1 **Tuesday, 12 May 2026**
2 **(2.24 pm)**
3 **MS LANGDALE:** Chair, may I call Dr Gibson, please?
4 **THE CHAIR:** Yes.
5 **DR JONATHAN GIBSON (affirmed)**
6 **Questioned by MS LANGDALE**
7 **MS LANGDALE:** Dr Gibson, you've prepared a statement for the
8 Inquiry dated 17 November 2025.
9 **A.** Yes.
10 **Q.** Can you confirm the contents are true and accurate as
11 far as you're concerned?
12 **A.** Yes.
13 **Q.** You are currently a consultant psychiatrist?
14 **A.** I am.
15 **Q.** Working where?
16 **A.** On Redwood 1 at Highbury Hospital.
17 **Q.** At the time that we're going to take you to, at the time
18 of VC's fourth admission in February 2021, what stage
19 were you at in your qualification process?
20 **A.** I was just transitioning from ST4, which is the fourth
21 year of higher specialist training, to ST5 which would
22 be the fifth.
23 **Q.** I think in your statement you describe yourself as
24 an apprentice, as it were, to Dr Thangavelu?
25 **A.** That is in effect what that role is, yes.

1 **Q.** So do you consult and liaise with him throughout that
2 role?
3 **A.** Yes.
4 **Q.** Did you find him open to conversation, communication,
5 et cetera?
6 **A.** Very much so.
7 **Q.** Can we go to the notes then, please, Dr Gibson, starting
8 NHFT0000168, page 219, and this your "Senior review"
9 conducted on 31 January 2021.
10 Tell us, while it's coming up, what the purpose of
11 the review is.
12 **A.** So that is the first review that would be done by
13 a senior clinician during a patient's admission.
14 They'll have an initial clerking which will be done by
15 a more junior resident doctor, and that senior review
16 will be either done by a registrar, such as myself, or
17 the consultant.
18 **Q.** Would you read the notes of prior admissions before
19 doing this?
20 **A.** Yes.
21 **Q.** So we can take it you have read the RiO notes from the
22 2020 admissions, 2021, and you've read all former
23 admission notes?
24 **A.** So I will have -- as I put in my statement, I will have
25 read sufficient notes to generate this background that

1 I created. It's likely some more notes as well, however
2 it is unlikely that I would have read everything that
3 had been written about him previously.
4 **Q.** Do you have any recollection now, accurately, of what
5 you read, or are you going to suggest by virtue of what
6 your ordinary practice was, you would have read most
7 things or everything?
8 **A.** Most things, particularly things that were summaries,
9 things like discharge letters, or ward rounds, or
10 clinical rationales of senior clinicians, that kind of
11 thing.
12 **Q.** We see at paragraph 2:
13 "[VC] received an antipsychotic treatment during
14 his first admission ... apparently good effects ...
15 stopped taking it shortly after discharge due to feeling
16 'better'."
17 You say in the second paragraph below that:
18 "[He] engaged with EIP following this ... [but]
19 appeared ambivalent about antipsychotic treatment. He
20 relapsed again in August 2021 following stopping
21 antipsychotics, which required PICU admission due to his
22 degree of agitation."
23 And:
24 "[He] ... engaged poorly with EIP following
25 discharge ..."

1 So had you garnered from the notes that in effect he
2 was not cooperating with a medication regime?
3 **A.** Yes, although I'd like to clarify: this picture is very,
4 very common for patients, such as VC, who would be
5 admitted in this way.
6 **Q.** Common for patients with psychosis or paranoid
7 schizophrenia?
8 **A.** Yes.
9 **Q.** What isn't necessarily common is the risk of violence,
10 is it, and that's why it's important to assess risk as
11 well as not taking medication or non-concordance?
12 **A.** Unfortunately violence is quite common amongst this
13 cohort of patients.
14 **Q.** Which cohort?
15 **A.** Patients with psychosis and, in particular,
16 schizophrenia.
17 **Q.** Particularly men; is that right? Particularly in young
18 men.
19 **A.** Particularly in young men, yes.
20 **Q.** 23% of people with schizophrenia have a violent
21 conviction, we learnt from Professor Fazel's work. Were
22 you aware of the association for young men with
23 schizophrenia --
24 **A.** Very much so.
25 **Q.** -- and violence? You were aware of that?

1 **A.** Yes, even that statistic is an understatement given the
2 lack of prosecution of patients who have this condition,
3 due to considerations with their mental health.
4 **Q.** Why do you think there are considerations of their
5 mental health that lead to lack of prosecution?
6 **A.** I think there is an unhelpful binary that is generated
7 where people who have psychosis are believed either de
8 facto to lack capacity or even that *mens rea* would not
9 be established and therefore prosecution is not pursued,
10 where it would be helpful to do so.
11 **Q.** Why would it be helpful to do so?
12 **A.** More appropriate management would be attained for such
13 people, such as the criminal justice route, for frankly
14 criminal acts, or disposal of forensic services for
15 those with mental disorders that are directly related to
16 their offending.
17 **Q.** Have you ever given a statement to support
18 a prosecution, of one of your patients?
19 **A.** I believe I have, but I can't recall the details.
20 **Q.** I don't want the details, just the principle. If you
21 were asked to provide a statement relating to an act of
22 causing harm or violence towards others, if a patient
23 had discussed that with you, would you be prepared to
24 give a statement explaining, for example, the discussion
25 the patient had had with you about it, what they said

1 about it or not?
2 **A.** Depending on the case, quite possibly.
3 **Q.** Do you think there's a culture out within psychiatry
4 that might lead people to give a different answer to
5 that? Ie, they wouldn't because of patient
6 confidentiality and couldn't contemplate doing that?
7 **A.** From my experience, no. From my experience in my
8 practice, actually the converse is true: that we
9 actively pressure for prosecution of certain violent
10 acts and are often met with not particularly helpful
11 responses from the police and CPS, particularly if the
12 offences are in the context of mental health settings.
13 So, for instance, assaults on nurses and things will
14 often just be ignored.
15 **Q.** If we look at this under "Assessment":
16 "[VC] ... slightly guarded in presentation, although
17 polite."
18 He corrected he'd been taking medication
19 continuously, and there was a misunderstanding about him
20 not taking water with medication. What did you make of
21 that response about not taking medication?
22 **A.** That that was his either perspective or what he wanted
23 me to believe.
24 **Q.** If we go further down:
25 "Asked about collateral history from parents. [He]

1 was ... guarded and asked that [you don't] speak to
2 them."
3 You:
4 "Explained the nature of confidentiality, but [he]
5 continued to request I did not speak to them ..."
6 What was your understanding and is your
7 understanding where a patient says that you shouldn't,
8 how much can you tell the next relative or, in this
9 case, VC's mother, and how much can you receive from
10 them, despite what he has said to you there?
11 **A.** So in terms of receiving information, we can receive any
12 and all information from the patient's family member.
13 In terms of giving information, that's quite
14 a complicated question, and varies on a case-by-case
15 basis. So in this instance, I can't remember the exact
16 detail, but I can imagine it was along the lines of, as
17 I've alluded to, but trailed off mid-sentence
18 unfortunately, that he was a grown man, responsible for
19 his own problems, he did not wish to burden his family
20 with these kinds of issues, which is a very common
21 response for people who are just admitted to psychiatric
22 wards.
23 **Q.** So is that your recollection: that where we see the
24 unfinished sentence, it should be "did not wish to
25 burden" or something similar?

1 **A.** I can't remember now, but I'm imputing.
2 **Q.** Under "MSC" we see you describe:
3 "His thoughts were concise and easy to follow, with
4 logical progression of thought and no obvious
5 delusions."
6 Why did you say that, that his thoughts were concise
7 and easy to follow?
8 **A.** So that is a reference that would be understandable to
9 psychiatrists, which is about the form of someone's
10 thoughts. So thought disorder as a symptom within
11 psychosis can be elicited even if a patient is denying
12 other symptoms, because you can't hide thought disorder.
13 Your thoughts will come out jumbled, you will jump from
14 idea to idea without any sort of logical progression.
15 So you may deny symptoms to me directly, but I can still
16 observe some symptoms there.
17 **Q.** Does that depend how good you are at masking --
18 **A.** So --
19 **Q.** -- that the thought might appear easy to follow, but in
20 fact it's going in a completely different disorderly
21 fashion?
22 **A.** Very hard to mask thought disorder.
23 **Q.** Why is that?
24 **A.** You don't necessarily have much control over it.
25 **Q.** Can we just have a look, what we know he wrote a couple

1 of months later to the Investigatory Powers Tribunal.
2 So if we can have INQY0000003, page 2 and 3.
3 So the Investigatory Powers Tribunal is an
4 independent judicial body and we know VC, a couple of
5 months after this, wrote to them explaining or
6 complaining, from his perspective, about his devices
7 being accessed everywhere, and what his complaint was.
8 He describes at page 3 the experience, if we can have
9 that enlarged, please:
10 "The experience consists in part of a constant
11 hostile communication with (with no intermissions) with
12 the complainant whenever he is awake that has lasted for
13 the following two years."
14 So if we went to the paragraph above -- I'm not
15 suggesting we do -- it became evident to him from May
16 2020. So by May 2022, a constant communication for the
17 following two years.
18 "In conjunction with this all aspects of the
19 complainant's life were recorded, and
20 telecommunications, personal electronic devices and
21 email accounts were accessed and monitored."
22 If we go to the bottom paragraph of the page, he
23 also complained about the link, the conduct -- sorry,
24 "complained of conduct to his mental health and
25 criminality" linking them. So he says:

9

1 "Throughout this period the complainant was
2 repeatedly told via this communication that the personal
3 information acquired was being passed to local
4 authorities and even members of the public, to entice
5 him to harass them and be detained. To ensure that the
6 complainant had little recourse to substantiate his
7 claims and seek redress the system curated an
8 experience, that could 'plausibly' be dismissed as
9 a sudden mental illness. The objective of the activity
10 as far as the complainant can ascertain is to harass and
11 misinform him so as to drain him mentally and coerce him
12 to commit criminal activities that retroactively justify
13 the illegal surveillance that the agencies committed.
14 The complainant asserts that the local police department
15 is aware and involved in the illegal activity and as
16 such that avenue for resolution is non-viable."
17 So that's his thought process. And describing it
18 over the period that in effect you were assessing him,
19 you obviously never saw that at the time, but going back
20 to the documents please, at 218, 219, "His thoughts were
21 concise and easy to follow". Did you have any sense
22 that this was in his mind?
23 **A.** No, and I --
24 **Q.** And this is a very elaborate --
25 **A.** Yes --

10

1 **Q.** -- delusional belief system?
2 **A.** -- incredibly elaborate.
3 **Q.** So what is it about psychiatry that at this point didn't
4 detect that or have a sense of that?
5 **A.** So I didn't have that degree of granularity, the
6 delusional framework, but I certainly had that which
7 Dr Lomas had sort of elicited previously about it.
8 I can't remember the exact wording but some
9 neuro-computer interface that he'd discussed. And so
10 I asked him questions about that, and he denied it.
11 **Q.** What questions were you asking him about that? Can you
12 remember?
13 **A.** I can't remember the precise questions but I would have
14 asked him something along the lines of "Oh previously
15 you've mentioned this neural computer interface, has
16 that been affecting you? Why do you think that
17 occurred?" Things like that.
18 **Q.** You say in your statement that you've referred to
19 multiple psychotic episodes within this review, and
20 therefore that implies a diagnosis of schizophrenia.
21 Was that your understanding, you were dealing with
22 a patient with paranoid schizophrenia?
23 **A.** Yes.
24 **Q.** Why does that not appear anywhere in the review, then,
25 in terms?

11

1 **A.** So I think that is an oversight. That was my working
2 assumption. I think the multiple psychotic episodes is
3 essentially can be viewed as a shorthand for that, but
4 yes, it was schizophrenia we were dealing with.
5 **Q.** To a layperson there does seem to be an avoidance of
6 referring or using that term. We don't see it on his
7 care plan under "Diagnosis", a document that he sees.
8 That said, we don't see a number of things on the care
9 plan that should be there. But this is important, isn't
10 it, as a diagnosis, and you haven't put that there
11 either?
12 **A.** No, but we --
13 **Q.** Is that because there's a fear of stigma and not
14 describing it thus?
15 **A.** In this instance, no. I think later we, in the ward
16 round entries, put the working diagnosis of
17 schizophrenia.
18 **Q.** NHFT0000168, page 220, please. 31 January. You, it's
19 recorded here:
20 "Dr Gibson plans to gain collateral history from his
21 family."
22 "No historic substance misuse. He has previously
23 punched police."
24 Why were you seeking further information -- this
25 actually should be highlighted, three paragraphs up, if

12

1 we can highlight, thank you.
2 "Dr Gibson plans to gain collateral history ..."
3 Why were you obtaining further information?
4 **A.** In order to get a holistic understanding of his case.
5 **Q.** Why is that important?
6 **A.** So I've addressed this in part in my statement. In
7 psychiatry, things are often unclear. Patients are --
8 self-report is often unreliable, either due to honest
9 misunderstandings, mental illness, or even outright
10 lying. Information from other sources is often
11 incomplete. Therefore we have to gain information from
12 multiple different sources to try and triangulate and
13 work out our best idea of what is going on.
14 **Q.** So if we go, please, to NHFT0000168, page 223, in the
15 second box down, we see on 2 February you telephoned
16 VC's mother Celeste.
17 "She explained [VC] seemed normal to his parents,
18 until they heard about the incident.
19 "He had been phoning more frequently, but there had
20 been no thoughts about stressors other than his
21 university work. He has been calling parents daily
22 since."
23 Did you ask about the contents of those telephone
24 calls and what he'd been saying?
25 **A.** I imagine I will have done but I can't say anything more

1 than is written there.
2 **Q.** And it records here:
3 "Celeste was worried about him. She thinks he is
4 scared of mental health services and feels persecuted by
5 them. She also expressed some frustration about our
6 lack of ability to share information based on
7 confidentiality, but accepted explanations."
8 When you phoned up, did you say who you were, and
9 that he was sectioned at that time, or not?
10 **A.** I don't recall. I'll have said who I was.
11 **Q.** A doctor?
12 **A.** Yes, I would have said, "I'm Dr Gibson".
13 **Q.** But not that you were doctor on a ward where he was
14 sectioned. Would you say you couldn't have said that,
15 because he doesn't appear to have known that?
16 **A.** I can't recall what I would have said, my normal
17 practice would be to say, "My name is Dr Gibson, I'm
18 a doctor working at Highbury Hospital."
19 **Q.** Do you think you were legally enabled to say, "Your son
20 is sectioned, and I want further information to know
21 what's been going on", or anything like that?
22 **A.** At the time, I don't know.
23 **Q.** Did you suggest, or not, given you'd discussed thoughts
24 of persecution with him, as you mentioned earlier, when
25 she said he's scared of mental health services and feels

1 persecuted by them, did you raise or say, "That may be
2 part of his illness or connected to his illness"? Or
3 something like that? Something that offered assistance
4 with triangulating that from her perspective?
5 **A.** I probably wouldn't have offered suggestions to that.
6 I may have asked a question, "Do you think that is part
7 of his illness?"
8 **Q.** Were you aware that he had withdrawn permission for his
9 care coordinator to share information with his family?
10 There was a tribunal in September 2021 and that he
11 didn't want information shared with his family by the
12 care coordinator? Did you know that?
13 **A.** I can't recall whether I was aware of that at the time.
14 **Q.** Did you know, therefore, that he was keeping things from
15 his family, in effect, for whatever reason you say, you
16 seem to remember he didn't want to burden them, but for
17 whatever reason he is not giving information, is he, to
18 his family, permitting accurate health information at
19 this point to be given to her, but you don't that?
20 **A.** I don't know.
21 **Q.** You don't know if you knew that?
22 **A.** I don't know if I knew it.
23 **Q.** Should you have known that?
24 **A.** It would be useful.
25 **Q.** If we go, please, to NHFT0000168, page 225, this is

1 a ward review, 3 February 2022. In the top paragraph
2 you describe VC's mother as being "... guarded on the
3 phone and didn't give much information".
4 In terms of assessing why she was guarded or
5 context, it would have been important to know, wouldn't
6 it, what VC may have been telling her and what
7 professionals were not able to tell her or thought that
8 they couldn't?
9 **A.** Sorry, I don't quite follow.
10 **Q.** You describe the mother as "guarded on the phone"?
11 **A.** Yes.
12 **Q.** What did you think underpinned the reason for being
13 guarded?
14 **A.** I can't recall exactly. I imagine it was because we
15 were unable to share the details of his admission to
16 her.
17 **Q.** So you were guarded and she may have been, in response?
18 **A.** Quite possibly.
19 **Q.** Right. It's quite different, isn't it? If you're
20 hesitant about sharing information because you think
21 VC's prevented you from doing so, it's not a very
22 natural conversation, is it, if the person at the end of
23 the line would like to actually know what's going on?
24 **A.** Indeed.
25 **Q.** Did you get any advice about what you could disclose or

1 share with VC's mother either from Dr Thangavelu or from
2 a Caldicott Guardian, or anything like that?
3 **A.** Yes, I spoke to Dr Thangavelu about it, about this case
4 on multiple occasions in supervision.
5 **Q.** What did he say in terms of how much you were able to
6 tell his mother about him being sectioned at this time
7 and the events with Christopher, which I'll come on to,
8 the student in the house?
9 **A.** So I cannot recall the details but given what I've done
10 subsequently, I think it's very likely the advice was to
11 gain as much information as possible from mother, but
12 not disclose information, and to follow VC's wishes,
13 essentially.
14 **Q.** We see in the third paragraph:
15 "Claudia has been his care coordinator since summer
16 2020 ... [She says] He is very guarded, and their
17 relationship has deteriorated over the years as he feels
18 persecuted by mental health services."
19 Did you see or ever read the tribunal decision about
20 VC --
21 **A.** I don't believe I did.
22 **Q.** -- at the time? Did you have access to it?
23 **A.** I don't know.
24 **Q.** I think we have sent it to you. If you have a look at
25 CYGN0000052, page 44. These was during his third

1 admission, Dr Gibson. Would that not routinely be in
2 notes, then, a tribunal decision?
3 **A.** It depends if they are uploaded. As I say, this
4 wouldn't be in the RiO running records; it would be a
5 separate thing in an uploads tab and it depends if that
6 goes to the patient records department and gets
7 uploaded. Often with patients that have been admitted
8 out of area to private sector beds, such as Priory, we
9 lack records for that.
10 **Q.** If we look at page 44, please, of the document:
11 "During his third admission" -- the first part of
12 the third admission -- it was at a place called Cygnet
13 and Dr Shoilekova was the Responsible Clinician. If we
14 look at the end, evidence summary page 44, we see:
15 "Dr Shoilekova describes that he takes medication as
16 prescribed and there have been no problems with escorted
17 leave. She remained of the view he suffers from
18 a psychotic disorder with persistent delusions of
19 persecution and control and ongoing auditory
20 hallucinations although it is 'a bit early' to give
21 a definitive diagnosis. She considered the illness was
22 relapsing and remitting although [he] had not fully
23 recovered since it began in 2020. [She] considered
24 there may be some negative symptoms including a marginal
25 but declining function in social interactions and a lack

1 of ability to pre-plan".
2 At the top of the next page:
3 "Based upon her recent assessment, she felt the
4 disorder remained at a degree warranting inpatient
5 treatment ..."
6 The next paragraph, paragraph 3:
7 "If discharged, she would be very concerned about
8 [VC's] own safety and that of others: he hears voices,
9 gains access to others' property and behaves in a way
10 perceived as threatening to others. He has been violent
11 towards others."
12 She gave that evidence to the tribunal, who accepted
13 that evidence, and his lack of insight and risks when
14 relapsing and that they could escalate rapidly. That
15 would have been an important document for you to see at
16 this time, wouldn't it?
17 **A.** It would have been, although that information was known
18 to us.
19 **Q.** So there's nothing new in that.
20 **A.** No.
21 **Q.** You deduced that from the notes. That can come down
22 again, please.
23 If we go back to page 225, so it's NHFT0000168,
24 page 225. It's the same ward review we were looking at
25 a moment ago and in the last paragraph, "Dr Gibson", it

1 says at the bottom:
2 "... explained [this is to VC] that they felt he
3 wasn't engaging with the crisis team, and being open
4 with them and they were worried he wasn't taking his
5 medications. VC reported that they were concerned as he
6 was [taking] ... the medication without water and
7 Dr Gibson explained that they were worried ... he was
8 spitting the medication out."
9 Did you have a discussion with the longitudinal
10 view? In other words, it wasn't whether he did or
11 didn't spit something out in a moment, this was over
12 a long period of time that he hadn't been taking
13 medication, and the evidence particularly at the AMHP
14 assessment where the bags of medication or the boxes of
15 medication were found that had not been used?
16 **A.** So in this instance, I believe this is a discussion with
17 VC about the initial rationale for admission, which was
18 what was discussed.
19 We were aware of the longitudinal history of poor
20 concordance with medication.
21 **Q.** We don't see a note of you and Dr Thangavelu, he'll give
22 his own evidence tomorrow, but do you ever say, "This
23 isn't a single incident but over a long period of time,"
24 and sit down with a catalogue of times it's happened?
25 **A.** Yes.

1 **Q.** When did you do that with him?
2 **A.** Oh, sorry. I thought you said, "Would you do that?"
3 **Q.** No. did you do that?
4 **A.** I don't know.
5 **Q.** We'll go through all of your records and see what you
6 think at the end.
7 But if we go, please, to page 226 we see:
8 "[VC] said his thoughts are 'normal' ... denies
9 people interfering with his thoughts. However, he was
10 questioning how people would interfere with his thoughts
11 and asked for more specific questions."
12 So when we went to the Investigatory Powers Tribunal
13 description of how he was thinking, he started to
14 develop that here, didn't he, with you: asking questions
15 about how people could interfere or would interfere with
16 his thoughts?
17 **A.** Yes, although when you asked about -- when you ask
18 patients with psychotic symptoms about, say, abnormal
19 possession of thought or interference of thoughts, it's
20 quite common for them to think of that as an unusual or
21 even ridiculous question and say: "That's not possible,
22 how could that even happen?" So it could be either that
23 he's referring to there.
24 **Q.** If we look, please, 3 paragraphs down, he was asked
25 about:

1 "... having a depot form of medication and he would
2 prefer not to have a depot. It was explained that
3 community team thought it would be beneficial to have
4 one however he said he didn't like needles and would
5 prefer to continue with tablets."
6 What did you think of his suggestion that he didn't
7 like needles?
8 **A.** I believed that he didn't like needles. That's very
9 common for patients not to like needles. It's very
10 common for patients not to like depots. It was him
11 giving his preference. It was our opinion that it would
12 be better if he was treated with a depot, and as I sort
13 of mention in my statement, this was a -- and I think we
14 actually go later into the plan here -- it's a question
15 of whether we could justify coercing him to have this
16 depot against his will.
17 **Q.** If we look, please, at NHFT0000168, page 229,
18 4 February, "COVID VACCINATIONS". We see reference
19 there, so shortly hereafter:
20 "1st and 2nd dose administered.
21 "Booster Dose to be administered."
22 And we know he also has blood tests. So were you
23 sceptical, or why weren't you sceptical when he said he
24 didn't like needles?
25 **A.** So people who don't like needles will have had the Covid

1 vaccine for multiple reasons. He didn't have the
2 vaccination on the ward; I believe that was given a year
3 prior. And in the context of the pandemic and the fear
4 that was associated with death associated with Covid.
5 I think a lot of people may have had that vaccination
6 when they wouldn't normally have done.
7 **Q.** So it was a question of assessing the benefit of the
8 treatment versus the fear of the needles?
9 **A.** Quite.
10 **Q.** So was that worth explaining in the review when he said
11 he didn't like needles, because the effects of not
12 having medication were going to be far worse, weren't
13 they?
14 **A.** Yes, and I believe that was discussed with them, and
15 likely at that point and certainly at a later ward
16 review with Dr Thangavelu.
17 **Q.** It doesn't look like you've discussed risk benefit with
18 him, have you?
19 **A.** It's not documented, no.
20 **Q.** Do you remember doing that?
21 **A.** No, but usually when I discuss depots with patients
22 I will explain the rationale why we would give a depot.
23 **Q.** If we go to NHFT0000168, page 228, please, 4 February,
24 second box, concerned that:
25 "... [he] was spotted at his old address ... by his

1 former flatmates ..."
2 And this was when he was on leave, and you were
3 concerned about that, weren't you. If we can have --
4 take this neatly, I hope. NHFT0007527, page 1 we see
5 there "Incident Description". You reported it as an
6 incident:
7 "[He] was let out on ... leave [with a planned
8 return time] of [3.07] ... His time of return was not
9 documented. [And] ... reportedly seen at his
10 accommodation by a former flatmate and this information
11 was passed to the ward. ... VC denies this occurred.
12 [This is on 3 February.] Based on leave record, it is
13 not possible to tell if allegation was accurate.
14 ...[VC] is reported to have assaulted flatmate, and to
15 prevented them from leaving ... prior to admission."
16 Then we see you complete NHFT0014974, page 1,
17 withdrawal of leave. And that's you, if we go to
18 page 3, 4 February 2022. And if we can have, please,
19 then NHFT0018361, page 1. You were concerned, and most
20 of the patients did not have a time of return on the
21 Section 17 leave record when you were checking this one.
22 And you were going to have to restrict his leave based
23 on suboptimal information because you were looking to
24 see if he had come back later.
25 **A.** Yes.

1 **Q.** If he had been where he had --
2 **A.** Yes.
3 **Q.** -- allegedly supposed to have gone, yeah?
4 **A.** So it wouldn't have been perfect information, but had he
5 for instance only been out for half an hour, as his
6 Section 17 leave stated, there would not have been time
7 for him to get there and back and that would have
8 substantiated his denials; whereas I had no information
9 to go on and I was frustrated about that.
10 **Q.** If we go to NHFT0018361, page 2, so just back to the
11 previous document over the page. You say:
12 "Based on leave record, not possible to tell if
13 allegation was accurate."
14 It wasn't so much the time that was important; it
15 was the fact that he'd gone back to his former flatmate,
16 the one he'd assaulted, wasn't it? That was the key
17 allegation --
18 **A.** Well, the issue is I didn't know, and this is getting
19 back to the fact that psychiatry, often we're operating
20 in a low-information environment, there's an allegation
21 and I put -- I restricted his leave as a result because
22 I believed, on balance, he probably did go back. But
23 I didn't know for definite, and trying to triangulate
24 that, get as much information as possible to
25 corroborate, I was not able to.

1 **Q.** I think it was Ellie Turner who spoke to you, if we go
2 to UNIN0000734, page 14. This is her side of the
3 conversation or note of the conversation:
4 "[Telephone call] to Redwood 1 to pass on details
5 ...
6 "Spoke [to] Dr Gibson, who was unaware ... [he] had
7 broken conditions of his s.17 leave. Advised [he] was
8 presenting as well on the ward. Dr Gibson took details
9 for Christopher and will call him for context around
10 alleged attempted assault ..."
11 So she had contacted you to let you know about that.
12 **A.** So I think she contacted the ward and then I called her
13 back.
14 **Q.** We find your call at NHFT0000168, page 228, please.
15 Your telephone call to Chris, the bottom box. We see:
16 "[Chris] explained there had been some concerns
17 about [VC's] presentation for about a month".
18 Didn't he, and he included descriptions of:
19 "Short screams were heard intermittently from his
20 room, thought to be him."
21 He also reported that:
22 "[VC had] ... entered another flatmate's bedroom in
23 the middle of the night and asked 'Can you hear that the
24 screaming?' ..."
25 Yes?

1 **A.** Yes.
2 **Q.** Did that remind you of what had happened in May 2020
3 when he was barging into houses or flats and going into
4 a neighbour's premises?
5 **A.** There's similarities.
6 **Q.** Did that cause you concern about the risk he posed?
7 **A.** Yes, it increased our suspicion that he was, in fact,
8 experiencing psychotic symptoms in the community.
9 **Q.** Did you discuss this telephone call with Christopher
10 with Dr Thangavelu?
11 **A.** Yes, I will have done.
12 **Q.** Did you ask him in the call about him turning up again?
13 **A.** Ask who, sorry?
14 **Q.** Christopher, about whether he had seen him again? So
15 you're asking him about how he was at the time, and the
16 events of the assault, but did you ask him about him
17 coming back or visiting the property?
18 **A.** I believe so, but I don't think it's documented.
19 **Q.** Did you think it was significant or not if he'd gone
20 back to the property of someone that he had assaulted?
21 **A.** It could have been significant, yes.
22 **Q.** Did you ask Christopher if he had anything on his phone
23 about the incident, and would you like to have seen it
24 for yourself?
25 **A.** It would have been useful. I didn't ask him, but it

1 would have been useful to know.
2 **Q.** Because people do record things on their phones, don't
3 they, and you knew he'd telephoned the police, not once
4 but twice, first to report the assault and secondly when
5 they were prevented from leaving the premises; did you
6 know that?
7 **A.** I didn't know he had telephoned twice. I knew that he'd
8 called the police.
9 **Q.** But as a young man he had phoned the police and was
10 worried enough to do that?
11 **A.** Yes.
12 **Q.** You say in your statement that at the time you thought
13 that this might have been the kind of situation that
14 emerged between two young men in a shared household,
15 this altercation, as VC described it?
16 **A.** Certainly -- yeah, an argument around hygiene issues, it
17 seemed to me like the kind of thing that would happen
18 quite normally, and was not necessarily associated with
19 psychosis. The violence that VC perpetrated as a result
20 of that was clearly disproportionate. I believe that
21 should have been dealt with via the criminal justice
22 route --
23 **Q.** Did you phone the police when you knew he may have gone
24 back there then, if you felt this was sufficiently
25 concerning for the criminal justice route, that

1 -- *(overspeaking)* --
2 **A.** No, I believe the assault should have been dealt with by
3 the criminal justice route. I know the police went and
4 interviewed Chris afterwards and I do not believe much,
5 if anything, was done about that.
6 **Q.** Can we just have a look at your statement, WITN0205001,
7 27, please, paragraph 64. You say there about the
8 "Short screams" that Christopher has told you about:
9 "... heard from his room could have been viewed in
10 this context but were less persuasive of psychotic
11 symptoms."
12 Do you see that paragraph, 64?
13 "The argument leading to the incident in which VC
14 held his flatmates 'hostage' appeared to be a domestic
15 argument about hygiene that escalated unnecessarily to
16 physical confrontation. This in and of itself was
17 something that might happen between any set of young men
18 in shared accommodation and while it could have been in
19 the context of psychotic symptoms, it did not persuade
20 me of this."
21 Have you seen it since, the events, how he was
22 holding --
23 **A.** The footage? Yes, I have.
24 **Q.** -- Christopher in a headlock, and preventing two of them
25 leaving, circling round, let letting one go, not the

1 other two?
2 **A.** Yes.
3 **Q.** Would you describe that as a domestic argument?
4 **A.** I think it's more serious than that and it's why I say
5 that I think that should have been dealt with via the
6 police.
7 **Q.** You didn't say that in your statement, you said --
8 **A.** I hadn't seen of the footage at that point.
9 **Q.** Do you think you should have done?
10 **A.** I should have seen the footage?
11 **Q.** Or you should have thought about what that event was?
12 **A.** So we did think about it. I don't think I had a full
13 picture of what it was at that point.
14 **Q.** You had spoken to Christopher, though --
15 **A.** Yes.
16 **Q.** -- we've hearing evidence from Christopher and sometimes
17 it's the questions we ask, isn't it, that get the
18 answers? Did you ask him, "Did you feel intimidated?
19 Was it scary?" Did you ask him emotive questions about
20 that?
21 **A.** I don't recall.
22 **Q.** What would you think you would have asked him, then, to
23 get the information you did?
24 **A.** I don't recall. I imagine I'd have said something like
25 "Can you describe what happened?" A very open question.

1 **Q.** It's not easy, is it, describing that as a young man if
2 you're intimidated and scared and stressed. It's not
3 easy, is it, always?
4 **A.** No.
5 **Q.** Clearly they were and it was a serious event?
6 **A.** Yes. Yes. A serious criminal event.
7 **Q.** Serious that VC was downplaying that significantly
8 talking to you about it, wasn't it?
9 **A.** Yes.
10 **Q.** Wasn't he?
11 **A.** He was.
12 **Q.** So it was important for you to objectively assess the
13 facts and what it represented in terms of his risk, and
14 see how he saw it for himself at that time?
15 **A.** Yes, and there was a clear disagreement between the
16 perspective of Chris and VC regarding that event.
17 **Q.** There's an MDT if we go to NHFT0000168, page 233, led by
18 Dr Thangavelu.
19 **A.** Sorry, could I just add on that that VC saw the fact
20 that the police did nothing about that event as evidence
21 that there was minimal wrong with it.
22 **Q.** Yes. That may well be the case, and important in the
23 psychiatric setting to tell him that that didn't mean it
24 was(?) serious and it wasn't a risk and it was something
25 that was very significant in terms of the risk he posed

1 to others.
2 **A.** Yes, but unfortunately this is a common issue in that
3 criminal acts are often downplayed or ignored in
4 patients who have psychosis.
5 **Q.** NHFT0000168, page 233, please, 7 February, the top box,
6 led by Dr Thangavelu, this is reflecting your
7 conversation:
8 "Reports hearing some screaming from his room and
9 reported ? hallucination from him. He has also been
10 behind on academic work."
11 So that's you reporting your conversation with
12 Christopher. This review or MDT doesn't refer to his
13 presentation being unusual for over a month and that's
14 what his flatmate had told you, hadn't he, that it was
15 unusual for over a month?
16 **A.** Yes.
17 **Q.** So that's significant, isn't it, that it wasn't just
18 a couple of days, it was a month or so that they were
19 concerned about strange behaviour?
20 **A.** Yes.
21 **Q.** This document doesn't refer to the Section 17 breach or
22 his explanation about it either, does it? It doesn't
23 mention that he breached the leave requirements and, in
24 fact, pursuant to this by 7 February it was reinstated
25 and unescorted, wasn't it, his leave?

1 **A.** It appears so, yes.
2 **Q.** So no discussion about the fact that he'd lied about the
3 breach and what had happened and it was simply
4 reinstated with no consequences. A bit like you saying
5 about the police, if there's a crime committed, there
6 were no consequences here that he lied to you and didn't
7 do what he was supposed to do on the leave --
8 **A.** I think there are very frequently minimal consequences
9 for his behaviour.
10 **Q.** If you go, please, to NHFT0000168, 234. This is a brief
11 one-to-one at the bottom of the page. This refers to VC
12 missing out on positive therapeutic engagements with
13 staff and peers. We've been through it with the nurses
14 today here, we've been through it with nurses at Cygnet.
15 Minimal engagement described as needs led when he really
16 needed something otherwise he'd be in his room on his
17 laptop.
18 Was the assumption that he'd be doing university
19 work if he was on his laptop? Sometimes here in this
20 admission between 3 and 5 am in the morning, was the
21 assumption that he'd be working and doing university
22 stuff?
23 **A.** I believe that's what he said he was doing.
24 **Q.** Would you ever challenge that, Dr Gibson, or ask a bit
25 more around that to see if a patient was actually doing

1 what they said on their laptop?
2 **A.** If we had reason to believe it, yes. It is unfortunate
3 that patients have often almost unrestricted access to
4 electronic equipment while on the ward, and it can cause
5 problems, and it tends to only be addressed when
6 problems occur with that equipment.
7 **Q.** Rather than a longitudinal view of if you've got unwell
8 people, there's a lot of stuff you can access on the
9 Internet that's very dangerous to access?
10 **A.** Indeed, and my preference would be that patients do not
11 have access to electronic equipment while inpatients,
12 but that would be in contravention of various human
13 rights provisions.
14 **Q.** What about if you had access to computers that were the
15 ward's, in effect, and you can check search histories
16 and the like, if you want to; would that have the same?
17 **A.** That would be preferable, as would the ward phone.
18 **Q.** But as far as you're concerned, there's no way of
19 enforcing or requiring patients to tell you or to have a
20 look at what they're doing until you find something has
21 happened?
22 **A.** Unless there is a specific reason to do so, no. These
23 things cause lots of problems on the ward, with
24 different patients, not necessarily VC.
25 **Q.** Can we just have a look again at another Cygnet

1 document, CYGN0000029, he did engage with an assistant
2 psychologist. So again that's a junior, not fully
3 fledged clinical psychologist at that point, who takes
4 a very full note of this. We don't need to read it all
5 out.
6 If we go down to the second paragraph, very clear
7 description:
8 "... police are planning things against him as they
9 have developed a technology ..."
10 A very vivid, accurate description of the assault
11 above it on the police.
12 **A.** Mm.
13 **Q.** Then if we go to the following page, speaking about
14 non-compliance with medication:
15 "... [VC] had spoken to his CCO about ending his
16 treatment due to no more symptoms ..."
17 Then under the plan at the bottom, last paragraph:
18 "Depot antipsychotic medication should be considered
19 if detained on Section 3."
20 So the value of those psychological interventions
21 and a different, presumably, approach to the
22 conversations in depth, he does seem to have said a lot
23 there, doesn't he?
24 **A.** He does, yes.
25 **Q.** The suggestion is depot antipsychotic sometime earlier.

1 If we go, please, back to NHFT0000168, page 238,
2 this is 10 February ward review and you're not there,
3 Dr Gibson. You would have seen, would you, the
4 penultimate paragraph of VC's contribution. Would you
5 have read the notes afterwards?
6 **A.** Probably.
7 **Q.** "Dr Thangavelu [had] explained ... he had been in
8 contact with his community consultant. [That's Dr Lloyd]
9 They were concerned as its ... 4th admission in 2 years.
10 VC said if they find a slight incident, they say there
11 is a concerns and there is a risk and take him to the
12 hospital to monitor him."
13 Again, really underplaying the events of violence in
14 the previous years, wasn't it?
15 **A.** -- *(overspeaking)* -- It can be viewed in that way, yes.
16 **Q.** "slight incident". Could be viewed?
17 **A.** Yes.
18 **Q.** Do you view it as that?
19 **A.** I view it as VC bargaining, essentially, to try and
20 avoid depot administration.
21 **Q.** We see at page 239 further discussion about that at
22 paragraph 4:
23 "Dr Thangavelu explained that the other option was
24 a depot which would be an injectable medication once
25 a month. ... he wouldn't have to think about ...

1 tablets every day ...might be a better option. VC said
2 'no' to starting a depot. He said .. he was satisfied
3 with the medications as it is, he has been on it for
4 a while. He said that when he had changed medications
5 in the past he had experience[d] side effects."
6 Did you, as one of the doctors treating him, look to
7 see whether there were any records of side effects? So
8 for example, we know at Cygnet, Dr Shoilekova told us
9 there were no side effects for haloperidol as far as she
10 was concerned, and she would have kept him on it, moving
11 across to the Priory for his third submission.
12 Did you track or trace the medications and whether
13 there were any side effects reported contemporaneously?
14 **A.** I don't believe so, no.
15 **Q.** Because when he's raising that issue, experiencing side
16 effects, again, important to corroborate, isn't it
17 whether he said anything at the time about that or
18 whether he's just inventing it at this point to avoid
19 the depot?
20 **A.** Yes, although, as Dr Thangavelu points out, the depot is
21 the same medication, just in a long-acting form. So if
22 he didn't have side effects on the oral, he wouldn't
23 have it on the depot, necessarily. If VC is saying he
24 had side effects to a different medication, he is
25 unlikely to be concordant, whether he had side effects

1 or not, if he's saying he had side effects. So it's
2 relevant to take into account what he's saying,
3 regardless of its veracity.
4 **Q.** Were you aware -- if we can have on screen, please,
5 NHFT0018527, page 1 -- that Dr Lloyd had emailed
6 Dr Thangavelu about depot? Please read that.
7 **A.** I have read this prior. I was not aware of the emails
8 at the time, although I did discuss the use of depot
9 with VC with Dr Thangavelu, in supervision, because it
10 was a difficult case that we had moral and ethical
11 implications.
12 **Q.** Looking at this it's important, isn't it, that the
13 Consultant Psychiatrist in the community is recommending
14 this and suggests you need to look at it. Did you not
15 know that at the time, that Dr Lloyd had sent that?
16 Even if you didn't see the email, did Dr Thangavelu
17 share with you that that's what she thought: Please
18 consider a depot, so we don't end up back at square one,
19 poor engagement and concordance of discharge.
20 **A.** I don't recall. I think it's in the ward round entry
21 there that, it was then the Community Team that was
22 recommending it. And I would imagine if you would
23 document if the Community Team is recommending it, if
24 Dr Lloyd is recommending it.
25 **Q.** You knew Claudia Birtles was, but it's significant that

1 the consultant is saying it too, isn't it?
2 **A.** Yes, it is.
3 **Q.** And appears not to have been taken into account in any
4 real way, her view?
5 **A.** I think it was taken into account. I think a different
6 decision was made.
7 **Q.** Let's have a look, please, at NHFT0000168, page 246:
8 "... quiet on the ward ... slammed the door in one
9 of the nurses face when trying to do physical
10 observations."
11 Again, that's not picked up anywhere in any
12 discussion around medication. Is that because that's
13 the kind of thing that happens? What's your view about
14 that?
15 **A.** Unfortunately, the nature of inpatient psychiatric wards
16 is that is the mildest of issues that we face.
17 **Q.** Do you look at it in context, whether there's similar
18 events or more serious events in the community?
19 **A.** You would do, yeah. You'd take it as holistic of the
20 patient's presentation.
21 **Q.** So it's relevant?
22 **A.** It's relevant but in the context of other patients who
23 are far more agitated and violent on the wards, this is
24 very low level.
25 **Q.** You lead the MDT at NHFT0000168, page 250, please, on 14

1 February. And it was explained, four paragraphs up from
2 the bottom that:
3 "... the community team thought ... a depot form of
4 medication would be beneficial."
5 I think it was Sue Middleton from Crisis who was
6 there and they of course had been observing him to spit
7 out medication. So were you aware it was both EIP and,
8 on the face of it, Crisis, who thought that depot would
9 be beneficial?
10 **A.** I don't know about Crisis, although I was aware, because
11 we'd documented it earlier, that Crisis had concerns
12 about his concordance with oral medication. So that
13 would be the natural corollary of that.
14 **Q.** If we go to NHFT0000168 page 251, the top box:
15 "Band 7 In-Reach to facilitate early discharge.
16 "Attended ... review ..."
17 This is Sue Middleton.
18 "... 4th admission in the past 2 years ... he would
19 be better placed on a depot and CTO as risk to others
20 increase when [VC] is unwell".
21 So why didn't you put him on a depot?
22 **A.** So that is a -- yeah, a large question. We thought that
23 the depot was the best treatment option for him, and
24 that's why we tried to persuade him of it on multiple
25 occasions, which he --

1 **Q.** Well, no more than the ones we've seen.
2 **A.** Yes, okay. We --
3 **Q.** Two or three.
4 **A.** Yes. He declined the depot, therefore the only means of
5 getting him to have that depot would have been coercion,
6 which would have been, as I've put in my statement, most
7 likely full face-down restraint by six to eight nurses
8 while he was forcibly injected with that medication,
9 which is quite a severe thing to do to someone, although
10 it can --
11 **Q.** It had happened to him before, you appreciate that. On
12 his inpatient admissions he'd had --
13 **A.** Yes --
14 **Q.** -- medication under restraint. That was necessary to
15 bring his illness under control -- *(overspeaking)* --
16 **A.** Short term rapid tranquilisation under restraint, yes,
17 and that is easier to justify when someone is presenting
18 with an immediate level of threat and agitation. I'm
19 not saying that it should never be done, I think
20 obviously it should be done, but it should be done
21 judiciously. So there's a lot of factors at play to
22 decide when you should overrule someone's wishes, and
23 enforce that.
24 There were -- yeah, various factors. So he himself
25 didn't want it. He was denying symptoms, both prior to

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1 admission, and during admission. His family said that
2 he wasn't having symptoms, and he'd been concordant with
3 medication.
4 **Q.** Wait a minute there. The family had said to you in that
5 short conversation when you were guarded and they were
6 guarded and when they were out of touch with him,
7 effectively.
8 **A.** Yes. That was the information -- *(overspeaking)* --
9 **Q.** So you put that in that context.
10 **A.** Of course, of course. And he was concordant with
11 medication on the ward. Against that, we had the
12 evidence from the community teams, the history of
13 violence and non-concordance, the evidence that I got as
14 a collateral from the -- Chris, the University student,
15 and our longitudinal sort of clinical perspective.
16 So it was a weighing whether that threshold was met.
17 **Q.** And do you think you adequately assessed his risk, risk
18 when untreated, his risk of violence to others when you
19 made that decision you shouldn't coerce him to have
20 medication?
21 **A.** As I've said in my statement, I believe that all the
22 factors were taken into account, however the wrong
23 decision was made. And I think --
24 **Q.** Why was that?
25 **A.** So why?

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1 **Q.** Why was the wrong decision made?
2 **A.** So there was a -- there was and there remains a culture
3 and a climate that emphasises the least restrictive
4 approach to patients with mental disorder and to enhance
5 their autonomy wherever possible. And that's the
6 context for the 2025 amendments to the Mental Health
7 Act, but it was also -- the general climate whenever you
8 would go to a conference, for most of the information
9 you'd get from the government, from the CQC, from the
10 Royal College, that we are being overly coercive, we are
11 not respecting patients' wishes, we should reduce
12 coercion wherever possible, and in particular there is
13 disparate coercion in particular demographic groups,
14 particularly young ethnic minority males.
15 **Q.** Was that a factor in this case that came into your mind,
16 or were you treating him as an individual?
17 **A.** I mean, it came in to my mind, but I treated him as an
18 individual. You -- it is impossible to disentangle
19 yourself from that climate, when it is going on. You do
20 your best to treat someone as an individual who is
21 sitting in front of you. The issue comes when you are
22 being told that you've got this disproportionate effect
23 on certain groups that psychiatry is institutionally
24 racist, that there is implicit bias that you're using,
25 and you sort of second-guess yourself. Am I making an

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1 accurate judgement of this patient's risk or am
2 I implicitly biased. I can't know that because that's
3 the nature of implicit bias.
4 **Q.** You say at the conclusion of your statement:
5 "... the trade-off between autonomy and safety ...
6 [has been moved] towards safety ... [in my] practice."
7 Can you expand on that? What do you mean about
8 that?
9 **A.** So this is something I find is not always understood in
10 that on the one hand you have patient autonomy and
11 people will often -- with mentally disordered patients
12 they will use their autonomy to disengage with treatment
13 and in order to increase the safety, so the risk to
14 other people, you need to be more coercive in your
15 practice. Thereby overrule patients' autonomy. And so
16 I have moved to be more coercive in my practice, as a
17 result. I think probably most psychiatrists have as a
18 result of that.
19 **Q.** Is treatment-based another term for more coercive? If
20 you're treatment based, you want to ensure your patient
21 has had adequate treatment? Because what we're
22 concerned with VC is that he didn't have adequate
23 treatment, did he? He didn't have the drugs or
24 medication to treat his illness?
25 **A.** Yes, but in order to ensure that he had adequate

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1 treatment he needs to be coerced to have that which
2 would have required restraints, it would have required
3 section 3 and CTO, and probably the provisions of the
4 CTO ongoing in the community, which is not guaranteed
5 that he would have been maintained on because he
6 probably would have got off the tribunal, given my
7 experience of the threshold for discharge in mental
8 health tribunals.
9 So this is a culture that is very broad about what
10 is the threshold at which we are going to coerce
11 patients. One concern that I -- and I think many other
12 psychiatrists -- have is that VC's case was not
13 extraordinary in any way. We see multiple patients like
14 this all the time with this level of risk, this pattern
15 of disengagement and, yeah, this could be much more
16 frequent than it is. These outcomes.
17 **Q.** So your evidence is that you see people who have already
18 committed offences that aren't charged by the police?
19 **A.** Yes.
20 **Q.** Violent offences in the community?
21 **A.** Yes.
22 **Q.** You treat them in hospital for the time that you have
23 them, and they're discharged not necessarily with CTOs
24 or anything requiring treatment thereafter?
25 **A.** Sometimes, yes. And with the capacity of inpatient

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1 services as they are, the number of inpatient beds for
2 the serving population has dramatically decreased over
3 the past 40 years. So we have much fewer beds to deal
4 with a much larger and sicker population, and therefore
5 there are multiple patients in the community at any one
6 time that are dangerous, and that need to come into
7 hospital, but there are no beds for them to be in. And
8 so there is constant pressure to discharge patients back
9 into the community.
10 **Q.** To be clear, in relation to VC, was bed or a lack of bed
11 ever an issue?
12 **A.** I don't know, but it's certainly a consideration
13 regarding Community Treatment Orders. So a common
14 frustration among psychiatrists who are dealing with
15 Community Treatment Orders is that the lack of
16 an available bed for recall actually affects the
17 effectiveness of a Community Treatment Order because you
18 may wish to recall a patient but because you're required
19 to identify a hospital bed and there may not be one, it
20 becomes functionally meaningless.
21 **Q.** So that reduces the number of CTOs that are applied for
22 in the first place; is that what you're saying?
23 **A.** To a degree, well, yes.
24 **Q.** Has it ever impacted your decision making in an
25 individual case?

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1 **A.** I try not to let it.
2 **Q.** But you've described it so it sounds like it does?
3 **A.** It's conversations that people have.
4 **Q.** Can we go back to a couple more documents, please,
5 NHFT0018830, page 1. This is an email that you sent to
6 Dr Seedat in February:
7 "We've got a chap on the ward ... you've seen in the
8 past. [...] tricky chap ... very guarded ... poor at
9 engaging with services."
10 When you said "tricky chap", what were you thinking?
11 **THE CHAIR:** Can we just have that bit?
12 **THE WITNESS:** Sorry?
13 **THE CHAIR:** It's just that bit is now up on the screen.
14 There we are.
15 **A.** I think I was probably referring to him being quite
16 guarded.
17 **MS LANGDALE:** You asked Dr Seedat if he would see him or
18 might see him, and you say:
19 "[It's]... not a requirement. I think he'd just
20 like a chat to clarify things ..."
21 If we go up to the top, please.
22 **A.** Yes.
23 **Q.** See Dr Seedat's response there:
24 "I have been going through my emails ...
25 "Is there still a required need ...?"

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1 And you say:
2 "... not a requirement ... he'd just like a chat to
3 clarify things ..."
4 Would you have liked Dr Seedat to see him at that
5 point? You've said he's a tricky chap. Dr Seedat has
6 that experience of him in 2020; would it have been
7 helpful?
8 **A.** That's why I sent the email.
9 **Q.** Yes, so you'd like him to. You were a higher trainee,
10 registrar, and he's a consultant, would it have been
11 difficult for you to say I really want you to see him?
12 **A.** I couldn't have forced him to do it in any way.
13 **Q.** No. Did you expect that he would?
14 **A.** Possibly.
15 **Q.** If we go to NHFT0019071, we see he also said the same to
16 Dr Lomas, didn't he? You were cc'd in.
17 "[He] popped over to ask if [VC] would consent to
18 answering questions from the police..."
19 And:
20 "... [VC] asked if he could have the opportunity to
21 speak with Dr Seedat ..."
22 When he said he popped over, how far apart are these
23 wards where Dr Seedat is working and Dr Lomas to where
24 you were?
25 **A.** Oh, a couple of minutes to walk, maximum.

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1 **Q.** If we can go, please, to 24 Feb, the discharge meeting.
2 That's NHFT0000168, page 260, we see:
3 "He denied any thoughts that people were tinkering
4 with his thoughts or influencing them over the past 4
5 weeks, [but he] was hesitant.
6 "When asked about ... future plans, he said that he
7 wishes to go back to his studies and back to normal
8 life.
9 "[And] ... no issues with medication.
10 "Discharge with 14 days of medication."
11 The description, his own description of wanting to
12 get back to his studies and normal life, it's fanciful
13 isn't it, really?
14 **A.** I wouldn't say fanciful. I think that's what he
15 believed -- *(overspeaking)* --
16 **Q.** You knew paranoid schizophrenia, that's a functional
17 illness, that's a serious illness, isn't it, that
18 requires medication, attention, therapeutic
19 intervention, all of those things if he was going to
20 live anything near a normal life?
21 **A.** Yes, although patients with schizophrenia can engage in
22 the wider community. They can complete university
23 courses if their condition is well managed.
24 **Q.** Have you managed many people with paranoid schizophrenia
25 who have completed a university course?

1 **A.** It tends to lead to them dropping out, but there have
2 certainly been people that have managed, yes.
3 **Q.** But the evidence from the University, I think, was that
4 it was extreme rare to have somebody --
5 **A.** Yeah --
6 **Q.** -- finish a course.
7 **A.** -- tends to lead to.
8 **Q.** Were you aware that it was interrupted as well, he had
9 taken an interruption of studies for a period of nine or
10 ten months. He was struggling. Did you find that kind
11 of information out?
12 **A.** I wasn't aware of the interruption of studies, but I was
13 aware of the difficulties from speaking to Ms Turner
14 from the University.
15 **Q.** Can we just have a look, please, at CQCM0017192:
16 Operational procedure Adult Mental Health Acute
17 Inpatient wards. It's a Nottinghamshire document.
18 If we go, please, to page 13. It sets out:
19 "Comprehensive assessment and formulation of
20 patient's needs inclusive of risk, is an ongoing process
21 throughout inpatient stay ..."
22 So it's four paragraphs down.
23 "... it is the named nurse along with the MDT's
24 ongoing responsibility to review, complete assessments,
25 interpret outcomes and plan care accordingly with the

1 patient/carer involvement in planning care wherever
2 possible."
3 So that was the policy that Nottinghamshire had, and
4 if we go to the NICE Guidelines as well, please,
5 NICE0000016, page 23, under "Treatment options".
6 "For people with an acute exacerbation or recurrence
7 of psychosis or schizophrenia, offer:
8 "oral antipsychotic medication ... In conjunction
9 with
10 "psychological interventions ..."
11 We see "Pharmacological interventions":
12 "For people with an acute exacerbation or recurrence
13 of psychosis ... offer oral antipsychotic medication or
14 review existing medication. The choice of drug should
15 be influenced by the same criteria recommended for
16 starting treatment ... [And] take into account the
17 clinical response ..."
18 We know he was on aripiprazole in the fourth
19 admission, did you and Dr Thangavelu discuss medication,
20 how that needed to be adapted, substituted? The
21 medication itself? Was that a matter for him?
22 **A.** Our opinion was that it needed to be depot or it should
23 be depot, sorry.
24 **Q.** What form, aripiprazole?
25 **A.** Aripiprazole depot should be -- *(overspeaking)* --

1 **Q.** What amount?
2 **A.** I would say aripiprazole only comes in 2, the dosages
3 for the depot and there is a standard dose of
4 400 milligrams monthly which is what he would have been
5 given.
6 **Q.** We see at page 29, of the same document, please, at the
7 bottom:
8 "Interventions for people whose illness has not
9 responded adequately to treatment".
10 "For people with schizophrenia whose illness has not
11 responded adequately ..."
12 Over the page:
13 "Review the diagnosis.
14 "Establish there has been adherence to antipsychotic
15 medication, prescribed at an adequate dose and for the
16 correct duration."
17 There was no attempt in the fourth admission, was
18 there, to see exactly when he had taken the medication
19 and he hadn't, and what the impact of that was on his
20 mental state?
21 **A.** We got information from the Crisis Team, who were
22 unclear about his concordance, which led us to believe
23 that he probably had not been fully concordant with his
24 medication, and we were aware of the history of
25 non-concordance which is why we'd recommended the depot.

1 **Q.** Can we go to the Theemis Report, please, NHFT0000530,
2 page 158.
3 So the Theemis Report, as you know, Dr Gibson, made
4 findings on medication management. And in respect of
5 the fourth admission on page 158, so it's NHFT0000530,
6 page 158. That's the wrong document. So NHFT0000530.
7 Thank you.
8 So we see there "Comment":
9 "This is the second admission in which [the] Care
10 Coordinator ... has voiced their views on what would
11 help to support VC's care and treatment in the community
12 and the subsequent actions were not aligned with their
13 views. This further supports the finding that the view
14 of the inpatient responsible clinician carries more
15 weight than the voice of those working with VC in the
16 community.
17 "In the fourth discharge, there was no evidence of
18 the family voice in the decision-making process. By
19 this point, VC had requested that his family not be
20 involved in his care, however the Trust's discharge
21 policy ... says:
22 "'When a patient is transferred/discharged to
23 a Trust service, information on the service must be
24 provided by the referring team to the patient, relatives
25 and carers. The involvement of family members is

1 essential even if this is against the patient's
2 expressed wishes. The member of staff given the
3 information must check what has been understood.'
4 "VC's family told the independent investigation that
5 they were aware he was undergoing a Mental Health Act
6 assessment in January 2022 because the AMHP contacted
7 VC's mother. However, they were not made aware of the
8 outcome."
9 Do you agree with those observations and criticisms
10 of the fourth admission?
11 **A.** Broadly, yes. Although I think it's important to
12 recognise that the inpatient RC is necessarily
13 responsible for treatment decisions as an inpatient.
14 They are the ones who are prescribing the medication and
15 using the Mental Health Act. So it is appropriate that
16 they are the ones that have the final decision, after
17 taking into account all other information.
18 **Q.** If we go to page 170 of the document, please. Last
19 paragraph on page 170. "Comment":
20 "The decision making around discharge appeared to
21 suggest a hierarchy of information relied upon in order
22 to make the decision regarding how to manage risks in
23 the community setting. The inpatient clinicians'
24 opinion appeared to carry the most weight [...]
25 community clinicians and family were raising concerns

1 about the need for a more formalised approach [...] and
2 the need to take more time in hospital to fully
3 understand how best to care for VC."
4 Time in hospital. It was a short admission, wasn't
5 it? Do you agree it was too short and didn't establish
6 a therapeutic treatment regime?
7 **A.** It was the duration of a Section 2.
8 **Q.** Why not convert it to a Section 3 for the treatment,
9 then, the treatment that was needed?
10 **A.** So I believe Dr Thangavelu did not think it was -- that
11 the statutory criteria were met to convert to Section 3.
12 **Q.** Did you discuss that with him?
13 **A.** I imagine we will have done in the supervision. On
14 reflection, looking back through this, I think it could
15 have been argued under the nature of his condition to
16 convert to Section 3 for the purposes of depot and CTO.
17 That would not have been a guaranteed outcome. You'd
18 have had to convince the second doctor, the AMHP in
19 particular, to make that application, um --
20 **Q.** You that the tribunal findings from September --
21 **A.** Yes.
22 **Q.** -- '21. They would have been hugely helpful in
23 demonstrating what was necessary.
24 **A.** I think they would have been very helpful. I think this
25 is probably why I refer to the culture and the practice

1 generally and the thresholds that have to be met, due to
2 the lack of capacity, is such that that is not a
3 guaranteed outcome that he'd have been able to argue
4 solely based on nature at this point.
5 I have had patients who I would consider to be more
6 concerning, people not agree to put in applications,
7 because of lack of degree, currently, and stated
8 intention to continue with oral treatment.
9 **Q.** Can we have the CQC report, please. CQCM0016518,
10 page 5 -- at the bottom of page 5. "Care planning and
11 engagement". Also "Risk assessment and record keeping".
12 The Inquiry has had plenty of evidence about that, but
13 dealing with care planning and engagement. Over the
14 next page, please.
15 Bottom of the page:
16 "Medicines management and optimisation".
17 Next page, page 7, the second and third bullet
18 point, please:
19 "From the beginning of the 2 years, there was an
20 obvious pattern of VC not taking his medicine while in
21 the community. Records also show that medicine had been
22 found in his flat, suggesting that he wasn't taking it.
23 This is similar to 3 of the 10 benchmarking cases we
24 looked at, where we found issues with medicines
25 monitoring.

1 "Despite multiple hospital admissions and evidence
2 that VC was still symptomatic on the treatment
3 prescribed, there was no real change to his care and
4 treatment. NICE guidelines are clear that people with
5 schizophrenia whose illness has not responded adequately
6 to treatment, should have their diagnosis and treatment
7 reviewed to ensure that it is an adequate dosage and for
8 the correct duration".
9 Do you agree that there was no longitudinal
10 analysis, including within the fourth admission, and
11 accordingly the medicines were not managed or optimised
12 in his case?
13 **A.** I don't agree, no. I think the longitudinal analysis
14 was done, which was why we recommended the depot. One
15 of the things that was interesting and difficult about
16 VC's fourth admission was that prior to each of his
17 previous admissions he had presented as floridly
18 psychotic and aggressive, which had been prompted by
19 poor concordance or ceasing medication, whereas for his
20 fourth admission there were no obvious psychotic
21 symptoms that could be elicited by any professionals,
22 and he stated he had been concordant with medication.
23 But you --
24 **Q.** But you had the screaming, didn't you? You had the
25 description from the screaming --

1 **A.** Yes.
2 **Q.** -- from his flatmate very early on in that admission,
3 and you won't have seen a statement that the Inquiry has
4 from many years ago from somebody who referred, 2014 to
5 2015, VC screaming or being heard to scream. So --
6 **A.** Not aware of that, no. But so -- and, yeah, we're
7 dealing with lots of ambiguity in psychiatry. So that
8 information about his poor concordance previously was
9 taken into account, as was the information regarding the
10 screaming. It's just that the decision, the outcome of
11 that, was not to enforce the depot.
12 **Q.** So if he didn't want it, you'd like him to have accepted
13 it, but if he didn't, you didn't want to coerce him to
14 do it?
15 **A.** It was not felt to meet the threshold to coerce him to
16 have it with restraint, no.
17 **MS LANGDALE:** Chair, those are my questions. I wonder if
18 that's a good time for a short break, and then time for
19 the CP questions.
20 **THE CHAIR:** Yes. Let's take a short break until 3.55.
21 **(3.40 pm)**
22 **(A short break)**
23 **(3.55 pm)**
24 **THE CHAIR:** Yes, Ms Patrick.
25 **Questioned by MS PATRICK**

1 **MS PATRICK:** Thank you, Chair.
2 Good afternoon, Dr Gibson, my name is Angela
3 Patrick. I ask questions for the families who were
4 bereaved on 13 June.
5 There are four things I'd like to ask you about.
6 The first is a few things that you were told about VC;
7 second, the allegations being made concerning VC;
8 contact with Dr Seedat and Dr Lloyd; and then finally
9 something about culture.
10 So the first thing, on things that you knew about
11 VC, there are two things I want to look at again and the
12 first is your phone call with Mrs Calocane. Could we
13 bring that up, please? The record is on the RiO records
14 NHFT0000168 and page 223. If we could expand that, that
15 would be very helpful for me to be able to read it.
16 Thank you.
17 Now you see there:
18 "She explained that [he] seemed normal to his
19 parents, until they heard about incident."
20 You've recorded that she'd heard about an incident,
21 had she?
22 **A.** So I imagine that is a reference to the call that the
23 AMHP made prior to the first Mental Health Act
24 Assessment.
25 **Q.** She refers not to a call with the AMHP; she refers to

1 there having been an incident. Can you recall what was
2 discussed?
3 **A.** No, I can only assume it was the AMHP informing about
4 the context of the Mental Health Act Assessment.
5 **Q.** The context. During that conversation, do you remember
6 if you were both operating on the same basis? You
7 understood that there had been an allegation of assault?
8 **A.** I don't, no.
9 **Q.** Thank you. It says, "[Calling] more frequently" and
10 then "... calling parents daily since". It's a change
11 in his behaviour, isn't it?
12 **A.** Yes.
13 **Q.** Would that be relevant to your assessment?
14 **A.** I think it would be the content of which would be the
15 most relevant rather than the frequency.
16 **Q.** Okay. Did she tell you what he was saying to her?
17 **A.** I don't recall any more than what I've documented at
18 that.
19 **Q.** But you see a record there about the reference to
20 stresses connected to university work; do you see that?
21 **A.** Yes.
22 **Q.** Did you know that university stress had been a factor in
23 previous admissions?
24 **A.** I believe so, yes, but I'm not definite.
25 **Q.** There's no further record of what those stresses were.

1 Can you recall if you asked about it?
2 **A.** I don't know, sorry.
3 **Q.** Do you remember if you called the University to ask
4 about it?
5 **A.** Yes, I spoke to Ellie Turner.
6 **Q.** Okay, we'll come back to that in a moment. We can see
7 there:
8 "... he is scared of mental health services and
9 feels persecuted by them."
10 When you heard that, did you make a connection with
11 what you were being told by the Community Team about how
12 they were reacting to them?
13 **A.** Yes. This is unfortunately a very common presentation
14 amongst patients who are detained against their will:
15 that they see mental health services as an arm of the
16 state, essentially, that will deprive them of liberty.
17 Which we do.
18 **Q.** And did. Can we turn to page 234 at the bottom, the
19 next entry I'd like to look at. We've heard that he
20 obviously was isolating himself, and wasn't really
21 engaging, but there was one one-to-one when he wanted
22 leave, and I want to look at this record of what he said
23 and what was recorded. If you look at part of the way
24 through that paragraph:
25 "He said that he did not believe that he had

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1 a mental health issue and ... was going to engage as
2 minimally as he could, keeping out of people's way and
3 not being a management problem until he can go back to
4 his life and continue with his education."
5 He was telling staff outright he would not engage;
6 would you have read that?
7 **A.** Quite possibly, yes. We were aware that his broad
8 intention was to avoid further restrictions on his
9 liberty, keep his head down, he said, just serve his
10 time. It's a common perspective amongst patients "I'll
11 do my time and then get out."
12 **Q.** Let me stop you there. That's not what he's saying
13 exactly, is it? You've got a patient here who you know
14 had a history of masking his symptoms, didn't you?
15 You're nodding. I think you have to say, "yes"?
16 **A.** Sorry, yes.
17 **Q.** You know he's got a history of masking symptoms. You
18 know that part of, as you've said, a common delusion, he
19 feels he's being persecuted. He's telling a nurse
20 outright that he's going to engage as minimally as he
21 could, and we've seen elsewhere in his notes where he's
22 admitted that in the past that's what he's done. "I'll
23 take my medication, I'll get discharged. I'll engage as
24 minimally as I can, and then I can go back to my
25 ordinary life."

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1 Was that not something that should have played
2 a critical role in your assessment of his presentation?
3 **A.** It played a role in his presentation. I would just
4 clarify the sense of persecution. Previously he had
5 quite an elaborate delusional framework where he was
6 persecuted by multiple Government agencies via various
7 fantastical means, whereas --
8 **Q.** Can we pause you there. You said it would play a role
9 in his presentation.
10 **A.** Certainly, yes, but as a persecution itself, he was,
11 from his perspective, being persecuted by mental health
12 services. That's not a delusion.
13 **Q.** I'm not questioning, you've given evidence on what you
14 understood as to that. Was this another factor just
15 saying expressly that he was going to set out
16 purposefully to engage as minimally as he could? Was
17 that not another factor relevant in your assessment of
18 his likelihood that he'd comply with his treatment,
19 either with you or with the Community Team, any
20 treatment you were recommending back in the community
21 voluntarily. Wasn't this just another indication that
22 he wasn't going to be concordant without some form of
23 compulsion?
24 **A.** It pushes in that direction, yes.
25 **Q.** Thank you. Can we turn to allegations, my second topic,

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1 concerning VC and I want to look again at your call with
2 Christopher. So if we could turn to NHFT0000168
3 page 228 and while that's coming up, you've said
4 information about the assault and about the return to
5 the flat, you've described that as an allegation.
6 Now, do you need to be shown beyond reasonable doubt
7 that a patient has harmed others, to be persuaded that
8 his ill health may be a danger to the safety of other
9 people?
10 **A.** I don't know. I think that use of allegation is just
11 reflecting that we don't know for definite, but we are
12 strongly suspicious of.
13 **Q.** Okay.
14 **A.** And I think we elaborate further in that.
15 **Q.** Okay. So we've got the conversation you had with
16 Christopher on the screen.
17 Now you've said about the screaming and you have
18 accepted that Christopher describing those screams in
19 the night that nobody else could hear forming part of
20 possible evidence that VC had been experiencing
21 psychotic symptoms over the last month, and you've
22 nodded again.
23 **A.** Sorry.
24 **Q.** Sorry, you have to say "yes" or "no".
25 **A.** Yes.

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1 **Q.** Now was that not also evidence supporting the Community
2 Team's understanding that he wasn't taking his
3 medication?
4 **A.** Potentially, it's evidence that he may have been
5 experiencing psychotic symptoms, and he may have been
6 experiencing them whether he was taking his medication
7 or not, but he was more likely to be experiencing them
8 had he not been taking his medication.
9 **Q.** Indeed. Now did you discuss that element with
10 Dr Thangavelu?
11 **A.** So yes, I will have discussed that with him.
12 **Q.** You would have. Now we've got no record there, and
13 you've already accepted that, that you asked Christopher
14 how he felt about VC returning to the flat, is there?
15 **A.** I don't believe there's a record of it, no.
16 **Q.** Can we turn to the MDT that comes next, which is on
17 page 232, please, over on to 233. Thank you. I think
18 we can see at the bottom there 7 February 2022, and the
19 actual note is on the next page. Thank you.
20 Now if you see that there:
21 "Report came in from school accommodation that
22 someone was noted to be in his flat."
23 That's not an accurate description of what you were
24 being told by the University, is it?
25 **A.** No.

1 **Q.** Is that your note?
2 **A.** No, I can't see who's written this one. It will have
3 been one of the resident doctors most likely who has
4 written that.
5 **Q.** You were in that meeting though, I can see you there.
6 **A.** I was in that meeting, yes.
7 **Q.** Yes.
8 **A.** But there's a little banner at the top which says who's
9 originated the note. I don't know if that's on the
10 previous page. Oh Esther Okoro, she was a resident
11 doctor at the time.
12 **Q.** Okay, you can scroll back down. We see what happens at
13 the end of that MDT, his leave is reinstated, isn't it?
14 **A.** Yes.
15 **Q.** "30mins unescorted leave ..."
16 Had there been any investigation of whether VC had
17 gone back to the flat where he'd experienced screaming
18 nobody else had heard, and where he had allegedly
19 assaulted his flatmates and held them hostage?
20 Anything? Had there been any investigation?
21 **A.** Beyond the discussion I had with the flatmate, and the
22 look at the Section 17 records, which were not there,
23 I don't believe there were anything further to that, no.
24 Oh sorry, I did discuss with VC as well, which he
25 denied. But I don't think there's anything more than

1 that.
2 **Q.** So we've seen the note. No note you've recorded
3 speaking to Christopher about it. Did you call the
4 police to ask if they'd been notified?
5 **A.** So should I have done or did I?
6 **Q.** Did you?
7 **A.** No.
8 **Q.** Did you ask the University if they had called the
9 police?
10 **A.** No.
11 **Q.** Were you giving VC the benefit of the doubt?
12 **A.** No, I restricted his leave. I believed that probably
13 he's gone and not abided by the Section 17 leave
14 restrictions, so I -- *(overspeaking)* --
15 **Q.** But you've reinstated his leave.
16 **A.** At that point, yes. That would have been MDT review and
17 it would have been a discussion with Dr Thangavelu about
18 leave.
19 **Q.** On the basis of an inaccurate account, seemingly.
20 **A.** So what's the inaccurate account?
21 **Q.** That there had been a report that someone was noted to
22 be in his flat.
23 **A.** I think that is an inaccurate documentation of what was
24 discussed. I think that is probably meant to say that
25 he was alleged to have been back in contravention of his

1 Section 17 leave.
2 **Q.** Okay. We'll move on to the next topic. Contact with
3 others. Now you've said after you had that call with
4 Christopher you would have seen a pattern in his earlier
5 admission -- from his earlier admissions.
6 **A.** Yes.
7 **Q.** Trespass, assaulting others et cetera.
8 **A.** Hearing voices, yes.
9 **Q.** Did you look back at notes from those earlier admissions
10 after that call with Christopher?
11 **A.** I don't know if I did, but I was aware of the history.
12 **Q.** Can we look at one note, please? It's at page 21 of the
13 RiO notes, please.
14 This is something we've all seen a number of times.
15 It's a note taken on 3 June by Dr Seedat, of an
16 annotation of conversations between VC and his brother.
17 I only want to look at one part and it is the fifth
18 paragraph down that starts:
19 "He says in the text", and I want to look at the
20 last sentence:
21 "He said the people would not mock him in person and
22 made some remark to wanting to hurt these people he was
23 hearing."
24 Can you recall if you would have read that?
25 **A.** No, I don't believe -- it's possible that I did but I

1 don't believe I read that.
2 **Q.** Wanting to hurt people: a record of an intent to harm
3 others when he was unwell. Was that something you knew
4 that VC was experiencing when he was unwell?
5 **A.** I don't think I was aware of intent to harm others when
6 he was unwell. I was aware of harm coming to other
7 people when he burst into flats and things, and him
8 committing harm to the police officers, for instance,
9 and nurses. But I don't recall being aware of this
10 particular intent, no.
11 **Q.** Okay. That is relevant, isn't it --
12 **A.** Yes.
13 **Q.** -- to your understanding of his risk. And if you didn't
14 see it, it couldn't form part of your assessment, could
15 it?
16 **A.** No, not part of mine. I don't know what Dr Thangavelu
17 was aware of.
18 **Q.** Okay. Now we've got the underlying notes and we know
19 what wasn't recorded. Detail about crushing heads in
20 hands. Wanting to hurt them permanently, and
21 a reference to "red rum".
22 **A.** Mm.
23 **Q.** "Red rum": would you know what that meant?
24 **A.** Yeah, "murder" backwards.
25 **Q.** And of course you didn't see any of that?

1 **A.** No.
2 **Q.** Would that have been relevant to your understanding of
3 VC's risk?
4 **A.** It would have been relevant, yes. But it would have
5 been a small part of a larger picture.
6 **Q.** Thank you. Now we've heard, and we won't go back to the
7 emails of Dr Seedat, but when you reached out to him,
8 was he your Clinical Director?
9 **A.** I don't recall. He has previously been Clinical
10 Director. I don't know if he was the Clinical Director
11 at that point.
12 **Q.** Okay. When you reached out to him, you didn't have any
13 discussion with him beyond the exchange of emails, did
14 you?
15 **A.** Not to my knowledge.
16 **Q.** Thank you. Just briefly, we've seen your emails with
17 Dr Lloyd urging you to impose a depot or to consider
18 depot. Have you ever been frustrated by the actions or
19 inactions of community consultants in the treatment that
20 they're affording your patients while they're in the
21 community?
22 **A.** I don't think I was the recipient of the email from
23 Dr Lloyd. I think that was Dr Thangavelu. But I-- not
24 routinely, no.
25 **Q.** Not routinely. The last topic. Ms Langdale has talked

1 to you a little bit about culture in psychiatry and
2 concerns over bias. I don't want to spend too long on
3 that, but can we just have a look at what you've said in
4 your witness statement together, please?
5 **A.** Yeah.
6 **Q.** It's WITN0205001 and it's page 39, I think. If it helps
7 the document manager, I'd like to look at paragraph 103,
8 please.
9 Can you see that, Dr Gibson?
10 **A.** Yes.
11 **Q.** We see there you're talking about:
12 "... the social cultural-climate at the time of VC's
13 care. I recall the discourse well and the accusations
14 that psychiatrists were uncaring, overly coercive, or
15 even outright racist, because of the data regarding
16 coercion ... [This] was constant discussion about
17 reform of the Mental Health Act to reduce coercion as a
18 result. I acknowledge this climate will have been felt
19 differently by different psychiatrists (particularly if
20 they were from ethnic minority backgrounds themselves)
21 but I recall feeling it viscerally and do not believe it
22 had no bearing on VC's care."
23 You're reflecting carefully there, aren't you?
24 **A.** Yes.
25 **Q.** You're right, "do not believe it had no bearing on VC's

1 care." It's a suggestion that you believe it did?
2 **A.** Yes, but I can't say precisely what. I suppose if you
3 have a general culture and discourse going in one
4 particular direction you would have to ignore --
5 particularly if it is from institutions, from the
6 Government, et cetera, you would have to ignore it
7 entirely, which you are not usually recommended to do.
8 **Q.** Indeed. You use that word "visceral". It's a strong
9 word to reflect your strength of feeling and to describe
10 how strongly you felt about the impact of these
11 discussions at the time of VC's care?
12 **A.** Yes. So I don't think I am racist, I think I try and
13 judge every patient on an individual basis. These kinds
14 of sort of allegations that the profession is
15 institutionally racist, that individual clinicians are
16 either themselves racist or have implicit bias, thereby
17 perpetuating this disproportionate care, is very
18 difficult to deal with.
19 **MS PATRICK:** Thank you, Dr Gibson. I have no further
20 questions for you.
21 **THE CHAIR:** Thank you.
22 Yes, Ms Cartwright.
23 **Questioned by MS CARTWRIGHT**
24 **MS CARTWRIGHT:** Good afternoon, Dr Gibson.
25 Dr Gibson, can I take you back to the email

1 Ms Langdale KC took you through which was your email to
2 Dr Seedat. NHFT0018830. Thank you.
3 Now, you've already been through the content, but we
4 can see in particular that Dr Seedat, in response, said
5 he was returning from leave and had been going through
6 his emails. But essentially this was you really seeking
7 to a more experienced consultant, would you agree, who
8 had been the Responsible Clinician for admission one and
9 two to essentially assist you; would you agree?
10 **A.** Yes, and that he had a working relationship with VC and
11 he seemed to want to discuss that previous admission
12 with him, yes.
13 **Q.** I think you were being fairly diplomatic when you said
14 you would have expected him possibly to have assisted
15 you; would you agree?
16 **A.** I don't think I was being overly-diplomatic. It's not
17 a requirement to do that. I think it would have been
18 helpful, but people will ask lots of favours every now
19 and again and people may not be able to do them.
20 **Q.** I know, but would you agree that, for a very real reason
21 you've already been asked about by Ms Patrick, there was
22 a real reason why Dr Seedat should have actively
23 assisted you, because he had made a decision not to
24 upload the significant risk information that the family
25 had provided to Dr Seedat to the RiO system, both in its

1 full content, or the full extent of the risk information
2 from VC.
3 So would you agree, particularly when he's saying he
4 was going back through his emails, that the very least
5 he should have done, bearing in mind this was now
6 a fourth revolving door admission of a complex patient,
7 is ensure that you and the treating consultant were
8 provided with all of the relevant risk information that
9 Dr Seedat was the only person aware of?
10 **A.** That's not what I was asking.
11 **Q.** I know it wasn't, but you're asking for help.
12 **A.** Yes, specifically for him to have a conversation with VC
13 to reinforce the importance of engagement with
14 a community treatment plan. And I wasn't aware of the
15 emails that he had, so I -- it would have -- I'm not
16 sure he would have even thought about that in relation
17 to this email.
18 **Q.** Well, can you help, how often are consultants provided
19 with documentation that gives a real picture of risk and
20 not upload it to records? I would suggest that's
21 probably pretty memorable for a consultant, when they
22 elect and choose not to put it in the medical records?
23 **A.** It's not very common we get information like that, no.
24 **Q.** All right. But can I ask you this, because you've
25 already said to Ms Langdale KC that the wards were less

1 than a two-minute walk, in fact a very short distance
2 away. But at any point after you sent this email, and
3 no doubt will have seen Dr Seedat on the corridors or at
4 other meetings, did he at any point speak to you about
5 VC?
6 **A.** I don't recall.
7 **Q.** You don't recall. Can I then secondly ask you, you were
8 asked by Ms Langdale as well about the opportunity, this
9 was the opportunity to, on this Section 2 admission, to
10 make it a Section 3 admission as had happened in the
11 past, in fact at Cygnet. Just whilst I deal with that,
12 is it your evidence that you did not have access to
13 Cygnet or the Priory records?
14 **A.** I don't believe we did.
15 **Q.** All right. And you said there was perhaps a case that
16 could be made for the nature of VC's --
17 **A.** It would have had to have been nature, not degree.
18 **Q.** All right. Can I just go through the factors why
19 I would suggest that had thought been given to nature,
20 the nature as a mental disorder at this point, it would
21 have crossed that threshold.
22 Would you agree, first of all, schizophrenia, the
23 nature of his mental disorder, was significant for risk
24 in terms of risk to violence? This was a fourth
25 admission that had been essentially precipitated by

1 a violent incident involving the police.
2 **A.** Yeah, that is the argument you would have made, yes,
3 that he had a significant history of violence,
4 non-concordance with medication, poor insight into his
5 illness, and that he was disagreeing with depot
6 medication which we believed was the appropriate course
7 of treatment, therefore it is necessary for him to be
8 detained in hospital to receive that treatment.
9 **Q.** So I'm going to just go through the further factors
10 which are the classical factors that are triggered on
11 nature: insight. He lacked insight completely in
12 respect of his mental disorder, or the need for him to
13 take his medication?
14 **A.** He did not completely lack insight but his insight was
15 not very good.
16 **Q.** Well, that gets him home on insight and nature; would
17 you agree?
18 **A.** You could argue it, certainly.
19 **Q.** The fact that it was a likelihood of relapse in the
20 future, there is now the longitudinal picture that the
21 Mental Health Tribunal didn't have at Cygnet where
22 another admission again where he's relapsed, again
23 because he's not taking his medication?
24 **A.** Yes, as I said.
25 **Q.** His previous response to treatment, again a fourth

1 occasion now on a detention where it's completely shown
2 he doesn't comply with treatment in the community?
3 **A.** That periodically he does not comply with treatment and
4 that that is the rationale, yes.
5 **Q.** It's not the "periodically"; he had, between his third
6 and fourth admission. That is the evidence; would you
7 agree?
8 **A.** That he had never taken --
9 **Q.** No, between the third and fourth. You're now in the
10 fourth admission; you had that further evidence that
11 he'd not complied with his treatment.
12 **A.** I don't know if there's evidence to say that he had no
13 medication in between those points.
14 **Q.** Again, did you speak to the Community Team about that?
15 Certainly if one looks at the records in RiO, it really
16 does support VC completely disengaging between the third
17 and the fourth.
18 **A.** I don't think we can say confidently that he had no
19 medication between the third and fourth admission.
20 I don't think he was fully concordant with his
21 medication. That's very clear, and that he had debates
22 about it being 10 milligrams versus 20 milligrams and
23 not picking up the medication on time. I completely
24 accept that. But I think it is a stretch to say that he
25 had no medication whatsoever during that period.

1 **Q.** But then would you agree as well: prognosis we've now
2 definitely got as well, as well as chronicity of his
3 condition as well?
4 **A.** Certainly got chronicity, yeah, and prognosis without
5 adequate treatment is not good, no.
6 **Q.** So can I ask at any point then did you have the
7 discussion with the consultant that Ms Langdale asked
8 you to engage with of how actually it should have been
9 considered bearing in mind the risk of --
10 **A.** We considered it. We had that discussion, I think
11 probably on several occasions during our supervision
12 about whether we could justify use of Section 3, CTO and
13 depot medication.
14 **Q.** But we don't see anywhere in the notes, would you agree,
15 how you've engaged with the statutory criteria for those
16 factors?
17 **A.** Not in the notes, I don't believe so. From memory,
18 I don't know.
19 **MS CARTWRIGHT:** Thank you. Those are my questions.
20 **THE CHAIR:** Yes, Mr Straw.
21 **Questioned by MR STRAW**
22 **MR STRAW:** Dr Gibson, I represent VC's family. Could we
23 have the RiOs back on screen, please, it is the
24 NHFT0000168 document at page 223.
25 This is the entry you've seen earlier on

1 February 2022 about your telephone call with Celeste
2 Calocane, and you've already been referred to a sentence
3 towards the bottom which said that:
4 "She [Celeste] also expressed some frustration about
5 our lack of ability to share information based on
6 confidentiality, but accepted explanations."
7 Now, does that indicate that you were aware that he
8 had declined consent for health services to share
9 information that was confidential with her?
10 **A.** So, I mean, I was aware that VC had declined consent.
11 I don't recall whether I was aware of the previous
12 declining of consent with Claudia Birtles, and I don't
13 know whether this indicates that.
14 **Q.** It's the words in particular:
15 "... [your] lack of ability to share information
16 based on the confidentiality ..."
17 That would indicate that he had declined consent to
18 share, wouldn't it?
19 **A.** Yes, I spoke to him and he declined consent and that's
20 why I didn't give the information, yeah.
21 **Q.** Okay. Thank you. Then just to clarify that a little
22 bit more, you were asked about this earlier, but I'd
23 like to go to a point in your witness statement that's
24 about this.
25 So could we have the witness statement on screen,

1 please, WITN0205001, page 20 at the bottom. So right at
2 the bottom there:
3 "I did not believe --"
4 As I understand it, you're discussing this
5 conversation with Celeste at this point. So:
6 "I did not believe there was an 'overriding public
7 interest' in disclosure of the circumstances of his
8 detention to his mother as there was no direct threat to
9 her. Instead, I believed I could gain all the required
10 information from her without breaking confidentiality.
11 His mother was aware of his previous history, so far as
12 I was aware, information about the current admission was
13 all that was being withheld."
14 Does that indicate that you withheld from her the
15 circumstances of his detention and information about the
16 current admission?
17 **A.** I believe so, yes.
18 **Q.** So, for example, the fact that he'd been admitted, where
19 he'd been admitted to --
20 **A.** *(The witness nodded)*.
21 **Q.** -- your role, that wasn't said to her?
22 **A.** No, I don't believe so.
23 **Q.** In that context, would you agree that she was
24 understandably frustrated at your ability to share
25 information?

1 **A.** Completely. Completely.
2 **Q.** Okay, thank you.
3 The next issue is something else that you mentioned
4 in your witness statement, in paragraph 97 -- I don't
5 think we need to have it up -- where you indicated there
6 was undue focus on VC's snapshot presentation rather
7 than the longer term pattern; do you recall that?
8 **A.** Sorry, do I recall --
9 **Q.** Sorry, do you recall that part of your witness
10 statement?
11 **A.** Yes.
12 **Q.** I'd just like to ask you about that, about the undue
13 focus, please.
14 In basic terms, what should happen, particularly for
15 someone who is guarded or masks their symptoms, that
16 there should be some analysis of previous relapses to
17 try and identify the signs of relapse, essentially?
18 **A.** Yes.
19 **Q.** So to pick a few examples, we've already discussed the
20 screaming, so the evidence from Chris that VC went into
21 a neighbour's bedroom at night and said, "Can you hear
22 that screaming?" We've heard evidence that the two
23 incidents on 24 May 2020 concerned VC breaking into
24 flats having heard screaming, and then there was another
25 incident when he was then admitted to hospital shortly

1 after that where he was unmedicated and he tried
2 breaking -- he said he could hear screaming from going
3 into a cupboard at a time when he was thought to be
4 relapsing, was thought to be psychotic?
5 In that context, Chris's evidence that he was
6 screaming, he said he heard screaming from a neighbour's
7 bedroom, that's pretty significant, isn't it?
8 **A.** Yes, and as I've mentioned in my statement, that led me
9 to increase my suspicion that he'd been experiencing
10 psychotic symptoms prior to admission.
11 **Q.** To take another example, we've seen on that entry about
12 Celeste that we just looked at a minute ago that she
13 said VC feels persecuted by the health services. It's
14 right, isn't it, that in previous relapses he expressed
15 paranoid delusions of being persecuted by the health
16 services?
17 **A.** Yes.
18 **Q.** So would you agree that the evidence by Celeste and
19 indeed others in February 2022, where he says, "I feel
20 persecuted", that's of more significance given the
21 history from other relapses?
22 **A.** It's of more significance, yes, but as I've mentioned to
23 the previous questioner, we were, from his perspective,
24 persecuting him. We were depriving him of his liberty
25 repeatedly for reasons he thought were spurious.

1 **Q.** Sure, and in the abstract him saying, "I feel
2 persecuted" in that context might be normal --
3 **A.** -- (overspeaking) --
4 **Q.** -- but in the context of him expressing profound
5 persecutory delusions during a previous relapse, this is
6 a sign of concern, it's a sign he may be relapsing at
7 this point?
8 **A.** Potentially, yes, but you have to take both -- this is
9 why I keep going back to psychiatry is a specialty in
10 which you cannot have perfect information and you need
11 to weigh different possibilities against each other. It
12 is incredibly common that patients feel persecuted by
13 psychiatric services because we detain them against
14 their will and often medicate them against their will.
15 **Q.** Is it common that patients express paranoid delusions
16 based on their schizophrenia that there are persecutions
17 against them by the health services?
18 **A.** Sometimes yes, but notably with VC during his fourth
19 admission he denied any of those paranoid delusions.
20 **Q.** Sure, but you're taking a longitudinal view?
21 **A.** Oh so historically certainly, and that was one of the
22 issues with this admission, that historically you had
23 this very clear set of psychotic symptoms and delusional
24 framework, which was incredibly elaborate, and then,
25 with us, it is not evident.

1 **Q.** Sorry, can we go back to the RiOs, please. Sorry to
2 jump around, it's the RiO document page 228, please at
3 the bottom of the page. So this is going back to your
4 call firstly from Ellie Turner.
5 She mentioned there, we can see about four lines
6 down:
7 "[VC] ... failed a progress task and submitted an
8 exam late. [She] explained this pattern of behaviour
9 had been typical during episodes of mental illness for
10 him in the past."
11 Was that another factor that sort of weighed towards
12 a relapse?
13 **A.** I think that's fairly obvious from the documentation.
14 **Q.** Okay. And then right at the bottom of the page is
15 a description from Chris about the assault first, and
16 then after this, it says right at the bottom:
17 "Chris explained [that VC] was 'acting strangely'
18 and refused to let them leave the flat."
19 Clearly this wasn't just a normal dispute about
20 cleanliness in the bathroom, was it?
21 **A.** I think it was far more severe than it should have been.
22 As I've said previously, I think the assault itself was
23 a criminal act that should have been dealt with via the
24 criminal justice system. As to the acting strangely,
25 that does increase his suspicion that afterwards there

1 is some potentially psychotic flavour to this, but the
2 rest of it does not have any hallmarks of it being
3 driven by psychotic symptoms.
4 **Q.** What about the -- so it's not just acting strangely,
5 it's acting strangely and refusing to let them leave.
6 **A.** Yes.
7 **Q.** That's pretty unusual, isn't it?
8 **A.** So from his perspective he wanted the police to resolve
9 this dispute, so he didn't want anyone to leave until
10 the police had come and resolved it, and as I've
11 previously noted, the police came and resolved it by
12 doing nothing -- or sorry, so doing nothing, but not
13 progressing things as they could have been for an
14 assault that someone perpetrated that was as significant
15 as it was.
16 **Q.** You describe this in your witness statement. You say
17 this was unusual and indicated he was suffering from
18 psychosis.
19 **A.** Yes.
20 **Q.** Is that right?
21 **A.** -- (overspeaking) -- *(unclear)* of that.
22 **MR STRAW:** Just one -- sorry, just two final issues, if
23 I may, Chair. They're very quick.
24 **THE CHAIR:** Yes.
25 **MR STRAW:** Thank you.

1 The first, in explaining why depot was not putting
2 him on a CTO with depot was the wrong decision you said
3 there was a series of factors. I'd just like to ask you
4 about one of them. One of them was you said it was most
5 likely that he'd have been put in full face-down
6 restraint in order to administer it.
7 Now, it's right, isn't it, that there's evidence
8 that he accepted taking oral medication in order to be
9 discharged from hospital?
10 **A.** Yes.
11 **Q.** That would indicate, wouldn't it, that he may accept
12 depot if he knew that he had to do that in order to be
13 discharged?
14 **A.** That's a hypothetical, potentially. I think it's
15 unlikely, it is unfortunately very -- it's not very
16 common. Unfortunately, for these kinds of patients
17 where there is a refusal to accept depot, it is not
18 infrequent that they require that level of coercion to
19 enforce the depot.
20 And I think most likely with VC, that would have
21 been what would have been required.
22 **Q.** Just the final question: race. Was VC's race or did
23 VC's race lead you to put in place more coercive
24 measures than you would have put in place if he was not
25 black?

1 **A.** What would they -- I don't think we were more coercive.
2 I don't think we were less coercive than we could have
3 been, but what more coercive were we?
4 **Q.** Just to take an example, the cancelling of leave. Was
5 VC's race a reason for that, for putting in place that
6 measure?
7 **A.** -- *(overspeaking)* --
8 **Q.** How about the other way around? Less coercive measures?
9 Did VC's race lead you to put in place less coercive
10 measures than would have been the place if he wasn't
11 black?
12 **A.** So not consciously, no. That's why I point to this
13 climate that was pointing in one direction and that
14 you'd have to just ignore it entirely.
15 **Q.** There's that climate, but there's also the evidence of
16 widespread disproportionate coercive measures against
17 black people. You were aware of that, weren't you?
18 **A.** Yes, and to my understanding of that is that is broadly
19 driven by the primarily socioeconomic factors that lead
20 people to become unwell in the first place. So things
21 like poverty, things like -- well, migration actually is
22 a risk factor for psychosis in itself, and also people
23 of ethnic minority backgrounds are less likely to engage
24 in treatment and, yeah, more likely -- I think there was
25 one review, more likely to perpetrate significant

1 violence in the context of schizophrenia.
2 So I think it is those reasons that you see that
3 disproportionate application of coercion. I think it is
4 therefore unhelpful to attribute that disproportionate
5 application of coercion to racism within the psychiatric
6 profession. I think that actually causes more harm.
7 **MR STRAW:** Okay. Thank you very much.
8 Thank you for the extra time, Chair.
9 **THE CHAIR:** Yes. Mr Beer.
10 **Questioned by MR BEER**
11 **MR BEER:** Dr Gibson, I just want to ask for some
12 clarification about some of the things that you say in
13 your witness statement which relate to broader issues
14 and to the future.
15 Can we start by looking at your witness statement,
16 please: WITN0205001, page 38, paragraph 100. It's just
17 the last five lines of paragraph 100 for a bit of
18 context, what you are about to say. You say:
19 "For my own involvement in his fourth admission,
20 I am of the opinion that depot antipsychotic should have
21 been enforced. This is on balance and after a long
22 period of reflection and consideration. I have detailed
23 the nuances [...] earlier in [my] ... statement."
24 And that reflects precisely the evidence you've
25 given us today orally.

1 Can we then turn to paragraphs 101 and following.
2 You say the "case brings up various issues regarding our
3 current social, cultural, political, and economic
4 climate."
5 Then paragraph 102, you say:
6 "The most important ... is the tension between
7 autonomy and safety. [...] There is a trade-off between
8 the two principles. [...] all too frequently I find
9 people do not recognise this and [...] believe both can
10 be maximised."
11 Then you say this:
12 "This veneration of autonomy is a product of our
13 tacit ideology of liberalism ..."
14 What do you mean by "the veneration of autonomy"?
15 **A.** I think that is something that is sought to be maximised
16 at all times, and I --
17 **Q.** By who?
18 **A.** Most people. Certainly the institutions involved in
19 this instance, but also including the government in its
20 most recent amendments to the Mental Health Act.
21 I believe the rationale for that was to increase
22 autonomy and to reduce coercion, and I have concerns
23 about the effects of those amendments.
24 **Q.** I'm going to come to those amendments by the Mental
25 Health Act 2025 in a moment. If we just go forward to

1 the paragraph 103, please. You say:
2 "This was the socio-cultural climate at the time of
3 VC's care."
4 What do you mean by the social-cultural climate at
5 the time of VC's care?
6 **A.** I think I've described it previously as the water in
7 which he swam. So this --
8 **Q.** Sorry, I missed that, the waters in which you swam?
9 **A.** Yes, just the climate that was going on at the time.
10 The newsletters, the conferences, the press releases,
11 those kinds of things that you would get from the
12 bodies, so the *(unclear*) government that were pushing in
13 a particular direction.
14 **Q.** You say:
15 "I recall the discourse well and the accusations
16 that psychiatrists were ..."
17 Then that part has been read to you.
18 Am I right in thinking that the discourse you're
19 referring to there is not discourse amongst clinicians
20 in the context of VC's case specifically, but is a wider
21 discourse?
22 **A.** Yes.
23 **Q.** By that wider discourse and the direction of travel that
24 you refer to, are you including within that politicians,
25 the Government, policymakers, the Royal College,

1 commentators, charities, and pressure groups?
2 **A.** Yes, very much so.
3 **Q.** All of the above or some of the above?
4 **A.** All of the above.
5 **Q.** You say in this paragraph in the fourth line:
6 "There was constant discussion about reform of the
7 Mental Health Act to reduce coercion as a result."
8 Are you talking there about constant discussion
9 about reform of the Mental Health Act 1983?
10 **A.** Yes.
11 **Q.** Are you referring to what eventually became the Mental
12 Health Act 2025?
13 **A.** Yes.
14 **Q.** Are you referring to a discussion which started with
15 Professor Sir Simon Wessely's report?
16 **A.** I believe so, otherwise I was not aware of that at the
17 time, the report itself and the details of it.
18 **Q.** Okay. His report: Modernising the Mental Health Act:
19 increasing choice, reducing compulsion, that may tell us
20 enough about the contents of the report but are you
21 essentially saying that that's the climate in which you
22 and other clinicians were operating in 2022?
23 **A.** Yes, that and a significant lack of capacity in
24 services.
25 **Q.** You say in your witness statement that the decision on

1 an enforced depot and the use of a CTO made at the time
2 was not unreasonable, but on long reflection and mature
3 consideration, you think it was wrong?
4 **A.** Yes.
5 **Q.** Do I understand from that that you did not think, at the
6 time, that Dr Thangavelu's decision was wrong?
7 **A.** No, I -- in fact, I-- at the time, I agreed with it,
8 after a multiple discussions with him about the -- the
9 ethics of it and the application of the Mental Health
10 Act.
11 **Q.** Does your reflection now suggest that this was an edge
12 case or an edge decision where different clinicians may
13 have made different decisions?
14 **A.** Very much so and I think that's what it felt like at the
15 time as well. That this was, yeah, very much an edge
16 case and we fell on one side of it. The opposite side
17 could have been argued, and in retrospect I think we
18 should have done that, but I do not think the original
19 decision was unreasonable in any way. And it's very
20 hard to disentangle myself from the events that occurred
21 subsequently. And I think I even say in the statement
22 that had they not occurred, his case was so common that
23 I don't think there would have been any scrutiny
24 whatsoever about it.
25 **Q.** Thank you. Lastly, you say in your statement that you

1 have concerns about how the Mental Health Act 2025,
2 which has now been enacted, but the relevant provisions
3 of which have not been brought into force, is to
4 operate. That's correct?
5 **A.** Yes.
6 **Q.** Can you summarise those concerns in relation to in
7 particular to the reduction of the availability of
8 coercive measures and the advancement of the principle
9 of patient autonomy that the 2025 Act carries into
10 effect?
11 **A.** Yes. So in brief, all of the things, all of the aspects
12 that reduce the potential for coercion. However,
13 specifically, I think the change to have patients who
14 have capacity not being allowed to be treated against
15 their will until a second opinion doctor comes to assess
16 is particularly problematic, given the current wait
17 times between putting an application for a second
18 opinion doctor and them actually coming to give the
19 assessment, which I would approximate to be between two
20 and six months currently. That would lead to massive
21 delays in care and probably lead to reduced coercion.
22 I think -- well, I know Dr Thangavelu's statement is
23 that he believed VC had capacity to make decisions
24 regarding his medication, and if that was in effect,
25 there would be no recourse beyond a SOAD to actually

1 have in force that depot, whereas at that time we did
2 have that power under the Mental Health Act. I think
3 the reduction in --
4 **Q.** Just stopping you there, just to break that last answer
5 down. Patients who have capacity will not be allowed to
6 be treated against their will until a second opinion
7 doctor assess them. You said that the SOAD wait time is
8 six months currently?
9 **A.** Between two and six months would be how I would
10 approximate it, based on my current experience.
11 **Q.** You say that would lead to massive delays in care and
12 lead to reduced coercion. Can you explain the latter
13 part of that, ie, reduced coercion?
14 **A.** So I think cases such as this where it's an edge case,
15 people are unlikely to maintain a patient, or possibly
16 even unlikely to be able to even justify detaining
17 patients on a ward for that long without what would be
18 considered appropriate treatment, until that SOAD can be
19 established.
20 **Q.** I think you were moving to a further point about the
21 Mental Health Act 2025.
22 **A.** I was. So the duration and time in which patients can
23 be treated against their will being reduced from
24 three months to two months I think is going to be
25 a problem. I think the change to nominated person

1 rather than the nearest relative is likely to cause
2 significant issues, because patients are going to be
3 incentivised to nominate people as their nominated
4 person who is likely to disagree with their care and
5 therefore either prevent appropriate treatment or put in
6 nearest nominated person discharge requests, which would
7 require much increased workload for the barring -- the
8 barring reports that RCs would have to do, and
9 potentially even displacement alongside.
10 I think some of the changes to the tribunals will be
11 problematic, as well, just within the increased volume
12 of tribunals that will be required.
13 **MR BEER:** Thank you very much.
14 **Questioned by THE CHAIR**
15 **THE CHAIR:** Yes, just in relation to that. You've
16 identified in your evidence, and also in your statement,
17 what you see as, I think, the two incompatible elements:
18 one the autonomy of the patient and the other is
19 coercion.
20 **A.** Yes.
21 **THE CHAIR:** Am I right in thinking that that really only
22 occurs in these cases of severe mental illness like
23 where there's a risk of violence?
24 **A.** Or risk to the patient themselves.
25 **THE CHAIR:** Or risk to the patient themselves, yes. I mean,

1 the violence could be to the patient themselves, but it
2 would be for public protection reasons or patient
3 protection reasons that you would get to that dilemma,
4 if I can put it that way.
5 **A.** That is the most pointed example, yes.
6 **THE CHAIR:** For the most part, it wouldn't apply to those
7 with less serious mental illness where there'd been no
8 history of violence or, for example I know that the
9 Mental Health Act specifically, for example, deals with
10 people with autism and other mental disorders, but as
11 far as schizophrenia is concerned, and cases where there
12 is a history and/or risk of violence, that's when you
13 come up against this difficulty; am I right in thinking
14 that?
15 **A.** Mostly, yeah, yes.
16 **THE CHAIR:** Mostly?
17 **A.** Yes.
18 **THE CHAIR:** Yes, thank you.
19 Right, well, we'll finish there now, and I just want
20 to remind everybody 9.15 tomorrow, because we have
21 a witness in a different timezone. Thank you.
22 **(4.47 pm)**
23 **(The hearing adjourned until 9.15 am the following day)**
24
25

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