

Wednesday, 13 May 2025

1
 2 (9.15 am)
 3 (Proceedings delayed)
 4 (9.17 am)
 5 **THE CHAIR:** Yes, Mr Carr.
 6 **MR CARR:** Yes. May I call, please, Dr Karthik Thangavelu?
 7 **THE CHAIR:** Yes. Good morning.
 8 **DR KARTHIK THANGAVELU (affirmed)**
 9 **Questioned by MR CARR**
 10 **MR CARR:** Dr Thangavelu, you have prepared a witness
 11 statement for this Inquiry dated 28 December 2025.
 12 **A.** That's correct.
 13 **Q.** Is that statement true to your best knowledge and
 14 belief?
 15 **A.** That's correct.
 16 **Q.** You're a Consultant Psychiatrist employed by the
 17 Nottinghamshire Healthcare NHS Foundation Trust?
 18 **A.** Yes.
 19 **Q.** You're currently on a sabbatical.
 20 **A.** That's correct.
 21 **Q.** At the time of VC's fourth admission to the Redwood ward
 22 in February 2022, a Section 2 detention, you were
 23 a consultant working on that ward.
 24 **A.** That's correct.
 25 **Q.** You were VC's Responsible Clinician --

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1 **Q.** The position was, as you've set out in your statement,
 2 he would not agree to depot, that's VC, and you did not
 3 think taking coercive steps under the Mental Health Act
 4 to enforce depot or use a CTO, Community Treatment
 5 Order, that you didn't think those steps were justified?
 6 **A.** No, the CTO would have come later on if he had gone on
 7 to Section 3, but at that stage it was the depot.
 8 **Q.** Yes. And you didn't think you were able to convert the
 9 Section 2 admission to a Section 3 for the purposes of
 10 putting in place a CTO to enforce depot?
 11 **A.** It wouldn't be lawful just for those purposes, but
 12 Section 2 patients could be converted to section 3, if
 13 necessary.
 14 **Q.** Could be, did you say?
 15 **A.** If they met the criteria for Section 3, Section 2
 16 patients can be placed under Section 3. But not purely
 17 for the purpose of getting them onto a CTO.
 18 **Q.** I'm going to explore, in your statement -- and it's
 19 a lengthy statement -- you set out the various reasons
 20 why you didn't feel you could take coercive steps and
 21 I'm going to go through those.
 22 If we can start by looking at the context the
 23 immediate context of the fourth admission, and it's
 24 document -- it's a Nottingham City Council document,
 25 NOCC0000043, and this is the AMHP report from the Mental

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1 **A.** I was.
 2 **Q.** -- for the purposes of that admission.
 3 **A.** Yes.
 4 **Q.** Your colleague, Dr Gibson, who was one of your trainees
 5 at the time, he gave evidence to this Inquiry yesterday;
 6 did you see that evidence?
 7 **A.** I did see most of it and I read the transcript.
 8 **Q.** So far as your direct involvement during VC's fourth
 9 admission you attended, didn't you, MDTs on
 10 31 January 2022, 7 February, 14 February, and
 11 21 February?
 12 **A.** That's correct, yes.
 13 **Q.** You attended two ward reviews where VC would have been
 14 present, 3 February and 10 February?
 15 **A.** And also the 24th.
 16 **Q.** That was a discharge meeting, wasn't it, that was akin
 17 to a ward review.
 18 **A.** Yes, that's correct.
 19 **Q.** Ultimately, the decision you made, the decision that was
 20 taken, was to discharge VC into the community on oral
 21 medication --
 22 **A.** Yes.
 23 **Q.** -- even though, to use your words, you were advocating
 24 for depot during the admission?
 25 **A.** Yes.

2

1 Health Act Assessment 28 January 2022, and if we go to
 2 page 5 of that document, please, we have the comments
 3 here of the assessing doctors, and it's the fourth
 4 paragraph on that page, starting with "Dr Lomas and
 5 Dr Manzar", both of whom, as is set out here, were
 6 previously acquainted with VC, and what is set out is
 7 second sentence:
 8 "... both felt that [VC] needs to be in hospital to
 9 manage his mental health. ... risk to others is high
 10 ... although during assessment he does not appear overly
 11 psychotic they believed that he was masking his symptoms
 12 and was very guarded with what he was willing to share.
 13 Community treatment is no longer a viable option as [VC]
 14 [was] ... not fully engaging and is refusing to meet in
 15 a more private place so that fuller discussions can be
 16 made."
 17 So in light of what is being set out by the doctors
 18 there, in terms of the complexity of the presentation,
 19 you've got somebody who the doctors believe is masking
 20 psychotic symptoms.
 21 **A.** Yes.
 22 **Q.** And who presents as with a high risk to others?
 23 **A.** Yes.
 24 **Q.** And is no longer safe in the community?
 25 **A.** That's correct, yes.

4

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

5

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

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1 his history. There were periods, certainly between the
2 first and second admission. From what I understood,
3 there were a couple of weeks where he became
4 non-compliant from the period from the second admission
5 to the third admission.

6 As far as the Community Team was concerned, even
7 though they suspected non-compliance, I don't think
8 there was anything concrete to say that he had become
9 non-compliant until August of 2021. I mean, that was
10 the picture I gleaned from looking through his notes.
11 But certainly between the third admission and the fourth
12 admission, the picture was again not consistent or
13 clearer. I mean, I certainly looked for evidence of it,
14 both from his care coordinator, also looking through his
15 records. I mean, it certainly felt like there was
16 a speculation that he might have become non-compliant.

17 Q. We'll come on to --

18 A. There wasn't any --

19 Q. We're going to go through some of the entries in the
20 history on the issue of non-concordance, but as a broad
21 proposition, this was a fourth admission in the space of
22 under two years, wasn't it?

23 A. That's correct.

24 Q. The three previous admissions, VC had been compliant
25 whilst an inpatient?

6

1 records?

2 A. Sorry, I'm just trying to look for the line, actually.

3 Q. 393.

4 A. Yes, sorry.

5 Q. If we can look, please, at an interview that you gave
6 for the purposes of an internal review, it's
7 NHFT0004709. And then page 3 of that document. This on
8 the issue of medication concordance. First paragraph on
9 that page, second sentence:

10 "VC gave a plausible explanation ... said he was
11 taking it [that's his medication] once a day not
12 realising a 10mg tablet not 20mg -- didn't seem
13 deliberately untruthful and sounded plausible."

14 A. That's correct.

15 Q. Sorry, go on?

16 A. That's correct, yes.

17 Q. If we can put the RiO records on, and I'm going to take
18 you through some of the entries in the records,
19 Dr Thangavelu, dealing with the issue of concordance.
20 First, page NHFT0000168 page 58. This is a Mental
21 Health Act Assessment. This is 14 July 2020, so it's
22 ahead of VC's second admission. The fourth paragraph on
23 that page:

24 "... clear from [the] ... assessment [that day] that
25 [VC] had decided to stop taking his medication 2 weeks

8

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

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

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

13 **Q.** So that's the period following the first admission.
 14 Then we have the second admission. If we go to
 15 page 79 of the records, please. This is during the
 16 second admission, these notes are from 21 July, it's
 17 a ward review led by Dr Seedat. If we go to the final
 18 paragraph on that page under the heading "Patient
 19 comments", about halfway down in that paragraph there is
 20 a reference to [VC] saying he:
 21 "... recognises the importance of continuing the
 22 medication after discharge more".
 23 Do you see that?

24 **A.** Yes.

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

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

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

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

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

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

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

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1 Dr Seedat explaining to [VC]:
 2 "... that it was his view that if he had not stopped
 3 taking his medication, he probably would not be here
 4 again. [VC] understands that he must take his
 5 medication regularly."

6 **A.** Yes, I can see that, yes.

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

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

15 **Q.** Well, following the second period of detention, and
 16 notwithstanding what is set out in this note, there's
 17 almost, aren't there, immediate grounds for concern as
 18 to VC's medication concordance with the Crisis Team.
 19 So if we go to page 119, this is an entry from 1
 20 August 2020, Clive Chimbi from the Crisis Team, halfway
 21 down the page, we have the paragraph that starts:
 22 "When we arrived this evening, he still had not
 23 taken his medications."
 24 This is immediately following the second admission
 25 when he's been told that he's become unwell again as a

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

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

9 **Q.** Shall we --

10 **A.** Unless he.

11 **Q.** Shall we look through the records, because that's just
 12 one of the crisis appointments. So shall we look
 13 through the others? Page 122, Crisis visit, 3 August,
 14 top of the page. Crisis come. And the purpose of their
 15 visit is to ensure concordance, isn't it? VC says, it's
 16 the second line:
 17 "... said he's already taken his morning meds. He
 18 showed me the meds with evidence of tablets having been
 19 dispensed."

20 **A.** Yes.

21 **Q.** Do you have that?

22 **A.** Yes.

23 **Q.** But he's told by the Crisis worker, next sentence:
 24 "... we need to do medication concordance with him."

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

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1 tablets have been dispensed. By that, I take it that
2 the tablets have been taken.
3 **Q.** Well, the point I was taking you to is the Crisis
4 workers are trying to do medication concordance. They
5 come. VC is told that they need to do medication
6 concordance, and if we look at page 123, this is the 4
7 August entry, again, when he is visited, third paragraph
8 down:

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

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

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

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

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

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

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

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

16 **A.** Yes.

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

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

15

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

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

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

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

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

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

5 **Q.** 3 September, this report is for.

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

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

19 **Q.** Did you --

20 **A.** But also it was --

21 **Q.** When you --

22 **A.** Sorry.

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

16

1 A. I didn't see that. I think it's the AMHP report you
2 said --

3 Q. If --

4 A. -- from 2021, but I know that as part of the inquest,
5 this came up before, I think.

6 Q. If we go back to the RiO records, page 199, and this is
7 an entry from 19 November 2021, and this touches on the
8 issue of 10 milligrams versus 20 milligrams, one of the
9 explanations that was given to you.

10 A. Yes.

11 Q. This is an entry by Claudia Birtles, his CCO. States:
12 "He had been taking 10mg OD since the admission.
13 Aware that he needs to take 20mg OD. Said he would do
14 so."
15 So there's no suggestion there, is there, that he
16 was confused or that he thought he should be taking ten
17 milligrams; it says instead he is aware that he needs to
18 take 20 milligrams and there's a commitment by him to do
19 so from that point.

20 A. That's true, that's true. It seems like there was
21 something going on there about what he might want to
22 take as opposed to what has been prescribed. I mean
23 that certainly seems to be, you know, what has been or
24 may have been happening, from looking at this.

25 Q. If we are on the same page, and if we go further down to
17

1 else, as to could it be that some of this be attributed
2 to the confusion over the address, which is a very
3 realistic prospect, if people are turning up at the
4 wrong address, he probably wouldn't have known that,
5 actually?

6 Q. Well, that's one -- (*overspeaking*). If we look at page
7 201 where VC is asked why he has missed appointments
8 with Dr Lloyd and whether it's because he didn't want to
9 see the EIP team, he said that wasn't the case, but
10 again, he doesn't suggest, does he "Well, I wanted to go
11 to the appointment, but there's some issue with my
12 address" or "You've gone to the wrong place" or
13 "I didn't receive the appointment letter"?

14 A. Yes, I can see that.

15 Q. So the suggestion -- and you go to some lengths to
16 outline this in your statement -- the suggestion that
17 the reason for non-engagement was because of confusion
18 as to VC's address. It doesn't seem to match up to the
19 records, does it?

20 A. I don't think it doesn't match up entirely because, as
21 I've said in the document, I mean, I wasn't
22 categorically saying well, that was the only reason why
23 VC was missing appointments, but when there is a clear
24 evidence to say that there was a confusion over the
25 address, it is a very realistic prospect that at least
19

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

8 Now, one of the points you make in your statement
9 was that while there was confusion over what address VC
10 was living at and that might explain why he wasn't
11 attending appointments, but from this entry here, it
12 seems clear, doesn't it, he's aware that he's missing
13 appointments and it's nothing to do with post going
14 missing.

15 A. No, I think from what I looked at, in terms of the
16 confusion over address, I don't think every missed
17 appointment could have been explained through that.
18 What I was inferring was certainly there was some
19 confusion over the address, and I know the team tried to
20 see him at this stated home address couple of times when
21 he was not there.

22 So what I was inferring there was -- so the bigger
23 picture might be that, say, he missed two out of three
24 appointments or two out of five appointments, but I was
25 just questioning myself, actually, more than anything
18

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

5 So -- and I can't explain why that may not be
6 a viable explanation at least to a degree, actually.
7 I mean clearly there are two homes. It's to the wrong
8 address.

9 Q. Can we look at the immediate context just prior to your
10 admission. So this is entries in December 2021 and
11 January 2022, page 202 of the RiO records. It's that
12 top entry at that page. The date is 17 December. That
13 is the last entry of VC collecting his medication. He's
14 noticed to be fixed in his staring, has a hostile edge
15 to him, and walks away mid-conversation.

16 But again, this is the last medication pick-up.
17 Then on any view, early 2022, he's going to be
18 non-concordant, isn't he?

19 A. I think what I observed from looking through his notes,
20 when -- so the context in which this was happening was
21 I asked -- well, Ms Birtles was suggesting that he was
22 non-compliant. I mean, quite frankly, I mean, she has
23 known the pattern for a long time. And VC immediately
24 responded to say that's incorrect, and he was only
25 referring to just the two months prior to the fourth
20

1 admission, to my ward since discharge from the Priory.

2 So when I did a quick look through RiO, I mean,
3 I think in that conversation it was also coming out that
4 there was a period soon after discharge where he was
5 allegedly taking 10 milligrams when he should have been
6 taking 20 milligrams, and he was saying that himself.

7 And I think Ms Birtles also suggested that was the case.

8 So when I looked at it, and I would have spent
9 probably a few minutes looking through that, just I did
10 a quick search and it showed that he had collected two
11 28-day supply between November and January before the
12 Crisis Team took over. I mean, I think probably the
13 dates seemed to match if you account for the fact that
14 he had been taking 10 milligrams until Ms Birtles
15 reminded him to take the 20, and his explanation at that
16 point was: "I thought each tablet was a 20 milligram
17 tablet until you told me that it was 10 milligrams."

18 That's how it panned out, actually. I mean,
19 I couldn't decide one way or the other. It's quite
20 possible that he had been taking 10 milligrams and what
21 I would have liked to see, or liked VC to have done, is
22 to just tell the team "Look, I don't like the
23 20 milligrams, would you consider getting me on the
24 10 milligrams?" And that's what I would have liked to
25 see, but just based on the evidence just to answer the

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1 established, even by the manufacturers themselves, that
2 20 milligrams and 30 milligrams is no more effective
3 than 10 milligrams. In fact, 10 milligrams is supposed
4 to be the optimal dose because it blocks 60-80% of the
5 dopamine receptor and anything above 10 milligrams goes
6 towards side effects. I mean, that's an established
7 fact -- (*overspeaking*) --

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

10 **A.** No, and I'm --

11 **Q.** Dr Thangavelu, if there's no difference between, or no
12 benefit to 20 milligrams or 30 milligrams above
13 10 milligrams then why do you prescribe anybody
14 20 milligrams?

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

17 **Q.** -- (*overspeaking*) --

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

22 **Q.** But I thought you said -- sorry, just so I'm following
23 the thread of this answer, I thought the answer you gave
24 a few moments ago was that there's no real benefit above
25 10 milligrams, for 20 milligrams or 30 milligrams, and

23

1 question around the tallying of the numbers.

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

11 **A.** I think he probably knew that the prescribed dose was
12 20 milligrams, but it might be that he didn't want to
13 take the 20 milligrams because it might not have suited
14 him, and it might be that the 10 milligrams was much
15 more suiting to him. I mean, I'm, again -- I'm --

16 **Q.** If that was the explanation --

17 **A.** -- speculating --

18 **Q.** -- Dr Thangavelu, if that was the explanation, that he,
19 despite being prescribed 20 milligrams, he didn't want
20 to take it because it was too much and he was taking
21 10 milligrams, that would be non-concordance, wouldn't
22 it? It would be him not complying with his
23 prescription.

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

22

1 when I've asked you why prescribe 20 milligrams you've
2 referred to the drug company.

3 So is this some kind of profit-making ruse --

4 **A.** No.

5 **Q.** -- by pharmaceutical companies?

6 **A.** Not at all. So all medications have a dose range, all
7 medications have a dose range, and that's borne out of
8 kind of the phased trials. So every medication has got
9 a dose range but that doesn't mean that the top-most
10 dose is better than the mid-dose or the lower dose.
11 What we know, with aripiprazole, particularly, is -- I
12 mean if you read the product characteristic of
13 aripiprazole from Otsuka pharmacy it would say, the 20
14 and the 30 do not have a great advantage over
15 10 milligrams.

16 So --

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

19 **A.** Sorry.

20 **Q.** Is the bottom line this: if VC has been prescribed
21 20 milligrams he's been told take 20 milligrams, he's
22 been reminded by his care coordinator that that's the
23 correct dosage and he's not doing so, he is not
24 concordant. Do you accept that?

25 **A.** I agree, I agree, I -- yeah.

24

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

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

8 A. Yes, yes.

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

13 A. That's correct.

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

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

21 Q. Would it be helpful to have the note from your ward
22 review? We can put that up. We can look at the
23 10 February one, page 238 [NHFT0000168]. And that third
24 paragraph from the bottom. I interrupted you, but this
25 is where you're having a discussion on this point. And

25

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

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

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

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

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

27

1 this is where VC is describing:

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

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

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

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

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

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

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

26

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

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

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

28

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

29

1 **Q.** Dr Shoilekova -- and this is borne out in the Cygnet
 2 notes -- her view and view of her team was that VC
 3 completely lacked insight. Was there any real
 4 difference between VC's acknowledgement of mental health
 5 problems then and during your admission?
 6 **A.** I think so. I know, certainly before the admission to
 7 the Cygnet, he was floridly psychotic, and it was quite
 8 evident that he lacked insight, and I have no doubt over
 9 it, actually. But the difference when he came to
 10 Redwood 1 was he was less symptomatic or nearly
 11 asymptomatic.
 12 He probably did have some residual symptoms prior to
 13 the fourth admission, as he would commonly see, because
 14 the illness rarely completely remits. It's only a third
 15 of people who have complete symptom remission.
 16 But certainly at that point, I agree that he
 17 probably had a total lack of insight, but as I was
 18 explaining earlier, insight is not to be seen as all or
 19 none all the time, it's very fluid, it's not static.
 20 There are so many factors which play up in the gaining
 21 back of insight.
 22 **Q.** Did you conclude that VC had a greater appreciation or
 23 that he did believe he suffered from a mental disorder
 24 in contrast to what Dr Shoilekova's written in that
 25 first bullet point?

31

1 that. But say, for example, on the 24th he was able to
 2 touch upon the other psychotic phenomena that he was
 3 experiencing which was more around the technology
 4 interference into his brain. That again showed that he
 5 was able to recognise some sort of experience that he
 6 was going through, but he may not want to call it as
 7 psychosis. And that's not unusual at all, when you talk
 8 to somebody. Particularly with psychosis, you do have
 9 these expressions of symptoms, but when you kind of try
 10 and push into that into "So does that mean that -- or
 11 would you agree that is a symptom of schizophrenia?",
 12 they just stop at that point, or retract a bit, for a
 13 number of reasons. But that doesn't make that -- make
 14 them completely insightful, because I've seen --
 15 **Q.** Can we look at Cygnet document 11, [CYGN0000011],
 16 please, and this is a document from VC's third
 17 admission. If we go to page 5, this is a report from
 18 Dr Shoilekova who was the Responsible Clinician whilst
 19 VC was at Cygnet during that third admission. This is
 20 from September 2021, 17 September, bottom box on that
 21 page:
 22 "[VC] does not believe he suffers from mental
 23 disorder and therefore he is adamant he does not need
 24 any treatment for that."
 25 **A.** Yes.

30

1 **A.** I couldn't tell if he had greater insight in that
 2 dimension because that's the dimension that most people
 3 will struggle to demonstrate a good insight, the
 4 disorder part of it, actually, or the diagnosis part
 5 of it.
 6 But where people gain insight often, when they come
 7 out of the acute episode, is the ability to recognise
 8 symptoms, which they may be able to pin down as the one
 9 that probably got them into difficulties, interpersonal
 10 difficulties, or intrapersonal difficulties, it may be
 11 that they deeply suffered within themselves. It might
 12 have made them feel anxious. It might have made them to
 13 act out.
 14 So it's that recognition that usually comes out, and
 15 when I spoke to VC on the 10th, I was able to see that
 16 although it was mainly around the first episode as he
 17 put it, there was evidence for it, actually. I couldn't
 18 completely dismiss that.
 19 So -- and that's what I was trying to explain --
 20 **Q.** -- (*overspeaking*) -- was there evidence that he
 21 acknowledged or recognised that he had a mental disorder
 22 or he suffered one beyond that first rational admission,
 23 as he described it?
 24 **A.** I don't think we progressed too much into that
 25 particular topic alone. But the discussion -- and as

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

33

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

35

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

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

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1 A. Looked at that --

2 Q. -- VC about that? Did you say to him, "Well look,

3 you're saying you feel aggrieved, but of these visits,

4 there's two you've missed, one where you were seen

5 taking something from your mouth and putting it in the

6 bin, and there's only two occasions where, or it appears

7 to be only two occasions where you put the medication in

8 your mouth, what's going on?"

9 Did you ask him for an explanation, or challenge him

10 on him feeling aggrieved, given what's recorded?

11 A. I think that topic was discussed either at the 72-hour

12 review or the 3rd of February. At some point it was

13 touched upon, and he was adamant that, well, if they had

14 wanted me to drink, or if they -- I think the way he put

15 it across was: "If I had known that that was going to

16 lead to this admission, then I would have just followed

17 what they wanted me to follow."

18 I mean, that's the way he put it, actually. And

19 I know of patients who do what they call a dry swallow

20 of tablets, and again I am not suggesting remotely that

21 he was compliant, but it just left us -- left me

22 questioning myself as to, well should I just dismiss all

23 of this? Or should I --

24 Q. My question was more about -- right now -- I'm about to

25 move on from this topic of insight, but it was

37

1 move on to his willingness to take oral medication, and

2 if we put your witness statement up it's page 72,

3 paragraph 240. You reference there the ward review 3

4 February 2022 and the fact that VC indicated

5 a willingness to continue taking his medication in the

6 form of tablets, felt it was easy to take tablets, and

7 connected to this point -- do you have that, 240,

8 page -- bottom of page 72 to the top of page 73.

9 If we go back again to the notes of the interview

10 for the purposes of the internal investigation,

11 NHFT0004709, page 2 of that document. At the final

12 paragraph, it's just coming up, the final paragraph on

13 that page, Dr Thangavelu, your note is to say that you:

14 "... didn't have any reason to believe VC was not

15 being truthful in his statements ... when he said he

16 intends to continue to comply with treatment ..."

17 Do you have it? Three lines from the bottom

18 onwards.

19 A. Yes.

20 Q. It's -- that issue, your view, as part of the decision

21 ultimately you made to discharge, his willingness to

22 take medication and whether there were reasons to be

23 concerned.

24 If we look, please, first at Cygnet document

25 CYGN0000056. This is the decision of the Mental Health

39

1 specifically about the question of insight, and you've

2 got somebody who is in front of you saying that they

3 feel aggrieved, they think the EIP have gone back on

4 their plan, they have reneged. But it seems plain,

5 doesn't it, from the records, that there was

6 an agreement with VC that he was to engage as

7 a condition of not being detained at first assessment

8 with Dr Skelton, and then what follows is not consistent

9 with engagement, is it?

10 A. No, I think that's where the confusion came about,

11 actually. I think my reading into the notes was that

12 the first visit or the second visit, the Crisis Team are

13 running late. He waited and he walked off. They called

14 him and he didn't come back. And then there was this

15 potential spitting of tablet, which I believed that the

16 Crisis Team on that more than him, but if we still keep

17 that as a potential question mark, the plan continued

18 with him, despite that --

19 Q. -- (*overspeaking*) -- Ultimately, were you sympathetic to

20 his feelings of aggravation? Is that the point that

21 you're --

22 A. I mean, that's --

23 Q. -- making? -- (*overspeaking*) --

24 A. -- that's his view and I --

25 Q. All right. Can we move on to a different topic? Can we

38

1 Tribunal. So this is from back in September 2021, it's

2 during VC's third admission. If we go to page 4 of that

3 document, there is a section at paragraph 8 which has

4 VC's name in bold at the beginning.

5 What this describes is VC representing to the

6 tribunal, it's a little over halfway down that

7 paragraph:

8 "[VC] said he would continue to take medication in

9 the community."

10 Do you see that?

11 A. Yes, yeah.

12 Q. That is indicating a willingness to continue taking

13 medication in the same way that you have noted, he

14 represented to you a willingness to continue taking

15 medication in the community.

16 But if we then look at the AMHP report, it's

17 a Nottingham City Council document NOCC0000038. This is

18 the report which resulted in the Section 2 during the

19 third admission being converted to a Section 3. If we

20 go to page 3 of that document, it's at the bottom of

21 page 3, and this assessment is 24 September,

22 Dr Thangavelu. So the very next day after the Mental

23 Health Tribunal hearing there VC refers to continuing to

24 take medication.

25 Bottom of that page, penultimate paragraph starts:

40

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

4 **A.** Yes.

5 **Q.** Then bottom line:

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

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

16 **A.** I did not.

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

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

41

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

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

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

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

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

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

19 **A.** It is, yes.

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

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

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

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

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

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1 fact that he had been non-compliant many a times.
2 I kind of really wanted him to be on a depot. I mean,
3 I wasn't kind of saying he doesn't need a depot, and --
4 **Q.** But here we're considering the issue, and the point, and
5 I took you to it in your interview where you say "didn't
6 have any reason to believe he was not being truthful",
7 in fact there was evidence available that he would
8 mislead, particularly if it meant him getting out of
9 hospital. And it's not just those entries, if we go to
10 the RiO records, please, page NHFT0000168 page 137.
11 It's the bottom box which gives us a date,
12 10 November 2020 and if we go to page NHFT0000168
13 page 138 we'll see the substance. And this is an
14 appointment with Dr Burri, that was a doctor in the EIP
15 team, and Claudia Birtles, his CCO.

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

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

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

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

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1 where he probably was not telling the truth, and I don't
 2 have any kind of major queries over that at all.
 3 But again the way I would see this is, it's just
 4 like how I was describing earlier. So he didn't like
 5 the ward. I think he's made it clear every time.
 6 Nobody likes the ward. It's not something anybody would
 7 want to come into. But he comes to the outpatients
 8 clinic and tells this, knowing that the person who is
 9 listening to it might react in a completely different
 10 way, to say, "Well I'm not going to trust you anymore."
 11 But at least he warranted(?) that information, which, in
 12 some ways -- again, it doesn't kind of go towards
 13 strengthening the case in any major way, but at least in
 14 some ways, he was able to recognise, "Perhaps there were
 15 people who were trying to help me but I let them down,
 16 and I'm telling you this so you know."
 17 **Q.** That might be what it says about that day, but in
 18 respect of his behaviour, his reliability, in
 19 circumstances where you say you had no reason to doubt
 20 his truth, it indicates, doesn't it, it shows that
 21 whilst an inpatient he is -- or is prepared to mislead
 22 those who are treating him in order to get out of
 23 hospital?
 24 **A.** That's certainly a very, very much a realistic, you
 25 know, possibility, and it did happen, and --

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1 with Fanuel because I believe he had got to know him
 2 from his previous admissions in Rowan 1, but I remember
 3 after my review, the ward review on the 10th, he had
 4 a further one-to-one session with Mr Shoko where he
 5 seemed more willing or insightful, and the point I'm
 6 trying to make is, yes, people don't come with full
 7 insight, people want to get out of hospital, but
 8 sometimes you see them putting in effort, and you can't
 9 completely disregard that. That's the point I was
 10 trying to make.
 11 **Q.** So far as engagement more generally on the ward, VC
 12 declined OT activities, didn't he? There were no real
 13 therapeutic activities noted, much beyond him being on
 14 his phone. He's largely described over the course of
 15 the fourth admission as being low profile and
 16 interacting with staff on a needs basis. Is that a fair
 17 summary of his time on --
 18 **A.** That is a fair summary, yes.
 19 **Q.** The hospital wasn't monitoring his phone or computer
 20 use, were they?
 21 **A.** No, we weren't.
 22 **Q.** Did you hear the evidence from Dr Gibson yesterday
 23 that -- well, firstly, he preferred for patients not to
 24 bring phones onto the ward, but if they were, it would
 25 be useful to be able to track phone or computer use or

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1 **Q.** Can we go to page NHFT0000168 page 234 of the RiO
 2 records, please. Because even during the admission
 3 before you, the fourth admission, there are some grounds
 4 to be concerned about VC's true willingness to engage.
 5 So if we go to the bottom of the page,
 6 8 February 2022 entry. This is a brief one-to-one with
 7 Mr Fanuel Shoko who indicates to VC that he is "missing
 8 out on therapeutic engagements", and VC's response is:
 9 "... he did not want to engage as he did not agree
 10 with the admission and the reasons why he is here. He
 11 said ... he did not believe he had a mental health issue
 12 and ... he [is] ... going to engage as minimally as he
 13 could, keeping out of people's way and not being
 14 a management problem until he can go back to his life
 15 and continue with his education."
 16 Now particularly in the context of the other entries
 17 we've looked at, doesn't that suggest somebody who is at
 18 risk at least of just trying to get by the admission --
 19 trying to get through the admission, sorry -- in order
 20 to be released back to the community with no real
 21 willingness to continue a treatment thereafter?
 22 **A.** There was no question that he didn't like staying in
 23 hospital. As I said before, nobody wants to. I mean,
 24 again, if I may just mention, he had a pretty --
 25 I wouldn't use the word good, but decent relationship

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1 to provide hospital phones and computers that would be
 2 capable of being tracked? Do you agree with that?
 3 **A.** I wouldn't agree with that, actually. I don't think
 4 that's -- I don't think that's the right approach to
 5 take.
 6 **Q.** Dealing with the issue of psychosis and you touched on
 7 this in a number of your answers already and the extent
 8 to which VC was presenting or wasn't presenting with
 9 symptoms of psychosis. Because of the lack of
 10 engagement on the ward, the nursing notes describing VC
 11 largely as disengaged, maintaining a low profile, being
 12 guarded on approach, it would have been difficult,
 13 wouldn't it, to recognise and identify the extent to
 14 which he may have been psychotic?
 15 **A.** Yes, that is true, yes.
 16 **Q.** Your own impression was that VC, on the occasions that
 17 you saw him, that he was guarded?
 18 **A.** Yes, I think the term "guarded" has been largely
 19 prevalent. However, what I would say is during the ward
 20 reviews I think he did let go of that guard mostly,
 21 compared to how he was presenting in, say, for example,
 22 in the communal area or other areas of the ward.
 23 There was something about him willing to talk,
 24 although he would be somewhat reserved and careful about
 25 how much information he wanted to give, but I thought he

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

3 **Q.** You explored with VC during the ward review the incident
4 which had led to the admission, so the assault of
5 Christopher, his flatmate. And you describe this, it's
6 paragraph 318 of your statement, page 95, you say:
7 "When [it] was explored ... with VC, he maintained
8 that it was an altercation and ... he refused to let
9 Chris leave because he wanted Chris to be present until
10 the Police came ..."

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

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

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

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

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

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

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

25 **Q.** Yes, so -- and they've reported it to the University,
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1 screaming' (referring to a different scream ...)".

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

5 **A.** He clearly had psychotic symptoms. I mean, I didn't
6 know the extent of those symptoms, whether it was
7 persistent or very much transient. I remembered from
8 his previous history, I think it was probably early
9 2021, and he had always complained about hallucinatory
10 experiences on and off, on and off, but he was saying
11 what I [video disruption] suggesting that he had
12 hallucinatory experiences. But I wasn't too sure about
13 the extent of it, but my comment --

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

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

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

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

16 **Q.** During the course of the fourth admission Dr Gibson
17 spoke to the flatmate, didn't he? We see it in the RiO
18 records page 228. As well as dealing with the assault,
19 Christopher discloses that there'd been concerns -- it's
20 the bottom box, bottom paragraph -- that:
21 "There had been concerns about VC's presentation for
22 about a month. Short screams were heard intermittently
23 from his room, which were thought to be him. He also
24 reportedly entered another flatmate's bedroom in the
25 middle of the night and asked 'can you hear that
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1 would be checking on him every ten minutes. So it would
2 be very unlikely that somebody must have missed those,
3 those other experiences. He could have still had those
4 experiences, I mean, I couldn't be 100 per cent sure,
5 but I didn't explore this particular part of the
6 hallucinations with him directly and I don't think --

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

8 **A.** Sorry?

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

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

11 **Q.** Can we deal --

12 **A.** Not --

13 **Q.** -- just before the break, please, can we just deal with
14 another entry. It's page NHFT0000168 page 260 and from
15 your discharge meeting with VC, and others. It's
16 the middle paragraph by the heading "Note", and there,
17 you alluded to this earlier in your evidence, but there
18 is the description of the conversation you had with VC
19 about his research into technologies which exist,
20 "computer brain interface", and what the note goes on to
21 record is that:
22 "He did feel that some outside him was influencing
23 him and controlling him but it didn't frighten him. He
24 denied that this was still happening and doesn't see any
25 reason for this to happen again. He was unsure as to
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1 who was doing [it] ..."

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

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

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

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

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1 **THE CHAIR:** Yes, Mr Carr.

2 **MR CARR:** Thank you.

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

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

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

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

14 **A.** That's correct.

15 **Q.** And he denied it?

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

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

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

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

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

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

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

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

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

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

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

23 (10.49 am)

(A short break)

24 (11.09 am)

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

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

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

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

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

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

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

21 **A.** Oh, sorry, okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 I became aware, yes.

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

6 **A.** He was. He was.

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

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

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

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

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

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

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

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

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1 Team, as you understood it?

2 **A.** I think that was one of the reasons, actually, that he
3 would want to stay well or get support and get through
4 the exams.

5 **Q.** All right. Can we deal with the issue of Section 2 and
6 Section 3. VC had been detained on a Section 2, a CTO
7 obviously wasn't available without a Section 3
8 detention.

9 Firstly, is it your view that the fourth admission
10 should have been on a Section 3?

11 **A.** I mean, I couldn't make a definitive statement on that,
12 actually. I think clearly the assessors at that time,
13 they themselves did not see --

14 **Q.** We've heard evidence from the assessors, but in terms of
15 you've received the patient, you've obviously seen the
16 notes. Is it your view that the fourth admission should
17 have been on a Section 3; "yes" or "no"?

18 **A.** I would say I would be leaning more towards no,
19 actually.

20 **Q.** If it had been on a Section 3, do you think you then
21 would have imposed a CTO?

22 **A.** It would have given us -- it would have given us a bit
23 more time to think, and I mean what comes
24 -- (*overspeaking*) --

25 **Q.** -- (*overspeaking*) -- do you think you would have imposed
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1 the severity of the risks of his safety, it was thought
2 there appropriate to convert to Section 3.

3 So in circumstances where you have a patient, and if
4 you conclude that they cannot be safely managed in the
5 community without depot to ensure concordance, then that
6 would be grounds, wouldn't it, for a Section 3 in order
7 to obtain a CTO?

8 **A.** I can't think that in itself is enough. It wouldn't be.
9 Obviously for the purposes of meeting the threshold for
10 Section 3, obviously you have the nature and degree
11 clause, you have the treatability clause, and the risk
12 clause, to self and others.

13 **Q.** VC did present with a risk to others, didn't he?

14 **A.** He did.

15 **Q.** And Dr Gibson's evidence yesterday was that he thought,
16 albeit on reflection, were grounds to convert VC's
17 section to a Section 3 on the basis of the nature of his
18 illness requiring a further period of detention. Do you
19 agree with that?

20 **A.** I think we can certainly have a case based on nature.

21 **Q.** His evidence was also that on reflection, he thinks
22 a depot should have been given, and do you agree with
23 that?

24 **A.** I mean based on all the factors I considered at that
25 point, I did not think a forced injection could be
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1 a CTO?

2 **A.** Not necessarily. I mean not necessarily. It would have
3 given us more time to think and then decide.

4 **Q.** You've set out in your statement that you consider it
5 not to be good practice to keep someone under detention
6 to convert to a Section 3 for the purposes of a CTO.

7 Just dealing with the issue of conversion from
8 Section 2 to Section 3, because we know that during the
9 third admission, when VC was at Cygnet, he was converted
10 to a section -- from a Section 2 to a Section 3, because
11 his consultant there, Dr Shoilekova, thought it was
12 unsafe for him to be discharged back into the community.
13 And of course the AMHPs supported the application; it
14 was converted to a Section 3.

15 So as a starting principle, you can convert from
16 Section 2 to Section 3, can't you?

17 **A.** You can, yeah. If they met the criteria, yes.

18 **Q.** And in support of that conversion, Cygnet document
19 CYGN0000013 at page 4. One of the doctors who wrote
20 a report in support of the Section 3 detention, the
21 reasons given, and it's the bottom six lines, refer to
22 although VC was compliant with medication whilst at
23 Cygnet, "significantly more settled", because of a lack
24 of insight, because of delusional beliefs, and because
25 he couldn't be safely managed in the community, given
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1 justified, if --

2 **Q.** Have you ever discharged someone on a CTO with
3 a condition of depot?

4 **A.** Very many times, yes.

5 **Q.** Dr Gibson's evidence yesterday described a culture, so
6 this is around the use of the Mental Health Act and the
7 use of restrictive practices, he described a culture and
8 a climate which emphasised the least restrictive
9 approach to patients and mental disorders, enhancing
10 their autonomy wherever possible. He described that
11 being the context for the recent amendments to the
12 Mental Health Act. And being part of the climate that
13 psychiatrists were operating at the time, and that being
14 that the message that you were getting from the
15 government, the CQC, the Royal College and at
16 conferences.

17 Does that reflect the culture that you felt you were
18 operating in at this time, emphasising least
19 restrictive, maximising patient autonomy?

20 **A.** I mean, it is built into the core tenets of the Mental
21 Health Act, so --

22 **Q.** Did you get the sense from those bodies, or from general
23 psychiatric culture, that you were, as a body of
24 professionals, being overly coercive and not respecting
25 patients' wishes?
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1 A. I wouldn't use the word "overly". I mean again, it's
2 about how you define that, actually. But having been in
3 this field for 25 years, I have certainly seen many
4 instances where I felt that least restrictive option was
5 available and could have been used when more coercive
6 route was taken.

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

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

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

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

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

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

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

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

8 THE CHAIR: Yes, thank you.

9 Yes, Ms Patrick.

10 **Questioned by MS PATRICK**

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

13 A. I can, yes.

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

20 A. Okay.

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

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

4 A. Certainly the dial has shifted more towards coercion.

5 Q. You have shifted more towards coercion?

6 A. Yes.

7 Q. Since when?

8 A. Since VC incident.

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

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

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

19 A. Death as in suicide, you mean?

20 Q. Including suicide, yes.

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

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

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1 admission?

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

4 Q. Yes.

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

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

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

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

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

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

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1 just those that you thought you needed to?
2 A. Only those I needed to.
3 Q. Okay. You've said you read the transcript of
4 Dr Gibson's evidence yesterday --
5 A. This morning. Sorry, just now before this, sorry.
6 Q. Do you recall I asked him about the note that Dr Seedat
7 added to the notes about VC's communications with his
8 family and him recording intent to harm others? Do you
9 recall if you read that note?
10 A. I think so. I can't quite remember the exact --
11 Q. Can I refresh your memory? Can we look at it? It's at
12 NHFT0000168 page 21.
13 Can you see that now, Dr Thangavelu?
14 A. I can see that now, yes.
15 Q. The part I took Dr Gibson to is in the fifth paragraph
16 down, the last sentence:
17 "He said the people would not mock him in person and
18 made some remark to wanting to hurt these people he was
19 hearing."
20 Did you read that at the time of VC's admission?
21 A. I don't recall reading that part, no.
22 Q. If you don't recall it, do you think you did not read
23 it?
24 A. I might have read it but I don't think it ... I mean
25 I don't recall having read it, actually, so I have to

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1 aripiprazole during the last admission?
2 A. It was hard to -- it was hard to establish that without
3 objective evidence. I mean, that was the type of
4 evidence I was seeking from the CTN about --
5 Q. Can I stop you there for a moment: did you ever ask for
6 the records from the Priory and Cygnet?
7 A. No, I did not. No.
8 Q. Thank you. I'm going to move on to another topic, and
9 it's the incident with Christopher.
10 Now, just before I turn to the notes, you've said
11 this morning, when Mr Carr was asking you about
12 medication, when you were looking at medication you'd
13 have taken a few minutes to look at VC's notes, wouldn't
14 you?
15 A. You mean the dispensing history, you mean?
16 Q. Or just his notes. If you were looking at VC, you said
17 this morning you'd take a few minutes to look over his
18 notes; is that right?
19 A. So what I said was I was looking for the dispensing
20 history since his discharge from Priory. So that was
21 I think -- I used the -- so there is a search function
22 where you can just put the date, from which date to
23 which date you want to look at. So yeah, that's what
24 I did.
25 Q. I apologise. Would you have read all of his notes or

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1 say probably I didn't.
2 Q. So this is a very unwell man. He lacks insight. An
3 appreciation that part of his history, when unwell, was
4 an intention to hurt others; that's relevant information
5 for you to have had, isn't it, Doctor?
6 A. Yes, it would have been certainly useful to have had
7 that information, yes.
8 Q. Just to be absolutely clear, I also asked Dr Gibson if
9 he had seen the notes which underlay this note, the
10 original, which had the information about "red rum" and
11 and smashing heads. I'm assuming, if you didn't read
12 this note, you didn't see the original record?
13 A. I mean I only came to know about the original record
14 during the process of the Inquiry, so yeah, I wouldn't
15 have.
16 Q. Thank you. If you please bear with me for a moment.
17 Now turning back to Christopher, can we look at
18 a section of your witness statement, please, it is
19 WITN0206001, and page 96, please. I think just if we
20 can take this quickly while it's coming up, your
21 appreciation, and you've raised this with Mr Carr this
22 morning, is that that incident with Christopher was not
23 driven out of psychosis. That was your view, wasn't it?
24 A. That was my opinion at that time. Yes. Based on --
25 yeah.

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1 Q. We have what you put in your witness statement here now.
2 We can see that. Can you see it, Dr Thangavelu?
3 Paragraph 319.

4 A. Yes.

5 Q. "My opinion at the time was that the incident with the
6 flatmate was not driven out of psychosis. There did not
7 appear to be any paranoia nor persecutory ideas
8 expressed towards the flatmate in that context. The
9 altercation was not in response to hallucinations or
10 other delusions or affective symptoms."

11 Then you go on to the police not acting on it.

12 But if we can just turn to the next paragraph, just
13 so we've got a complete picture, you say:

14 "It is of course possible that VC was not truthful,
15 both with regard to his previous and current symptoms,
16 and sought to conceal symptoms during every attempt by
17 mental health professionals to elicit them throughout
18 the period of admittance. However, the lack of such
19 objective evidence during the entire period of admission
20 to hospital did not in my opinion support such
21 a conclusion."

22 Now, you've mentioned staff observations on the ward
23 as part of that. Now, whatever they saw, VC was being
24 medicated throughout his time on the ward, wasn't he?

25 A. He was, but he didn't display any symptoms from day one

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1 already. You've heard the reference to the screaming?

2 A. Yes.

3 Q. Dr Gibson said, "Obviously that was evidence that might
4 point towards him experiencing psychotic symptoms."

5 I think you'd accept that's right?

6 A. That's correct, yes.

7 Q. That makes the talking about it being over a month. Did
8 you talk to Dr Gibson about that, this being pointing
9 towards VC experiencing symptoms and possible relapse?

10 A. I can't quite remember if we specifically talked about
11 that symptom as a sign of relapse, but I think the
12 impression we made, at least I made out of that, was
13 that he was having residual symptoms which is the most
14 common presentation in psychosis, because people don't
15 achieve a 100% clearance of symptoms, even with
16 medications. Usually there will be some residual
17 symptoms for the majority of the patients. You can wax
18 and wane as well, the impression --

19 Q. Can I pause you there, Dr Thangavelu. Look at this
20 entry, it's in front of you. The flatmates are
21 reporting this in the context of this violent incident.
22 He's reporting VC hearing screaming nobody else can hear
23 and him trespassing into others' space. Dr Gibson
24 accepted that showed a real pattern, pattern, which
25 echoed the previous admissions; do you accept that?

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1 onwards.

2 Q. Was he being medicated from day one?

3 A. He was, but the way these medications work, such that
4 say, for example, I mean, with aripiprazole in
5 particular, it takes (*unclear*) half life of the
6 medication to receive -- to reach what we call a stable
7 state, and for aripiprazole it can be anywhere between
8 two weeks or more. So the effect of medication wouldn't
9 kick in straight away. Some effects might be, so like
10 sedation, so that sort of things can sometimes kick in.
11 But for the true antipsychotic effect to kick in, it
12 takes some time.

13 Q. But he was on medication. Can we turn to what he was
14 telling you in the ward review on 3 February. That's at
15 page 226 of the RiO notes. We may not have to go to it,
16 I'm just bringing it up so you can refresh your memory.
17 You deal with it in your witness statement.

18 He told you it was a long time since he heard
19 voices, "maybe over a year ago"; is that right?

20 A. Yeah, I think clearly if it's recorded like that, that's
21 what he would have said, yes.

22 Q. Yes. It's been highlighted there; can you see it?

23 A. Yes, I can, yes.

24 Q. The call with Christopher was recorded the next day, if
25 we can scroll down to 228, and we've had this up

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1 A. I agree there are similarities, yeah.

2 Q. Did you appreciate that pattern at this time during this
3 admission?

4 A. Perhaps not at a very intense level. I think that was
5 probably -- it might have been -- again I'm just
6 hypothesising here --

7 Q. Please don't hypothesise.

8 A. Okay.

9 Q. Did you appreciate that there was a pattern between
10 previous relapses and his presentation in early 2022?

11 A. Yes, I appreciated the pattern there, but --

12 Q. Did you appreciate it then?

13 A. Yes. I mean, clearly that was the whole purpose of
14 admission, actually: that we wanted to assess whether
15 there are any symptoms. And certainly at the point of
16 admission there were no concerns in terms of any
17 positive symptoms of psychosis, but this information
18 came along and the assessment just continued actually,
19 so he was still on 30-minute observations for I think
20 maybe a couple of weeks or something, actually, and then
21 he got dropped. The lowest observation people can go
22 down to is one hour. So every one hour people get
23 checked, so he was mostly spending time in the communal
24 area anyway, actually, I think. When I say communal
25 area --

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- 1 **Q.** Dr Thangavelu, can I ask you to stop and listen to the
2 question. I'm going to move you on to the next
3 document. I'd like to look at the MDT that happens
4 after you've got this new information. It's at
5 pages 232 over on to 233 [NHFT0000168]. You see, if we
6 go to the very bottom of the page, 7 February, and if we
7 scroll over, we see the MDT note. Can we see that?
8 **A.** Yes.
9 **Q.** And it's led by you, isn't it?
10 **A.** Yes.
11 **Q.** And the first entry:
12 "Report came from school accommodation that someone
13 was noted to be in his flat."
14 As a record of him breaching his Section 17 leave,
15 to return to an apartment where he had heard screams
16 that nobody else heard, and had assaulted his flatmate,
17 that's not an accurate description, is it?
18 **A.** So, no, the -- the record there is not accurate as well
19 as information that I was made aware of at the time.
20 I think there was a reported sighting but I don't think
21 it was in his flat.
22 **Q.** Okay. There's then it refers to "screaming", question
23 mark "hallucination". There's no reference to drawing
24 a connection with the patterns with the behaviour on
25 previous relapse, is there?

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- 1 Now, we see, if we can go to the bottom of page 201,
2 please, an entry for 17 December. If we go over on to
3 the next page, please. Can you see that there? This is
4 one of the rare occasions he comes to collect his
5 medication, and he is described as being "very curt",
6 "staring", having a "hostile edge".
7 Can you see that, Dr Thangavelu?
8 **A.** Yes, I can, yes.
9 **Q.** Now you've talked about there being some
10 misunderstanding about addresses. Just to absolutely
11 pin this down, he says -- he's asked: anything to hand
12 over to his care coordinator? He asks: "who came to his
13 house the other day, was it you?"
14 So he knew they were trying to reach him at home,
15 didn't he?
16 **A.** He did, but, again, my understanding was that Ms Birtles
17 contacted his mother, and mother contacted VC and --
18 **Q.** This is -- just to help you with the timing, this is
19 after she's contacted his mother.
20 He then goes on to say, he was told:
21 "No, it was Dr Lloyd and Claudia, he asked what
22 address they went to, I stated it was a Beeston
23 address."
24 So she's giving him every opportunity there to say,
25 "That's the wrong address, I now live at Raleigh Park",

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- 1 **A.** I mean the way --
2 **Q.** Dr Thangavelu, is it recorded that you discussed that
3 the information Christopher gave you echoed the previous
4 relapses?
5 **A.** I can't say if it was recorded or not. I don't recall.
6 **Q.** The entry is in front of you.
7 **A.** I mean this meeting was just more of a feedback meeting,
8 so Dr Gibson was just feeding back what he was told by
9 Christopher. So it's just a summary of what was -- what
10 were we informed of from the last few days, actually, so
11 it just captures a summary of new information, if you
12 like.
13 **Q.** Okay. He's behind --
14 **THE CHAIR:** You're running over time. So do you want to
15 move on to your last point?
16 **MS PATRICK:** Indeed.
17 **THE CHAIR:** I've got the point you're making.
18 **MS PATRICK:** Can I take you to another entry, we can move to
19 concordance and what's said about addresses.
20 Can we look at NHFT0000168 page 199 briefly, please.
21 It's at the bottom of the page we start at 14 December.
22 If we can scroll over. You've been taken through some
23 of these entries of the Community Team trying to reach
24 VC. And we've seen what you've said about
25 a misunderstanding about addresses.

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- 1 isn't she?
2 **A.** She is, yes, definitely.
3 **Q.** Would you have read this note?
4 **A.** I think I did read this note, yes.
5 **Q.** You just weren't giving enough weight to what the
6 Community Team were recording, were you?
7 **A.** I did. I mean, I don't deny this at all, actually and,
8 clearly, he had an opportunity to correct them then and
9 there, that he had gone to a wrong address. Clearly he
10 walked away, but again --
11 **Q.** Was it not clear on the records that not only was he
12 non-concordant, he was deliberately disengaging and
13 trying to avoid the Community Team so far as he could?
14 **A.** I mean, he had just turned up to collect a month's
15 supply of medication, so it wasn't a total
16 disengagement. But he was clearly quite upset and was
17 showing resentment towards Community Team for
18 implicating them for the admission. I mean, I fully
19 sympathise with the Community Team, I mean, they were
20 doing their best, but --
21 **Q.** Can I stop you there. On that MDT I took you to on
22 8 February, at that time you know that the Community
23 Team think he's non-concordant. You know he's breached
24 his Section 17 leave. You reinstate his leave, and this
25 morning you've discussed, on discharge, that you were

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

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

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

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

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1 with the contents of those notes?

2 **A.** Ideally, yes, but I think I simply would not have had
 3 time to do that. I think in my witness statement I have
 4 broken down my time availability for the ward, which was
 5 14 hours per week for eight patients. And at that time,
 6 I had a whole day of review back-to-back. I was working
 7 in the community which was nine miles away and I had 150
 8 patients for three days.

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

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

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

15 **A.** No, no.

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

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

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

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

6 **THE CHAIR:** Thank you.
 7 Yes, Ms Cartwright.

8 **Questioned by MS CARTWRIGHT**

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

12 **A.** I can.

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

17 **A.** No.

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

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

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

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

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

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

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

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

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1 support a serious issue as to non-concordance with
2 medication by VC since his discharge from the Priory?
3 **A.** I think I touched upon this earlier. So there was issue
4 of missing appointments, clearly, which I thought at
5 least partly was related to the address confusion.

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

10 Clearly there was evidence that he was very curt or
11 very superficial in his engagement. I did pick that up.

12 In fact, the whole reason to not go down the more
13 coercive route was for me to build that relationship.
14 I mean, I work with the Assertive Outreach Model a lot,
15 and I still do. Engagement is the key and for
16 engagement to happen you need to build trust, and you
17 use every opportunity to build trust. And I used this
18 opportunity.

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

23 **A.** He wasn't engaging in the ward activities, but he never
24 hesitated to meet his needs in the way he wanted to.

25 I mean, the first thing he asked for was a leave to

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1 ensured VC engaged with and considered.

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

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

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

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

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

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

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

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

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

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

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

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

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1 patient.

2 **A.** I wouldn't completely agree with that. I mean, the
3 diagnosis in itself has got no relevance to whether
4 somebody should be on a Section 2 or Section 3. I think
5 on this occasion the assessors felt that there was
6 a need for reassess or reassessment or reformulation,
7 which is very much accepted as reasoning for Section 2
8 for somebody who has previously been diagnosed with
9 schizophrenia and been on Section 3.

10 **Q.** Finally, then, please, within the medical records for
11 31 January 2022, you reference that they needed to
12 collate the collateral information to justify depot.

13 Would you agree that there's much information that
14 was not collated as part of that? You didn't collate
15 the Priory records that should have been obtained, and
16 without that you are missing a huge chunk of VC's
17 medical records?

18 **A.** Priory records would have been helpful, but we had the
19 Discharge Summary.

20 **Q.** But it's more than helpful, it is part of VC's records
21 that you didn't have access to, and it was his last
22 admission.

23 **A.** I think the Discharge Summary was there.

24 **Q.** But bearing in mind as well that there's a contract
25 between the Trust and the Priory, that you should have

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1 have time to go to it -- VC gave an account that he was
2 receiving his depot medication -- sorry, his
3 aripiprazole -- from the Cripps Medical Centre when you
4 were discussing the depot with him. Did you look to see
5 and check if the GPs were providing him with the
6 aripiprazole, bearing in mind VC had given that
7 explanation when you discussed depot and it's page 239
8 of the RiOs [NHFT0000168] for the reference.

9 **A.** I remember that entry and that was entirely my fault.
10 The way it happened was the ward reviews happen in
11 a very conversational style, not in an interrogative
12 style, actually. So I was kind of going through
13 questions with him saying "Well, have you been taking
14 medications? Have you been collecting medications?"
15 And he was saying yes. And out of ignorance, I slipped
16 the words "So have you been collecting it from Cripps
17 Medical Centre?" And he just said "Yes". Then, when
18 I was looking through the notes, it was very evident
19 that he was collecting it from Stonebridge, and it stuck
20 in my head, that's why I remember, I thought: why on
21 earth did he say he was collecting it from Cripps? I
22 mean, I didn't challenge him, but I just thought it was
23 an oversight or he didn't hear me properly or he must
24 have misunderstood me or something.

25 **Q.** Can I ask you then in terms of the harm that VC had

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1 obtained those and you should have obtained the Cygnet
2 records.

3 **A.** If there was a system in place for that transfer of
4 records to happen easily, of course we would have made
5 use of it to the full extent. There were no systems in
6 place.

7 **Q.** But you should have contacted the police to get the
8 collateral information from them, bearing in mind the
9 offences that VC had been involved with.

10 **A.** I agree, we could have certainly -- I think we should
11 have put in more effort to contact the police. I mean,
12 I did request for the PNC check from the very first MDT
13 meeting, but I don't think that was followed through.

14 We didn't have an easy access liaison person at the
15 time and they have been put in place since then and we
16 have been making use of that, and that has been a real
17 help.

18 **Q.** You should have got more information from the University
19 who themselves were advocating and seeking a Community
20 Treatment Order for VC?

21 **A.** Ellie Turner was very much involved. I think she was
22 instrumental in arranging for the admission, I think.

23 **Q.** Then could you assist, you -- and also the GP, because
24 one of the entries where you discussed at the meeting
25 with VC -- and just for the reference, I'm not going to

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1 caused --

2 **THE CHAIR:** Ms Cartwright, I thought we'd come to your last
3 point.

4 **MS CARTWRIGHT:** Can I then just ask this very briefly: were
5 you aware that one of the members of the public, Feven,
6 that she had fractured her spine and received spinal
7 surgery? Were you aware of that, as well as all the
8 other members of the public that had sustained harm,
9 both physical and psychological, as a result of VC?

10 **A.** I was aware of that tragic incident. I mean, that was
11 very much evident from the RiO alerts that you would see
12 straight away.

13 **Q.** It's not just the incident, it's the severity of the
14 injuries she sustained. Were you aware of the fractured
15 spine that required spinal surgery and pins?

16 **A.** I didn't know the full details, no.

17 **Q.** So you didn't know about that injury, and would you
18 agree from --

19 **A.** I knew about the injury.

20 **Q.** How did you --(overspeaking) --

21 **A.** Sorry, it said a back injury -- sorry?

22 **Q.** Well, what did you understand to be the back injury
23 she'd sustained?

24 **A.** What it said on RiO was she sustained a back injury
25 requiring surgery. I didn't know any more than that.

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1 **MS CARTWRIGHT:** Thank you very much.
 2 **THE CHAIR:** Yes, Mr Straw.
 3 **Questioned by MR STRAW**
 4 **MR STRAW:** Dr Thangavelu, I represent VC's family.
 5 You accepted earlier in response to questions from
 6 Mr Carr that VC was very guarded and masked, and that
 7 there were several instances when he was not telling the
 8 truth in order to be discharged.
 9 Now you would agree, wouldn't you, that it was
 10 particularly important for someone like that, not just
 11 to rely on his word?
 12 **A.** Yes, I agree, yes.
 13 **Q.** You had to look beyond that and take a longitudinal
 14 view.
 15 **A.** True.
 16 **Q.** And by a longitudinal view, I mean look for patterns.
 17 So look at previous relapses, identify relapse
 18 indicators.
 19 **A.** Yes.
 20 **Q.** You failed to do that, didn't you? You took him at his
 21 word and failed to identify relapse indicators.
 22 **A.** I wouldn't agree with that, actually. We looked at the
 23 previous patterns, and this submission was quite
 24 different to the previous patterns. It didn't -- it
 25 pretty much happened because of the incident with the

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1 **Q.** Just quickly moving on, if I may. The next relapse
 2 indicator I'd like to ask you about, paranoid or
 3 persecutory delusions.
 4 Now we've seen Dr Manzar's assessment on
 5 28 January 2022 describes VC as very suspicious and
 6 paranoid, in the RiO notes at page 220 [NHFT0000168],
 7 that's 31 January, VC is described as "paranoid and
 8 wide-eyed." And then there are several entries
 9 describing him saying he feels persecuted by mental
 10 health services.
 11 Now paranoia, suspicion, persecution, if we look at
 12 the pattern of previous relapses, those were relapse
 13 indicators, weren't they?
 14 **A.** I mean the first thing I would say is that paranoia is a
 15 thought disorder. You can't look at somebody and say
 16 they are paranoid because you don't know what they are
 17 thinking. They may appear frightened. I mean that's
 18 what we saw largely in VC. He was guarded because he
 19 wasn't expecting to come into hospital, he came in, he
 20 didn't like the place so he did appear wide-eyed and
 21 guarded.
 22 In terms of the persecution from services, certainly
 23 the way I understood was he was -- I think increasingly,
 24 he was getting worried that "If I say something, they're
 25 going to put me back in hospital."

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

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

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

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

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

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

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

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

14 **A.** I mean, again I wouldn't jump into a conclusion that
 15 it's a relapse indicator. When we talk about deception
 16 or lying, common sense would say that somebody was lying
 17 or deceiving because they are afraid of something. But
 18 that's what happens with everybody. You would lie
 19 because you're afraid of the consequences.

20 **Q.** Okay.

21 **A.** Whether that is a sign of relapse, I couldn't be
 22 completely sure.

23 **Q.** The fourth one I'd like to deal with is trespass. We
 24 know he trespassed on his former university
 25 accommodation, and if one looks back at May 2020,

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1 there's two incidents of trespass in the course of acute
2 relapse -- sorry, relapse into acute psychosis.
3 He's then taken to a ward. He hears screaming in
4 a cupboard during the course of what was recognised to
5 be a relapse. Then July 2020, again, trespass in the
6 course of a relapse. This was another relapse
7 indicator, wasn't it?
8 **A.** It certainly would raise the alarm bells as to whether,
9 you know, there was a motive or purpose behind. It
10 could be -- I mean, it needs to be explored. Certainly
11 I wouldn't dismiss that. I would certainly explore.
12 **Q.** Thank you.
13 The next topic I'd like to ask you about just very
14 briefly is your decision not to put VC on a CTO and
15 depot with Section 3.
16 Now, you explained earlier you gave your reasons for
17 why you decided not to do that, and they included,
18 firstly, you said to Mr Carr: "There was nothing
19 concrete to show that VC was non-compliant until
20 August 2021". But you later accepted that in fact the
21 RiO notes showed that he was non-compliant prior to the
22 second admission.
23 Then you, a little later, said that between the
24 third to the fourth admission it was only speculation
25 that he might have become non-compliant, but then

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1 **Q.** Were you not concerned what would happen beyond the
2 short to medium term?
3 **A.** I think that would be very difficult to foresee as
4 a prognosis for any patient with schizophrenia, because
5 there are so many dynamic factors, situation factors,
6 social factors, psychological factors, environmental
7 factors.
8 I don't think anyone can see beyond the medium --
9 the short to medium term, but that's the very nature of
10 the illness.
11 **Q.** What happened three times before this was that after the
12 short to medium term, VC disengaged, stopped taking
13 medication, relapsed, and was involved in violent and
14 aggressive incidents. Now, given that history, it was
15 highly likely that that is what would happen again this
16 time, wasn't it?
17 **A.** I certainly wouldn't want that to happen to VC. Quite
18 the opposite of that. I really wanted him to get well,
19 remain stable, and get on with his life. And that's
20 what we want for everybody we look after, and that's why
21 I was very much advocating for the depot, but equally,
22 balancing that out with his preference under the clear
23 agreement that if things, you know, if things go off the
24 rails, we are not going to accept anything other than
25 more coercive treatment. And that's the line I took.

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1 you later accepted to Mr Carr that in fact he had been
2 non-compliant. You said:
3 "I'm not suggesting remotely he was compliant."
4 What I'd like to ask you, doctor, is are you giving
5 a misleading picture here to try to excuse the wrong
6 decision?
7 **A.** No, I don't know what other concrete evidence people had
8 at that time, actually. That would be my -- that would
9 be my point. When you come to that point around
10 I didn't have concrete evidence, but neither did anyone
11 else to say. We were all speculating that the reason
12 for relapse was non-concordance. It may well be -- and
13 I know for a fact that non-compliance is one of the most
14 common reasons for non-compliance (*sic*) and so does
15 somebody who is extremely psychologically stressed, not
16 sleeping at night, working in a warehouse, having
17 university deadlines to meet, had just come out of
18 hospital, there could be many reasons. And we can't
19 just go down in a blinkered way one alleyway, actually.
20 So that we should keep an open mind. That's what I'm
21 suggesting.
22 **Q.** Okay, and the last issue I'd like to ask you about is
23 earlier, you said you thought VC would engage in the
24 short to medium term; do you remember that?
25 **A.** That's correct, yes.

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1 **MR STRAW:** Okay, thank you very much.
2 **THE CHAIR:** Yes, Mr Beggs?
3 **MR BEER:** (*Off microphone - inaudible*).
4 **THE CHAIR:** I'll take that as a "no, thank you" from you, Mr
5 Beer.
6 Yes, Mr Beggs.

Questioned by MR BEGGS

8 **MR BEGGS:** Doctor, I'm confining my questions to issues
9 relating to the police. Do you recall that you were
10 asked by Ms Patrick about your view that the incident
11 with the flatmate, about two weeks earlier than the
12 relevant comment, was not driven by psychosis?
13 **A.** That was my opinion from the information that we had at
14 the time.
15 **Q.** And you commented at paragraph 319, which is at page 96
16 of the Doctor's statement, if that can be shown to him
17 [WITN0206001], you commented that the police had already
18 decided not to pursue this incident.
19 Who told you that?
20 **A.** I'm trying to think. Certainly we ceded. I can't
21 remember if anyone else did, actually. I can't be 100
22 per cent sure.
23 **Q.** Yes. Did you contact the police yourself or have your
24 staff contact the police to ask about the details of
25 that incident?

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1 A. No, I think that was certainly something that should
 2 have happened. I mean I did request for the PNC check,
 3 not necessarily contact the police, but I think we were
 4 told right at the outset, I think it was at the very
 5 first ward review on the 3rd that when the EIP team
 6 tried to contact the police they were either not sharing
 7 information or forthcoming. I think at one point it got
 8 escalated to a sergeant. It felt like it got nowhere.
 9 But that's not the reason to not contact
 10 -- *(overspeaking)* --
 11 Q. Can I interrupt, not to be rude because I've only got
 12 five minutes, but you didn't in fact try to contact the
 13 police about the incident with the flatmate, did you?
 14 A. No, no, I mean that's what I said. I didn't.
 15 Q. And I think you now accept, I think you said to
 16 Ms Cartwright, that perhaps better liaison with the
 17 police is a significant learning point going forward,
 18 isn't it?
 19 A. Absolutely.
 20 Q. And in the same vein you did ask, didn't you, for
 21 someone to get hold of the PNC information on VC. You
 22 asked --
 23 A. That's right, that was -- *(overspeaking)* --
 24 Q. But in fact you accept in your statement, at two
 25 different paragraphs, that it appears that wasn't done.

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1 said criminal damage, but I know it was going towards
 2 caution. That much I knew. But I didn't make any
 3 direct correspondence with the police, no.
 4 Q. At the time, in 2022, do you think there was a cultural
 5 bias or disinclination or reluctance on the part of
 6 psychiatry to make contact with the police and obtain
 7 more detail?
 8 A. I didn't sense that. We used to have good relationship
 9 with the police, I remember. I think it fell by the
 10 wayside at some point, I don't know why. But I wouldn't
 11 say there was a cultural reluctance. We always wanted
 12 to work together.
 13 Q. But you accept, don't you, because you say as much in
 14 paragraph 478 of your statement at 143, page 143, that:
 15 "Accessing essential information from public sector
 16 agencies such as police in a more readily available
 17 manner would be useful."
 18 And that's stating the obvious, isn't it?
 19 A. Indeed.
 20 Q. So perhaps one of the recommendations going forward that
 21 you would endorse would be to make the process of
 22 accessing data from the police easier for psychiatrists?
 23 A. Yes, it should work much, much better, yes.
 24 Q. My final question is: I think, however, you did reflect
 25 some positivity since this tragedy, because you said

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1 Do you accept that?
 2 A. That's correct.
 3 Q. You also say in your statement at paragraph 227 -- if
 4 you want to have a look at it, it's at page 70. Do you
 5 see almost in the middle of the page:
 6 "I did not have any direct correspondence from
 7 police related to any of the incidents from the past."
 8 So pausing there. That -- it's self-evident,
 9 therefore, you didn't have a full forensic history, did
 10 you?
 11 A. No, I didn't.
 12 Q. And --
 13 A. Sorry --
 14 Q. And --
 15 A. -- *(overspeaking)* --
 16 Q. I don't think you ever tried to contact the police
 17 yourself, did you?
 18 A. Not personally directly, because some of the information
 19 were already in his records, for example, the assault
 20 towards police. I know that was being investigated
 21 because Dr Lomas was going to do a statement and he came
 22 to the ward, et cetera. I was aware of that.
 23 I knew that the incidents leading to the first
 24 episode, and the first contact, even, I think that was
 25 going -- I mean, I think, in one of our ward reviews it

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1 that there has been an improvement in interagency
 2 working with the appointment of, you described them as,
 3 Police Liaison Officers. Do you recall saying that?
 4 A. I do. I mean, I don't work at Nottingham right now, but
 5 yes -- *(overspeaking)* --
 6 Q. That was my question: were you talking about Nottingham
 7 or were you talking about more generally?
 8 A. I was talking more about Nottingham, sorry.
 9 MR BEGGS: Yes, thank you very much, doctor.
 10 THE CHAIR: Yes, thank you.
 11 Ms Patry?
 12 **Questioned by MS PATRY**
 13 MS PATRY: Dr Thangavelu, I ask questions on behalf of the
 14 University of Nottingham. Can you hear me?
 15 A. I can.
 16 Q. Thank you. Three short topics, if I may. The first is
 17 what the University knew about this admission; the
 18 second is what the University knew about the Section 17
 19 leave; and thirdly, what the University knew or didn't
 20 know about the discharge of VC at the end of his time
 21 with you.
 22 Turning to the first topic, please. It sounds from
 23 the evidence that you've given this morning that you
 24 were aware of the incident that had taken place on
 25 15 January with VC's flatmates.

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1 A. That's correct.

2 Q. Were you also aware that he had -- that the flatmates
3 had been removed from the flat temporarily, but that
4 Ms Turner's position is that she very much wanted them
5 to go back to their home because they had exams at the
6 time; were you aware of that?

7 A. I don't recall that specific information.

8 Q. All right. Well, he was detained on 28 January, so
9 shortly after the assaults had taken place. The
10 University's position is that it wasn't informed of that
11 admission.

12 Now, given that they had been removed from their
13 flat, why were no steps taken by you or your team to
14 inform the University contemporaneously that he had been
15 detained?

16 A. I think it may be related to two factors, actually. So
17 one was I don't think VC was ever willing for us to make
18 contacts with the University. I think he clearly made
19 it -- I certainly remember personally asking him I'd be
20 happy to do an EC for him. I don't think he wanted us
21 to make contact.

22 And secondly, personally, I can only speak for
23 myself, I wasn't fully aware of the -- again, the
24 systems and processes in place for, say, NHS contacting
25 the University. I think I might have wrongly assumed

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1 any of this out, other than the fact, the paragraph that
2 starts:

3 "He explained that he would like to go to the gym",
4 seven paragraphs down. Do you see that?

5 "He explained ... he would like to go to the gym and
6 would like ... to go to the gym and the shop. His
7 routine at the gym is 1.5 hours."

8 Then you explained to him that because he's on
9 section, if doesn't come back, et cetera:

10 "... the police would have to be involved. It was
11 agreed [right at the end of that paragraph] that it
12 would start at 30 mins leave initially."

13 Do you see that? So that appears to be that
14 unescorted leave was granted, as I say, less than a week
15 before he was admitted. We can agree that, can't we?

16 A. Yes, so if I may just expand on that. So as for the
17 Mental Health Act, leave within hospital grounds,
18 technically it's not a Section 17 leave at all because
19 patients can in theory go to the hospital grounds, or
20 it's up to the local detaining authority to define where
21 the boundaries are. So technically they could ask
22 "I want to go to the café on site", and they can come
23 back in 30 minutes. But it would have to be done after
24 an assessment of any imminent risks, et cetera.

25 But what we have always done in our wards, in my

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1 that it all goes through the mental health support
2 service for the University, actually, because Ellie
3 Turner was -- Ms Turner was involved, I might have --
4 I think I did assume that that's a conduit into
5 university. But that might be my mistake.

6 Q. Would you accept that they should have been informed of
7 the admission?

8 A. I mean, again, it depends on whether VC would have
9 capacity to say "yes" or "no" to that matter.

10 Q. All right. I'm going to turn to the second topic which
11 is the Section 17 leave.

12 Now, there's been a bit of evidence about this
13 already, I'm not going to ask you to repeat anything.
14 Six days after he was detained he was given Section 17
15 leave, unescorted leave. And at paragraph 306 of your
16 statement on page 91 [WITN0206001], which we can turn up
17 or not, you indicate that he was allowed unescorted
18 leave twice a day because he said he wanted to go to the
19 gym; do you recall that?

20 A. Yes.

21 Q. Can we look briefly at the RiO notes on this please
22 NHFT0000168, and can we start at page 226, please. I'm
23 going to take you through chronologically here what was
24 said. Now, if we see 226 is the first review that you
25 undertake with him, and he's -- I'm not going to read

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1 ward at least, was to have a clear record of the leave
2 we said we would have to agree that at the ward review
3 for them to leave, and that's what this is.

4 Q. Can I be clear, though, where does it say that he has to
5 stay on hospital grounds? Can we look, if we scroll
6 further down to the end of this entry we can see the
7 plan that was agreed:

8 "Chase university regarding accommodation.
9 "S[ection]17 leave for 30 mins twice a day
10 unescorted".

11 That would rather suggest that it's not limited to
12 hospital grounds.

13 A. No. I mean I was just explaining how the leave system
14 generally works. So regardless of what it is, people
15 can have leave within the hospital grounds, and if they
16 do that, you can't police that because the hospital
17 grounds are not gated with a high fence. People can
18 choose to leave. But this specific leave was for him to
19 get enrolled at the Henry Mellish Centre which is
20 a centre which is close to us, and a lot of our patients
21 go and make use of that facility.

22 There was also an on-site gym, which is in the next
23 block. So I thought 30 minutes is reasonable time to
24 get those things sorted, and he was informed that if he
25 didn't return back we'll have to call the police.

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1 Q. So given that you had given him 30 minutes unescorted
2 leave twice a day and you had not put any conditions on
3 that, why did you not warn the University that he was
4 being granted leave, given that he'd assaulted a fellow
5 student a matter of weeks before?

6 A. I mean VC --

7 Q. Wasn't it a risk that he would return to the
8 accommodation?

9 A. No. So VC, the incident happened on the 15th. Clearly,
10 it's a sad event, but he was in the community for a long
11 period of time. He was only admitted on the 28th.
12 There are no bail conditions, there were no
13 restrictions, restriction orders. He was a free man in
14 the community. And then when he gets admitted, I don't
15 know on what grounds I can suddenly say, "You can't
16 leave," when he had been in the community for that long.

17 Q. I'm sorry to interrupt you. My question is -- your
18 evidence is he was a free man, he could do what he
19 wanted with his leave. Why did you not warn the
20 University, given the obvious risks to the students,
21 that he had previously been with -- well, at least to
22 the student that he'd assaulted previously? Why didn't
23 you inform the University?

24 A. Because he wasn't meant to go to the University. He was
25 meant to go to the gym, get enrolled, and come back.

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1 228, please, at 10.39 am. There's a restriction of his
2 leave, and then if we keep going on to 233, or 222, 232
3 and 233, we can see what happens after that. His leave
4 was restricted until 7 February, but then, if we look
5 at -- if we're scrolling further down, keep going, the
6 MDT lead by you -- this is the top box on the 7th; do
7 you see that?

8 A. Yes.

9 Q. It's reinstated, 30 minutes unescorted leave, and
10 unescorted leave to the gym. Now, again, given that he
11 had now breached -- I wouldn't say breached the
12 conditions because you didn't impose a condition, but
13 given that he had now returned to the University and
14 seen the flatmate that he assaulted, why was the
15 University not warned at this stage that he was being
16 given unrestricted leave again?

17 A. Well, the second --

18 Q. There was a clear risk -- (*overspeaking*) -- because it
19 had happened?

20 A. If you look at the Section 17 form that is attached to
21 this, the notes are not accurate. If you look at the
22 Section 17 form that's attached to this, done on the
23 7th, it would clearly say "30 minutes unescorted leave
24 to local grounds and shops", and "escorted leave to gym"
25 but also by then we had gathered information from Ellie

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1 That was the purpose of the leave.

2 Q. Well, as we know he did go to the University. That's
3 the first thing he does, we know that.

4 A. (*The witness nodded*).

5 Q. If we look on to page 227 and 228, we can see how this
6 unfolds. If you could just scroll up. Can we just
7 pause there for a moment and look at the entry on
8 3 February at 3.44 pm, the second box there, you
9 referred to the fact that you thought he might be using
10 this time to enrol at the gym, but of course that's not
11 right, is it, because we can see here that the plan is
12 that he is going to have an induction session with the
13 Henry Mellish, which I think is the gym, on 4 February
14 and then go to gym sessions on 7th, 14th and 21st.

15 So on the third, when he visited the University,
16 there wasn't even a plan for him to go to the gym, was
17 there?

18 A. No, I think the -- I wouldn't have known this at the
19 point of --

20 Q. That's fair enough. If we then look at the entry at the
21 bottom of that page at 6.50, we have the telephone call
22 from the University saying that he's been seen by one of
23 the students he shared accommodation with. So he'd gone
24 back to the accommodation.

25 Now, can we see what happens at that -- after that,
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1 Turner that he is not banned from -- not banned, but if
2 he needs to go back to the University to hand in the
3 keys, he can do that and get his belongings, but he
4 needs to be accompanied by a security guard. That was
5 the only thing that was told to us. And I apologise if
6 there were -- there was an expectation that this was
7 a requirement, but I -- we didn't -- we -- yeah, we were
8 not aware that that was expected from the University,
9 because Ellie Turner was very much aware of this, she
10 was --

11 Q. With a --

12 A. -- in contact --

13 Q. I'm going to ask my very last question which is about
14 discharge. He was discharged on 24 February. The
15 University was not informed by you or anyone on your
16 team of that discharge, and he was being released back
17 into the community. Why was the University not informed
18 of that discharge?

19 A. I don't think VC gave us consent to contact. That was
20 my understanding at the time.

21 Q. Isn't VC's consent overridden in circumstances where
22 there's a risk?

23 A. It could be, but I don't think we would have restricted
24 him to the ward for those reasons, because I can't
25 detain somebody under the Mental Health Act --

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1 Q. No, I wasn't asking you whether you should detain him.
 2 A. Okay.
 3 Q. I was asking why you didn't let the University know that
 4 --(overspeaking) --
 5 A. That probably is --
 6 Q. -- (unclear) a clear ongoing risk --
 7 A. Yes, yes.
 8 Q. -- to neighbours and flatmates. Why you didn't just
 9 tell them that he was being discharged.
 10 Do you know how Ms Turner found out he was being
 11 discharged?
 12 A. I came to know later, I think, VC called --
 13 Q. And she called VC --
 14 A. Okay.
 15 Q. -- and he told her.
 16 A. Yeah.
 17 Q. Thank you.
 18 A. Again, yes. In hindsight, we should have got that
 19 better. I agree.
 20 MS PATRY: I'm really grateful, thank you.
 21 THE CHAIR: Thank you.
 22 **Questioned by THE CHAIR**
 23 THE CHAIR: Just a couple of questions I wanted to ask.
 24 The first, when you were dealing with his medication
 25 you said there was no real difference between

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

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1 10 milligrams and either 20 or 30 milligrams, and that
 2 if he had wanted to go on to 10 milligrams, that's what
 3 you would have done; is that right?
 4 A. I would have certainly taken that route, your Honour.
 5 I think we've done that many times, working in Assertive
 6 Outreach teams, but there is a general anxiety around
 7 what we call steep prescribing, and once you go up, you
 8 hesitate to come down.
 9 THE CHAIR: Yes, but what indication that you had got that
 10 10 milligrams would have been effective?
 11 A. I think it's more of balance between the effectiveness
 12 and the side effects.
 13 So the literature behind all of this, the scientific
 14 evidence behind all of this, is 10 milligrams of
 15 aripiprazole has got the best balance between the effect
 16 and the side effect. So on that basis, you can try
 17 that, with close monitoring. There is no guarantee that
 18 will be better, because for some people 20 might be
 19 better. But what I was trying to emphasise was one size
 20 doesn't fit all. You have to work with what the patient
 21 is experiencing because only they can experience --
 22 THE CHAIR: That's the question I was going to ask you. Who
 23 is calling the shots on the medication here? You as the
 24 psychiatrist prescribing, or the patient?
 25 A. It's the psychiatrist working with the patients. So

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

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1 agreed to it.
 2 And if things were to deteriorate, if they were to
 3 kind of come back to my ward, I would have straight away
 4 gone with that. It was just I had ethical dilemmas that
 5 I struggled to overcome on that occasion, having taken
 6 into consideration every factor. I mean, obviously, the
 7 terrible tragedy happened and we are looking at it
 8 through a different lens, and I still don't know --
 9 I mean, I've discharged so many patients like VC, worse
 10 risk history, without any significant concerns. Some of
 11 them had come back straight away, some of them had
 12 stayed much longer in the community. But on that
 13 occasion, I took into consideration all of the factors
 14 I had in front of me, and --
 15 **THE CHAIR:** But the community clinicians who were going to
 16 have to manage him and deal with him were specifically
 17 saying to you that he needed a depot, weren't they?
 18 **A.** I took that really seriously, and I spoke to him in
 19 quite a bit of length. We all did. And I think, on
 20 reflection at least, there were a couple of factors. If
 21 he had been, say, for example, if he had been unwell
 22 during the course of admission, or there were any other
 23 concerns which were clearly pointing towards depots as
 24 the only option, I would have. And again, the depot
 25 would be somewhat meaningless unless the CTO is imposed.

1 And that that in itself has got a number of caveats,
 2 actually. I mean, it's been now more or less clearly
 3 established by five randomised trials that CTOs don't
 4 prevent the desired outcomes.
 5 We live in -- psychiatry particularly, we are at the
 6 crunch point where you're expected to manage the
 7 person's best interest, the families' best interest, the
 8 Community Teams' best interest, all working within the
 9 legal framework, but he was still there as a scholar who
 10 has to take into consideration the best available
 11 evidence, and put that within the framework, and there
 12 are significant challenges, and on top of that,
 13 obviously there are particular issues.
 14 I mean, it is a very unique place to be in, as
 15 a psychiatrist having to balance this.
 16 **THE CHAIR:** Thank you.
 17 Right, well, we'll start again at 2.00. Thank you.
 18 **MR CARR:** We were proposing before the lunch break that we
 19 could --
 20 **THE CHAIR:** Shall we do that, actually, if we start again at
 21 1.45 and then you can read out your documents. Thank
 22 you.
 23 **MR CARR:** Thank you.
 24 **(12.48 pm)**
 25 **(The short adjournment)**

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