First episode" is usually used where,
 16 irrespective of how long someone has been experiencing
 17 symptoms, when they come to services and this is their
 18 first contact or their first opportunity for their
 19 condition to be assessed, they would fall within this
 20 framework of first-episode psychosis. It doesn't mean
 21 that this is the first time this is happening. It's the
 22 first time that a person has been assessed, and
 23 determined, or formulated to be experiencing a psychotic
 24 experience.
 25 Q. Page 49, please, 17 June:
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1 symptoms being labelled as illness.
 2 We had several conversations around how this illness
 3 is treated, around medication and, having established
 4 treatment, it then becomes the responsibility of the
 5 individual to ensure that they continue taking their
 6 medication. Some responsibility has to fall on them,
 7 but in addition to that, we can set up processes and
 8 monitoring sort of plans to try and ensure or try and
 9 determine whether someone is being compliant or not.
 10 And this is why the involvement of the Crisis Team/IP
 11 team was important in the community that they monitor
 12 this, and address it accordingly, depending on whether
 13 there is evidence to suggest compliance or there is
 14 evidence to suggest non-compliance.
 15 Q. If we have NHFT0000021, page 1, this is the referral
 16 from the ward to the Crisis Resolution Home Team,
 17 setting out, in paragraph 1:
 18 "... believed [to be] suffering from mental health
 19 problems and seemingly responding to unseen stimuli with
 20 evidence of thought disorder. He believed he heard
 21 screaming and was trying to rescue the neighbour, who
 22 resulted in jumping out her first floor window and
 23 injuring herself."
 24 We have seen, the Inquiry has seen, many written
 25 accounts of that event and heard the evidence from the
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1 "Reviewed [VC] and spoke to mother who was also
 2 present.
 3 "Answered questions about his presentation,
 4 diagnosis of first-episode psychosis and explaining why
 5 no specific label used and how this was not useful at
 6 this time.
 7 "He was discharged from hospital today and section
 8 rescinded.
 9 "He must continue his medication for at least 6 to 9
 10 months minimum and seek medical advice if wishes to
 11 stop."
 12 You did not know at all whether he was going to do
 13 that, did you?
 14 A. In terms of whether he was --
 15 Q. Take his medication. He must continue his medication
 16 you said "must", but in the time you had had to see him,
 17 you had no way of knowing whether he would do that or
 18 not?
 19 A. That would be very difficult to do that.
 20 Q. So when you say "he must continue his medication", that
 21 was necessary for his treatment but you didn't really
 22 know whether he would really do it or not? That was
 23 going to be the responsibility of who?
 24 A. At the time of discharge, we had come to a point where
 25 VC had understood our formulation in terms of his
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1 victim herself, but as far as you're concerned, who was
 2 responsible for that summary of the event?
 3 A. That was completed by the nursing staff.
 4 Q. Mm-hm, trying to rescue the neighbour. Did you see this
 5 summary?
 6 A. No, I didn't.
 7 Q. If you had, would you have been concerned that there was
 8 suggestion that there was trying to rescue a neighbour
 9 when you'd seen material where he was expressing
 10 concerns he was being monitored by neighbours, was
 11 angry, and wanted to go there with a different purpose
 12 from rescuing the neighbour, presumably?
 13 A. I think that was meant to say "rescue the mother" as
 14 opposed the neighbour.
 15 Q. So you think the two accounts have been conflated there?
 16 A. Yes.
 17 Q. Because it's very different, isn't it --
 18 A. Yes.
 19 Q. -- rescuing your mother or being angry and harming
 20 a neighbour who is monitoring you?
 21 A. That's correct, and I think they meant to write "mother"
 22 as opposed to "neighbour".
 23 Q. They may both be delusional beliefs, but one presents
 24 a much bigger risk, doesn't it --
 25 A. Yeah.
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1 Q. -- a risk formulation, risk analysis, risk scenarios,
2 how much at risk are his neighbours, people at close
3 proximity to him?
4 A. Yes.
5 Q. So this doesn't get off to a good start from the Crisis
6 Resolution Home Team, does it, in terms of telling them
7 about the patient and what they need to be worried
8 about; would you agree with that?
9 A. Yes.
10 Q. Described in paragraph 3:
11 "No longer chaotic, aggressive, or hyperactive. ...
12 now denies auditory hallucinations and has insight into
13 his current condition. ... believed [he] is
14 experiencing a first episode ..."
15 You don't mention at all here that you're concerned
16 about a functional illness, something moving towards
17 that. Why isn't that mentioned on this discharge
18 referral?
19 A. I think, again, as I said, this was completed by the
20 nursing staff, and I guess they attempted to summarise,
21 based on their perception of what was documented on the
22 notes, and they may not have written it here in the full
23 context of what was being thought about.
24 Q. They didn't see the document you'd had sent to you.
25 Again, do you think that would have been wise that those

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1 even during the first admission, his interactions with
2 me were very open and frank for the most part. VC never
3 denied experiencing the things that he had experienced.
4 He was quite open with me. He talked about his
5 experiences, how they had been affecting him and
6 I thought we had quite candid and open conversations
7 about it. And subsequently to that, when I asked him
8 whether these same experiences were taking place, VC was
9 quite clear to me to say that he was no longer; he felt
10 the medication had helped, and he made this connection
11 that his belief systems probably were related to illness
12 and improvement of illness would mean resolution of his
13 symptoms.
14 He recognised this was coming from him rather than
15 from an external source.
16 Q. Do you think that the therapeutic relationship or
17 therapeutic alliance, as it's sometimes referred to,
18 leads to over-optimism in taking the accounts of
19 a patient?
20 A. I wouldn't necessarily agree whether over-optimism.
21 I think we all have to be optimistic and hopeful that
22 our patients will get better. It's important that we
23 develop good working relationships so that it creates an
24 atmosphere of openness and -- openness and willingness
25 to discuss things. And I think that's quite important,

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1 involved with his care at the time should have seen that
2 document?
3 A. Yeah.
4 Q. Because here we have:
5 "Concerns are that once [VC] returns to his flat in
6 Nottingham, he will be exposed to the same triggers that
7 are likely to have caused his psychotic breakdown,
8 (stress, isolation and sleep deprivation)."
9 Nothing about mind control and being monitored and
10 paranoid.
11 A. At the time it was felt and believed that VC had
12 responded to treatment. If VC had responded to
13 treatment, and his symptoms were in control, then that
14 would not be a concern.
15 Q. Between 4 and 17 June, was it possible to assert that?
16 It's such a short period, isn't it?
17 A. I think we have to go by whatever evidence we find in
18 terms of the assessments that we make. I don't think we
19 can -- that is what we have to work with. And all the
20 indications suggested that VC was much improved. He was
21 no longer experiencing or expressing or exhibiting
22 behaviours that would suggest psychotic experiences.
23 Q. Or he was masking them from you. You knew that his
24 ability to mask was a significant question, wasn't it?
25 A. I would say, at the time that I had contact with him,

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1 because other than accessing people's thoughts,
2 feelings, without that, it's very difficult to make any
3 proper assessments, no matter how long you interview
4 an individual.
5 Q. Is that the importance of gathering information outside
6 of the patient?
7 A. And includes also gathering information from outside the
8 patient. It's not -- and it's not the case that we just
9 rely on the patient in terms of what the patient says.
10 We do try and obtain informations from important others
11 that VC may have had regular contact with.
12 Q. Can we have, please, NHFT000020. Actually, I think
13 it's five zeros, 20, page 1, and have 1 and 2 --
14 A. Before we move on, can I just ask one question?
15 Q. Of course.
16 A. On the crisis document --
17 Q. If we go back to that, then. 21.
18 A. Yes. I'm probably just getting myself mixed up.
19 I think on the RiO records there may be that there was
20 a meeting between myself and the Crisis Team before he
21 was discharged. During that time, I had informed the
22 Crisis Team, even though it was not present in this
23 document, about the concerns that I had about VC's
24 presentation, the thinking that this was more functional
25 rather than -- or more likely functional rather than it

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1 being just precipitated by stress or social isolation,
2 et cetera.

3 **Q.** Who did you have that meeting with?

4 **A.** I'm wondering whether this was during the first
5 admission or second admission. That's where I'm
6 slightly confused.

7 **Q.** We'll get to it if it's the second. So it that comes
8 down for a moment, NHFT0000021. Sorry, 20.
9 NHFT0000020. It's back to the one to the local mental
10 health team.

11 What was the involvement or proposed involvement
12 from the local mental health team? We see a similar
13 referral letter from the ward to the one that we've seen
14 to the Crisis Team. So what was the thinking here?

15 **A.** So initially when a referral was made to the local
16 mental health team, the local mental health team came
17 back and said they didn't feel that VC was registered
18 with a GP. Local mental health teams, specifically the
19 Early Intervention in Psychosis team work on based on
20 where a patient is registered with. It's to do with
21 commissioning in terms of outcome of services. Services
22 are commissioned.

23 So it is important that the GP is known because the
24 GP then dictates which specific local mental health team
25 will take on his care.

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1 state, and depending on if there is a certain decision
2 that VC makes about where he is going to live, then the
3 appropriate EIP team should be contacted, and there
4 should be an appropriate handover to that team.

5 The purpose of the EIP team is to obviously take on
6 VC's care in the community, monitor his mental state,
7 his risk, ensure compliance, and also support him with
8 both psychosocial interventions as well, as required.

9 **Q.** Can we look, please, at the discharge, NHFT0000223,
10 page 2. If we have 2 and 3 on the same screen. If we
11 look on the screen, we see in the first paragraph on
12 page 2:

13 "... it became apparent that [VC] was hearing voices
14 and responding to unseen stimuli. In addition he had
15 persecutory ideas and believed that some people were
16 after him. [VC] was hence admitted under a Section 2
17 for assessment, as this was his first presentation ..."

18 It doesn't mention here, does it, the length of the
19 psychotic episode and the history of illness prior to
20 admission?

21 **A.** No, that information was available within the progress
22 notes. The summary was -- or this discharge summary was
23 a summarised version of what had brought him into
24 hospital and subsequently what was done during the
25 admission. I concur that it didn't include all the

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1 The nursing staff eventually confirmed that this was
2 Cripps mental health service, or GP services, which
3 meant we were now able to be certain which EIP service
4 would be responsible for VC's care in the community.

5 This referral was made during his admission as is
6 the process where we identify someone to have
7 first-episode psychosis. You refer them to the
8 appropriate EIP team.

9 What became complicated was that, at the point of
10 discharge, it was unclear whether VC was going to stay
11 long enough in Nottingham or whether he was going to
12 move on to Birmingham.

13 And because of this uncertainty, I made the decision
14 that in this case it would be appropriate for the Crisis
15 Team to be involved, rather than EIP. Because the EIP
16 team would be involved if they were going to have
17 a longer-term role. It would be unhelpful if the EIP --
18 if he did move to Birmingham, the EIP team would have
19 known very little about him and hence would then have
20 had to transfer care from their service to the
21 Birmingham service.

22 So on that basis I felt that the transitioning team,
23 which is the Crisis Team, which sits between inpatient
24 and community services, would be the correct team to
25 monitor him, support him, monitor his medication, mental

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1 information.

2 **Q.** Well, it doesn't need to include all of it, but
3 a summary is a key summary, isn't it? Not everyone is
4 going to read progress notes and RiO notes to find an
5 entry seven paragraphs down like we are.

6 **A.** Yeah.

7 **Q.** The summary of how long the episode was thought to have
8 existed is important, isn't it?

9 **A.** This summary is mostly read by GPs, and I feel that, as
10 long as mental health services who would be the primary
11 caregivers, during the course of the person's illness,
12 are aware of that, they are the ones who are going to be
13 involved in the interventions and the monitoring.

14 **Q.** Did you ever speak to his GP or any GP?

15 **A.** No.

16 **Q.** Why not, if they're so important in monitoring?

17 **A.** I think, as I said, the monitoring was going to be done
18 by the mental health team as opposed to GPs. GPs, in
19 situations like this, have very little involvement in
20 the care. The care is predominantly delivered by the
21 EIP team -- (*overspeaking*) --

22 **Q.** Who prescribes the medication then? I mean, you flagged
23 up that medication is important, you've told him that
24 he'd have to take it for as long as six to nine months.
25 Who was going to prescribe the medication?

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1 A. The situation in VC's case was slightly complicated in
2 that in what would have normally happened was that, if
3 VC had an established address and he was living in
4 Nottingham, his medication would have been managed and
5 prescribed by the EIP team, which is what their standard
6 practice is.

7 In this situation, in view of VC was unclear in
8 terms of where he was going to be, the only alternative
9 option we had was for VC to get his medications from his
10 GP.

11 Q. So --

12 A. Otherwise it would not have gone to his GP.

13 Q. So why not contact his GP, check that he even had a GP,
14 or a relationship with the GP --

15 A. We confirmed that he did have a GP practice, and he was
16 seen sometime in the course of that period when he was
17 registered with Cripps on one occasion, they confirmed
18 that he was a patient.

19 Q. Would you not routinely, then, contact or telephone a GP
20 if you're discharging a patient into primary care and
21 they need to provide medication? Wouldn't it be helpful
22 and good working together to do that?

23 A. The intention is that the discharge summary would do
24 that. It is very rare that I would discharge patients
25 directly to a GP. If I was, then I would contact the

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1 Yes?

2 A. Yes.

3 Q. And it was his mother who was concerned, I think, that
4 he hadn't been seen, and in this way you sent the email,
5 did you? You are aware of that and sent the email?

6 A. Yes, I did.

7 Q. You must have experience of community services in
8 practice. Were you confident that when you discharged
9 him with concerns about him masking and not being
10 straightforward or open about his situation, that this
11 was a risky, risky situation to discharge him to the
12 community at this point?

13 A. I didn't think it was risky on the basis that at the
14 time when he was discharged, his mental health had
15 improved and he was at a point where I felt he could be
16 safely managed in the community.

17 The purpose of this email was twofold. At this time
18 I was also the Clinical Director for services, and not
19 only was I trying to highlight this situation, but I was
20 also trying to determine, on a more global position,
21 whether teams had moved on to face-to-face contact. As
22 you would realise that we were during Covid,
23 face-to-face contact that dramatically reduced, and was
24 on a very limited basis. And in view of that, we had
25 progressed with the pandemic, we were at a point in time

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1 GP. Because that would be a final care of -- final
2 period of care, from secondary services.

3 Q. If we look at the top of the page, there's no reference
4 within this to the evidence of masking that you were
5 worried about, where you've said "dig deeper" when he
6 was on the ward. So that doesn't appear either, which
7 is an important thing for someone to know about,
8 isn't it?

9 A. No this, as I said, was conveyed to the local mental
10 health team who were the predominant assessors and
11 providers of care in the community. And that is where
12 my focus was.

13 Q. Well, if we see WITN0163046, page 2, letter from you
14 sent on the 22 June. You say to Ben D, consultant:
15 "[You] ... recently discharged [VC] ... and crisis
16 were going to do 3 day follow up and short term until he
17 decided if he was staying in Nottingham or ...
18 Birmingham ...

19 "... not sure why face to face visits are not
20 happening, the message given was ... it is due to ...
21 COVID situation ...

22 "I feel follow up needs to be face to Face with this
23 chap as he did not let things out and will give the
24 impression ... all is well.

25 "Please can you guys look into [it] ..."

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1 where there was a view from senior management that we
2 should try and move more towards face-to-face
3 consultation.

4 So I was trying to understand as to why a phone call
5 conversation was made rather than a face-to-face, and
6 I was trying to impress that if face-to-face were not
7 happening, I would like to understand why the service
8 was not doing face-to-face, because we should be getting
9 back to face-to-face. And in VC's case, I emphasised
10 the reason why I thought face-to-face was important.

11 Q. Can we have, please, NHFT0000168, page 55. You'll see
12 a note in the bottom box:

13 "[VC's] mother ... [calling] ... asked to speak to
14 someone ..."

15 This is a call to the City South LMHT.

16 "... she thinks [VC's] mental state may be
17 deteriorated, she said she'd been speaking to [him] ...
18 recently and his conversation wasn't making much sense
19 ... asking if [he] was getting any support from services
20 ... thinks [VC] may not be taking his medication as
21 prescribed, she was asking for an update on [his] care".

22 If we go, please, to page 56, we see Street Triage.
23 14 July:

24 "... asked [VC] -- [bottom paragraph] -- if he could
25 recall the previous incident prior to admission. He

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1 stated ... he could ... recognised that he was unwell
 2 ... denied feeling unwell at present. Thought this
 3 evening's events were 'mild' in comparison. The longer
 4 I spoke to [VC] he seemed to lose his composure
 5 somewhat; sighing at times and then smiling
 6 inappropriately. I got the impression that [VC] [is]
 7 ... attempted to conceal his symptoms."
 8 You know there was another episode on this evening,
 9 back to the same residences, requiring restraint by
 10 somebody, a neighbour and others around him, and
 11 a neighbour that we've heard evidence from.
 12 So it was that you conducted, didn't you, if we go
 13 to NHFT000168, page 57 and 58, next to each other, you
 14 conducted the assessment at 4.08 on 14 July?
 15 **A.** That's correct.
 16 **Q.** We see at 58:
 17 "[VC] minimised the potential risk to others, he did
 18 not fully acknowledge the risks of his action to others
 19 especially when this had happened at his last admission
 20 ... the person had to jump [from] the first floor and in
 21 the process hurt their back and needed surgery."
 22 The entry that follows is:
 23 "He said the right things, that he had made
 24 a mistake not taking his meds. He would now take them
 25 but he was still not convinced that he was unwell nor
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1 where VC confirmed with me that he had not taken
 2 medication.
 3 **Q.** Mm-hm. But he knew that you already knew that, because
 4 of the --
 5 **A.** Yes.
 6 **Q.** -- evidence of the tablets being found, so there's
 7 nowhere else to go, is there?
 8 **A.** No.
 9 **Q.** "It was ... concerning that [VC] was unmoved or unfaced
 10 regarding his actions ... did not appreciate the danger
 11 he put others in due to his actions based on what he
 12 felt to be happening and true but this was not happening
 13 in true reality."
 14 He doesn't only just communicate this to you, you
 15 know that that is what he thinks from the all the text
 16 messages and material that you have been sent, that his
 17 mind is being taken over by other people.
 18 **A.** Yes.
 19 **Q.** You decide, if we look at NHFT0000037, page 14, poor
 20 concordance to medication, "clearly a risk to others and
 21 to himself", then I can't read what you said after:
 22 "To himself from ...?"
 23 It'll come on the screen in a moment.
 24 **A.** Retaliation.
 25 **Q.** Sorry, can you read that sentence out?
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1 did he feel he needed to be in hospital."
 2 Is that what was said to you? He didn't think he
 3 was unwell, didn't think he needed to be in hospital?
 4 **A.** That's correct.
 5 **Q.** What did you deduce from that?
 6 **A.** I deduced that clearly VC had become unwell again, and
 7 this is more likely on the basis that he had stopped
 8 taking his medication as he later confirmed that he had
 9 not been taking medication for over two weeks. Hence it
 10 was not surprising that his presentation was clearly
 11 suggestive of being unwell, presenting with a psychotic
 12 clinical picture, and demonstrating poor insight.
 13 **Q.** When you say, "He said he hadn't been taking the
 14 medication", there was a two-week strip of medication
 15 found, wasn't there, the aripiprazole?
 16 **A.** (*The witness nodded*).
 17 **Q.** So he couldn't not say that he had taken it. He was
 18 forced into that admission, wasn't he, because the
 19 medication was still there?
 20 **A.** Yes.
 21 **Q.** So it wasn't as though he volunteered "I wasn't taking
 22 medication", he was caught out for not taking
 23 medication. Is there a difference, from your
 24 perspective?
 25 **A.** Yes, and as I said, it was a subsequent conversation
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1 **A.** "He is clearly a risk to others and to himself from
 2 retaliation."
 3 **MS LANGDALE:** "There is treatment available in hospital."
 4 Chair, that's probably a convenient moment to stop.
 5 **THE CHAIR:** Yes. All right, we'll start again at 1.55.
 6 Thank you.
 7 (12.53 pm)
 8 (The short adjournment)
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