Wednesday, 13 May 2025

(9.15 am)

(Proceedings delayed)

(9.17 am)

THE CHAIR: Yes, Mr Carr.

MR CARR: Yes. May I call, please, Dr Karthik Thangavelu?

THE CHAIR: Yes. Good morning.

DR KARTHIK THANGAVELU (affirmed)

Questioned by MR CARR

MR CARR: Dr Thangavelu, you have prepared a witness statement for this Inquiry dated 28 December 2025.

A. That's correct.

Q. Is that statement true to your best knowledge and belief?

A. That's correct.

Q. You're a Consultant Psychiatrist employed by the Nottinghamshire Healthcare NHS Foundation Trust?

A. Yes.

Q. You're currently on a sabbatical.

A. That's correct.

Q. At the time of VC's fourth admission to the Redwood ward in February 2022, a Section 2 detention, you were a consultant working on that ward.

A. That's correct.

Q. You were VC's Responsible Clinician --

A. I was.

Q. -- for the purposes of that admission.

A. Yes.

Q. Your colleague, Dr Gibson, who was one of your trainees at the time, he gave evidence to this Inquiry yesterday; did you see that evidence?

A. I did see most of it and I read the transcript.

Q. So far as your direct involvement during VC's fourth admission you attended, didn't you, MDTs on 31 January 2022, 7 February, 14 February, and 21 February?

A. That's correct, yes.

Q. You attended two ward reviews where VC would have been present, 3 February and 10 February?

A. And also the 24th.

Q. That was a discharge meeting, wasn't it, that was akin to a ward review.

A. Yes, that's correct.

Q. Ultimately, the decision you made, the decision that was taken, was to discharge VC into the community on oral medication --

A. Yes.

Q. -- even though, to use your words, you were advocating for depot during the admission?

A. Yes.

Q. The position was, as you've set out in your statement, he would not agree to depot, that's VC, and you did not think taking coercive steps under the Mental Health Act to enforce depot or use a CTO, Community Treatment Order, that you didn't think those steps were justified?

A. No, the CTO would have come later on if he had gone on to Section 3, but at that stage it was the depot.

Q. Yes. And you didn't think you were able to convert the Section 2 admission to a Section 3 for the purposes of putting in place a CTO to enforce depot?

A. It wouldn't be lawful just for those purposes, but Section 2 patients could be converted to section 3, if necessary.

Q. Could be, did you say?

A. If they met the criteria for Section 3, Section 2 patients can be placed under Section 3. But not purely for the purpose of getting them onto a CTO.

Q. I'm going to explore, in your statement -- and it's a lengthy statement -- you set out the various reasons why you didn't feel you could take coercive steps and I'm going to go through those.

If we can start by looking at the context the immediate context of the fourth admission, and it's document -- it's a Nottingham City Council document, NOCC0000043, and this is the AMHP report from the Mental

Health Act Assessment 28 January 2022, and if we go to page 5 of that document, please, we have the comments here of the assessing doctors, and it's the fourth paragraph on that page, starting with "Dr Lomas and Dr Manzar", both of whom, as is set out here, were previously acquainted with VC, and what is set out is second sentence:

"... both felt that [VC] needs to be in hospital to manage his mental health. ... risk to others is high ... although during assessment he does not appear overly psychotic they believed that he was masking his symptoms and was very guarded with what he was willing to share. Community treatment is no longer a viable option as [VC] [was] ... not fully engaging and is refusing to meet in a more private place so that fuller discussions can be made."

So in light of what is being set out by the doctors there, in terms of the complexity of the presentation, you've got somebody who the doctors believe is masking psychotic symptoms.

A. Yes.

Q. And who presents as with a high risk to others?

A. Yes.

Q. And is no longer safe in the community?

A. That's correct, yes.

Q. So the purposes of the admission to Redwood was to improve that situation, to change that situation?
A. Yes, for assessment to establish if there is anything going on.
Q. If we can start looking, then, at some of the reasons why ultimately VC was not discharged on depot, a point you make in your statement -- and it's page 55 of your statement, paragraphs 175 -- it will come up on the screen in a moment. You say in your statement:
"He was [referring to VC, throughout the] (... period of this admission) he was fully compliant with the medications."
A. That's correct.
Q. During previous admissions, VC had also been fully compliant, hadn't he? This was the fourth admission and during the first, second and third he had been compliant or become compliant with medication in those admissions?
A. That's my understanding, yes.
Q. So by the stage of this fourth admission, it was clear, wasn't it, or it should be clear, that compliance as an inpatient by VC was not translating to compliance in the community?
A. I would say certainly there were periods where that did not translate into a full compliance in the community. However, it hasn't been a consistent picture throughout

his history. There were periods, certainly between the first and second admission. From what I understood, there were a couple of weeks where he became non-compliant from the period from the second admission to the third admission.
As far as the Community Team was concerned, even though they suspected non-compliance, I don't think there was anything concrete to say that he had become non-compliant until August of 2021. I mean, that was the picture I gleaned from looking through his notes. But certainly between the third admission and the fourth admission, the picture was again not consistent or clearer. I mean, I certainly looked for evidence of it, both from his care coordinator, also looking through his records. I mean, it certainly felt like there was a speculation that he might have become non-compliant.
Q. We'll come on to --
A. There wasn't any --
Q. We're going to go through some of the entries in the history on the issue of non-concordance, but as a broad proposition, this was a fourth admission in the space of under two years, wasn't it?
A. That's correct.
Q. The three previous admissions, VC had been compliant whilst an inpatient?

A. Yes.
Q. And in the community he had not been compliant.
A. At times, yes.
Q. Dealing with the issue of non-concordance, and you've just referred to it in your previous answer, what you or how you describe it in your witness statement, it's page 56 at paragraph 183, you say:
"... it was suggested that the reason for relapse was a possible non-concordance all (although this was ... disputed by VC)."
And in paragraph 184 you say:
"[You] ... made every attempt to establish evidence for non-compliance in the months preceding this admission ..."
And you couldn't conclude that relapse is really due to non-compliance.
When you refer to making every attempt to establish evidence, was that a matter of going through the records and looking at what patterns existed?
A. That's correct, but also trying to correlate that with the history from VC himself and his care coordinator.
Q. So far as the conclusion you reach, is it right to say, it's your paragraph 393, page 117 of the statement, there you describe VC as "generally concordant". Was that the conclusion you reached, having looked at the

records?
A. Sorry, I'm just trying to look for the line, actually.
Q. 393.
A. Yes, sorry.
Q. If we can look, please, at an interview that you gave for the purposes of an internal review, it's NHFT0004709. And then page 3 of that document. This on the issue of medication concordance. First paragraph on that page, second sentence:
"VC gave a plausible explanation ... said he was taking it [that's his medication] once a day not realising a 10mg tablet not 20mg -- didn't seem deliberately untruthful and sounded plausible."
A. That's correct.
Q. Sorry, go on?
A. That's correct, yes.
Q. If we can put the RiO records on, and I'm going to take you through some of the entries in the records, Dr Thangavelu, dealing with the issue of concordance. First, page NHFT0000168 page 58. This is a Mental Health Act Assessment. This is 14 July 2020, so it's ahead of VC's second admission. The fourth paragraph on that page:
"... clear from [the] ... assessment [that day] that [VC] had decided to stop taking his medication 2 weeks

after his discharge from hospital. He believed that he was well ..."

This is fairly early on, isn't it? You've got the first admission, and two weeks after being discharged from the first admission on medication there is clear evidence of non-concordance.

A. Certainly from that record, he had stopped his medication and I believe that information probably came from him himself and it is one of the most common things you see after the first episode or the first admission. When people get well, they wanted to almost experiment with coming off the medication, yes.

Q. So that's the period following the first admission.

Then we have the second admission. If we go to page 79 of the records, please. This is during the second admission, these notes are from 21 July, it's a ward review led by Dr Seedat. If we go to the final paragraph on that page under the heading "Patient comments", about halfway down in that paragraph there is a reference to [VC] saying he:

"... recognises the importance of continuing the medication after discharge more".

Do you see that?

A. Yes.

Q. Then towards the bottom of the page it refers to

Dr Seedat explaining to [VC]:

"... that it was his view that if he had not stopped taking his medication, he probably would not be here again. [VC] understands that he must take his medication regularly."

A. Yes, I can see that, yes.

Q. That position there, similar, really, isn't it, to what you believed during your admission: you believed that you had a commitment from VC to continue taking medication post-discharge?

A. There are parallels, and we sometimes have these scenarios repeated many, many times, actually, even with people who had been through the condition for several years.

Q. Well, following the second period of detention, and notwithstanding what is set out in this note, there's almost, aren't there, immediate grounds for concern as to VC's medication concordance with the Crisis Team.

So if we go to page 119, this is an entry from 1 August 2020, Clive Chimbi from the Crisis Team, halfway down the page, we have the paragraph that starts:

"When we arrived this evening, he still had not taken his medications."

This is immediately following the second admission when he's been told that he's become unwell again as a

result of not taking medication, has indicated that he understands the need to take it and straightforward that there are issues with concordance, aren't there?

A. It would be hard to draw some firm conclusions based on just that one observation. I mean, it's possible that he was trying to be evasive by stating that he couldn't find them, but equally it could well be that he had misplaced.

I mean, it's again one of those things where you don't want to jump into a conclusion straight away. I mean, it's possible that he, you know, he maybe he didn't want to take it on that day, perhaps. I mean, these medications can be quite powerful, obviously these are psychotropic medications that hit the brain, and can cause all sorts of side effects as well, actually, and it could well be that at that particular point in time he may not have felt inclined to take it then and there -- *(overspeaking)* -- it could be --

Q. A patient not wanting to take medication, that aversion to taking medication as is required to stay well and to reduce risks, that is a concern, isn't it, as to concordance?

A. I don't know if we can call that as an aversion. I mean, he's not expressing anything there to say --

Q. I appreciate that, but you said maybe he didn't want to

take medication that day, and I'm saying that you're speculating that that might be the reason. If that was the reason, if that was the aversion, then that would not be a matter of reassurance, would it? It would create a concern as to concordance?

A. I mean, again, we are speculating a number of possible scenarios. You know, we won't know for sure what ultimately happened --

Q. Shall we --

A. Unless he.

Q. Shall we look through the records, because that's just one of the crisis appointments. So shall we look through the others? Page 122, Crisis visit, 3 August, top of the page. Crisis come. And the purpose of their visit is to ensure concordance, isn't it? VC says, it's the second line:

"... said he's already taken his morning meds. He showed me the meds with evidence of tablets having been dispensed."

A. Yes.

Q. Do you have that?

A. Yes.

Q. But he's told by the Crisis worker, next sentence:

"... we need to do medication concordance with him."

A. So clearly on this occasion it seems to suggest that the

tablets have been dispensed. By that, I take it that the tablets have been taken.

Q. Well, the point I was taking you to is the Crisis workers are trying to do medication concordance. They come. VC is told that they need to do medication concordance, and if we look at page 123, this is the 4 August entry, again, when he is visited, third paragraph down:

"He [states] ... that [he's] ... already taken [the] medication ..."

So again, not allowing for the Crisis Team to ensure concordance.

A. Yes. Again, I don't know if he was challenged on that occasion as to why he didn't wait for them, and whether he was asked to show his supply to just check if the right numbers are there to match up with what -- (overspeaking) --

Q. So it's potentially explicable, but what we're doing here is we're looking, because you said you would have looked for the evidence as to concordance, and so we're seeing something of a pattern emerging.

If we go to page 136, please. And this is later in the year. It's the middle entry, 6 November 2020 by Gary Carter. He's part of the EIP team. And in the middle of the note on that page he writes:

"I took with me one months supply of medication because they were due (overdue indeed) [VC] said he had about 10 left."

So again, this is another clear indication, isn't it, of non-concordance, at least ten days' non-concordance?

A. I mean, I'm not dismissing the possibility of non-concordance, but in mental health work, this is not an unusual scenario. I've been to many home visits where there would be medications, a strip of medications half taken, that might have been from some time ago, because there's always a bit of an overlap between so when the prescription is written for, when the pharmacy have issued it, and when the CPN takes them. I mean, it's possible that he was untruthful, that's very much a possibility.

Q. Yes. There are perhaps a number of possibilities, but the strong indication from this is that VC is not concordant, because he is supposed to have run out of medication. The EIP team are dealing with prescriptions. His prescription is overdue. The fact he's still got ten tablets left indicates that he is not being concordant; he's not been taking the medication he should have.

A. It's very much a possibility, yes. I mean, I, again,

the confirmatory evidence would be to just make sure that is the number adding up? So I mean that's what we do. You ask them to show the pack, you do a pill count and see how many days have been missing; does it tally with the last dispensing? So that would be the confirmatory test but it's quite possible that he wasn't complying as he should have been.

Q. If we look, please, take this document down, if we look at the Nottingham City Council document NOCC0000050. This is the AMHP report for the 3 September assessment by Amie Staples. If we go, please, to page 3 of this report, we can see the final four lines of that first paragraph:

"There was a bag of unused medication dating back to February 2021."

A. Yes.

Q. Now that's in circumstances where VC had told a doctor, Dr Sasidharan, on 10 August 2021, that he was compliant with his medications. If there is a bag of unused medication going back to February 2021, again this is further strong evidence, isn't it, that he is not concordant in the community?

A. I mean this sort of evidence is what we would want to see. It points towards -- I mean to me it means two things, actually. So one is -- so if you say "bag of

unused medication dating back to February 2021", does that mean -- sorry, I don't know when this was picked up, but I think this was probably bit late, I think I remember seeing --

Q. 3 September, this report is for.

A. Yes, so six, seven months' worth of medication. So that would be, if it was 10 milligrams or 20 milligrams of aripiprazole that he was on, it should be 200 tablets actually, if it is 20 milligrams or 400.

If we have that amount of medication, and clearly he hadn't taken from February till August of that year, but certainly this is pointing towards the pattern of non-concordance. But I would be interested to know why was it? Was it because he was taking half the dose himself without telling the team? Or was he just taking it a bit patchy? Because we know sometimes patients take four days, five days, rather than seven days. There could be a number of possibilities.

Q. Did you --

A. But also it was --

Q. When you --

A. Sorry.

Q. When you were looking into, when you were looking for evidence of concordance, did you see this report and read it?

A. I didn't see that. I think it's the AMHP report you said --
Q. If --
A. -- from 2021, but I know that as part of the inquest, this came up before, I think.
Q. If we go back to the RiO records, page 199, and this is an entry from 19 November 2021, and this touches on the issue of 10 milligrams versus 20 milligrams, one of the explanations that was given to you.
A. Yes.
Q. This is an entry by Claudia Birtles, his CCO. States:

"He had been taking 10mg OD since the admission. Aware that he needs to take 20mg OD. Said he would do so."

So there's no suggestion there, is there, that he was confused or that he thought he should be taking ten milligrams; it says instead he is aware that he needs to take 20 milligrams and there's a commitment by him to do so from that point.
A. That's true, that's true. It seems like there was something going on there about what he might want to take as opposed to what has been prescribed. I mean that certainly seems to be, you know, what has been or may have been happening, from looking at this.
Q. If we are on the same page, and if we go further down to

the conversation with Celeste, that's VC's mum, and this deals with the issue of engagement with appointments. There, it refers to a conversation with VC over the weekend and the importance of attending outpatient appointments being reiterated. VC told his mum he had a deadline that week, would contact his CCO to request the appointment to be rearranged.

Now, one of the points you make in your statement was that while there was confusion over what address VC was living at and that might explain why he wasn't attending appointments, but from this entry here, it seems clear, doesn't it, he's aware that he's missing appointments and it's nothing to do with post going missing.
A. No, I think from what I looked at, in terms of the confusion over address, I don't think every missed appointment could have been explained through that. What I was inferring was certainly there was some confusion over the address, and I know the team tried to see him at this stated home address couple of times when he was not there.

So what I was inferring there was -- so the bigger picture might be that, say, he missed two out of three appointments or two out of five appointments, but I was just questioning myself, actually, more than anything

else, as to could it be that some of this be attributed to the confusion over the address, which is a very realistic prospect, if people are turning up at the wrong address, he probably wouldn't have known that, actually?
Q. Well, that's one -- *(overspeaking)*. If we look at page 201 where VC is asked why he has missed appointments with Dr Lloyd and whether it's because he didn't want to see the EIP team, he said that wasn't the case, but again, he doesn't suggest, does he "Well, I wanted to go to the appointment, but there's some issue with my address" or "You've gone to the wrong place" or "I didn't receive the appointment letter"?
A. Yes, I can see that.
Q. So the suggestion -- and you go to some lengths to outline this in your statement -- the suggestion that the reason for non-engagement was because of confusion as to VC's address. It doesn't seem to match up to the records, does it?
A. I don't think it doesn't match up entirely because, as I've said in the document, I mean, I wasn't categorically saying well, that was the only reason why VC was missing appointments, but when there is a clear evidence to say that there was a confusion over the address, it is a very realistic prospect that at least

some of those appointments could be due to the address issue itself. I mean, that can happen to any of us, and particularly for students who may not be updating the address of the GP appointments, and so on.

So -- and I can't explain why that may not be a viable explanation at least to a degree, actually. I mean clearly there are two homes. It's to the wrong address.
Q. Can we look at the immediate context just prior to your admission. So this is entries in December 2021 and January 2022, page 202 of the RiO records. It's that top entry at that page. The date is 17 December. That is the last entry of VC collecting his medication. He's noticed to be fixed in his staring, has a hostile edge to him, and walks away mid-conversation.

But again, this is the last medication pick-up. Then on any view, early 2022, he's going to be non-concordant, isn't he?
A. I think what I observed from looking through his notes, when -- so the context in which this was happening was I asked -- well, Ms Birtles was suggesting that he was non-compliant. I mean, quite frankly, I mean, she has known the pattern for a long time. And VC immediately responded to say that's incorrect, and he was only referring to just the two months prior to the fourth

admission, to my ward since discharge from the Priory.
So when I did a quick look through RiO, I mean, I think in that conversation it was also coming out that there was a period soon after discharge where he was allegedly taking 10 milligrams when he should have been taking 20 milligrams, and he was saying that himself. And I think Ms Birtles also suggested that was the case.
So when I looked at it, and I would have spent probably a few minutes looking through that, just I did a quick search and it showed that he had collected two 28-day supply between November and January before the Crisis Team took over. I mean, I think probably the dates seemed to match if you account for the fact that he had been taking 10 milligrams until Ms Birtles reminded him to take the 20, and his explanation at that point was: "I thought each tablet was a 20 milligram tablet until you told me that it was 10 milligrams."
That's how it panned out, actually. I mean, I couldn't decide one way or the other. It's quite possible that he had been taking 10 milligrams and what I would have liked to see, or liked VC to have done, is to just tell the team "Look, I don't like the 20 milligrams, would you consider getting me on the 10 milligrams?" And that's what I would have liked to see, but just based on the evidence just to answer the

question around the tallying of the numbers.

Q. On the point of 10 milligrams and this explanation, we'll come in a few moments to when this explanation emerges, but VC's medication had been increased from ten to 15 milligrams on 10 November 2020, hadn't it, and then from 15 milligrams to 20 milligrams on 1 February 2021. So wouldn't it be really completely implausible that he was in any real doubt up to a year later, or several months later, as to what the correct dosage of his medication was?

A. I think he probably knew that the prescribed dose was 20 milligrams, but it might be that he didn't want to take the 20 milligrams because it might not have suited him, and it might be that the 10 milligrams was much more suiting to him. I mean, I'm, again -- I'm --

Q. If that was the explanation --

A. -- speculating --

Q. -- Dr Thangavelu, if that was the explanation, that he, despite being prescribed 20 milligrams, he didn't want to take it because it was too much and he was taking 10 milligrams, that would be non-concordance, wouldn't it? It would be him not complying with his prescription.

A. It would be non-concordance. However, what I would say is from a psychopharmacology point of view, it's well

established, even by the manufacturers themselves, that 20 milligrams and 30 milligrams is no more effective than 10 milligrams. In fact, 10 milligrams is supposed to be the optimal dose because it blocks 60-80% of the dopamine receptor and anything above 10 milligrams goes towards side effects. I mean, that's an established fact -- *(overspeaking)* --

Q. Is 30 milligrams the therapeutic dose, isn't that where the therapeutic dose begins?

A. No, and I'm --

Q. Dr Thangavelu, if there's no difference between, or no benefit to 20 milligrams or 30 milligrams above 10 milligrams then why do you prescribe anybody 20 milligrams?

A. That is a very good question. That's unfortunately how --

Q. -- *(overspeaking)* --

A. The answer is that's unfortunately how the drug companies kind of manufacture and market because for some people, 20 milligrams might be needed, and for some people 30 might be needed. But 10 milligrams --

Q. But I thought you said -- sorry, just so I'm following the thread of this answer, I thought the answer you gave a few moments ago was that there's no real benefit above 10 milligrams, for 20 milligrams or 30 milligrams, and

when I've asked you why prescribe 20 milligrams you've referred to the drug company.
So is this some kind of profit-making ruse --

A. No.

Q. -- by pharmaceutical companies?

A. Not at all. So all medications have a dose range, all medications have a dose range, and that's borne out of kind of the phased trials. So every medication has got a dose range but that doesn't mean that the top-most dose is better than the mid-dose or the lower dose. What we know, with aripiprazole, particularly, is -- I mean if you read the product characteristic of aripiprazole from Otsuka pharmacy it would say, the 20 and the 30 do not have a great advantage over 10 milligrams.
So --

Q. We're probably going down a slightly different avenue but --

A. Sorry.

Q. Is the bottom line this: if VC has been prescribed 20 milligrams he's been told take 20 milligrams, he's been reminded by his care coordinator that that's the correct dosage and he's not doing so, he is not concordant. Do you accept that?

A. I agree, I agree, I -- yeah.

Q. Thank you. Can we deal with the issue of insight, please. Your witness statement, page 68, paragraph 217, Dr Thangavelu. In respect of VC's insight you describe that "he had reasonable levels of insight into the nature of his symptoms, disorder and treatment."

Do you see that, at the bottom of that paragraph on the screen? Do you have that.

A. Yes, yes.

Q. And later in your statement, it's page 103, paragraph 349, you describe how VC "felt aggrieved by the EIP team having a low threshold to admit him to hospital when he felt it was not necessary".

A. That's correct.

Q. So you're describing on the one hand somebody with the reasonable levels of insight, and also his feelings of aggravation because he doesn't accept that he should have been in hospital on the occasions that he had been.

A. I think my understanding from talking to him was that he felt the admissions were not necessary. Again, I'm only kind of reflecting on what I saw.

Q. Would it be helpful to have the note from your ward review? We can put that up. We can look at the 10 February one, page 238 [NHFT0000168]. And that third paragraph from the bottom. I interrupted you, but this is where you're having a discussion on this point. And

this is where VC is describing:

"... that he had 'one recognised episode' which was the first admission and that [one] was 'totally rational' [...] but the following ones were not rational."

So he's accepting, and it's written:

"He accepts ... his behaviour leading up to the first admission was uncharacteristic but not prior to the following episodes as the experiences never reappeared."

A. Yes. That's what he was saying, yes.

Q. That -- or is that consistent with reasonable levels of insight, given what you know about the second admission, that's VC stopping taking his medication, assaulting a neighbour, barging into the flat, having to be restrained. Third admission when he presents with delusions as to medical practitioners conspiring against him, and violently and brutally attacks police officers.

Given the background to those two detentions, is VC's description here of the two later admissions being irrational, does that show good insight?

A. What I would say is I wasn't just basing it on this one particular discussion. I think, on this occasion, I mean this, I remember, was a very long meeting actually, we discussed several things on that day. But

say, for example, towards I think either the meeting before then that was probably the 3rd of February, I think he was still touching upon some experiences, and again towards the end on the 24th he was talking about experiences which he's had before the third admission, so --

Q. Do you want to go to that note? Do you want me to put it on screen? It's page NHFT0000168 page 226. And the first paragraph when he's describing the last admission, you can see it in the second sentence:

"He said that during the last admission, it was to do with hospital disagreement as the hospital wanted to continue the treatment."

You said you weren't basing it on one discussion. This is a second discussion I'm taking you to, and you only saw him three times. Does that entry there, does that indicate reasonable or good insight?

A. I was referring to his expression of symptoms rather than the admission when he clearly was not happy about the third admission, and when he was discussing with me on the 10th, I think he used the word, "first episode" and I think there was some merit to it in that the two admissions, the first two admissions happened in very quick succession, and it's most probable that it was part of one episode. But that aside, what I was

mentioning about the insight -- I mean, again, without going too much into the details, the way we understand insight, it's not an all-or-none phenomena, most psychiatrists would say that. It's never to be seen as an all-or-none phenomena, and it's not static.

There are three dimensions to it. The first one is recognition of symptoms; the second one is perhaps linking those symptoms to some of the behaviour; and the third level of insight is what we call as the attribution to a condition. And most patients with mental problems actually fail at the third dimension of attributing it to an illness, or a diagnosis or a label, whichever way you want to call it, because their way of making sense of their experiences may not be matching with a biomedical model or psychological model, and that is the most common phenomena that you see, when you are trying to test for people's insight. Again, insight is not something you can easily test by just asking a set of questions, but when you have a conversation --

Q. Dr Gibson gave evidence yesterday as to the limited information available to the discipline of psychiatry, but when considering insight, to what extent would you take into account a patient's description of previous episodes? Whether they accepted that they were ill, whether they were able accurately to describe

circumstances leading to an admission?
A. I think that's a valid point and I think that's something I would want to see in patients when discussing about the episodes. But again, it's not something that you would see kind of clear-cut in patients. I mean, it may be difficult, if, you know, if you haven't spoken to somebody who had been through this before, but the way it would come out is usually in trickles actually. So they may be holding back their guard about admitting that they have been unwell when you ask them a direct question, but in other conversations they might say "Yeah, the voices were bothering me," and so it depends to a somewhat --
Q. Focusing on the conversations that you had and just considering the evidence base that was available to you as to insight, in circumstances where VC was describing his last admission as being to do with a hospital disagreement, when in fact it involved him assaulting police officers in the way that he did, and for him to suggest that there was no rational reason for that admission, do you consider that to be consistent with good insight or poor insight, or do you say -- *(overspeaking)* --
A. That particular part doesn't really add up to the argument for good insight. Certainly I wouldn't say

that. But say, for example, on the 24th he was able to touch upon the other psychotic phenomena that he was experiencing which was more around the technology interference into his brain. That again showed that he was able to recognise some sort of experience that he was going through, but he may not want to call it as psychosis. And that's not unusual at all, when you talk to somebody. Particularly with psychosis, you do have these expressions of symptoms, but when you kind of try and push into that into "So does that mean that -- or would you agree that is a symptom of schizophrenia?", they just stop at that point, or retract a bit, for a number of reasons. But that doesn't make that -- make them completely insightless, because I've seen --
Q. Can we look at Cygnet document 11, [CYGN0000011], please, and this is a document from VC's third admission. If we go to page 5, this is a report from Dr Shoilekova who was the Responsible Clinician whilst VC was at Cygnet during that third admission. This is from September 2021, 17 September, bottom box on that page:

"[VC] does not believe he suffers from mental disorder and therefore he is adamant he does not need any treatment for that."

A. Yes.

Q. Dr Shoilekova -- and this is borne out in the Cygnet notes -- her view and view of her team was that VC completely lacked insight. Was there any real difference between VC's acknowledgement of mental health problems then and during your admission?
A. I think so. I know, certainly before the admission to the Cygnet, he was floridly psychotic, and it was quite evident that he lacked insight, and I have no doubt over it, actually. But the difference when he came to Redwood 1 was he was less symptomatic or nearly asymptomatic.

He probably did have some residual symptoms prior to the fourth admission, as he would commonly see, because the illness rarely completely remits. It's only a third of people who have complete symptom remission.

But certainly at that point, I agree that he probably had a total lack of insight, but as I was explaining earlier, insight is not to be seen as all or none all the time, it's very fluid, it's not static. There are so many factors which play up in the gaining back of insight.
Q. Did you conclude that VC had a greater appreciation or that he did believe he suffered from a mental disorder in contrast to what Dr Shoilekova's written in that first bullet point?

A. I couldn't tell if he had greater insight in that dimension because that's the dimension that most people will struggle to demonstrate a good insight, the disorder part of it, actually, or the diagnosis part of it.

But where people gain insight often, when they come out of the acute episode, is the ability to recognise symptoms, which they may be able to pin down as the one that probably got them into difficulties, interpersonal difficulties, or intrapersonal difficulties, it may be that they deeply suffered within themselves. It might have made them feel anxious. It might have made them to act out.

So it's that recognition that usually comes out, and when I spoke to VC on the 10th, I was able to see that although it was mainly around the first episode as he put it, there was evidence for it, actually. I couldn't completely dismiss that.

So -- and that's what I was trying to explain --
Q. -- *(overspeaking)* -- was there evidence that he acknowledged or recognised that he had a mental disorder or he suffered one beyond that first rational admission, as he described it?
A. I don't think we progressed too much into that particular topic alone. But the discussion -- and as

I said, that meeting was very long, we discussed several things on that day --
Q. Can we deal with a different issue, then.
A. Okay.
Q. And I've taken you to the part of your witness statement where you describe VC being aggrieved that the EIP team had a low threshold to admit him, and in your witness statement it's paragraph 329, page 98, when you're describing VC's engagement with the Crisis Team, immediately prior to the fourth admission, you say:
"He only missed one of the appointments out of nine ... despite his efforts he felt the mental health services reneged upon the agreement ..."
Was that a view you were sympathetic to? Did you think VC was reasonable in that view?
A. I mean I don't know if I would use the word "sympathetic" but I was empathetic, actually, towards him. I was putting myself into his shoes, rightly or wrongly. I mean, that's what we do. And I was aware that he was probably in the middle of exams, and he might have been under a lot of stress and getting somebody for daily visits when you have -- I know he was also working I think at the time, actually, in a warehouse. So I think he was managing his exams, the University side of things, the job, and obviously he

has -- he had to agree to come and meet people on a daily basis.
Q. Was it your view that he had engaged with the Crisis Team and that the Crisis Team or EIP team had reneged on the agreement?
A. He only engaged at the superficial level. Yeah, that was my impression. I didn't think that he engaged in any, you know, deep, meaningful way. He wouldn't sit and have a chat. He would come and have -- just put a tablet in the mouth and leave. I mean the way I saw VC was he was very much a matter-of-fact person. He -- I didn't see any psychosis(?) in him --
Q. Just focusing on the position of engagement because the position was that there had been a Mental Health Act assessment on 19 January, and this is the one where Dr Skelton was at, where it was decided that VC would not be detained and there was a plan of community treatment. We can see this, this is the Nottingham City Council document NOCC0000040, page 5. It's at the bottom of this page under the heading "Discussion with [VC]":
"[VC] accepted the plan of community treatment. [VC] advised he would prefer for these community appointments to take place not at his home address."
It sounds like there was some debate about that:

"... [But] it was concluded that as long as he engages with the crisis team the plan could be trialled. Yes? So that was the plan that was put in place as a basis for him not being detained. And then if we look at the subsequent AMHP report, it's Nottingham City Council document NOCC0000043. And if we go, please, to page 5, and again, we've looked at this before but now we'll go to the third paragraph, three lines down:
"Dr Lomas again explained that he has been seen by at least 7 different professionals in the past 9 days and 5 of them could not be certain that he had taken his medication. [He] did not fully engage in the assessment and when questions he would state that this was not relevant to this time now."
And you'd obviously reviewed the notes, but there's only two occasions noted where it's clear that he's consumed medication, isn't it, on those Crisis appointments?
A. Um --
Q. Twice he doesn't attend, once he's seen taking something from his mouth and putting it in the bin, he walks off, he doesn't engage.
A. The engagement was superficial. I mean, that was clear. He wasn't staying back to have a chat with them, despite their attempts. And from --

Q. Would that not be a red flag for insight, then? If you have a patient in front of you who is saying he's aggrieved by the EIP team, he feels that health professionals have reneged on an agreement; would that not show a lack of insight where there's a clear plan for engage and it's clear on the documents that he's not complied?
A. Again, I'm not trying to defend his position at all here, but I don't know how much of this was discussed with him. And you do have patients who, I've certainly seen patients who would say, "Well you only asked me to come and meet you and take the tablet in front of you, and I did that in front of you. What more do you want?"
It's hard for me to -- and again, I am kind of -- I wasn't too sure myself, actually, as to what really went on there. Did he actually not take the medication at all? Or did the Crisis Team get wrong? I mean, it was so ambiguous because the way the records were documented was that he'd put the tablet in his mouth but he would not drink. Certainly there was, again, the incident leading to the suspected spitting of the tablet. Again, it didn't say that they clearly saw it. It was very vague and ambiguous. So when I
--(overspeaking) --
Q. Did you speak to --

A. Looked at that --
Q. -- VC about that? Did you say to him, "Well look, you're saying you feel aggrieved, but of these visits, there's two you've missed, one where you were seen taking something from your mouth and putting it in the bin, and there's only two occasions where, or it appears to be only two occasions where you put the medication in your mouth, what's going on?"
Did you ask him for an explanation, or challenge him on him feeling aggrieved, given what's recorded?
A. I think that topic was discussed either at the 72-hour review or the 3rd of February. At some point it was touched upon, and he was adamant that, well, if they had wanted me to drink, or if they -- I think the way he put it across was: "If I had known that that was going to lead to this admission, then I would have just followed what they wanted me to follow."
I mean, that's the way he put it, actually. And I know of patients who do what they call a dry swallow of tablets, and again I am not suggesting remotely that he was compliant, but it just left us -- left me questioning myself as to, well should I just dismiss all of this? Or should I --
Q. My question was more about -- right now -- I'm about to move on from this topic of insight, but it was

specifically about the question of insight, and you've got somebody who is in front of you saying that they feel aggrieved, they think the EIP have gone back on their plan, they have reneged. But it seems plain, doesn't it, from the records, that there was an agreement with VC that he was to engage as a condition of not being detained at first assessment with Dr Skelton, and then what follows is not consistent with engagement, is it?
A. No, I think that's where the confusion came about, actually. I think my reading into the notes was that the first visit or the second visit, the Crisis Team are running late. He waited and he walked off. They called him and he didn't come back. And then there was this potential spitting of tablet, which I believed that the Crisis Team on that more than him, but if we still keep that as a potential question mark, the plan continued with him, despite that --
Q. -- *(overspeaking)* -- Ultimately, were you sympathetic to his feelings of aggravation? Is that the point that you're --
A. I mean, that's --
Q. -- making? -- *(overspeaking)* --
A. -- that's his view and I --
Q. All right. Can we move on to a different topic? Can we

move on to his willingness to take oral medication, and if we put your witness statement up it's page 72, paragraph 240. You reference there the ward review 3 February 2022 and the fact that VC indicated a willingness to continue taking his medication in the form of tablets, felt it was easy to take tablets, and connected to this point -- do you have that, 240, page -- bottom of page 72 to the top of page 73.
If we go back again to the notes of the interview for the purposes of the internal investigation, NHFT0004709, page 2 of that document. At the final paragraph, it's just coming up, the final paragraph on that page, Dr Thangavelu, your note is to say that you:
"... didn't have any reason to believe VC was not being truthful in his statements ... when he said he intends to continue to comply with treatment ..."
Do you have it? Three lines from the bottom onwards.
A. Yes.
Q. It's -- that issue, your view, as part of the decision ultimately you made to discharge, his willingness to take medication and whether there were reasons to be concerned.
If we look, please, first at Cygnet document CYGN0000056. This is the decision of the Mental Health

Tribunal. So this is from back in September 2021, it's during VC's third admission. If we go to page 4 of that document, there is a section at paragraph 8 which has VC's name in bold at the beginning.
What this describes is VC representing to the tribunal, it's a little over halfway down that paragraph:
"[VC] said he would continue to take medication in the community."
Do you see that?
A. Yes, yeah.
Q. That is indicating a willingness to continue taking medication in the same way that you have noted, he represented to you a willingness to continue taking medication in the community.
But if we then look at the AMHP report, it's a Nottingham City Council document NOCC0000038. This is the report which resulted in the Section 2 during the third admission being converted to a Section 3. If we go to page 3 of that document, it's at the bottom of page 3, and this assessment is 24 September, Dr Thangavelu. So the very next day after the Mental Health Tribunal hearing there VC refers to continuing to take medication.
Bottom of that page, penultimate paragraph starts:

"[VC] said that he is not experiencing any psychosis. Says his [mental disorder] disorder stopped in early August 2021 and so he stopped his medication."

A. Yes.

Q. Then bottom line:

"[VC] said he does not have any [mental health] needs so does not require treatment. He accepts [going to the next page] treatment because he has no choice whilst on Section but doesn't see the need for it and perceives no benefit or side effects. He stated [that] if the section ends he would leave hospital and resume his university studies and not have contact with [the mental health] services."

Had you read that report at any point during your management of VC during that fourth admission?

A. I did not.

Q. It raises concern, doesn't it, looking at that, it raises concern for two reasons: one, you have the fact that VC is saying well, he's only complying with taking medication because he's required to because he's on a section.

A. Certainly on that occasion he did, and I didn't have any doubt about his desperation to get out of hospital. I'm pretty sure that's what he was trying to do during that admission and perhaps -- *(overspeaking)* --

Q. It's the same issue, isn't it, that you were grappling with, the same risks that you were grappling with because you're having to consider whether or not you can justify a depot. One of the grounds that you don't do so is because he's complying with medication whilst he's an inpatient, he's saying that he's willing to continue to take oral medication in the community, but we have here him telling an AMHP worker that, albeit on that section, well he's taking medication there, because he's compelled to do so, but once he's in the community, he's not going to do so.

A. I mean, that's again a very, you know, valid point, and I don't disagree, that probably was a concern that I did have as well. I mean, the chances of him coming off the medication when he leaves the hospital, I mean, that's a realistic prospect in any case, actually. I mean, people even go on to depot and then don't turn up for the very next depot on the due date, and that happens all the time.

But the only difference that we have, I saw, during my admission, was he was not floridly psychotic from day one. I mean, either his symptoms were in remission, partial remission at least. Now, if the argument was that he hadn't taken the medication since leaving hospital, from Priory, that was three months

unmedicated, but he was still largely asymptomatic from day one. I mean, he probably had some *(unclear)* symptoms -- *(overspeaking)* --

Q. Perhaps slightly wandering from the point in the entry in this document. What we have, it's significant, isn't it, you have VC indicating that he will comply when he has to but when he doesn't have to, he won't. And that is a risk factor, isn't it? It's a risk factor for non-concordance in the community.

A. It is certainly a potential risk factor, yes.

Q. The second significance of this is, as we've just seen, it comes just a day after he's told the tribunal that he would continue to take medication, and an implication is that he's misled the tribunal, he's told the tribunal what he thinks they want to hear in order for him to get out of hospital.

A. On that occasion, certainly it seems that way.

Q. That's another risk factor, isn't it?

A. It is, yes.

Q. You say "on that occasion", when you're going through the documents looking for evidence, you're looking for evidence that that tells you how this patient behaves and what past behaviours can tell you about future risks.

A. Certainly potentially. I mean, I did not dismiss the

fact that he had been non-compliant many a times. I kind of really wanted him to be on a depot. I mean, I wasn't kind of saying he doesn't need a depot, and --

Q. But here we're considering the issue, and the point, and I took you to it in your interview where you say "didn't have any reason to believe he was not being truthful", in fact there was evidence available that he would mislead, particularly if it meant him getting out of hospital. And it's not just those entries, if we go to the RiO records, please, page NHFT0000168 page 137. It's the bottom box which gives us a date, 10 November 2020 and if we go to page NHFT0000168 page 138 we'll see the substance. And this is an appointment with Dr Burri, that was a doctor in the EIP team, and Claudia Birtles, his CCO.

In this, he discloses, it's in the third paragraph on that page, that during his second admission:

"He [had] told [his] ward doctor that he no longer hear[d] voices but he said ... is not the case and he only said that because he was tired [of] ... being in hospital."

So this more evidence in your own Trust records, isn't it, of VC misleading those treating him when on a section in order to get out of hospital.

A. I mean, as I said, there were clearly several instances

where he probably was not telling the truth, and I don't have any kind of major queries over that at all.

But again the way I would see this is, it's just like how I was describing earlier. So he didn't like the ward. I think he's made it clear every time. Nobody likes the ward. It's not something anybody would want to come into. But he comes to the outpatients clinic and tells this, knowing that the person who is listening to it might react in a completely different way, to say, "Well I'm not going to trust you anymore." But at least he warranted(?) that information, which, in some ways -- again, it doesn't kind of go towards strengthening the case in any major way, but at least in some ways, he was able to recognise, "Perhaps there were people who were trying to help me but I let them down, and I'm telling you this so you know."

Q. That might be what it says about that day, but in respect of his behaviour, his reliability, in circumstances where you say you had no reason to doubt his truth, it indicates, doesn't it, it shows that whilst an inpatient he is -- or is prepared to mislead those who are treating him in order to get out of hospital?

A. That's certainly a very, very much a realistic, you know, possibility, and it did happen, and --

Q. Can we go to page NHFT0000168 page 234 of the RiO records, please. Because even during the admission before you, the fourth admission, there are some grounds to be concerned about VC's true willingness to engage.

So if we go to the bottom of the page, 8 February 2022 entry. This is a brief one-to-one with Mr Fanuel Shoko who indicates to VC that he is "missing out on therapeutic engagements", and VC's response is:

"... he did not want to engage as he did not agree with the admission and the reasons why he is here. He said ... he did not believe he had a mental health issue and ... he [is] ... going to engage as minimally as he could, keeping out of people's way and not being a management problem until he can go back to his life and continue with his education."

Now particularly in the context of the other entries we've looked at, doesn't that suggest somebody who is at risk at least of just trying to get by the admission -- trying to get through the admission, sorry -- in order to be released back to the community with no real willingness to continue a treatment thereafter?

A. There was no question that he didn't like staying in hospital. As I said before, nobody wants to. I mean, again, if I may just mention, he had a pretty -- I wouldn't use the word good, but decent relationship

with Fanuel because I believe he had got to know him from his previous admissions in Rowan 1, but I remember after my review, the ward review on the 10th, he had a further one-to-one session with Mr Shoko where he seemed more willing or insightful, and the point I'm trying to make is, yes, people don't come with full insight, people want to get out of hospital, but sometimes you see them putting in effort, and you can't completely disregard that. That's the point I was trying to make.

Q. So far as engagement more generally on the ward, VC declined OT activities, didn't he? There were no real therapeutic activities noted, much beyond him being on his phone. He's largely described over the course of the fourth admission as being low profile and interacting with staff on a needs basis. Is that a fair summary of his time on --

A. That is a fair summary, yes.

Q. The hospital wasn't monitoring his phone or computer use, were they?

A. No, we weren't.

Q. Did you hear the evidence from Dr Gibson yesterday that -- well, firstly, he preferred for patients not to bring phones onto the ward, but if they were, it would be useful to be able to track phone or computer use or

to provide hospital phones and computers that would be capable of being tracked? Do you agree with that?

A. I wouldn't agree with that, actually. I don't think that's -- I don't think that's the right approach to take.

Q. Dealing with the issue of psychosis and you touched on this in a number of your answers already and the extent to which VC was presenting or wasn't presenting with symptoms of psychosis. Because of the lack of engagement on the ward, the nursing notes describing VC largely as disengaged, maintaining a low profile, being guarded on approach, it would have been difficult, wouldn't it, to recognise and identify the extent to which he may have been psychotic?

A. Yes, that is true, yes.

Q. Your own impression was that VC, on the occasions that you saw him, that he was guarded?

A. Yes, I think the term "guarded" has been largely prevalent. However, what I would say is during the ward reviews I think he did let go of that guard mostly, compared to how he was presenting in, say, for example, in the communal area or other areas of the ward.

There was something about him willing to talk, although he would be somewhat reserved and careful about how much information he wanted to give, but I thought he

did let go of that guard during the ward reviews more than other times.

Q. You explored with VC during the ward review the incident which had led to the admission, so the assault of Christopher, his flatmate. And you describe this, it's paragraph 318 of your statement, page 95, you say:

"When [it] was explored ... with VC, he maintained that it was an altercation and ... he refused to let Chris leave because he wanted Chris to be present until the Police came ..."

Ultimately, your view was that the incident was not one that resulted from psychosis.

A. I mean, that was my opinion, and --

Q. Have you seen the footage of the incident since?

A. Since, yes. I mean, I wasn't aware of the footage, actually.

Q. Having seen that footage, it's a significant event, isn't it? Describing it as an altercation is significantly underplaying what had happened.

VC has put a housemate in a headlock and held them hostage because they have asked him to clean up behind himself?

A. Yes, there's no doubt that must have been a -- yeah, a very frightening experience for the flatmates.

Q. Yes, so -- and they've reported it to the University,

the police have been called.

Now, Dr Skelton's view was that there was a relationship between VC's mental health and the assault. Do you not consider that disproportionate, completely disproportionate response to be as a result of VC's condition?

A. Potentially, but I think -- and again, I am trying to not let the footage to influence my opinion here -- but I think at that point at least, when we had the initial conversation with him, we didn't know about the headlock. I think the way it came across was about this argument following this dispute over hygiene use in the flat and they were wrestling, I think that was the word used. And I was going by what I had at that point, rather than what eventually came out.

Q. During the course of the fourth admission Dr Gibson spoke to the flatmate, didn't he? We see it in the RiO records page 228. As well as dealing with the assault, Christopher discloses that there'd been concerns -- it's the bottom box, bottom paragraph -- that:

"There had been concerns about VC's presentation for about a month. Short screams were heard intermittently from his room, which were thought to be him. He also reportedly entered another flatmate's bedroom in the middle of the night and asked 'can you hear that

screaming' (referring to a different scream ...)".

This was discussed with you in the MDT on 7 February, but those are indications, aren't they, of psychosis?

A. He clearly had psychotic symptoms. I mean, I didn't know the extent of those symptoms, whether it was persistent or very much transient. I remembered from his previous history, I think it was probably early 2021, and he had always complained about hallucinatory experiences on and off, on and off, but he was saying what I [video disruption] suggesting that he had hallucinatory experiences. But I wasn't too sure about the extent of it, but my comment --

Q. Did you explore that report of screaming with him? Did you say, "Well, your flatmates say you hear screaming and that they hear screaming from your room and that you've asked them whether they hear screaming?" Did you explore that with VC?

A. I don't recall specifically exploring that part. I mean, we were asking questions around hallucinations, during the period of admission, and also quite surprisingly, there were no collateral evidence about him experiencing hallucinations from, say, for example, nursing staff, from day one onwards, because he was on ten-minute observations, even when he was asleep, people

would be checking on him every ten minutes. So it would be very unlikely that somebody must have missed those, those other experiences. He could have still had those experiences, I mean, I couldn't be 100 per cent sure, but I didn't explore this particular part of the hallucinations with him directly and I don't think --

Q. Should you have? Should you have explored it with him?

A. Sorry?

Q. Should you have explored it with him?

A. I think I should have. I mean --

Q. Can we deal --

A. Not --

Q. -- just before the break, please, can we just deal with another entry. It's page NHFT0000168 page 260 and from your discharge meeting with VC, and others. It's the middle paragraph by the heading "Note", and there, you alluded to this earlier in your evidence, but there is the description of the conversation you had with VC about his research into technologies which exist, "computer brain interface", and what the note goes on to record is that:

"He did feel that some outside him was influencing him and controlling him but it didn't frighten him. He denied that this was still happening and doesn't see any reason for this to happen again. He was unsure as to

who was doing [it] ..."

Now whilst there is that denial that it was ongoing and that may have been reassuring, was there any concern about the fact that this did appear to be a belief that VC had, that someone had the ability outside him to control him, he didn't know who it was and he felt it had happened, even if it wasn't ongoing. Isn't that still an indication of somebody with psychotic beliefs?

A. The way it came across was -- so I was kind of pressing him particularly around this terminology of thought insertion, delusions of control, and so on. And I think -- if I remember right, the way it came across was he was saying, "No, I don't have it."

So I mean, I think I used the timeframe, four weeks there actually, and that was for a particular reason, because -- two reasons. I mean some of these questions are difficult to ask, and if you're trained with something called a present state examination or scan, you would want to use that timeframe to pin down, because patients sometimes, you know, may not know what timeframe to refer to.

The way he put it across was it happened some time in the past, but he wasn't saying it was happening now or in recent times. That was my understanding from the way he described it actually, and I thought --

Q. Was it significant that he thought it was real? Was it significant that he wasn't saying "Well, I used to believe this but now I realise that was a symptom of mental health and nobody was really controlling my thoughts"?

A. I think that's quite important. I mean, this was one of his main symptoms: that domain of being controlled. I mean that perhaps showed some kind of evolution of insight. It could be that, or it could be that he was starting to trust us more. I mean I think I reflected on that, actually, more recently. And I thought he had no reason to disclose that to us on that day, actually because that was going to --

Q. This was the day of discharge, wasn't it?

A. That's right, and I felt the fact that he was saying that, knowing that we might just change our mind and stop him, made me think that perhaps he was recognising his symptoms more, might be a sign that he was gaining some insight.

MR CARR: Chair, that might be a good time.

THE CHAIR: Yes, I think we'll take a break now. We'll start again at 11.05. Thank you.

(10.49 am)

(A short break)

(11.09 am)

THE CHAIR: Yes, Mr Carr.

MR CARR: Thank you.

Dr Thangavelu, we are going to go through a number of reasons that led you to conclude that you could not enforce a depot. I'm just going to deal very briefly with a few more.

Your statement refers to the lack of incidents, incident, on the ward. It's right, isn't it, and you recognise in your statement, that VC slammed the door when a nurse was trying to undertake her observations?

A. That's correct, yes.

Q. Whilst he was on leave, it was reported that he had gone to his -- to the University?

A. That's correct.

Q. And he denied it?

A. That's correct. But we -- yeah. Although it was not completely established, we think that he did.

Q. Yes, and you describe in your statement, paragraph 307, you say your:

"... impression of [it] was that when the subject was broached initially, VC was fearful to admit the truth."

I mean, basically what you're saying there is he lied about it?

A. I think that was my impression at the time.

Q. There ought to have been a risk assessment following him going back to university, shouldn't there?

A. University, as in like accommodation, or --

Q. No. So when he'd gone on leave and gone back to the University when he wasn't supposed to have done, your team should have performed a risk assessment as a result of that?

A. I mean, risk assessment should be part and parcel of our routine care anyhow, but I'm not entirely sure about the University side of things because as far as I knew, at the time at least, there were no, say, restriction orders or anything of that nature.

Q. So you don't think that should have triggered a specific risk assessment? Is that where you're getting to?

A. I mean, I'm just trying to understand what that risk assessment would have looked like, actually, to return back to uni. Because he was attending uni before admission, and nothing had changed --

Q. Dr Thangavelu, specifically in respect of leave. Okay? So he's been granted leave --

A. Oh, sorry, okay.

Q. -- he's gone out, he's lied about where he's been. That ought to have informed a risk assessment; do you agree or do you disagree?

A. Yeah, no, sorry. Yes, in that sense, yeah. I mean, the

leave was short periods of leave to hospital grounds and local areas to attend gym, so that was the broad scope of the leave at that point.

Q. Okay. Can we deal now with the relevance and the way it attached to VC's refusal to agree to depot.

Now, one of the points that VC raised was that in the past when he changed medication he'd experienced side effects, but you explained to him, didn't you, that depot was the same medication. So a fear of side effects was not a good reason not to have depot, was it?

A. No, I think what he was saying at that point, I know when we read the records it may not completely stand out, because what he was saying was, when he got changed to a different medication, I think he was referring to the last time that got changed, might be Cygnet, I think. He didn't agree with it or like the side effects. And then it occurred to me whether he thought, am I going to change him to that medication, actually? And I then I said, "No, it's just the same medication that you're taking orally that will be given in an injectable form."

Q. The issue about needles -- and you address this in your statement -- but you were aware, weren't you, or you'd become aware that VC had received Covid vaccinations?

A. Yeah, I wasn't aware at that time but since then

I became aware, yes.

Q. But what would have been clear, both from the notes of previous admissions and from his time on your ward, was that he was keen to be discharged, wasn't he, VC? Keen to get on with his life?

A. He was. He was.

Q. So why not say to him "Well, you can only be discharged -- you can be discharged but only on a depot. We're not convinced on your concordance, so the condition for you being released has to be on a depot," and see whether he would agree in those circumstances?

A. I mean, I would have definitely -- that would have definitely crossed my mind at the time, but I can't quite remember if I was actively pursuing that line of thinking or not, but the impression I had, I mean, it was mostly the meeting on the 10th, actually, so it was -- we were trying -- I was trying to convince him somehow, and make him agree, and he was quite resistant to the notion of depot, which he had been saying for a while.

Q. If you're trying to convince him, why not make it clear that so far as you were concerned and the team were concerned, the way for him to be discharged would be on a depot because that would ensure his concordance and see whether he would agree in those circumstances?

Because you didn't make it a condition, did you, of him being discharged?

A. I wasn't attaching it to the condition of discharge, no. But again, I -- I mean, that perhaps wouldn't serve the purpose in any way, actually, because he could just get discharged and then stop. That happens a lot of time, actually. So people will have the first dose and they may leave, and won't turn up for the next depot, actually.

Q. In your statement, it's your paragraph on page 111, you describe feeling that:

"... there was a high-likelihood [that] VC would successfully engag[ing] with [his] community mental heath team following discharge ..."

Given what had happened following the previous three discharges, what gave you comfort that this time was going to be different?

A. I think I qualified that statement by saying in the short to medium term, not the long term.

Q. Yes, what gave you comfort that this was going to, following this discharge, there would be successful engagement, given the recent history?

A. I think there were a couple of things, actually. I mean, one was, I felt that he was coming to a realisation that if he, for want of better word, if he

messes about with the medication or completely disengages, then -- because I did tell him at the meeting on the 10th very clearly that "we want to have assurance from you, you have to engage, and that might be weekly meetings, et cetera, and that if you disengage we won't have a second chance."

I thought he took it on board and I thought there would be, well, that could have been one of the factors. Also, if I remember right, I think he was -- one of the main drivers for him to get out of the hospital of many factors was he was keen to get back to the studies. He kept on coming back to the topic, you know, very frequently, and it was quite evident. I think he had to postpone his exams and -- sorry, a course for a year and then he went back to it in October after the discharge from his third admission, and he had just a few months left to get through the finish line. And I -- I mean, that was one of the factors, I have to admit that --

Q. Just to so I am clear, the question was: what did you think was going to be different this time, and it was the fact that he was almost about to finish university, was that the --

A. Well, he had reasons to -- what's --

Q. Well, he had reasons to get out of hospital, what reasons did he have for engaging with the Community

Team, as you understood it?
A. I think that was one of the reasons, actually, that he would want to stay well or get support and get through the exams.
Q. All right. Can we deal with the issue of Section 2 and Section 3. VC had been detained on a Section 2, a CTO obviously wasn't available without a Section 3 detention.
Firstly, is it your view that the fourth admission should have been on a Section 3?
A. I mean, I couldn't make a definitive statement on that, actually. I think clearly the assessors at that time, they themselves did not see --
Q. We've heard evidence from the assessors, but in terms of you've received the patient, you've obviously seen the notes. Is it your view that the fourth admission should have been on a Section 3; "yes" or "no"?
A. I would say I would be leaning more towards no, actually.
Q. If it had been on a Section 3, do you think you then would have imposed a CTO?
A. It would have given us -- it would have given us a bit more time to think, and I mean what comes -- *(overspeaking)* --
Q. -- *(overspeaking)* -- do you think you would have imposed

a CTO?
A. Not necessarily. I mean not necessarily. It would have given us more time to think and then decide.
Q. You've set out in your statement that you consider it not to be good practice to keep someone under detention to convert to a Section 3 for the purposes of a CTO.
Just dealing with the issue of conversion from Section 2 to Section 3, because we know that during the third admission, when VC was at Cygnet, he was converted to a section -- from a Section 2 to a Section 3, because his consultant there, Dr Shoilekova, thought it was unsafe for him to be discharged back into the community. And of course the AMHPs supported the application; it was converted to a Section 3.
So as a starting principle, you can convert from Section 2 to Section 3, can't you?
A. You can, yeah. If they met the criteria, yes.
Q. And in support of that conversion, Cygnet document CYGN0000013 at page 4. One of the doctors who wrote a report in support of the Section 3 detention, the reasons given, and it's the bottom six lines, refer to although VC was compliant with medication whilst at Cygnet, "significantly more settled", because of a lack of insight, because of delusional beliefs, and because he couldn't be safely managed in the community, given

the severity of the risks of his safety, it was thought there appropriate to convert to Section 3.
So in circumstances where you have a patient, and if you conclude that they cannot be safely managed in the community without depot to ensure concordance, then that would be grounds, wouldn't it, for a Section 3 in order to obtain a CTO?
A. I can't think that in itself is enough. It wouldn't be. Obviously for the purposes of meeting the threshold for Section 3, obviously you have the nature and degree clause, you have the treatability clause, and the risk clause, to self and others.
Q. VC did present with a risk to others, didn't he?
A. He did.
Q. And Dr Gibson's evidence yesterday was that he thought, albeit on reflection, were grounds to convert VC's section to a Section 3 on the basis of the nature of his illness requiring a further period of detention. Do you agree with that?
A. I think we can certainly have a case based on nature.
Q. His evidence was also that on reflection, he thinks a depot should have been given, and do you agree with that?
A. I mean based on all the factors I considered at that point, I did not think a forced injection could be

justified, if --
Q. Have you ever discharged someone on a CTO with a condition of depot?
A. Very many times, yes.
Q. Dr Gibson's evidence yesterday described a culture, so this is around the use of the Mental Health Act and the use of restrictive practices, he described a culture and a climate which emphasised the least restrictive approach to patients and mental disorders, enhancing their autonomy wherever possible. He described that being the context for the recent amendments to the Mental Health Act. And being part of the climate that psychiatrists were operating at the time, and that being that the message that you were getting from the government, the CQC, the Royal College and at conferences.
Does that reflect the culture that you felt you were operating in at this time, emphasising least restrictive, maximising patient autonomy?
A. I mean, it is built into the core tenets of the Mental Health Act, so --
Q. Did you get the sense from those bodies, or from general psychiatric culture, that you were, as a body of professionals, being overly coercive and not respecting patients' wishes?

A. I wouldn't use the word "overly". I mean again, it's about how you define that, actually. But having been in this field for 25 years, I have certainly seen many instances where I felt that least restrictive option was available and could have been used when more coercive route was taken.

Q. He described the message that was coming through to psychiatrists that there was a disproportionate impact on certain groups. He said that psychiatry or what was being told to psychiatrists was that psychiatry was institutionally racist and that there was an implicit bias.

Now did you have a sense of that sort of message being imposed on you?

A. I didn't necessarily feel that way, actually, and I think we are all quite independent in our practice. It depends on --

Q. -- *(overspeaking)* -- Do you feel you had to second-guess decisions on the basis that you might have implicit bias?

A. I mean it's hard to completely disentangle yourself from that but I think, you know, we all stick to our core principles, and ethics and values, and we will all be defined somewhat differently by that.

Q. He described to having moved to being more coercive in

his own practice. For your own part, do you consider that your practice is more towards the coercive end or more towards the patient autonomy end?

A. Certainly the dial has shifted more towards coercion.

Q. You have shifted more towards coercion?

A. Yes.

Q. Since when?

A. Since VC incident.

Q. You described having used depot and having released people on a CTO with depot, have you released people on a CTO for depot on grounds of protection of the public; so for risk to others?

A. Yes, we have had patients who have come through the forensic pathways stepped down from forensic unit into adults units, so yeah, I have dealt with.

Q. So far as your patients, have you had experience of deaths shortly following a discharge of a patient of yours?

A. Death as in suicide, you mean?

Q. Including suicide, yes.

A. Suicide, yes -- well, not -- well, 12 years ago there was certainly an incident which happened soon after, I think soon after discharge or during leave, but, I mean, I haven't had any homicides in my career, no.

Q. The only suicide was the 12 years ago one?

A. No, no, no, there have been other suicides. I mean, I was working both on the ward and the community and it was one of those rare jobs and I was split between two and had a significant caseload and, yeah, if you just go by the population statistics, yes, I have had incidents.

MR CARR: Thank you, Chair. Those are my questions for this witness.

THE CHAIR: Yes, thank you.

Yes, Ms Patrick.

Questioned by MS PATRICK

MS PATRICK: Good morning, Dr Thangavelu. Can you see me and hear me?

A. I can, yes.

Q. Thank you. My name's Angela Patrick. I represent the families who were bereaved on 13 June 2023. I have four things I want to ask you about: medication, the incident with Christopher, disengagement and non-concordance, and then a little bit about one email concerning the investigations after 13 June. Okay?

A. Okay.

Q. Just before I get to those, Mr Carr asked you just now if you had ever used a CTO and depot when discharging, and you referred to using it in the context of forensic patients who'd been stepped down. Have you ever used a CTO with depot on a patient who's never had a forensic

admission?

A. I have. I think the question Mr Carr put was in the context of public safety.

Q. Yes.

A. And immediately, there a patient example came to my mind who had been to the forensic pathways, but I have had patients on CTO. I mean, as I said, I was working both on the ward and the community for 12 years straight, and I've had patients on CTO both ends, actually, of discharge patients on CTO and I've had received patients on CTO.

Q. It's public safety that's the matter, isn't it? If there's a risk to public safety, it doesn't matter if the patient is on a forensic pathway or not. That's the question for you, isn't it?

A. Oh yes, I mean, the patients who had been on CTO in the adult side, not all of them had -- not all of them were placed on CTO because of public safety. That's all I was referring to. I mean, some of that would be for other reasons as well.

Q. Okay. Going back to my questions, on medication, you've said VC talked to you about side effects connected with changing medication. Did you have the records from the Priory and Cygnet?

A. No, unfortunately I don't think we had that, no.

Q. Did you know, through your conversations with him or otherwise, that he'd been changed onto haloperidol for weeks in September and October?
A. I've since --
Q. No, not since. At the time, during the admission, did you know he had been changed onto haloperidol?
A. I think the change happened, if I remember right, yeah, I think the train of events was when he was admitted, he was waiting for -- I did know. That's the answer.
Q. You did know?
A. Yeah.
Q. Okay. Did you know that it was only on 7 October that he'd been titrated down off of haloperidol and put back on to aripiprazole? Did you know that?
A. I don't recall knowing that timeframe, no.
Q. That was relevant information for you to have had, wasn't it? His medication history. Important for you to know it, wasn't it?
A. So I knew -- so what I knew was, when he came out of Priory he was on aripiprazole. When he went into Cygnet he was on haloperidol. So I knew that at some point it got swapped, but I didn't know the exact timeframe.
Q. Thank you. In considering concordance, and whether he had been concordant in the community, did you ever consider whether he'd been properly stabilised back onto

aripiprazole during the last admission?
A. It was hard to -- it was hard to establish that without objective evidence. I mean, that was the type of evidence I was seeking from the CTN about --
Q. Can I stop you there for a moment: did you ever ask for the records from the Priory and Cygnet?
A. No, I did not. No.
Q. Thank you. I'm going to move on to another topic, and it's the incident with Christopher.

Now, just before I turn to the notes, you've said this morning, when Mr Carr was asking you about medication, when you were looking at medication you'd have taken a few minutes to look at VC's notes, wouldn't you?
A. You mean the dispensing history, you mean?
Q. Or just his notes. If you were looking at VC, you said this morning you'd take a few minutes to look over his notes; is that right?
A. So what I said was I was looking for the dispensing history since his discharge from Priory. So that was I think -- I used the -- so there is a search function where you can just put the date, from which date to which date you want to look at. So yeah, that's what I did.
Q. I apologise. Would you have read all of his notes or

just those that you thought you needed to?
A. Only those I needed to.
Q. Okay. You've said you read the transcript of Dr Gibson's evidence yesterday --
A. This morning. Sorry, just now before this, sorry.
Q. Do you recall I asked him about the note that Dr Seedat added to the notes about VC's communications with his family and him recording intent to harm others? Do you recall if you read that note?
A. I think so. I can't quite remember the exact --
Q. Can I refresh your memory? Can we look at it? It's at NHFT0000168 page 21.

Can you see that now, Dr Thangavelu?
A. I can see that now, yes.
Q. The part I took Dr Gibson to is in the fifth paragraph down, the last sentence:

"He said the people would not mock him in person and made some remark to wanting to hurt these people he was hearing."

Did you read that at the time of VC's admission?
A. I don't recall reading that part, no.
Q. If you don't recall it, do you think you did not read it?
A. I might have read it but I don't think it ... I mean I don't recall having read it, actually, so I have to

say probably I didn't.
Q. So this is a very unwell man. He lacks insight. An appreciation that part of his history, when unwell, was an intention to hurt others; that's relevant information for you to have had, isn't it, Doctor?
A. Yes, it would have been certainly useful to have had that information, yes.
Q. Just to be absolutely clear, I also asked Dr Gibson if he had seen the notes which underlay this note, the original, which had the information about "red rum" and and smashing heads. I'm assuming, if you didn't read this note, you didn't see the original record?
A. I mean I only came to know about the original record during the process of the Inquiry, so yeah, I wouldn't have.
Q. Thank you. If you please bear with me for a moment.

Now turning back to Christopher, can we look at a section of your witness statement, please, it is WITN0206001, and page 96, please. I think just if we can take this quickly while it's coming up, your appreciation, and you've raised this with Mr Carr this morning, is that that incident with Christopher was not driven out of psychosis. That was your view, wasn't it?
A. That was my opinion at that time. Yes. Based on -- yeah.

Q. We have what you put in your witness statement here now. We can see that. Can you see it, Dr Thangavelu? Paragraph 319.
A. Yes.
Q. "My opinion at the time was that the incident with the flatmate was not driven out of psychosis. There did not appear to be any paranoia nor persecutory ideas expressed towards the flatmate in that context. The altercation was not in response to hallucinations or other delusions or affective symptoms."
Then you go on to the police not acting on it.
But if we can just turn to the next paragraph, just so we've got a complete picture, you say:
"It is of course possible that VC was not truthful, both with regard to his previous and current symptoms, and sought to conceal symptoms during every attempt by mental health professionals to elicit them throughout the period of admittance. However, the lack of such objective evidence during the entire period of admission to hospital did not in my opinion support such a conclusion."
Now, you've mentioned staff observations on the ward as part of that. Now, whatever they saw, VC was being medicated throughout his time on the ward, wasn't he?
A. He was, but he didn't display any symptoms from day one

onwards.
Q. Was he being medicated from day one?
A. He was, but the way these medications work, such that say, for example, I mean, with aripiprazole in particular, it takes *(unclear)* half life of the medication to receive -- to reach what we call a stable state, and for aripiprazole it can be anywhere between two weeks or more. So the effect of medication wouldn't kick in straight away. Some effects might be, so like sedation, so that sort of things can sometimes kick in. But for the true antipsychotic effect to kick in, it takes some time.
Q. But he was on medication. Can we turn to what he was telling you in the ward review on 3 February. That's at page 226 of the RiO notes. We may not have to go to it, I'm just bringing it up so you can refresh your memory. You deal with it in your witness statement.
He told you it was a long time since he heard voices, "maybe over a year ago"; is that right?
A. Yeah, I think clearly if it's recorded like that, that's what he would have said, yes.
Q. Yes. It's been highlighted there; can you see it?
A. Yes, I can, yes.
Q. The call with Christopher was recorded the next day, if we can scroll down to 228, and we've had this up

already. You've heard the reference to the screaming?
A. Yes.
Q. Dr Gibson said, "Obviously that was evidence that might point towards him experiencing psychotic symptoms."
I think you'd accept that's right?
A. That's correct, yes.
Q. That makes the talking about it being over a month. Did you talk to Dr Gibson about that, this being pointing towards VC experiencing symptoms and possible relapse?
A. I can't quite remember if we specifically talked about that symptom as a sign of relapse, but I think the impression we made, at least I made out of that, was that he was having residual symptoms which is the most common presentation in psychosis, because people don't achieve a 100% clearance of symptoms, even with medications. Usually there will be some residual symptoms for the majority of the patients. You can wax and wane as well, the impression --
Q. Can I pause you there, Dr Thangavelu. Look at this entry, it's in front of you. The flatmates are reporting this in the context of this violent incident. He's reporting VC hearing screaming nobody else can hear and him trespassing into others' space. Dr Gibson accepted that showed a real pattern, pattern, which echoed the previous admissions; do you accept that?

A. I agree there are similarities, yeah.
Q. Did you appreciate that pattern at this time during this admission?
A. Perhaps not at a very intense level. I think that was probably -- it might have been -- again I'm just hypothesising here --
Q. Please don't hypothesise.
A. Okay.
Q. Did you appreciate that there was a pattern between previous relapses and his presentation in early 2022?
A. Yes, I appreciated the pattern there, but --
Q. Did you appreciate it then?
A. Yes. I mean, clearly that was the whole purpose of admission, actually: that we wanted to assess whether there are any symptoms. And certainly at the point of admission there were no concerns in terms of any positive symptoms of psychosis, but this information came along and the assessment just continued actually, so he was still on 30-minute observations for I think maybe a couple of weeks or something, actually, and then he got dropped. The lowest observation people can go down to is one hour. So every one hour people get checked, so he was mostly spending time in the communal area anyway, actually, I think. When I say communal area --

Q. Dr Thangavelu, can I ask you to stop and listen to the question. I'm going to move you on to the next document. I'd like to look at the MDT that happens after you've got this new information. It's at pages 232 over on to 233 [NHFT0000168]. You see, if we go to the very bottom of the page, 7 February, and if we scroll over, we see the MDT note. Can we see that?
A. Yes.
Q. And it's led by you, isn't it?
A. Yes.
Q. And the first entry:

"Report came from school accommodation that someone was noted to be in his flat."

As a record of him breaching his Section 17 leave, to return to an apartment where he had heard screams that nobody else heard, and had assaulted his flatmate, that's not an accurate description, is it?
A. So, no, the -- the record there is not accurate as well as information that I was made aware of at the time. I think there was a reported sighting but I don't think it was in his flat.
Q. Okay. There's then it refers to "screaming", question mark "hallucination". There's no reference to drawing a connection with the patterns with the behaviour on previous relapse, is there?

A. I mean the way --
Q. Dr Thangavelu, is it recorded that you discussed that the information Christopher gave you echoed the previous relapses?
A. I can't say if it was recorded or not. I don't recall.
Q. The entry is in front of you.
A. I mean this meeting was just more of a feedback meeting, so Dr Gibson was just feeding back what he was told by Christopher. So it's just a summary of what was -- what were we informed of from the last few days, actually, so it just captures a summary of new information, if you like.
Q. Okay. He's behind --
THE CHAIR: You're running over time. So do you want to move on to your last point?
MS PATRICK: Indeed.
THE CHAIR: I've got the point you're making.
MS PATRICK: Can I take you to another entry, we can move to concordance and what's said about addresses.

Can we look at NHFT0000168 page 199 briefly, please. It's at the bottom of the page we start at 14 December. If we can scroll over. You've been taken through some of these entries of the Community Team trying to reach VC. And we've seen what you've said about a misunderstanding about addresses.

Now, we see, if we can go to the bottom of page 201, please, an entry for 17 December. If we go over on to the next page, please. Can you see that there? This is one of the rare occasions he comes to collect his medication, and he is described as being "very curt", "staring", having a "hostile edge".

Can you see that, Dr Thangavelu?
A. Yes, I can, yes.
Q. Now you've talked about there being some misunderstanding about addresses. Just to absolutely pin this down, he says -- he's asked: anything to hand over to his care coordinator? He asks: "who came to his house the other day, was it you?"

So he knew they were trying to reach him at home, didn't he?
A. He did, but, again, my understanding was that Ms Birtles contacted his mother, and mother contacted VC and --
Q. This is -- just to help you with the timing, this is after she's contacted his mother.

He then goes on to say, he was told:

"No, it was Dr Lloyd and Claudia, he asked what address they went to, I stated it was a Beeston address."

So she's giving him every opportunity there to say, "That's the wrong address, I now live at Raleigh Park",

isn't she?
A. She is, yes, definitely.
Q. Would you have read this note?
A. I think I did read this note, yes.
Q. You just weren't giving enough weight to what the Community Team were recording, were you?
A. I did. I mean, I don't deny this at all, actually and, clearly, he had an opportunity to correct them then and there, that he had gone to a wrong address. Clearly he walked away, but again --
Q. Was it not clear on the records that not only was he non-concordant, he was deliberately disengaging and trying to avoid the Community Team so far as he could?
A. I mean, he had just turned up to collect a month's supply of medication, so it wasn't a total disengagement. But he was clearly quite upset and was showing resentment towards Community Team for implicating them for the admission. I mean, I fully sympathise with the Community Team, I mean, they were doing their best, but --
Q. Can I stop you there. On that MDT I took you to on 8 February, at that time you know that the Community Team think he's non-concordant. You know he's breached his Section 17 leave. You reinstate his leave, and this morning you've discussed, on discharge, that you were

going to give him a last chance. Did you not think at any time that he'd failed on three previous chances at concordance? He was never going to be well without compulsion, was he, Dr Thangavelu?

A. I wouldn't write somebody off just like that. I'd want to weigh up things, and I was looking for -- I was looking for reasons to go for a forced depot. I wouldn't have hesitated if it was very blatantly obviously clear in my head. But I was struggling on that occasion because I was trying to weigh up --

Q. Can I suggest, in weighing up, you gave too much of the benefit of the doubt to VC and didn't pay attention to what was right in front of you?

A. I wouldn't say that that was a completely correct judgement because, I mean, I can go through what I was weighing up in my head. There was confusion about the address, which might have at least partly contributed to the disengagement. He was just out of hospital and went straight back to uni having to do the exams, do the warehouse job, and meet up with them on a regular basis. He was still expressing his resentment towards EIP team. There were a number of factors which I did take into consideration, and I also did take into consideration the fact that he was asymptomatic, largely asymptomatic. Certainly he was having some symptoms, not completely --

THE CHAIR: I think, Dr Thangavelu, you've given those answers to Mr Carr previously and I've written them down, so thank you.

MS PATRICK: Thank you very much, Dr Thangavelu. No, more questions.

THE CHAIR: Thank you.

Yes, Ms Cartwright.

Questioned by MS CARTWRIGHT

MS CARTWRIGHT: Good morning, Dr Thangavelu. I ask questions on behalf of the survivors. Can you see and hear me?

A. I can.

Q. It's right, isn't it, Dr Thangavelu, that you made not one single entry into the RiO notes in the time when VC was in his fourth admission. None of those entries were made by you?

A. No.

Q. None of those entries have been endorsed to say you've reviewed them; would you agree?

A. I did review the entries, but you don't have to endorse them necessarily.

Q. Well, again, if you accessed the RiOs to review them, would you agree that best practice is that you make an entry that produces the audit trail that actually shows that you've reviewed and read them and you've agreed

with the contents of those notes?

A. Ideally, yes, but I think I simply would not have had time to do that. I think in my witness statement I have broken down my time availability for the ward, which was 14 hours per week for eight patients. And at that time, I had a whole day of review back-to-back. I was working in the community which was nine miles away and I had 150 patients for three days.

Q. That's your explanation why you've made no note, but equally you made no discharge letter for this fourth admission as the Responsible Clinician, did you?

A. No, there is no expectation that the Responsible Clinician do the discharge letter.

Q. Well, you didn't do the Discharge Summary either?

A. No, no.

Q. Certainly in the GP records there's no evidence, whilst they're aware of the fourth admission, there's no Discharge Summary or discharge letter that's been received by the GP.

So would you agree, again, bearing in mind you've made the decision as the Responsible Clinician, not to convert the Section 2 to a Section 3, not to give depot injections, and not to consider a Community Treatment Order, that you should have addressed your mind to those matters and recorded them bearing in mind you've

essentially put in place a plan that depot will be considered if VC relapses?

A. So this was discussed in every ward review. It would be inappropriate to make a comment about what would come, in terms of saying it would be progressing on to Section 3 and CTO, because he can't -- you can't determine that. It has to be taken on a case-by-case basis, and it's very time specific, actually.

Q. I appreciate that, and that's what I'm suggesting, Dr Thangavelu, that you should have documented the fact-specific factors on Section 2, Section 3, CTO and depot, that you'd considered in this case for VC, bearing in mind this was his fourth revolving door admission as a patient with paranoid schizophrenia?

A. I would have certainly done that, and certainly I -- I mean, since then I've been dedicating more time to documentings *(sic)* myself. I mean, that has been one of my learnings as well. I think that's good practice.

Q. The next I want to generally deal with, and it's clear from your evidence that you now have reviewed the records in RiO, so what I want to address at a high level is that between the third admission and his time in the community, and his fourth admission, so it's the RiO [NHFT0000168] pages at 193-217, if they are read from start to finish, would you agree that they actually

support a serious issue as to non-concordance with medication by VC since his discharge from the Priory?

A. I think I touched upon this earlier. So there was issue of missing appointments, clearly, which I thought at least partly was related to the address confusion.

With regards to collecting the medications, he did turn up to collect two months' worth of medication at the month's interval and that was the period of time he was out before the Crisis Team took over.

Clearly there was evidence that he was very curt or very superficial in his engagement. I did pick that up. In fact, the whole reason to not go down the more coercive route was for me to build that relationship. I mean, I work with the Assertive Outreach Model a lot, and I still do. Engagement is the key and for engagement to happen you need to build trust, and you use every opportunity to build trust. And I used this opportunity.

Q. Would you agree that in the fourth admission, if we look at the notes, VC wasn't engaging; he was engaging in no therapeutic activity on the ward, he was isolative in his bedroom, and he was not engaging?

A. He wasn't engaging in the ward activities, but he never hesitated to meet his needs in the way he wanted to. I mean, the first thing he asked for was a leave to

attend the gym. He wanted an hour and a half, and he did get enrolled in one of the gyms down the road and he was attending it, actually.

Q. But Doctor, appropriate medical treatment, and what I'm going to suggest is VC, this should have been a Section 3 on his fourth admission, because VC needed appropriate medical treatment as a patient who had a diagnosis of paranoid schizophrenia, and would you agree under the Mental Health Act appropriate medical treatment is not just the medication, it's the psychological interventions, the specialist mental health rehabilitation, the rehabilitation and care that needed to be part of the package of care that VC had to engage with to ensure he -- before a safe discharge.

A. I would be the first one to stand up for biopsychosocial treatment, but -- and I -- I spent a year doing rehab, but just keeping him on a Section 3 inpatient unit much longer, it's not make him necessarily engaged. In fact it will institutionalise him much longer.

Q. Well, no one is suggesting it's institutionalisation, but he's not had any psychosocial therapy that he's engaged with to help him form his insight, and bearing in mind this was now his fourth admission, that is just what VC needed before there was any possibility of a safe discharge, and that's something you should have

ensured VC engaged with and considered.

A. When we say psychosocial therapy or involvement, it largely depends on what matters most to the patient. And for him, clearly he wanted to get back to his studies and get on with his life. And what we need to do is support him to achieve those things. And that's not going to be achieved by locking him up forever, or much longer.

Q. But would you -- just on a principle of discharge, that there wasn't a safe discharge because no one actually checked that VC was living at 209 Ilkeston Road, and he had been guarded, it's documented in the RiO notes. You essentially had to draw that address out of him, and so that was highly suggestive of some suspicion around that address.

But in any event, even if that hadn't occurred, for there to be a safe discharge, someone needed to go and check this accommodation before VC was discharged.

A. Checking the accommodation is a very fair point. I would have certainly liked to, but unfortunately the way it all panned out was he was waiting for this accommodation, it only came through in the last few days, actually, and I would have normally expected the Community Team to link up with him. I think I was requesting Ms Birtles to make contact with him and she

did text him, but I don't think she managed to meet him up. But I would have expected, if he had gone on leave, say for example, to meet him up there. That's what we normally do.

Q. Just on that point, before the final point, please, would you agree that VC needed appropriate medical treatment and therefore, you said before, you essentially said you were leaning more to a "no," whether it should be a Section 3, but would you agree that VC needed appropriate medical treatment so Section 3 was the appropriate section that Section 2 should have been converted to?

A. No. I mean, as I was saying just a bit earlier, appropriate medical treatment is not just medications -- as you said, actually. So clearly needs a lot of psychosocial support and psychosocial support -- the main aspect of psychosocial support is get them rehabilitated in the community. That's the core principle of it.

Q. All right. We have heard expert evidence as well from Mr Ruck Keene who has suggested that, as a general rule, if you know about a patient, the patient circumstances, it's not appropriate to use Section 2, essentially that's then mandating you should be moving to Section 3 and particularly if they are a paranoid schizophrenia

patient.
A. I wouldn't completely agree with that. I mean, the diagnosis in itself has got no relevance to whether somebody should be on a Section 2 or Section 3. I think on this occasion the assessors felt that there was a need for reassess or reassessment or reformulation, which is very much accepted as reasoning for Section 2 for somebody who has previously been diagnosed with schizophrenia and been on Section 3.
Q. Finally, then, please, within the medical records for 31 January 2022, you reference that they needed to collate the collateral information to justify depot.
Would you agree that there's much information that was not collated as part of that? You didn't collate the Priory records that should have been obtained, and without that you are missing a huge chunk of VC's medical records?
A. Priory records would have been helpful, but we had the Discharge Summary.
Q. But it's more than helpful, it is part of VC's records that you didn't have access to, and it was his last admission.
A. I think the Discharge Summary was there.
Q. But bearing in mind as well that there's a contract between the Trust and the Priory, that you should have

obtained those and you should have obtained the Cygnet records.
A. If there was a system in place for that transfer of records to happen easily, of course we would have made use of it to the full extent. There were no systems in place.
Q. But you should have contacted the police to get the collateral information from them, bearing in mind the offences that VC had been involved with.
A. I agree, we could have certainly -- I think we should have put in more effort to contact the police. I mean, I did request for the PNC check from the very first MDT meeting, but I don't think that was followed through.
We didn't have an easy access liaison person at the time and they have been put in place since then and we have been making use of that, and that has been a real help.
Q. You should have got more information from the University who themselves were advocating and seeking a Community Treatment Order for VC?
A. Ellie Turner was very much involved. I think she was instrumental in arranging for the admission, I think.
Q. Then could you assist, you -- and also the GP, because one of the entries where you discussed at the meeting with VC -- and just for the reference, I'm not going to

have time to go to it -- VC gave an account that he was receiving his depot medication -- sorry, his aripiprazole -- from the Cripps Medical Centre when you were discussing the depot with him. Did you look to see and check if the GPs were providing him with the aripiprazole, bearing in mind VC had given that explanation when you discussed depot and it's page 239 of the RiOs [NHFT0000168] for the reference.
A. I remember that entry and that was entirely my fault. The way it happened was the ward reviews happen in a very conversational style, not in an interrogative style, actually. So I was kind of going through questions with him saying "Well, have you been taking medications? Have you been collecting medications?" And he was saying yes. And out of ignorance, I slipped the words "So have you been collecting it from Cripps Medical Centre?" And he just said "Yes". Then, when I was looking through the notes, it was very evident that he was collecting it from Stonebridge, and it stuck in my head, that's why I remember, I thought: why on earth did he say he was collecting it from Cripps? I mean, I didn't challenge him, but I just thought it was an oversight or he didn't hear me properly or he must have misunderstood me or something.
Q. Can I ask you then in terms of the harm that VC had

caused --
THE CHAIR: Ms Cartwright, I thought we'd come to your last point.
MS CARTWRIGHT: Can I then just ask this very briefly: were you aware that one of the members of the public, Feven, that she had fractured her spine and received spinal surgery? Were you aware of that, as well as all the other members of the public that had sustained harm, both physical and psychological, as a result of VC?
A. I was aware of that tragic incident. I mean, that was very much evident from the RiO alerts that you would see straight away.
Q. It's not just the incident, it's the severity of the injuries she sustained. Were you aware of the fractured spine that required spinal surgery and pins?
A. I didn't know the full details, no.
Q. So you didn't know about that injury, and would you agree from --
A. I knew about the injury.
Q. How did you *--(overspeaking)* --
A. Sorry, it said a back injury -- sorry?
Q. Well, what did you understand to be the back injury she'd sustained?
A. What it said on RiO was she sustained a back injury requiring surgery. I didn't know any more than that.

MS CARTWRIGHT: Thank you very much.
THE CHAIR: Yes, Mr Straw.
Questioned by MR STRAW
MR STRAW: Dr Thangavelu, I represent VC's family.

You accepted earlier in response to questions from Mr Carr that VC was very guarded and masked, and that there were several instances when he was not telling the truth in order to be discharged.

Now you would agree, wouldn't you, that it was particularly important for someone like that, not just to rely on his word?

A. Yes, I agree, yes.
Q. You had to look beyond that and take a longitudinal view.
A. True.
Q. And by a longitudinal view, I mean look for patterns. So look at previous relapses, identify relapse indicators.
A. Yes.
Q. You failed to do that, didn't you? You took him at his word and failed to identify relapse indicators.
A. I wouldn't agree with that, actually. We looked at the previous patterns, and this submission was quite different to the previous patterns. It didn't -- it pretty much happened because of the incident with the

flatmates, but the way the incident happened with the flatmates was quite different to the previous incident, including the very first incident and the second incident.

Q. Dr Thangavelu, I'm sorry to interrupt. I don't have very much time so can I ask you about a few specific aspects of that. You've already been asked about the screaming and so on, I'm not going to repeat that, but the assault, the evidence from Chris in particular, we've seen in the RiO notes that Chris explained that there was firstly an assault, then after that, VC was acting strangely and refused to let them leave the flat.

Now, that was a sign of concern, wasn't it?

A. It certainly was a sign of concern, certainly at face value. But it appeared that the reason -- I mean, again, if that was the real reason or not, we wouldn't know, but the reason VC gave was he didn't know that that was illegal; because the flatmates called the police, he wanted them to be present till the police arrived.

My understanding of that was perhaps he wanted to be seen as someone not having committed anything wrong when the police turn up, and if those guys were not there, he might have been scared that the police might have mistake him or something, actually, or -- yeah.

Q. Just quickly moving on, if I may. The next relapse indicator I'd like to ask you about, paranoid or persecutory delusions.

Now we've seen Dr Manzar's assessment on 28 January 2022 describes VC as very suspicious and paranoid, in the RiO notes at page 220 [NHFT0000168], that's 31 January, VC is described as "paranoid and wide-eyed." And then there are several entries describing him saying he feels persecuted by mental health services.

Now paranoia, suspicion, persecution, if we look at the pattern of previous relapses, those were relapse indicators, weren't they?

A. I mean the first thing I would say is that paranoia is a thought disorder. You can't look at somebody and say they are paranoid because you don't know what they are thinking. They may appear frightened. I mean that's what we saw largely in VC. He was guarded because he wasn't expecting to come into hospital, he came in, he didn't like the place so he did appear wide-eyed and guarded.

In terms of the persecution from services, certainly the way I understood was he was -- I think increasingly, he was getting worried that "If I say something, they're going to put me back in hospital."

That's the last thing you want of somebody who has been harbouring some really complex persecutory ideas. You want them to trust you, without the fear of being locked up.

Q. Okay. The next factor, the next factor I suggest is a relapse indicator, is deception. So he provided a false address, he claimed to be taking medication when he wasn't, and he lied about the University.

Now, when one looks back at previous relapses, he also provided false information. You went through that with Mr Carr earlier.

Would you agree that this factor, so being deceptive, was a further relapse indicator?

A. I mean, again I wouldn't jump into a conclusion that it's a relapse indicator. When we talk about deception or lying, common sense would say that somebody was lying or deceiving because they are afraid of something. But that's what happens with everybody. You would lie because you're afraid of the consequences.
Q. Okay.
A. Whether that is a sign of relapse, I couldn't be completely sure.
Q. The fourth one I'd like to deal with is trespass. We know he trespassed on his former university accommodation, and if one looks back at May 2020,

there's two incidents of trespass in the course of acute relapse -- sorry, relapse into acute psychosis.

He's then taken to a ward. He hears screaming in a cupboard during the course of what was recognised to be a relapse. Then July 2020, again, trespass in the course of a relapse. This was another relapse indicator, wasn't it?

A. It certainly would raise the alarm bells as to whether, you know, there was a motive or purpose behind. It could be -- I mean, it needs to be explored. Certainly I wouldn't dismiss that. I would certainly explore.

Q. Thank you.

The next topic I'd like to ask you about just very briefly is your decision not to put VC on a CTO and depot with Section 3.

Now, you explained earlier you gave your reasons for why you decided not to do that, and they included, firstly, you said to Mr Carr: "There was nothing concrete to show that VC was non-compliant until August 2021". But you later accepted that in fact the RiO notes showed that he was non-compliant prior to the second admission.

Then you, a little later, said that between the third to the fourth admission it was only speculation that he might have become non-compliant, but then

you later accepted to Mr Carr that in fact he had been non-compliant. You said:

"I'm not suggesting remotely he was compliant."

What I'd like to ask you, doctor, is are you giving a misleading picture here to try to excuse the wrong decision?

A. No, I don't know what other concrete evidence people had at that time, actually. That would be my -- that would be my point. When you come to that point around I didn't have concrete evidence, but neither did anyone else to say. We were all speculating that the reason for relapse was non-concordance. It may well be -- and I know for a fact that non-compliance is one of the most common reasons for non-compliance *(sic)* and so does somebody who is extremely psychologically stressed, not sleeping at night, working in a warehouse, having university deadlines to meet, had just come out of hospital, there could be many reasons. And we can't just go down in a blinkered way one alleyway, actually. So that we should keep an open mind. That's what I'm suggesting.

Q. Okay, and the last issue I'd like to ask you about is earlier, you said you thought VC would engage in the short to medium term; do you remember that?

A. That's correct, yes.

Q. Were you not concerned what would happen beyond the short to medium term?

A. I think that would be very difficult to foresee as a prognosis for any patient with schizophrenia, because there are so many dynamic factors, situation factors, social factors, psychological factors, environmental factors.

I don't think anyone can see beyond the medium -- the short to medium term, but that's the very nature of the illness.

Q. What happened three times before this was that after the short to medium term, VC disengaged, stopped taking medication, relapsed, and was involved in violent and aggressive incidents. Now, given that history, it was highly likely that that is what would happen again this time, wasn't it?

A. I certainly wouldn't want that to happen to VC. Quite the opposite of that. I really wanted him to get well, remain stable, and get on with his life. And that's what we want for everybody we look after, and that's why I was very much advocating for the depot, but equally, balancing that out with his preference under the clear agreement that if things, you know, if things go off the rails, we are not going to accept anything other than more coercive treatment. And that's the line I took.

MR STRAW: Okay, thank you very much.

THE CHAIR: Yes, Mr Beggs?

MR BEER: *(Off microphone - inaudible).*

THE CHAIR: I'll take that as a "no, thank you" from you, Mr Beer.

Yes, Mr Beggs.

Questioned by MR BEGGS

MR BEGGS: Doctor, I'm confining my questions to issues relating to the police. Do you recall that you were asked by Ms Patrick about your view that the incident with the flatmate, about two weeks earlier than the relevant comment, was not driven by psychosis?

A. That was my opinion from the information that we had at the time.

Q. And you commented at paragraph 319, which is at page 96 of the Doctor's statement, if that can be shown to him [WITN0206001], you commented that the police had already decided not to pursue this incident.

Who told you that?

A. I'm trying to think. Certainly we ceded. I can't remember if anyone else did, actually. I can't be 100 per cent sure.

Q. Yes. Did you contact the police yourself or have your staff contact the police to ask about the details of that incident?

A. No, I think that was certainly something that should have happened. I mean I did request for the PNC check, not necessarily contact the police, but I think we were told right at the outset, I think it was at the very first ward review on the 3rd that when the EIP team tried to contact the police they were either not sharing information or forthcoming. I think at one point it got escalated to a sergeant. It felt like it got nowhere. But that's not the reason to not contact

-- *(overspeaking)* --

Q. Can I interrupt, not to be rude because I've only got five minutes, but you didn't in fact try to contact the police about the incident with the flatmate, did you?

A. No, no, I mean that's what I said. I didn't.

Q. And I think you now accept, I think you said to Ms Cartwright, that perhaps better liaison with the police is a significant learning point going forward, isn't it?

A. Absolutely.

Q. And in the same vein you did ask, didn't you, for someone to get hold of the PNC information on VC. You asked --

A. That's right, that was -- *(overspeaking)* --

Q. But in fact you accept in your statement, at two different paragraphs, that it appears that wasn't done.

Do you accept that?

A. That's correct.

Q. You also say in your statement at paragraph 227 -- if you want to have a look at it, it's at page 70. Do you see almost in the middle of the page:

"I did not have any direct correspondence from police related to any of the incidents from the past."

So pausing there. That -- it's self-evident, therefore, you didn't have a full forensic history, did you?

A. No, I didn't.

Q. And --

A. Sorry --

Q. And --

A. -- *(overspeaking)* --

Q. I don't think you ever tried to contact the police yourself, did you?

A. Not personally directly, because some of the information were already in his records, for example, the assault towards police. I know that was being investigated because Dr Lomas was going to do a statement and he came to the ward, et cetera. I was aware of that.

I knew that the incidents leading to the first episode, and the first contact, even, I think that was going -- I mean, I think, in one of our ward reviews it

said criminal damage, but I know it was going towards caution. That much I knew. But I didn't make any direct correspondence with the police, no.

Q. At the time, in 2022, do you think there was a cultural bias or disinclination or reluctance on the part of psychiatry to make contact with the police and obtain more detail?

A. I didn't sense that. We used to have good relationship with the police, I remember. I think it fell by the wayside at some point, I don't know why. But I wouldn't say there was a cultural reluctance. We always wanted to work together.

Q. But you accept, don't you, because you say as much in paragraph 478 of your statement at 143, page 143, that:

"Accessing essential information from public sector agencies such as police in a more readily available manner would be useful."

And that's stating the obvious, isn't it?

A. Indeed.

Q. So perhaps one of the recommendations going forward that you would endorse would be to make the process of accessing data from the police easier for psychiatrists?

A. Yes, it should work much, much better, yes.

Q. My final question is: I think, however, you did reflect some positivity since this tragedy, because you said

that there has been an improvement in interagency working with the appointment of, you described them as, Police Liaison Officers. Do you recall saying that?

A. I do. I mean, I don't work at Nottingham right now, but yes -- *(overspeaking)* --

Q. That was my question: were you talking about Nottingham or were you talking about more generally?

A. I was talking more about Nottingham, sorry.

MR BEGGS: Yes, thank you very much, doctor.

THE CHAIR: Yes, thank you.

Ms Patry?

Questioned by MS PATRY

MS PATRY: Dr Thangavelu, I ask questions on behalf of the University of Nottingham. Can you hear me?

A. I can.

Q. Thank you. Three short topics, if I may. The first is what the University knew about this admission; the second is what the University knew about the Section 17 leave; and thirdly, what the University knew or didn't know about the discharge of VC at the end of his time with you.

Turning to the first topic, please. It sounds from the evidence that you've given this morning that you were aware of the incident that had taken place on 15 January with VC's flatmates.

A. That's correct.
Q. Were you also aware that he had -- that the flatmates had been removed from the flat temporarily, but that Ms Turner's position is that she very much wanted them to go back to their home because they had exams at the time; were you aware of that?
A. I don't recall that specific information.
Q. All right. Well, he was detained on 28 January, so shortly after the assaults had taken place. The University's position is that it wasn't informed of that admission.
Now, given that they had been removed from their flat, why were no steps taken by you or your team to inform the University contemporaneously that he had been detained?
A. I think it may be related to two factors, actually. So one was I don't think VC was ever willing for us to make contacts with the University. I think he clearly made it -- I certainly remember personally asking him I'd be happy to do an EC for him. I don't think he wanted us to make contact.
And secondly, personally, I can only speak for myself, I wasn't fully aware of the -- again, the systems and processes in place for, say, NHS contacting the University. I think I might have wrongly assumed

that it all goes through the mental health support service for the University, actually, because Ellie Turner was -- Ms Turner was involved, I might have -- I think I did assume that that's a conduit into university. But that might be my mistake.
Q. Would you accept that they should have been informed of the admission?
A. I mean, again, it depends on whether VC would have capacity to say "yes" or "no" to that matter.
Q. All right. I'm going to turn to the second topic which is the Section 17 leave.
Now, there's been a bit of evidence about this already, I'm not going to ask you to repeat anything. Six days after he was detained he was given Section 17 leave, unescorted leave. And at paragraph 306 of your statement on page 91 [WITN0206001], which we can turn up or not, you indicate that he was allowed unescorted leave twice a day because he said he wanted to go to the gym; do you recall that?
A. Yes.
Q. Can we look briefly at the RiO notes on this please NHFT0000168, and can we start at page 226, please. I'm going to take you through chronologically here what was said. Now, if we see 226 is the first review that you undertake with him, and he's -- I'm not going to read

any of this out, other than the fact, the paragraph that starts:
"He explained that he would like to go to the gym", seven paragraphs down. Do you see that?
"He explained ... he would like to go to the gym and would like ... to go to the gym and the shop. His routine at the gym is 1.5 hours."
Then you explained to him that because he's on section, if doesn't come back, et cetera:
"... the police would have to be involved. It was agreed [right at the end of that paragraph] that it would start at 30 mins leave initially."
Do you see that? So that appears to be that unescorted leave was granted, as I say, less than a week before he was admitted. We can agree that, can't we?
A. Yes, so if I may just expand on that. So as for the Mental Health Act, leave within hospital grounds, technically it's not a Section 17 leave at all because patients can in theory go to the hospital grounds, or it's up to the local detaining authority to define where the boundaries are. So technically they could ask "I want to go to the café on site", and they can come back in 30 minutes. But it would have to be done after an assessment of any imminent risks, et cetera.
But what we have always done in our wards, in my

ward at least, was to have a clear record of the leave we said we would have to agree that at the ward review for them to leave, and that's what this is.
Q. Can I be clear, though, where does it say that he has to stay on hospital grounds? Can we look, if we scroll further down to the end of this entry we can see the plan that was agreed:
"Chase university regarding accommodation.
"S[ection]17 leave for 30 mins twice a day unescorted".
That would rather suggest that it's not limited to hospital grounds.
A. No. I mean I was just explaining how the leave system generally works. So regardless of what it is, people can have leave within the hospital grounds, and if they do that, you can't police that because the hospital grounds are not gated with a high fence. People can choose to leave. But this specific leave was for him to get enrolled at the Henry Mellish Centre which is a centre which is close to us, and a lot of our patients go and make use of that facility.
There was also an on-site gym, which is in the next block. So I thought 30 minutes is reasonable time to get those things sorted, and he was informed that if he didn't return back we'll have to call the police.

Q. So given that you had given him 30 minutes unescorted leave twice a day and you had not put any conditions on that, why did you not warn the University that he was being granted leave, given that he'd assaulted a fellow student a matter of weeks before?
A. I mean VC --
Q. Wasn't it a risk that he would return to the accommodation?
A. No. So VC, the incident happened on the 15th. Clearly, it's a sad event, but he was in the community for a long period of time. He was only admitted on the 28th. There are no bail conditions, there were no restrictions, restriction orders. He was a free man in the community. And then when he gets admitted, I don't know on what grounds I can suddenly say, "You can't leave," when he had been in the community for that long.
Q. I'm sorry to interrupt you. My question is -- your evidence is he was a free man, he could do what he wanted with his leave. Why did you not warn the University, given the obvious risks to the students, that he had previously been with -- well, at least to the student that he'd assaulted previously? Why didn't you inform the University?
A. Because he wasn't meant to go to the University. He was meant to go to the gym, get enrolled, and come back.

That was the purpose of the leave.
Q. Well, as we know he did go to the University. That's the first thing he does, we know that.
A. *(The witness nodded)*.
Q. If we look on to page 227 and 228, we can see how this unfolds. If you could just scroll up. Can we just pause there for a moment and look at the entry on 3 February at 3.44 pm, the second box there, you referred to the fact that you thought he might be using this time to enrol at the gym, but of course that's not right, is it, because we can see here that the plan is that he is going to have an induction session with the Henry Mellish, which I think is the gym, on 4 February and then go to gym sessions on 7th, 14th and 21st.
So on the third, when he visited the University, there wasn't even a plan for him to go to the gym, was there?
A. No, I think the -- I wouldn't have known this at the point of --
Q. That's fair enough. If we then look at the entry at the bottom of that page at 6.50, we have the telephone call from the University saying that he's been seen by one of the students he shared accommodation with. So he'd gone back to the accommodation.
Now, can we see what happens at that -- after that,

228, please, at 10.39 am. There's a restriction of his leave, and then if we keep going on to 233, or 222, 232 and 233, we can see what happens after that. His leave was restricted until 7 February, but then, if we look at -- if we're scrolling further down, keep going, the MDT lead by you -- this is the top box on the 7th; do you see that?
A. Yes.
Q. It's reinstated, 30 minutes unescorted leave, and unescorted leave to the gym. Now, again, given that he had now breached -- I wouldn't say breached the conditions because you didn't impose a condition, but given that he had now returned to the University and seen the flatmate that he assaulted, why was the University not warned at this stage that he was being given unrestricted leave again?
A. Well, the second --
Q. There was a clear risk -- *(overspeaking)* -- because it had happened?
A. If you look at the Section 17 form that is attached to this, the notes are not accurate. If you look at the Section 17 form that's attached to this, done on the 7th, it would clearly say "30 minutes unescorted leave to local grounds and shops", and "escorted leave to gym" but also by then we had gathered information from Ellie

Turner that he is not banned from -- not banned, but if he needs to go back to the University to hand in the keys, he can do that and get his belongings, but he needs to be accompanied by a security guard. That was the only thing that was told to us. And I apologise if there were -- there was an expectation that this was a requirement, but I -- we didn't -- we -- yeah, we were not aware that that was expected from the University, because Ellie Turner was very much aware of this, she was --
Q. With a --
A. -- in contact --
Q. I'm going to ask my very last question which is about discharge. He was discharged on 24 February. The University was not informed by you or anyone on your team of that discharge, and he was being released back into the community. Why was the University not informed of that discharge?
A. I don't think VC gave us consent to contact. That was my understanding at the time.
Q. Isn't VC's consent overridden in circumstances where there's a risk?
A. It could be, but I don't think we would have restricted him to the ward for those reasons, because I can't detain somebody under the Mental Health Act --

Q. No, I wasn't asking you whether you should detain him.
A. Okay.
Q. I was asking why you didn't let the University know that --*(overspeaking)* --
A. That probably is --
Q. -- *(unclear)* a clear ongoing risk --
A. Yes, yes.
Q. -- to neighbours and flatmates. Why you didn't just tell them that he was being discharged.
Do you know how Ms Turner found out he was being discharged?
A. I came to know later, I think, VC called --
Q. And she called VC --
A. Okay.
Q. -- and he told her.
A. Yeah.
Q. Thank you.
A. Again, yes. In hindsight, we should have got that better. I agree.
MS PATRY: I'm really grateful, thank you.
THE CHAIR: Thank you.

Questioned by THE CHAIR

THE CHAIR: Just a couple of questions I wanted to ask.
The first, when you were dealing with his medication you said there was no real difference between

10 milligrams and either 20 or 30 milligrams, and that if he had wanted to go on to 10 milligrams, that's what you would have done; is that right?
A. I would have certainly taken that route, your Honour. I think we've done that many times, working in Assertive Outreach teams, but there is a general anxiety around what we call steep prescribing, and once you go up, you hesitate to come down.
THE CHAIR: Yes, but what indication that you had got that 10 milligrams would have been effective?
A. I think it's more of balance between the effectiveness and the side effects.
So the literature behind all of this, the scientific evidence behind all of this, is 10 milligrams of aripiprazole has got the best balance between the effect and the side effect. So on that basis, you can try that, with close monitoring. There is no guarantee that will be better, because for some people 20 might be better. But what I was trying to emphasise was one size doesn't fit all. You have to work with what the patient is experiencing because only they can experience --
THE CHAIR: That's the question I was going to ask you. Who is calling the shots on the medication here? You as the psychiatrist prescribing, or the patient?
A. It's the psychiatrist working with the patients. So

obviously when you prescribe, you are meant to check how effective it is and whether they are experiencing any side effects, and --
THE CHAIR: You had information, didn't you, both from the two previous treating psychiatrists, Dr Lomas and also Dr Manzar, who'd had previous engagement with him, that they agreed to the admission because they were very concerned about the risks he posed and the fact that he was not -- he was masking his symptoms. Would you agree with that?
A. I agree.
THE CHAIR: And we then had, and you can just quickly look at that, which is NHFT0018527. It's an email from Dr Lloyd to you and Claudia Birtles saying that they would like -- that's the Community Team -- him to be on a depot. And these are, including Claudia Birtles, all people, Dr Lomas, Dr Manzar and Claudia Birtles, who have had previous dealings with him, and they are asking you to put him on a depot with a really "robust plan at the point of discharge". That didn't happen, did it?
A. No, I really wanted that to happen, and --
THE CHAIR: Well --
A. -- the only way --
THE CHAIR: -- I'm going to ask you, why didn't it? Because you're the Responsible Clinician in charge of his care.

So you've given us some reasons, but I think that it's right we heard from Dr Gibson yesterday that it was the -- the key thing was that you didn't want to enforce it, take the coercive measure of putting him face down, with a number of people to hold him down, and give him the injection. Was that the determining factor or not?
A. Not entirely. That was one of the factors, your Honour, but there were a number of other factors which I took into consideration, which I explained --
THE CHAIR: You have already set those out. But have you ever discharged somebody or have you ever imposed a depot in those circumstances where you've had to have somebody held down, or not?
A. Many a times. I have personally given rapid tranquilisation myself, as a junior doctor. When the necessity was there, I've never hesitated to, and --
THE CHAIR: Why not on this occasion? That's what I'm asking.
A. It's just that on balance there were a number of factors which made me give him another chance. I mean, I wouldn't have discharged him without a clear medication plan or to a team with no resources to manage. I felt that he could be closely monitored and be agreed with that, he -- I insisted that on him, that it'll have to be regular monitoring and so on. He

agreed to it.

And if things were to deteriorate, if they were to kind of come back to my ward, I would have straight away gone with that. It was just I had ethical dilemmas that I struggled to overcome on that occasion, having taken into consideration every factor. I mean, obviously, the terrible tragedy happened and we are looking at it through a different lens, and I still don't know -- I mean, I've discharged so many patients like VC, worse risk history, without any significant concerns. Some of them had come back straight away, some of them had stayed much longer in the community. But on that occasion, I took into consideration all of the factors I had in front of me, and --

THE CHAIR: But the community clinicians who were going to have to manage him and deal with him were specifically saying to you that he needed a depot, weren't they?

A. I took that really seriously, and I spoke to him in quite a bit of length. We all did. And I think, on reflection at least, there were a couple of factors. If he had been, say, for example, if he had been unwell during the course of admission, or there were any other concerns which were clearly pointing towards depots as the only option, I would have. And again, the depot would be somewhat meaningless unless the CTO is imposed.

And that that in itself has got a number of caveats, actually. I mean, it's been now more or less clearly established by five randomised trials that CTOs don't prevent the desired outcomes.

We live in -- psychiatry particularly, we are at the crunch point where you're expected to manage the person's best interest, the families' best interest, the Community Teams' best interest, all working within the legal framework, but he was still there as a scholar who has to take into consideration the best available evidence, and put that within the framework, and there are significant challenges, and on top of that, obviously there are particular issues.

I mean, it is a very unique place to be in, as a psychiatrist having to balance this.

THE CHAIR: Thank you.

Right, well, we'll start again at 2.00. Thank you.

MR CARR: We were proposing before the lunch break that we could --

THE CHAIR: Shall we do that, actually, if we start again at 1.45 and then you can read out your documents. Thank you.

MR CARR: Thank you.

(12.48 pm)

(The short adjournment)

I N D E X