1 **Thursday, 7 May 2026**
2 **(1.55 pm)**
3 **MS LANGDALE:** Chair, may I call Dr Shoilekova, please?
4 **DR KALINA GEORGIEVA SHOILEKOVA (sworn)**
5 **Questioned by MS LANGDALE**
6 **MS LANGDALE:** Dr Shoilekova, you've prepared a statement for
7 the Inquiry dated 11 December 2005. Can you confirm the
8 contents are true and accurate as far as you are
9 concerned?
10 **A.** Yes.
11 **Q.** Tell us, please, about your qualifications and role as
12 a psychiatrist, and particularly your role in respect of
13 VC.
14 **A.** Yes. I qualified in general medicine, my medical degree
15 in 1979, in Sofia, Bulgaria. After that, in 1984, my --
16 following quite intense training in psychiatry, my
17 specialty in psychiatry, was acknowledged. And since
18 then, till 1994 I have been working in psychiatry in
19 different roles in my home country.
20 From 1994 to 2002, I have been Consultant
21 Psychiatrist in Ingutsheni Hospital, Bulawayo, Zimbabwe.
22 **Q.** Sorry, can you go a bit slower. So you were
23 a psychiatrist where? No, sorry, stay sitting down,
24 that's fine.
25 **A.** No, I prefer sometimes if that's all right.

1 **THE CHAIR:** Yes, do stand up, sit down, whichever is easier
2 for you.
3 **THE WITNESS:** If that's all right.
4 **THE CHAIR:** Yes, so long as we can pick up what you're
5 saying on the microphone. Excellent, thank you.
6 **MS LANGDALE:** Where did you say you were working as
7 a psychiatrist?
8 **A.** In the second city of Zimbabwe, the name of the city is
9 Bulawayo, the name of the hospital is Ingutsheni
10 Hospital. I was working there as Consultant
11 Psychiatrist and Deputy Medical Director for
12 eight years, till 2002.
13 From 2002 until now, I have been working in
14 different roles in the United Kingdom. From 2002 until
15 2020, I worked for the Tees, Esk and Wear Valleys
16 NHS Trust, initially in the combined role of a community
17 and inpatient Consultant Psychiatrist, and from 2008,
18 2010 onwards, as an inpatient consultant, initially on
19 an acute psychiatric ward, followed by, from 2010, until
20 2020, as a Consultant Psychiatrist in a Psychiatric
21 Intensive Care Unit.
22 I retired from NHS in 2020, and after that for three
23 and a half -- two and a half years, rather, worked for
24 Cygnet, initially for a female hospital near Durham,
25 but, as from June 2021, at Victoria House Hospital in

1 Darlington, where I was working part-time as
2 a consultant in the newly established Psychiatric
3 Intensive Care Unit.
4 **Q.** Thank you. So that takes us to where we are in the
5 evidence, September 2021, and we know that following
6 detention and seclusion at the Cassidy Suite they were
7 looking, Nottinghamshire Trust were looking for a place
8 to have VC in a Psychiatric Intensive Care Unit.
9 If we can go, please, to CYGN0000085, page 1.
10 Dr Shoilekova, some documents are going to come on the
11 screen.
12 **A.** Yes.
13 **Q.** Some of them you will not have written yourself.
14 **A.** Yes.
15 **Q.** But if you can help me with my questions, do.
16 **A.** Sure.
17 **Q.** If you can't, say so. We see here the "Gatekeeping
18 Referral Form" for the intensive care bed.
19 **A.** Yes.
20 **Q.** And we see a description:
21 "[VC] has been non-concordant with antipsychotic
22 medication ..."
23 We see in the next box, "Current Mental State &
24 Presentation":
25 "... presenting with relapse of psychosis ...

1 persecutory beliefs about being monitored by the
2 government, and does not recognise that he is unwell.
3 He is adamant he is mentally well and that we have no
4 right to intervene in his life. He states that his
5 relationship with mental health services has ended and
6 he will have no more to do with us. Refusing medication
7 ... extremely antagonistic towards healthcare staff."
8 Under the box "What are the risks which make
9 [Psychiatric Intensive Care Unit] ... necessary?":
10 "... risk of serious physical assault to healthcare
11 staff."
12 Then we see a description of what was required to
13 keep an attack under control, and to remove him to the
14 Cassidy Suite. And this document, we see on page 3, is
15 dated 3 September.
16 **A.** That's right.
17 **Q.** And if we can have, please, now CYGN0000070, page 1.
18 This is a referral to Victoria House.
19 **A.** Yes.
20 **Q.** Setting out at the front, patient details. Over the
21 page, page 2, next of kin. Details. Page 3, "What are
22 the current risks?":
23 "Agitation and Aggression ..."
24 Description of the attack and what was required to
25 subdue him.

1 Then, "Prior to Detainment" in the box below:
2 "[VC] had gone to a neighbours flat who was staying
3 above him, knocked at his door to confront ... as to why
4 he was discussing him as he had heard voices to that
5 effect ... barged into the persons flat and wanted [to
6 know] ... what he was doing ... other neighbours came to
7 the rescue and called the police.
8 "... known to services with a diagnosis of
9 psychosis."
10 Continuing over the page:
11 "He continued to experience auditory hallucinations
12 and fixated on persecutory ideas relating to the
13 government."
14 **A.** Yes.
15 **Q.** That can come down, please.
16 We know that you first refused the referral, didn't
17 you. If we have NHFT0000168, page 178 on the screen,
18 please, in the top box. Nottinghamshire were seeking
19 this bed from a number of places, and we see at page 178
20 at the top, on 6 September, Cygnet declines on this
21 occasion.
22 **A.** Yes.
23 **Q.** "... our nursing team being predominantly female and ...
24 the risks presented by this gentleman ..."
25 Was it common that you would decline based on the

5

1 risks of a patient?
2 **A.** It wasn't uncommon. Some of the referrals to be
3 declined. Be it because there were no beds, the PICUs
4 were exceptionally full at that time. Be it because the
5 patient might have required seclusion and the seclusion
6 suite at Albert Ward would have been occupied. Or be it
7 because there were exceptional circumstances where the
8 staff were felt not to be neither in number, knowing
9 abilities to deal with restraint if that were to be
10 required of a --
11 **Q.** So they may not be qualified in restraint or enough
12 people to deal with --
13 **A.** No, no, no, they are. They are all qualified in
14 restraint. I'm sorry, I didn't mean that to sound this
15 way.
16 **Q.** Right.
17 **A.** But there are cases where a more higher number of staff
18 would be required to restrain one patient.
19 **Q.** Do you think that was the concern here?
20 **A.** The concern here was presumably that there was not
21 enough manpower, and I mean male power, to deal with
22 that. And these are exceptional circumstances, but they
23 might happen on a PICU.
24 **Q.** If we see at the bottom of the same page, 178, the
25 clinical intervention and seclusion required, it was

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1 indeed the case that he was given medication under
2 restraint, wasn't he? We can see that he was
3 restrained, haloperidol 10mg, IM administered, this was
4 in the Nottinghamshire, it's the Cassidy Suite,
5 6 September. Also on 7 September, medication given
6 under passive restraint and if we can have 187, please,
7 NHFT0000168, 187, in the second box we see by
8 9 September -- it will come up in a moment -- we see by
9 9 September, second box:
10 "Patient no longer in seclusion and has been
11 accepting oral medications. Referrals resent into
12 Cygnet for reconsideration."
13 And at that time Cygnet accepts the patient?
14 **A.** Yes.
15 **Q.** In terms of documents that you have, we helpfully have
16 from Cygnet the documents you must have had to be
17 forwarded to the Inquiry, and if we can go, please, to
18 CYGN0000106, page 1, would you have looked at all of the
19 documents that you did get in?
20 **A.** Yes. Yes.
21 **Q.** What do you normally get in? When a patient is referred
22 in these circumstances, what would you expect to
23 receive?
24 **A.** We would expect to have the detention papers, which will
25 include the medical recommendations, the application for

7

1 detention, and the report from the Approved Mental
2 Health Professional.
3 **Q.** You had those in VC's case, didn't you?
4 **A.** Yes, yes, we had that. We would expect any other
5 relevant information to be really passed on to us, but
6 we do realise that this is not always possible,
7 especially if somebody has been in seclusion, especially
8 if somebody comes from a different PICU in a different
9 part of the country. We would expect to have discharge
10 summaries from previous hospital admissions. We would
11 expect to have some summary of how the patient has been
12 doing or at least letters from the community
13 psychiatrist to the GP surgery as how the patient was
14 doing and how he presented at outpatient reviews.
15 We do fully realise that this is not always possible
16 and it wasn't there initially when he was admitted, but
17 we asked for it. It is established practice to be aware
18 that something is missing, and then ask for it.
19 The first stop is normally to ask for a GP summary
20 which gives a very broad view as to what might have
21 happened, and then their acts were to look for further
22 information.
23 **Q.** Just pausing there, you didn't get the discharge
24 summaries?
25 **A.** No.

8

1 **Q.** You do get this document --
2 **A.** We did.
3 **Q.** -- which is prepared by Busayo Ajewole and that is
4 September 2021?
5 **A.** Yes.
6 **Q.** We see the heading "Risk and Safety Assessment" people
7 can read if we can enlarge the bottom box, please, and
8 then over the page, with the top box.
9 **A.** Yes.
10 **Q.** We see in that top box:
11 "Historically when unwell he has [forced] entry into
12 his neighbours' houses under the influence of his
13 psychotic experiences, though no violence has resulted."
14 What do you think this means by "no violence has
15 resulted"? When you read that, what did you ascertain
16 from that or think from that?
17 **A.** Well, what I ascertained from that, because I have read
18 already the referral documents for PICU, is that I will
19 need to understand better what exactly has happened,
20 because the referral documents refer to some serious
21 injuries to police officers and, historically, they also
22 refer to some quite risky encounter, or with a colleague
23 or neighbour which led to the neighbour having serious
24 injuries.
25 So I cannot really comment on why this specific

1 sentence appears here but what it does normally mean is
2 that further information needs to be asked for and
3 considered.
4 **Q.** If we see in the next paragraph, at the bottom:
5 "No further incident of violence or aggression
6 towards others ... usually a very polite and gentle,
7 personable young man."
8 A very polite and gentle, personable young man: what
9 would you think about that?
10 **A.** That is normally under the pre-fix of pre-morbid
11 personality when psychiatric and mental health history
12 is described, and it is an important informative point
13 to compare out-of-character behaviour which might be
14 contributable to mental disorder to the pre-illness,
15 pre-morbid personality of the patient, and I interpreted
16 it in that way, that before coming ill, he was a kind
17 and caring person who would not be physically violent.
18 **Q.** Can we look at page 3, please. That's the risk
19 formulation. People can read that and see that.
20 **A.** Yes, I can see that.
21 **Q.** You can see that?
22 **A.** Yes.
23 **Q.** You said a moment ago that this document would make you
24 realise you needed to understand more about the
25 background and any violence?

1 **A.** Mm-hm.
2 **Q.** How would you do that? How did you go about that in
3 this case, to find out about earlier events?
4 **A.** Ask about the written information from the Community
5 Mental Health Team who have been looking after him,
6 getting in touch with the care coordinator, and ask for
7 further information from the inpatient services the
8 patient would have been involved with. For example,
9 discharge summaries.
10 **Q.** You got documents. We'll go to documents you have, but
11 did you speak directly with anybody who'd been involved
12 in his care?
13 **A.** Apart from his care coordinator, who was --
14 **Q.** Claudia Birtles.
15 **A.** -- attending remotely, no, I didn't.
16 **Q.** Was that when she joined a Teams meeting?
17 **A.** Yes, and around --
18 **Q.** -- remotely.
19 **A.** -- his Mental Health Act assessment.
20 **Q.** So did you ever realise, or come to know, that in terms
21 of violence towards others, about an assault on his
22 flatmate called Sebastian in July 2021? Did you ever
23 know about that?
24 **A.** I read about it *post-factum*, so I'm not sure I did know
25 about that at the time I was looking after VC.

1 **Q.** Well, if we don't see it in the records, is it likely
2 you didn't know about it?
3 **A.** It is likely.
4 **Q.** Can we have, please, CYGN0000052, page 33, on the
5 screen. This is the AMHP report.
6 **A.** Yes.
7 **Q.** If we can go, please, to page 2 -- sorry, page 34. That
8 sets out further detail --
9 **A.** Mm-hm.
10 **Q.** -- of background events in May 2020.
11 **A.** Mm-hm.
12 **Q.** "... breaking into two of his neighbours' homes due to
13 his belief ... mother was inside them being harmed ...
14 subsequently arrested and detained in hospital ...
15 neighbour was so distressed by his behaviour ... that
16 she leapt out of the window."
17 **A.** Mm-hm.
18 **Q.** Bottom paragraph:
19 "On his last successful face-to-face visit
20 [31 August], [VC] disclosed he had stopped his treatment
21 as he believes that he has been the victim of
22 a conspiracy and has never been mentally unwell."
23 **A.** Yes.
24 **Q.** If we go to 35, please, the box at the top, the last
25 four lines. When the assessment was undertaken and the

1 attack on the officers happen:
2 "There was a bag of unused medication dating back to
3 February 2021."
4 Did you see that?
5 **A.** Yes, I did see that. It is unclear -- if you allow me
6 to expand on that, it is unclear whether there was a bag
7 which had a date of February 2021 on it, and I am aware
8 that he has been supplied with his medication either two
9 weekly or four weekly in the community. It doesn't
10 necessarily indicate that since February until September
11 he has the bags of all these seven months who were seen
12 by the AMHP. That's the one point I want to make.
13 On the other -- in a very close paragraph to this
14 one you're referring to, the AMHP indicates that,
15 broadly, Mr VC, over the last year, has been doing well
16 and engaging with the Community Mental Health Team.
17 **Q.** Shall we find that, if we go to page 34.
18 **A.** Yeah, yeah.
19 **Q.** Where do you say she says that?
20 **A.** If you allow me two seconds.
21 **Q.** Yes.
22 **A.** So that is the page. That is the first box.
23 **Q.** The first box, 34:
24 "He has been working and accepting of his
25 appointments with his Community Psychiatric Nurse."

1 **A.** "Since his discharge from hospital [in July], [VC] has
2 broadly accepted treatment and support/monitoring from
3 secondary ... services. He deferred his final year of
4 studies but appeared motivated to recommence [that] ..."
5 **Q.** So that was significant information, was it, for you,
6 coming fresh to the case, as it were --
7 **A.** Yes.
8 **Q.** -- from which you inferred that he was accepting
9 treatment and support. What would you think that meant:
10 accepting treatment?
11 **A.** I thought at the time that it meant that he has been
12 accepting his medication.
13 **Q.** Do you agree, if you look at page 35, though, the bag of
14 unused medication dating back, on one view, was capable
15 of meaning it's all there from February 2021, seven
16 months of not taking it?
17 **A.** It's possible.
18 **Q.** Yes.
19 **A.** It's one of the possibilities. On the other hand, the
20 medical recommendations did indicate that he recently
21 stopped his medication.
22 **Q.** So where there was a contradiction, did you seek to
23 clarify that --
24 **A.** Sure.
25 **Q.** -- with the AMHP or with anyone else?

1 **A.** Sure. Yes, yes. We did seek to clarify that, and we
2 thought the best person to clarify that was the care
3 coordinator.
4 **Q.** Claudia Birtles?
5 **A.** Correct.
6 **Q.** So did you speak to her about it --
7 **A.** Yes, we did.
8 **Q.** -- *(overspeaking)* -- an email from her?
9 **A.** She did express her views that she cannot be a hundred
10 per cent sure whether the patient has been compliant or
11 non-compliant with his medication. But it express
12 even -- she did express even more relevant, for the
13 time, view that he was actually superficial in
14 engagement with her, and she believed that he never was
15 symptom-free and she believed that he never regained
16 insight.
17 **Q.** And we'll come to her records. So she was clear that he
18 didn't not have insight, not symptom-free, and she --
19 **A.** No.
20 **Q.** -- didn't think he was taking his medication.
21 **A.** Yes.
22 **Q.** Couldn't prove it concrete-wise but she thought he
23 wasn't.
24 **A.** Yes.
25 **Q.** You were under no doubt she thought he wasn't and --

1 **A.** Yes, yes, no, no, I wasn't in any doubt about that.
2 **Q.** If we go then, please, to CYGN0000036, page 15. There's
3 a number of different records, and the way you take them
4 is of interest to us as well at Cygnet, because of what
5 we've seen before.
6 **A.** Okay.
7 **Q.** So I'm going to take you through these notes, some of
8 the notes, just to get a feel of how notes are taken.
9 This of course is Psychiatric Intensive Care. Would
10 you take more notes because it's Psychiatric Intensive
11 Care than you might if he was on more --
12 **A.** Maybe not more, but maybe the notes will be shorter, due
13 to pressures of immediate activities which have to be
14 done on the ward.
15 **Q.** If we go to page 15 in the bottom box, please. I'm
16 afraid it is as it is because these are digitalised
17 records -- *(overspeaking)* --
18 **A.** Yes, yes, I realise.
19 **Q.** -- uploaded, so they're blurry. And if we go to the
20 bottom entry, "Notes by Psychiatrist":
21 "30 year old ... Engineering student admitted ...
22 ... two previous admissions ...
23 "... originally admitted about eight days ago
24 following what he termed as a misunderstanding between
25 him and services ... reported attending the previous

1 hospital he had been admitted ...to to inform them he
2 wanted to come off medication. Aripiprazole as he was
3 well now and was told that he needed to go to the
4 community centre, he attended this and told them the
5 same, only for the staff to turn up at his house with a
6 warrant and the police.
7 "[He's] been on Aripiprazole, previous presentation
8 has been auditory hallucinations and paranoid,
9 persecutory delusions. The auditory hallucinations had
10 led him to attend neighbours flats on three separate
11 occasions, with one leading to the injury of the flat
12 resident because she had gotten scared and jumped out of
13 the window, severe injuries had been sustained requiring
14 surgery for her.
15 "He believes the police are planning things against
16 him as they have developed a technology to input voices
17 into people's minds. [That] ... is what they have done
18 to him ...
19 "... no history of aggression or forensic history.
20 No allergies."
21 Again, in the context of what was above it, how do
22 you read "There is no history of aggression or forensic
23 history"?
24 **A.** So I'm more than sure that this is the admission
25 clerking of the patient when he was admitted to Victoria

1 House Hospital on the 11th.
2 How do I read "There is no history of aggression or
3 forensic history"? I can only speculate that this
4 refers to the time before the mental illness started,
5 because there is a clear history of aggression and
6 violence since the mental illness has started, or at
7 least the mental health services knew about him.
8 **Q.** If we can have now, please, CYGN0000001, page 27, an
9 admission assessment document. Just so we can see the
10 types of document completed at this point and what they
11 say. So page 27. Completed by senior nurse, I think,
12 John Lavender. If we go to page 28, can we have the
13 whole box of 28, please. Documents height, I think
14 that's 6 foot, weight 12 stone --
15 **A.** Yeah.
16 **Q.** -- 82 kilograms. If we go to page 29. These are
17 questions, are they?
18 **A.** Yes.
19 **Q.** How did you get the answers to these? Is this from the
20 patient or some other way? Do you know?
21 It's completed by the nurse.
22 **A.** Mm-hm.
23 **Q.** So presumably information from the patient, is it?
24 **A.** Yes.
25 **Q.** We see page 30 as well.

1 **A.** Yes.
2 **Q.** 31, 32, "to be completed by a doctor".
3 **A.** Yes.
4 **Q.** Mental health status: "Section 2". You're named as the
5 "Responsible Clinician".
6 **A.** Correct.
7 **Q.** What does that mean in this context? What's your role?
8 **A.** So the Responsible Clinician is a Mental Health Act
9 term, so to say. It normally implies that is the
10 Consultant Psychiatrist who makes the fundamental
11 decisions about implementation of the Mental Health Act,
12 about detention, about leave, about discharge from
13 section, and about making a case for further detention
14 of the patient, and representing the hospital at Mental
15 Health Act tribunals.
16 **Q.** If we go, please, to page 34, "Thought content". Is
17 this your entry:
18 "Persecutory and paranoid delusions"?
19 **A.** No, that's not my entry. That is the entry from
20 clerking of the patient. It's a bit of a duplication of
21 documents.
22 **Q.** And from the referral, and if we look at page 35,
23 reference to "Insight":
24 "Partial. Does not believe he should be in hospital
25 but agrees he needs medication", is recorded there.

1 Can we -- sorry. Did you want to say something?
2 **A.** Mm. Sorry, just to comment, he comes to Albert Ward
3 after spending eight days in -- mostly in seclusion but
4 still being given medication, and part of it
5 intramuscularly. So one would expect some partial
6 acknowledgement, if not insight, to have developed at
7 that point.
8 **Q.** Can we go to CYGN0000001, page 55, please. This is also
9 completed on the 11th.
10 **A.** Yes.
11 **Q.** This is a "Hospital admission risk assessment", and we
12 see under "Harm to Others", "Actual or stated intent of
13 harming others ...": "Yes".
14 "History -- Yes".
15 "Current -- Yes".
16 "Threatening/intimidating behaviour -- Yes, Yes."
17 "Damage to property", it says "No"; "unknown" about
18 history. In fact he did have a history of that --
19 **A.** Yes.
20 **Q.** -- had that been explored or ascertained. So "Yes",
21 although it does -- some comment "unknown" there.
22 **A.** Mm.
23 **Q.** Reference to, in the "Treatment/Illness Related Risks",
24 "...absconding/DNA [et cetera] AWOL... Yes".
25 Why is that recorded as a risk?

1 **A.** AWOL will mean absent without leave and will increase
2 the risks of firstly not receiving treatment, secondly
3 exacerbation of symptoms, and thirdly, if someone has
4 been significantly violent recently, the risk of
5 violence as well. And that's why AWOL, or absent
6 without leave, is considered to be a risk to be taken
7 seriously --
8 **Q.** In these circumstances --
9 **A.** -- any mental health ward, not only PICU wards.
10 **Q.** And we see "Lack of capacity to decide on care -- Yes",
11 so lack of capacity?
12 **A.** Lack of capacity, yes.
13 **Q.** With this background assessment where you've noted risk
14 of AWOL, leaving the ward, and risk of harming to
15 others, would you be concerned if a hammer was found on
16 his possession in the hospital? I'm not saying it was
17 in Cygnet, but if he was on the ward or came in with
18 a hammer with him, what questions, if any, would you ask
19 about that?
20 **A.** If, in --
21 **Q.** If the patient --
22 **A.** Hypothetically?
23 **Q.** This risk assessment completed, if the patient had
24 a hammer --
25 **A.** Yes, I would --

21

1 **Q.** -- on the ward and you were told that as a Consultant
2 Psychiatrist that they had a hammer in their possession,
3 what would you do or say?
4 **A.** So I will have two lines of questions. First line of
5 question would be to clarify why exactly the hammer is
6 in his possession and to what is the intention to have
7 it. But it's highly unlikely that the hammer will end
8 up in patient's possession in on the PICU ward because
9 we do have regular searches and we do have quite
10 a vigilant staff about any --
11 **Q.** What about if it was a general ward, then? Take
12 yourself out of PICU, if it was on a general ward and
13 a patient of yours had a hammer?
14 **A.** Similarly, I will have lines of questioning about the
15 patient and I will try to understand what the
16 situation -- why the hammer is there, how did it get
17 there, what are the intentions, and I will ask the
18 hammer to be given back to -- for safekeeping. And the
19 second line of questioning will be for staff, because
20 staff really should have been aware if something like
21 that happens on the ward. It will be worrying, of
22 course it will be worrying.
23 **Q.** Why would it be a worry? You say "of course". If it
24 seems obvious, tell us anyway. Why would it be a worry?
25 **A.** Because it can be used and because it might have caused

22

1 more physical, not to mention other harm to other
2 patients and staff on the ward, if it's found on the
3 ward.
4 **Q.** Just finishing off with the risk assessment, please,
5 page 56:
6 "Lack of positive social contacts, poor support
7 mechanisms, culturally isolated."
8 Currently, no; History, no.
9 It's not clear from the evidence that you have
10 received by the 11th that you would suggest no there or
11 it's put in there that there is a not a lack of positive
12 social contacts.
13 Again, is that relying on the patient or other
14 information?
15 **A.** It is relying on the patient. It's done at the point of
16 admission. I'm not the author of that --
17 **Q.** Understood.
18 **A.** -- form.
19 **Q.** Can we go -- sorry, go on. Finish.
20 **A.** And I have probably had a look at it, at the first
21 review with VC, but I cannot recollect much about the
22 reasoning behind.
23 **Q.** Can we go to something where you were present and will
24 know more about, which is the CYGN0000036, page 13, and
25 it's the ward round, and this is an entry entered on

23

1 your behalf, Dr Shoilekova, and your notes of the ward
2 round?
3 **A.** Mm-hm.
4 **Q.** So it's 36, page 13, we're going to have to go
5 a paragraph at the time and I'm going to let people read
6 it, including yourself, of course, Dr Shoilekova, before
7 I ask any questions. So can we just have the top
8 paragraph enlarged and then we'll go slowly through the
9 document.
10 If we can scroll gently up under "Content of
11 thoughts", we see the reference:
12 "An altercation between himself and a hospital staff
13 led to his admission ..."
14 Is that the word that the patient or VC used, an
15 "altercation"?
16 **A.** No, that would be a kind of the version the admin staff
17 has used because it's happening in the time when the
18 conversation with the patient is already going on and
19 the admin staff are taking notes. But content of
20 thoughts would mean kind of summarised quasi-quotes of
21 what the patient have said. I wouldn't say he --
22 I can't remember at all him using words like
23 "altercation" between himself and staff.
24 **Q.** Can you tell actual remember it now or were you having
25 to rely on the notes? Is this a consultation with

24

1 a patient you can picture in your mind or has time moved
2 on and you're not able to do that?
3 **A.** I can remember it now.
4 **Q.** Can you?
5 **A.** I can remember it now. He was quite guarded, he was
6 very suspicious. He was staring and perplexed. I was
7 of the strong impression that he was hearing voices at
8 the time. The conversation was very fragmented, the
9 answers were very short, and at times abrupt.
10 I did not feel threatened or I didn't feel any risk
11 of immediate violence.
12 **Q.** To you?
13 **A.** To myself, as might happen with other patients. But the
14 degree of distress and perplexity was such as to
15 indicate a very acute and very florid mental illness.
16 **Q.** If you look at this third paragraph:
17 "He wanted to ask a few questions about his
18 diagnosis as he has researched about it and they told
19 him to go to the community health centre and he went
20 there and they told him to stop the medication because
21 he feels he didn't need it."
22 Again, is this something he told you about or is
23 this a record of something he has done previously?
24 **A.** That is something which I might have asked him and he
25 might have answered. Because he was at that point

1 starting to look for explanations as to what's happening
2 to him. And we knew at that point that he has been to
3 the hospital where he had been admitted before, to ask
4 why they were involved in the persecution and conspiracy
5 against him, and didn't get any answers.
6 **Q.** We see that at paragraph 4 and 5, if we can just scroll
7 up beyond those, please, now:
8 "He mentioned that it includes thought being induced
9 in his mind that he is not aware of ... all types of
10 thoughts being induced and they were continuous,
11 generally unpleasant ...
12 "He has never felt his life is in danger ..."
13 Can we scroll down, please.
14 "He mentioned that he has been on over 6 months and
15 it is coming to an end because the voices are
16 dissipating and it has reduced over a few weeks."
17 What was that about? Can you remember that?
18 **A.** I remember him saying that the voices had started but
19 now have stopped but he was not contributing that to
20 receiving a very powerful antipsychotic medication for
21 over a week in hospital, which he hadn't received
22 before. And he gave that ceasing of the voices an
23 explanation which was quite delusional, that whoever was
24 the agency was, orchestrating his persecution and
25 thought interference, have decided to stop, because

1 six months was the timespan they were doing it.
2 **Q.** Did you understand at this point that he had
3 a functional illness and that it was paranoid
4 schizophrenia, as opposed to episodes of psychosis?
5 **A.** I have asked myself many times, since I understood about
6 the Inquiry, that question. Yes, initially my gut
7 feeling was paranoid schizophrenia. But paranoid
8 schizophrenia has got a specific diagnostic criteria
9 which we need to adhere to, and one of them is
10 persistent group of symptoms -- which he had -- for
11 a persistent period of time, which we -- I at that point
12 was not convinced he had. So that's why, at such times,
13 a broader term might be used still to say that someone
14 is seriously ill and psychotic but unsure on that stage.
15 **Q.** Did you ever see -- it doesn't look as though you had
16 Dr Seedat's records of an inpatient? But did you see
17 that he had stated in terms "likely diagnosed paranoid
18 schizophrenia" back in July 2020?
19 **A.** No, we didn't have access to the inpatient --
20 **Q.** Would it have been helpful to have that?
21 **A.** It would have been helpful, yes.
22 **Q.** To understand that, at that stage, he was --
23 **A.** Yes.
24 **Q.** -- querying symptoms being as long as six to nine
25 months?

1 **A.** Yeah, yeah. It would have been helpful but we didn't
2 have access to the inpatient notes. We did have access
3 to the outpatient case notes.
4 **Q.** This fragmentation of care between services is not ever
5 beneficial, it looks like, for the patient, is it, if
6 there's not information that's spread through the
7 various hospitals -- (overspeaking) --
8 **A.** I cannot argue with that. It is not beneficial. It is
9 not beneficial not only for the patients; it is not
10 beneficial for the staff as well.
11 **Q.** Does that hamper your capacity to diagnose and
12 understand risk?
13 **A.** It delays our capacity and it generates a lot more --
14 how can I call it -- research work, detective work, as
15 to find the relevant information in the whole ocean of
16 information which is repetitive, and --
17 **Q.** Would you have wanted, for example, I'm not going to
18 take you to text, if you've been following the Inquiry
19 you will know what they were about, that VC had written
20 texts to his brother talking in terms that he was
21 thinking about red rum? Would you know what that meant
22 if someone --
23 **A.** No, I learned what that meant. I didn't know at the
24 time but, no, I didn't have any knowledge that such
25 texts did exist.

1 **Q.** If you had seen that those delusional beliefs were
2 taking him to the place where he said he wanted to
3 commit criminal acts and the mental health authorities
4 were doing this to conspire against him to make him look
5 mentally ill, would this have mattered to you to
6 understand the delusional beliefs and their impact in
7 his mind?
8 **A.** Sure. It would matter. But to put that into context,
9 these are not unusual, these are statements, which in
10 one shape, form or the other, come to us from many, many
11 patients, and distinguishing the extremely rare patient,
12 who would proceed and act on that from the majority of
13 patients who would research that, write about that, talk
14 about that, but never proceed do such a horrible,
15 horrible act.
16 **Q.** If they talk about harming others and they have evidence
17 of harming others --
18 **A.** They do, they do.
19 **Q.** -- where do you put them in terms of risk: risk of doing
20 something serious?
21 **A.** It depends how risk depends or is informed by the mental
22 state. Because our role is to understand better and
23 effect and influence how the mental health informs the
24 risk, and if the risk is indeed dependent on the acuity
25 of the mental disorder, to treat that mental disorder.

1 How do you deal with that? It is -- what I wanted to
2 say, maybe, was that risk is very changeable. Risk is
3 fluctuating, changeable entity. It depends on many
4 factors.
5 **Q.** But the past is a good indicator for the future, isn't
6 it, for risks?
7 **A.** It is. Of course it is.
8 **Q.** So it might be dynamic and it might be changing but if
9 there are indications that relapse involves violence
10 towards others, that is likely to be an ongoing risk,
11 isn't it? Relapse, violence, if that's the history --
12 **A.** Yes, it is --
13 **Q.** More likely to indicate it is a risk for the future?
14 **A.** Sure, sure, it is.
15 **Q.** Can we just look at page 36, CYGN0000036, 12, and this
16 is the plan with medication which I assume, doctor,
17 you're in charge of when he's at Cygnet in terms of the
18 medication that's prescribed and used?
19 **A.** Yes, yes.
20 **Q.** So then let's look, if we can, under "Plan" and enlarge
21 that significantly, please. We see your plan for
22 medication there increasing --
23 **A.** Yes.
24 **Q.** So what's the logic behind the medication and the
25 increase there?

1 **A.** So he has been on -- prescribed the same medication, be
2 it in intramuscular or oral form, in Nottingham for
3 eight days. The daily dose there was 10mg per day.
4 Haloperidol is a potent antipsychotic, one of the most
5 effective antipsychotics which we have in our disposal
6 here. The optimal dose of that medication and any
7 medication is a matter of gradual increase until
8 efficacy is achieved, but not for the cost of serious
9 side effects. So that's why the optimal dose in very
10 broad terms for haloperidol starts from 10 milligrams
11 daily, and it can be 30 milligrams daily, however, that
12 is very high dose which is no longer allowed. The
13 maximum dose, the last time I was prescribing
14 haloperidol, allowed was 20 milligrams, and if not less
15 on the current day.
16 So increasing the dose was seeking better efficacy,
17 and monitoring the side effects. In this case, there
18 were no side effects. And that had to be taken for
19 a long period of time.
20 **Q.** A long period?
21 **A.** And when I say long, I mean for a fair trial of efficacy
22 of medication we need at least four weeks.
23 **Q.** So in terms of establishing the efficacy of medication
24 in this patient, at any point do you think it would have
25 been necessary to have a four-week trial to see how

1 effective it was, whatever drug you -- *(overspeaking)* --
2 **A.** It can be clearer earlier than that but you -- people
3 don't need to give up early, because it does take time
4 for the efficacy really to develop, even when initially
5 it doesn't seem to be the case. That was not the case
6 here. I thought that, after the second week of
7 receiving medication, that's meaning after the
8 mid-September, roughly, there has been some improvement,
9 be it patchy, be it in some of the symptoms, not all of
10 the symptoms, but there was a softening of the symptoms,
11 so to say.
12 **Q.** What about aripiprazole as a drug? We know in his first
13 admission he had 5 milligrams of aripiprazole. How
14 effective did you or do you find that in your practice?
15 **A.** I'm a PICU consultant or at least I was a PICU
16 consultant. We rarely use aripiprazole.
17 **Q.** Why?
18 **A.** Probably because we need to achieve more tangible
19 efficacy and effect for a short period of time, to
20 settle down. The mostly used antipsychotic medications
21 in PICUs, haloperidol, and zuclopenthixol, which is also
22 similarly effective. Aripiprazole maybe has its value
23 in community monitoring because many people do prefer to
24 have that medication because it does have very minimal
25 side effects.

1 **THE CHAIR:** Sorry, you're just dropping your voice. Can you
2 keep your voice up so we can hear what you're saying.
3 **THE WITNESS:** Oh sorry. I'd better sit down maybe too.
4 **THE CHAIR:** Maybe, but if you do stand up please can you
5 keep your voice up.
6 **THE WITNESS:** I will. Sorry about that.
7 **MS LANGDALE:** So patient's wishes about side effects are one
8 factor in deciding the medication, but the treatment
9 efficacy is a more important matter and one for the
10 psychiatrist to assess; do you agree?
11 **A.** I agree.
12 **Q.** Can we have, please, CYGN0000036, page 8, and this is
13 a ward round on 21 September, and we need the top box
14 enlarged please. Doctor, this where you refer earlier
15 to Claudia Birtles making it clear that as far as she
16 was concerned:
17 "... he had never recovered to the premorbid levels
18 of functioning -- superficial in contact, blunted in
19 affect *[sic]*, hearing voices ... these 'not bothering
20 him' ..."
21 So she sets that out, doesn't she, in a team ward
22 round? I don't think you were at that ward round but
23 you've seen those notes and that's where you understood
24 she'd said that; is that right?
25 **A.** That appears right. I have no recollection. It sounds

1 like that.
2 **Q.** And we see there descriptions of VC who he says
3 "conspiring against him".
4 **A.** *(The witness nodded)*.
5 **Q.** "... as a matter of punishment for breaking the lock
6 down rules."
7 Of course this treatment was all occurring during
8 lockdown, and we see reference on admissions as to
9 whether people were infected or not infected.
10 **A.** Yes.
11 **Q.** In terms of your work and generally, how did that
12 impact, if at all, on VC's treatment or assessment
13 during his time at PICU?
14 **A.** So at that time, the worst of the lockdowns have been
15 over, but there was -- there were themes around the
16 lockdown in his delusional beliefs which we have seen
17 with other patients as well. For example, he was saying
18 that he has been subject to that persecution and thought
19 interference because he broke the lockdown rules,
20 wouldn't explain how exactly and why other people who
21 have broken the lockdown rules wouldn't be.
22 But can I make a point about this entry? I think
23 that is my entry, actually. I have done it, I have
24 written it, that's why I haven't written my name as
25 present there.

1 **Q.** I understand. So you're a psychiatrist who actually
2 takes some of your own notes at the same time or sets
3 them out?
4 **A.** It's -- it is not unheard of. We do take our own notes.
5 **Q.** And here we have diagnosis:
6 "Paranoid psychosis? Paranoid Schizophrenia".
7 **A.** Yes.
8 **Q.** "Depot antipsychotic medication should be considered if
9 detained on section 3".
10 **A.** Mm-hm.
11 **Q.** We know that was Claudia Birtle's view, that a depot was
12 necessary. Was that discussed in this ward round?
13 **A.** The depot?
14 **Q.** Yes.
15 **A.** It was discussed, yes. That was the time when the care
16 coordinator told us that she believes that longer-term
17 CTO and a depot would be beneficial.
18 **Q.** Can we go to CYGN0000036, page 3, please, and the second
19 entry from the top. If we can enlarge that second entry
20 from the top, please. Is that page 3? CYGN0000036,
21 page 3? I think it's further up.
22 It's the second entry from the top.
23 "[VC] reported he want[ed] to know when he could
24 move to a step down. He reported that he would prefer
25 to continue on tablets as to be on depot injection ...

1 denied any side effects and reported has been sleeping
2 well."
3 Again, the patient's view about the medication
4 that's right for treatment, it is but that, isn't it:
5 a view and a factor determining what's the right
6 treatment?
7 **A.** It is. It is normally, specifically looked at, what the
8 patient's view about his treatment is, because that is
9 a good predicting factor as to whether the patient will
10 be compliant or not with the medication. It can be
11 overruled.
12 **Q.** Exactly, and he can be compelled to comply even if the
13 patient didn't want -- *(overspeaking)* --
14 **A.** Yes, the Mental Health Act gives the Responsible
15 Clinician and the team the powers to overrule the
16 refusal and, in a PICU, we do overrule many of the
17 refusals for reasons which are clearly set up in the
18 Mental Health Act Code of Practice.
19 **Q.** Do you think it's the same in general psychiatry? Is
20 there a reluctance to overrule the patient's views and
21 to be focused on the maxim of least restrictive
22 principle, independence of the patient, choice of the
23 patient, rather than required treatment?
24 **A.** I wouldn't say I would make any distinguishing between
25 PICU and general psychiatry. I would say there are

1 different places where that happens more frequently than
2 other places, but I haven't done any systemic research
3 on that.
4 However, the tendency over the last five years at
5 least with the amendments of the Mental Health Act show
6 exactly into that direction more empowerment of the
7 patient, more involvement of the patient, in
8 decision-making, higher threshold for detention, and
9 asking for second opinion of doctors if the patient's
10 view are to be overruled. So it's a difficult balance.
11 It's a very difficult balance.
12 For myself, the ability to engage with the patient
13 and reach a stage where I would be more hopeful that at
14 least partial insight is achieved, and there is a better
15 chance of complying with medication rather than not
16 complying with it. I would rather reach that without
17 restriction -- restrictive measures. But I have done it
18 many more times than I can remember, when need be with
19 restriction.
20 **Q.** And how long do you permit uncertainty around whether
21 the person's taking the medication or not?
22 **A.** In the community?
23 **Q.** Yes. How long is it before you say: actually, I've
24 tried to work with you, I've tried to give you the
25 option of this, but the treatment requires something

1 else?
2 **A.** So I worked as a community psychiatrist for at least
3 eight years. They were different years. They were
4 years where the inpatient services were better equipped
5 with beds. As you might be aware, the bed availability
6 was capped with 40% around 2010. I worked in the
7 community, and in inpatients between 2002 and 2010. And
8 then admitting patients in hospital, informally,
9 voluntarily was a common practice. And in hospital, we
10 would address compliance with medication. We would
11 address change of medication. We would monitor response
12 to treatment.
13 There is no rule as to -- back to your question.
14 I'm sorry about that derailment. Back to your question.
15 There is no rule as to how long to wait if there is
16 non-compliance with medication. That will depend on
17 what risks that weight will imply.
18 **Q.** And was the informal admission useful if there weren't,
19 as the psychiatrists considered, grounds to detain, but
20 you could have someone in a hospital setting as
21 a voluntary patient to assess whether the medication was
22 working?
23 **A.** Yes.
24 **Q.** And they were taking it?
25 **A.** Yes. The answer to that is yes.

1 **Q.** Can we go, please, to CYGN0000036, page 1. It is
2 a different and final entry from the difficult-to-read
3 notes. So page 1, the third entry, please, from the
4 top. It's the one "Had a brief chat", so it's the third
5 down on page 1. Next to "Approved pending". That's it,
6 thank you.
7 "Had a brief chat with [VC] whilst in the garden He
8 chatted about the TV show he has been watching and said
9 it's good but disturbing."
10 Then the support worker is asking about what he's
11 studying at university.
12 We see references, when he's at Cygnet, to him being
13 in his bedroom for a long period of time.
14 **A.** Yes.
15 **Q.** Not coming out of his room.
16 **A.** Yes.
17 **Q.** And here he's talking about a TV show that was "good but
18 disturbing". Did you, and can you, monitor what
19 patients are watching or looking at on their phones when
20 they're in PICU?
21 **A.** Normally there is no access to the Internet in PICU,
22 unless -- unless that is authorised. But I understand
23 that has changed. And in that circumstances, it will be
24 very difficult to monitor what the patients are watching
25 on -- online, so to say.

1 **Q.** We've seen, the Inquiry has had obviously information
2 that those treating him at the time wouldn't have had,
3 material that VC was viewing on his phone or online.
4 **A.** Mm-hm.
5 **Q.** Do you think, as a psychiatrist, would you ask patients
6 about that? "What do you look at? What are you
7 disturbed by? What are you influenced by?"
8 **A.** Normally information about that comes from staff on the
9 ward, because they pick up the clues and can ask these
10 questions, and if they report some concerns, I will ask
11 the probing questions.
12 **Q.** Can we go now to risk assessment tool that's used on
13 PICU. If we can go to CYGN0000001 page 189, and we see
14 four of these assessments, undertaken weekly. More than
15 weekly, I think, at the beginning. But if we look at
16 page 189, please. We see "Risks" and noted or rated
17 low, moderate or high, aren't they, with low to the
18 left, moderate is on its own, and then high. It looks
19 like there's three categories there with the highest
20 risk to the right, yes?
21 **A.** Yes.
22 **Q.** So we see here on 11 September, this is the first
23 assessment, if we go over the page, high risk of
24 violence, and he's assessed as "Moderate" there. Can we
25 see?

1 **A.** Yes, I can see.
2 **Q.** Referral documents, the second box state he's no longer
3 taking medication, so that's risk rated as moderate as
4 well?
5 **A.** Yes.
6 **Q.** And then if we go to page 192, it's a four-page
7 document, "Violence":
8 "[VC] can present with violence and aggression and
9 is unpredictable."
10 **A.** Mm-hm.
11 **Q.** So that's the first one completed.
12 **A.** Yes.
13 **Q.** Can we then go to CYGN0000001, page 185, this one is
14 14 September. Risks are low: suicide and self-harm. If
15 we go over the page, risk of harm to others at this
16 point still moderate.
17 So if we go over the page: risk of non-compliance,
18 moderate.
19 **A.** Yes.
20 **Q.** So he's gone down right, from high to moderate?
21 **A.** Well, normally when a new patient who is not known for
22 the team is admitted with similar set of information,
23 the risks are identified as high. After the first ward
24 round and MDT discussion, they might be reduced because
25 of the protective --

1 **Q.** The environment --
2 **A.** The environment.
3 **Q.** So the risk is only identified for in that environment
4 because --
5 **A.** In that environment, at that moment in time, yes.
6 **Q.** If we go to page 187, please. I don't know if this is
7 in error but we see where "social media related risk"
8 is, that appears at high but then there is no current
9 risk identified. Can you see there?
10 **A.** "Social media related risk". I thought that's low,
11 isn't it?
12 **Q.** Maybe just -- it's clearly not the case. It says, "No
13 current risk identified"?
14 **A.** No.
15 **Q.** But there was nothing of concern expressed about that at
16 the time. That's a --
17 **A.** I can't recollect any concern about that at the time.
18 **Q.** Then the next risk assessment, if we go to CYGN0000001,
19 page 72, "Patient strengths":
20 "Currently studying at university ... supportive and
21 understanding family network of support."
22 Again, the factual background, how he was studying
23 at university, or the depth of relationship with his
24 family network, what were you relying on or would the
25 risk assessor be relying on for that?

1 **A.** These are the so-called protective factors, and they are
2 part of each and every risk assessment, alongside with
3 the predisposing factors, precipitating factors --
4 **Q.** I understand that but these are going to be relying on
5 what the patient has said: studying at university,
6 supportive and understanding family network?
7 **A.** Yes.
8 **Q.** Because we've got Claudia Birtles's social circumstances
9 report we'll come to in a moment for the tribunal but,
10 as far as assessment of risk is concerned, what's the
11 information that's taken into account for this? Do you
12 know?
13 **A.** It has taken into account that he has got a goal to
14 pursue and he has declared that this is his goal: to
15 continue with his university studies, and he has got
16 supportive family who -- whom he -- I recollect he
17 indicated that he is in constant telephone contact with.
18 And these are important factors to mitigate risk.
19 **Q.** I think, in fact, this one's the fourth one. There's
20 a third one I don't need to take you to. The format is
21 the same -- risks low, moderate, high -- with some
22 description in the far box.
23 **A.** Mm-hm.
24 **Q.** They're undertaken weekly, are they, on PICU?
25 **A.** Yes, if need be more frequently, if there is

1 a significant change.
2 **Q.** Can we just look at a couple of patient review notes as
3 well, in MDT. So if we can go, please, to CYGN0000060,
4 page 1. This is 14 September. That's the reference
5 I referred you to earlier:
6 "... he appears preoccupied [in the box at the
7 bottom] with evidence of thought blocking ..."
8 At the bottom, thank you.
9 **A.** Yes.
10 **Q.** "... where there is some delay in response on engagement
11 ... presents with isolative behaviours where he will
12 spend long periods in his bedroom and offer minimal
13 engagement."
14 If we can go to the MDT's discussion, please, at
15 CYGN0000060, page 3. This is the reference of the note
16 that you've taken --
17 **A.** Mm-hm.
18 **Q.** -- and your ward note setting out the discussion and
19 overleaf, page 4, please. "Key Checks by Doctor":
20 Does he have the capacity to consent? No.
21 Does he have an advanced directive statement in
22 place? No.
23 "Does the medication prescribed as listed on the
24 medication card tally with what has been authorised on
25 the current treatment certificate?"

1 Not applicable, three-month rule.
2 What does that mean?
3 **A.** That means that if the patient has been detained for
4 more than three months in hospital and if the patient
5 lacks capacity to consent to his treatment at that
6 point, a second opinion appointed doctor needs to come
7 and approve his treatment. And that happens after three
8 months of detention, that's why it's called three-months
9 rule.
10 **Q.** If we have a look, please, at page 5 of the same
11 document, "Risk formulation":
12 "Please complete a risk formulation and date that
13 informs action points ...
14 "Consider the four Ps (Precipitation, predisposing,
15 perpetuating and risk management plan)."
16 **A.** Mm.
17 **Q.** Then there's action points. So risk formulation, if you
18 can go back to that box, please. What's that aimed at?
19 **A.** That is aimed at using that format, the major facts of
20 the admission, leading to admission, discussion of the
21 predisposing, perpetuating, precipitating factors and
22 the protective factors to inform a risk reduction plan.
23 This is normally done. The leading role in that is to
24 the psychologist on the ward but doctors, nurses,
25 occupational therapists ideally should sit down together

1 with the patient and go through that risk formulation.
2 I know that this has been done, though it wasn't
3 done on that date, and that's why there is nothing
4 mentioned in --
5 **Q.** That's true with the others as well. Is that because
6 you're looking at, in your assessment of him, as an
7 inpatient at that time --
8 **A.** Yes.
9 **Q.** -- in Psychiatric Intensive Care, you don't appear to be
10 doing a formulation for any other setting, for example
11 in the community, do you?
12 **A.** So he was detained on Section 2, which required
13 assessment of his mental health. And the risk
14 assessment on that stage was really quite here and now,
15 in principle, as to advice as to what the current
16 situation is and how to deal with it. But the risk
17 formulation, as a result of the formulation of the risk
18 factors, might have been more longer-term oriented. And
19 indeed, it was.
20 **Q.** Can we go, please, to CYGN0000033, page 3, "Patient
21 Review", summary of an MDT discussion. We see VC, at
22 the bottom box:
23 "... asked when he will be transferred to an acute
24 ward and we reassured him we're working on it and trying
25 to work out his transfer.

1 "We discussed his online university education and he
2 stated it is going well but the only challenge he has is
3 not knowing when he will be discharged. Dr Shoilekova
4 explained to him in that he may not need a lengthy
5 admission in an acute ward."
6 We see many examples of doctors telling VC what he
7 might want to hear, in particular circumstances, rather
8 than digging deeper. Do you think, at this stage in the
9 assessment and with what you did and did not know about
10 him, giving any reassurance or indication that he may
11 not need a lengthy admission was appropriate?
12 **A.** No, and that is not, I'm afraid, a correct narrative as
13 to what has been said. What has been said is an
14 explanation that what Section 3 means, and that was
15 after he was detained on Section 3 and was deeply
16 disappointed by that. And the explanation which
17 I normally give to people who are detained on Section 3
18 is that this can last six months but can last less and
19 can last longer than that and, also, that the section
20 can be discharged by the Responsible Clinician and by
21 the Mental Health Tribunal. I would never even dream of
22 promising patients that they will stay less on a shorter
23 period in hospital, because that is something which
24 nobody -- nobody -- can know exactly how things will
25 develop.

1 **Q.** So this was in the context of telling him you were going
2 to convert it into a Section 3 or --
3 **A.** No, that was after he was detained on Section 3.
4 **Q.** So had you explained to him at any point that you were
5 going to support the Section 3 --
6 **A.** Yes.
7 **Q.** -- detention?
8 **A.** Yes.
9 **Q.** So he knew you thought he needed to be in hospital
10 longer and to be detained.
11 **A.** Yes.
12 **Q.** And what did you think, at the point of converting to
13 Section 3, his period of detention was likely to be for
14 treatment purposes?
15 **A.** As I said, I expected longer period after stabilising to
16 a degree to be managed on an acute ward nearer to his
17 home. I expected at least two to three months'
18 admission to established on maintenance medication of
19 some type --
20 **Q.** Two to three months?
21 **A.** Yes.
22 **Q.** In a ward?
23 **A.** Mm-hm. Followed by successful periods of leave, be it
24 overnight leave, and also, if possible, to start
25 a psychological therapy to develop in that period of

1 time or to regain insight, which would be important.
2 **Q.** Could we have, please, CYGN0000029, page 1. I'll move
3 over to 2 as well. And this is an assistant
4 psychologist's "Formulation", dated 22 September.
5 **A.** Mm-hm.
6 **Q.** So at Cygnet he sees an assistant psychologist; is that
7 right?
8 **A.** That's correct.
9 **Q.** And we see setting out how he's presenting. We see in
10 that second box at the top:
11 "... believes police are planning things against him
12 ..."
13 A very realistic description of the attack in the
14 paragraph above towards the police officers.
15 **A.** Yes.
16 **Q.** "... aggressive ... had to call for more support ...
17 several officers attended ... continued to be
18 aggressive. ... officers went to restrain him ...
19 seriously repeatedly assaulted the male police officer
20 ... punched and headbutted him several times ... able to
21 wrestle the handcuffs off of a female officer and use as
22 a weapon ... eventually subdued ..."
23 And explaining what that took.
24 Then if we go down to "Predisposing (vulnerability
25 factors)":

1 "[VC] ... unable to give any reasons which may have
2 triggered this first episode ... denied drug use/family
3 history or any stressful events.
4 "He has had two admissions last year."
5 And if we go to the next page, page 2,
6 "Perpetuating" -- perpetuating concerns, presumably.
7 **A.** Yes.
8 **Q.** "[VC] lives alone ... does not feel he requires any
9 further support in the community."
10 Protective factors listed, and then "Plan":
11 "Depot antipsychotic medication should be considered
12 if detained on section 3".
13 So first of all, the value of those psychotherapies,
14 it looks like somebody's really had an in-depth
15 conversation, and an assistant psychologist as well.
16 **A.** Yeah, that was assistant, yeah.
17 **Q.** Mm-hm.
18 **A.** And the value of that is that this is conducted with the
19 patient and there at the formulation meeting he is
20 allowed to ask questions. That is a pretty good summary
21 of the available information we had at that point,
22 including the ward rounds.
23 **Q.** Mm-hm. And indeed, those presupposing vulnerability
24 factors, triggering events, could have been picked up
25 and continued in psychological therapy.

1 **A.** Sure.
2 **Q.** Could we have, please, CYGN0000083, page 1.
3 "Occupational Therapy Initial Assessment". And we see
4 "What [does he] ... need help with?"
5 At the bottom box:
6 "... spoken about having a gym induction ... like to
7 keep myself physically fit ... not much to do on the
8 ward."
9 He sets that out.
10 "I do some reading and use the internet for
11 listening to podcasts."
12 And if we go over the page, please, to page 2, his
13 own "Social skills", he says:
14 "... a social person, friendly ... outgoing ...
15 don't push people past their own boundaries ... I make
16 friends easily ..."
17 And talks about housemates he gets on well with.
18 Again, that needed psychological intervention, didn't
19 it, in circumstances where he'd assaulted his flatmate.
20 **A.** Yes.
21 **Q.** And he's reported self-report here with information that
22 could have challenged that. Do you agree? That's the
23 value --
24 **A.** I agree.
25 **Q.** -- *(overspeaking)* -- of that information?

1 **A.** I agree, yes. And that was information which was shared
2 with us by the occupational therapist of the ward round.
3 **Q.** So you, as the Consultant Psychiatrist, would value
4 multidisciplinary input, presumably?
5 **A.** Yes.
6 **Q.** We know -- that can come down, if we can have
7 CYGN0000011, please. It's your report to the Mental
8 Health Tribunal. We know he appealed against his
9 detention.
10 **A.** Yes.
11 **Q.** And you provided a report, if we go to CYGN0000011,
12 page 3. We can perhaps highlight your view. If we
13 highlight that there, give people a chance to read it,
14 at the bottom, the bottom box.
15 **A.** Yes.
16 **Q.** If we can go over to the next page, please, for the top
17 box, page 4. And if we can go, please, to page 5, the
18 bottom box, 15. We see:
19 "[VC] does not believe he suffers from mental
20 disorder ... is adamant he does not need any treatment.
21 "[VC] will most probably in longer term benefit from
22 depot antipsychotic medication.
23 "However, if discharged from hospital now, highly
24 unlikely [VC] will comply with the recommended treatment
25 regime at all, and will not engage with community mental

1 health services."
2 And if we go to page 7, please, and highlight the
3 top box.
4 "[VC] lacks insight, does not believe he needs
5 treatment or any support in relation to his mental
6 health. If discharged ... he will not comply with his
7 medication, and will not engage with mental health
8 services in the community.
9 "His mental health will deteriorate ... actions will
10 be driven by the content of ... delusional beliefs and
11 hallucinatory experiences, and aggravated by low
12 distress threshold and increased impulsivity, which
13 might result in violent attacks on others, or violent
14 retaliation ...
15 "... if discharged from hospital ... he will be a
16 risk to his own health (through non-compliance and
17 non-engagement), to the safety of others, and to his own
18 safety (through retaliation)."
19 So you were very clear about the risks, weren't you?
20 **A.** Yes, that was done -- that report was written on
21 17th September.
22 **Q.** September. Mm-hm.
23 **A.** That was just six days after admission, and at that
24 point I was following the detention criteria and the
25 risks identified by the Mental Health Act for continuous

1 detention, and he met all of them.
2 **Q.** If we go, please, to CYGN0000056, page 3, we see the
3 industrial tribunal decision.
4 **A.** Yes.
5 **Q.** And we see at paragraph 3, at paragraph 3:
6 "She planned [that's you] to recommend s[ection]3
7 detention, on the basis ... he is young and it is
8 'essential that treatment is given early to give him far
9 better chances of long term functioning'. [She] ... does
10 not think [he] has recovered his insight ... he has 'the
11 potential to' if he complies with treatment; if his
12 insight does not improve she would recommend a depot."
13 So that's the evidence you gave to the tribunal,
14 isn't it?
15 **A.** Yes.
16 **Q.** "In terms of insight [she] ... has never seen insight
17 starting to form -- as of yesterday it did not appear
18 ... [VC] had insight into his condition when he met the
19 psychologist and 'gaining insight overnight would be
20 a very unusual occurrence'. Dr Shoilekova said whilst
21 you have to rely on what patients tell you that has to
22 be matched with other assessments."
23 You "denied ... symptoms are 'residual'"; they have
24 not improved sufficiently to allow critical thinking to
25 take over ... [or VC] to take back control of the

1 management of his mental illness."
2 And if we can go, please, over the page to page 5.
3 The top box, (iii), the tribunal's reasons for its
4 decision --
5 **A.** Yes.
6 **Q.** -- include this one:
7 "Less than three weeks ago [VC's] delusions were
8 sufficiently severe and distressing so as to cause him
9 to seriously assault a police officer and require
10 physical restraint. This is the second time his illness
11 has resulted in someone else suffering a significant
12 injury."
13 **A.** Yes.
14 **Q.** And we see at 13(i) further down the page, please:
15 "There is unequivocal evidence that the risk to
16 others when [VC] is unwell are high and that relapse
17 occurs rapidly and is difficult to manage. These risks
18 eventuated very recently and it is important that they
19 are minimised so far as is reasonable before [VC] is
20 discharged into the community."
21 Do you agree with those findings?
22 **A.** Yes, yes.
23 **Q.** Thank you. That can come down and this may be a good
24 time for the afternoon break, Chair.
25 **THE CHAIR:** Yes, thank you.

1 **THE WITNESS:** Thank you.
2 **THE CHAIR:** We'll take a break until 3.35. Thank you.
3 **(3.19 pm)**
4 **(A short break)**
5 **(3.35 pm)**
6 **MS LANGDALE:** Whichever is easiest for you.
7 Dr Shoilekova, was there any formal MDT discussion
8 after the tribunal findings, specifically focusing on
9 whether there needed to be a re-evaluation of
10 strengthening his treatment plan?
11 **A.** The tribunal made their decision based on the
12 recommendations of the MDT team and, certainly, they
13 were not different from what has been said at the
14 tribunal hearing by the team. So there was no specific
15 discussion as to reflect the tribunal's decision but, of
16 course, we were satisfied that they have reached the
17 decision they did, and we did go ahead with the Mental
18 Health Act Assessment in view of placing VC on
19 Section 3, which was the treatment section of the Mental
20 Health Act.
21 **Q.** But you have given evidence, haven't you, that he needed
22 to comply with treatment, and you had said if he didn't
23 improve his insight, you'd recommend a depot?
24 **A.** Yes.
25 **Q.** You'd already learnt from Claudia Birtles that he'd had

1 a significant history of not complying with medication?
2 **A.** *(The witness nodded)*.
3 **Q.** So in the light of the tribunal's acceptance of that
4 evidence, and the seriousness of it, in the end he's
5 deprived of his liberty because he has no insight --
6 **A.** Yes.
7 **Q.** -- and he needs treatment. So having supported the
8 detention, an equally important measure was to support
9 the treatment and get that treatment going effectively,
10 wasn't it? So would that have not necessitated, at that
11 point, thinking about starting a depot? Because you
12 could have done it on the admission, couldn't you? You
13 could have done it on the Section 3 admission?
14 **A.** So several lines of answer in that question. Firstly,
15 what depot? Would that be haloperidol depot or
16 different substance of the depot?
17 **Q.** Does that mean -- pausing there, you would need to
18 establish what was the most effective treatment before
19 introducing it by a depot.
20 **A.** We needed to establish -- sorry to interrupt. I didn't
21 mean to. Yes. We needed to establish the most
22 efficient treatment.
23 **Q.** Can you change a depot in the same way you'd change the
24 medication orally though, so if you'd started it and
25 after two or three weeks, well, that's not effective,

1 you just change to a different medication in a depot
2 form?
3 **A.** You normally would change the medication, firstly
4 testing on oral tolerability and then started in
5 a depot. However, when VC was in the community, it
6 wasn't sure whether he was or not taking his
7 aripiprazole and, when he was in hospital, we were more
8 confident that he was taking his oral antipsychotic, and
9 we observed not only him swallowing the tablets but we
10 observed gradual improvement with that. And gradual
11 improvement, if continued, together with psychological
12 therapy, let us say cognitive behavioural therapy for
13 psychosis, might significantly improve insight as well.
14 And that is an ongoing assessment in such cases to
15 decide and to evaluate which would be the best way
16 forward.
17 He was adamant that he will take his oral tablets
18 and he was also adamant that he will not accept depot
19 injection.
20 **Q.** Do you think there are other steps you could have taken
21 to mitigate the effect of fragmentation of care, for
22 example, on that point, speaking directly to Dr Seedat,
23 about where he'd said that before about medication and
24 just hadn't done it and where he'd been recorded in the
25 notes to telling doctors he was not hearing voices, to,

1 in effect, enable his discharge from hospital -- in
2 other words, that he was manipulating to get his
3 preferred outcome. Do you think you could have got
4 better information about his history of that from
5 previous admissions and previous history of care?
6 **A.** Of course.
7 **Q.** How would you do that? How could you have done that?
8 **A.** Well, practically, it would have been very demanding,
9 because I was working three days a week and I was
10 looking after nine acutely unwell patients, and the fact
11 of the matter with PICU is that the average length of
12 stay is very, very short.
13 **Q.** Do you have admin support? Someone who could have
14 located the notes, the RiO notes from his first
15 admissions to just put in front of you a bundle like
16 this?
17 **A.** Yes, there was one admin support for the whole hospital
18 of more than 35 patients, and it was -- and I did ask
19 the admin support to go ahead and ask for GP summary.
20 However, I could not have delegated to the admin support
21 to speak to a colleague of mine. Ideally I could have
22 spoken.
23 **Q.** Or ask for the inpatient records relating to the first
24 and the second admission. They would have been more
25 useful to you, presumably, than the GP summary we've

1 seen, prepared by a nurse?
2 **A.** But the GP summary is something you receive within
3 24 hours at least at that time, whilst we have asked for
4 the inpatient case notes but we never received them.
5 **Q.** You've asked for them, did you?
6 **A.** We asked for everything possible -- the Discharge
7 Summary, the case notes -- but what we received there is
8 in the bundle: it was the outpatient case notes and the
9 letter from the Cassidy Suite to the University.
10 **Q.** On the subject of the University, he was a student, you
11 knew that. Whose responsibility was it to tell the
12 university about the admission with you, the detention
13 and the onward detention on an acute ward? Did you
14 consider that you should have phoned them to let them
15 know about that?
16 **A.** I cannot recollect any consideration about that because
17 he told us that he has put his university studies on
18 hold for the time being. That's what we were told --
19 **Q.** If you had thought he was a risk to students or other
20 people at the University, would you have contacted the
21 University?
22 **A.** Certainly, certainly, but we were not planning any
23 discharge --
24 **Q.** No. You were --
25 **A.** -- on that stage at all.

1 **Q.** Can we have CYGN0000013, page 4, please, and this is
2 your assessment. It can be on the screen for VC, for
3 the Section 3 and, while we're getting it, how readily
4 can you convert from a Section 2 to a Section 3 during
5 an admission? Is it something you've commonly done?
6 **A.** For some patients, Section 3 is not necessary, because
7 either the assessment does not reveal a mental disorder
8 which necessitates further detention or they accept
9 a further treatment and involvement. For many patients,
10 however, the initial period of up to 28 days, which
11 Section 2 allows of detention, are not enough. Insight
12 is not achieved, compliance is not achieved, and some of
13 the risks remain prominent --
14 **Q.** Do you think the Act fulfils its purpose that, where you
15 need to keep someone in for further treatment you're
16 confident about navigating that and using Section 3, are
17 you?
18 **A.** Yes.
19 **Q.** You clearly did that here?
20 **A.** Yes.
21 **Q.** But is that just not an issue for you as a psychiatrist:
22 if you think you need to addressed someone and keep them
23 in longer, you do?
24 **A.** Yes, under the Mental Health Act.
25 **Q.** Of course, guided by the Act.

1 **A.** Yes.
2 **Q.** But if you think it's necessary for them or the safety
3 of others?
4 **A.** And the safety of others, the Act clearly states that
5 the safety of others is a consideration when a detention
6 is considered.
7 **Q.** In the top paragraph here of your summary, you've
8 referred to VC's acts in the past, gaining:
9 "... access to neighbours' properties causing
10 significant distress and, be it unintentionally, harm."
11 Again, on the subject of information sharing, do you
12 think it would have been relevant and important to fact
13 check that? Would you ever contact the police to find
14 out what had happened?
15 **A.** No, I didn't contact the police but I read the referral
16 letter from the doctor who witnessed the incident
17 leading to Section 2 detention on the --
18 **Q.** Dr Lomas?
19 **A.** Yes.
20 **Q.** That can come down, please.
21 Can we have CYGN0000015, page 1, and this is the
22 "Notification of discharge/transfer ..." It is in fact
23 dated 4 October, I think, although the transfer's the
24 first. And this is to the Priory Arnold. Did the Trust
25 tell you that the only option for VC was a step down to

1 a placement rated as inadequate by the CQC? Did you
2 know that?
3 **A.** No.
4 **Q.** Would you --
5 **A.** I didn't know.
6 **Q.** -- expect to be told that?
7 **A.** Sadly, no.
8 **Q.** You wouldn't --
9 **A.** And neither the decision to -- which placement will be
10 chosen was the decision which Cygnet had any saying in.
11 That was a decision made by the commissioners.
12 **Q.** If we see this discharge, page 1, we see the diagnosis
13 now, you're listed as the Responsible Clinician:
14 "Paranoid schizophrenia."
15 **A.** Mm-hm.
16 **Q.** "Discharge recommended by: MDT.
17 "Mental state examination on discharge:
18 "good self-care, blunted effect, denies delusional
19 beliefs and perceptual abnormalities; lacks insight;
20 will not consider depot antipsychotic injections.
21 "Impression: [currently improving] Paranoid
22 Psychosis ...
23 "Risk to others: moderate.
24 "Prior to admission ... high risk of violence and
25 aggression, nursed in seclusion for a week prior to

1 transfer."
2 If we go over the page, page 2, we see a blood test,
3 page 3.
4 **A.** Yeah.
5 **Q.** Can we go to the bottom box of "Non-compliance with
6 medication" on page 3 please. Further down:
7 "Non-compliance with medication: moderate.
8 "Referral documents state [VC] said he was no longer
9 taking ... medication ... had no intention of continuing
10 with the treatment, he wouldn't say exactly when he
11 stopped that ... had been days".
12 This I think was completed by Dr Engel who is giving
13 evidence, isn't she?
14 **A.** Yes.
15 **Q.** But I think it is -- it's not signed off by you, is it?
16 But did you see it?
17 **A.** Yes, I normally see. This is discharge notification
18 that is a short version of Discharge Summary, which
19 normally is prepared couple of days after discharge.
20 **Q.** Well, this is after discharge because this is dated
21 4 October.
22 **A.** Yes.
23 **Q.** So if we go --
24 **A.** Shortly after discharge.
25 **Q.** Mm-hm.

1 **A.** Or transfer, and in this case I believe VC was
2 transferred on a Saturday, and that's why there is
3 a couple of days' delay between the 11th and 14th.
4 **Q.** Why doesn't it include, where medication is referred to,
5 the fact that you think a depot is required and have
6 said that, and the absence of insight, and also Claudia
7 Birtles, the CPN, had? Because we've seen the documents
8 where you're clearly speaking about a depot and
9 treatment, but it doesn't appear anywhere here, does it?
10 **A.** That is a short version. It's a discharge notification,
11 just there is a Discharge Summary which might follow a
12 little bit after that, which I would expect is more
13 detailed in that respect.
14 **Q.** If we go, then, to CYGN0000012, this is the document
15 you're referring to.
16 **A.** I can't see anything else. Yes.
17 **Q.** Yes? So we see at the front "Paranoid schizophrenia",
18 "Medication", "Plan", "Transferred for ongoing care in
19 acute ward."
20 **A.** Yeah.
21 **Q.** No suggestion that you think that the depot is required.
22 There's a history after that, "Past Psychiatric
23 History", "Mental State Examination ..."
24 **A.** Okay.
25 **Q.** But there is no reference to the important issue of

1 depot, is there?
2 **A.** I can see only the first page, but absolutely take what
3 you're saying. However --
4 **Q.** If you look at page 2 --
5 **A.** Mm-hm.
6 **Q.** -- no reference there to you suggesting a depot.
7 "... a depot has been considered".
8 We see under "Past psychiatric history":
9 "His compliance with treatment has been
10 questionable, hence a depot has been considered."
11 **A.** Yes.
12 **Q.** Nothing about you thinking that was necessary --
13 **A.** Probably --
14 **Q.** -- absent insight.
15 **A.** Probably. That is not exactly necessary, because this
16 is a common knowledge in psychiatry, and every
17 consultant in psychiatry would consider that logically
18 and as a normal consideration of further treatment.
19 It's nothing out of the ordinary to specify that so and
20 so --
21 **Q.** But it's your view. It's not the fact of a depot being
22 considered, it was the fact that it was your view and
23 the tribunal findings --
24 **A.** Yeah, yeah.
25 **Q.** -- and we've yet to hear whether the subsequent

1 psychiatrist read the tribunal findings and the
2 recommendation you'd made. It's the history of the
3 patient, isn't it, that you, with experience and
4 understanding of his condition after that insight --
5 that that period of admission, have said that about his
6 lack of insight and treatment.
7 **A.** Yes, yes.
8 **Q.** Nor does it say that a treatment course of two to
9 three months might be advisable in the circumstances.
10 **A.** No, that is not an advice. That was a kind of a span of
11 time, based on previous knowledge and experience at
12 least. I could not recommend length of time of
13 detention, because detention and, according to the
14 Mental Health Act, detentions should be discontinued at
15 the time when the detention criteria are no longer met.
16 **Q.** I appreciate you couldn't recommend, but something to
17 the effect of "It seems to me" or "It seems to us",
18 something that steers --
19 **A.** Yeah.
20 **Q.** -- the next person picking up the patient --
21 **A.** *(The witness nodded)*.
22 **Q.** -- where you yourself recognise you don't get thorough
23 enough information on short term admissions.
24 **A.** Yes.
25 **Q.** Particularly in someone who has had three admissions

1 already, and is moving on to another hospital.
2 **A.** And certainly that has been very clearly said in the
3 tribunal report and is clearly said in the tribunal
4 decision.
5 **Q.** Do you think the discharge letter gave a sufficient full
6 picture, handing over to the Priory?
7 **A.** Reasonably good picture, without the knowledge as to
8 what might have happened after that, and nobody had that
9 knowledge at the time, I'm afraid. But the diagnosis,
10 the treatment, the recommendations, the risk assessment,
11 were reasonably good, as far as I am concerned.
12 **Q.** Finally -- from me on policy, Cygnet policy, "Family and
13 carer involvement". If we have CYGN0000117, page 3
14 please, involvement of family and carers.
15 And the policy, as it's put up on the screen,
16 provides that there should be, at 6.1:
17 "... involvement of family and carers ...
18 individual's care should be recognised as good
19 practice."
20 **A.** Yes.
21 **Q.** Do you think that at Cygnet, you should have told VC's
22 nearest relative about the decision to step down to
23 acute care?
24 **A.** Yes, normally, that should be the case.
25 **Q.** And as far as the University is concerned, do you think

1 that you should have told them the same thing?
2 **A.** Stepping down?
3 **Q.** Yeah, given that he'd had that admission and that
4 knowing he was a student at the University --
5 **A.** Not without the consent of the patient, because VC
6 consented for his nearest relative to be informed about
7 his progress and any changes in the treatment plan. But
8 as far as the University is concerned, unless we had
9 concerns on that specific point, that not telling them
10 might generate risks to the safety of others. We
11 wouldn't overrule his consent unless that was our
12 concern about the safety of others.
13 But I must really, probably reiterate that there was
14 no plan for discharge on that stage. He was transferred
15 to a psychiatric ward with 24 hours observation,
16 treatment monitoring, monitoring of his mental health.
17 He was on a treatment section detained under the Mental
18 Health Act.
19 **MS LANGDALE:** Understood. Those are my questions, thank
20 you.
21 **THE CHAIR:** Yes, Mr Moloney.
22 **Questioned by MR MOLONEY**
23 **MR MOLONEY:** Dr Shoilekova, good afternoon, I've only two
24 topics to ask you about, please: first of all, a topic
25 that Ms Langdale King's Counsel has just dealt with, in

1 essence fragmentation of care and what might be included
2 within a Discharge Summary, in order to mitigate that
3 fragmentation of care; and then, secondly, haloperidol
4 and your prescription of haloperidol in your treatment
5 of VC.
6 **A.** Yes.
7 **Q.** Can we please just look at the Discharge Summary that
8 you said was prepared a couple of days after VC was
9 transferred out of your care, and that's CYGN0000012,
10 and to page 6 of that once we get there, please, because
11 this deals with concordance with medication or
12 non-compliance with medication. Ms Langdale has raised
13 with you how it is that there is no reference to your
14 considered view that depot medication would be desirable
15 for this person, and this deals with the compliance of
16 VC with medication?
17 **A.** Yeah.
18 **Q.** Now, we see that, whilst you have stated earlier about
19 he had told that he was no longer taking his medication
20 and no intention of continuing with the treatment, and
21 so on -- that's the earlier -- but we see then from
22 21 September 2021 "[VC] has been concordant with his
23 medications since admission", and then 28 September
24 2021, "[VC] has been compliant with all prescribed
25 medications since the last review period".

1 So a more optimistic assessment of the position by
2 that time and at the time of transfer. Then, if we go
3 to the top of the page, if we could, we see,
4 "Non-compliance with medication: moderate".
5 Now, is there a danger that that is an underestimate
6 of the position, that the non-compliance with medication
7 is moderate, given your experience of VC, or really
8 should it be more serious than that, given what was
9 known over the long period since his first admission?
10 **A.** I am not sure what the context of that --
11 **Q.** I apologise, Dr Shoilekova. You didn't write this
12 Discharge Summary.
13 **A.** No.
14 **Q.** It was Dr Engel but, as you have told Ms Langdale, you
15 saw it later, didn't you?
16 **A.** Of course, of course.
17 **Q.** Absolutely.
18 **A.** Of course I take full responsibility for that. I'm just
19 tying to understand, "Non-compliance with medication:
20 moderate" maybe refers to risk following transfer.
21 **Q.** But, of course, that's really what I'm getting to: that,
22 essentially, in terms of fragmentation of care, what the
23 Priory needs to know is that you consider that RiO is
24 appropriate -- sorry, that depot is appropriate --
25 **A.** Yes.

1 **Q.** -- and here, all we have is essentially a moderate risk
2 of non-compliance on transfer to Priory, rather than
3 what maybe should be addressed in order to reduce
4 fragmentation of care: the risk of non-compliance when
5 released into the community?
6 **A.** Yes.
7 **Q.** Yes, then can I also ask you one -- and also Ms Langdale
8 asked you about your opinion as to -- and if I get this
9 wrong, then please correct me -- that, in essence, that
10 what you would have liked to have seen was a period of
11 stabilisation on an acute ward before then moving on to
12 two to three months in a local ward before release into
13 the community and that was your view. Now, that isn't
14 in the Discharge Summary.
15 In terms of, as it were, trying to mitigate
16 fragmentation of care, would it be useful for, as it
17 were, successor clinician to see your opinion? Not
18 necessarily to slavishly follow it, but to see it so
19 that then they might contact you if there are any
20 issues?
21 **A.** Yeah.
22 **Q.** Yes.
23 **A.** So that was self-understanding and is self-understanding
24 between psychiatrists that if somebody has initiated and
25 finalised detention under Section 3, that wouldn't mean

1 three weeks' or four weeks' admission, that would mean
2 admission in longer terms: at least two to three months,
3 on average. But this is the hypothesis. This is
4 a prediction.
5 **Q.** Of course.
6 **A.** This is something which I would not really recommend,
7 because it's a matter of ongoing assessment of how the
8 detention criteria continued to be met or not to be met.
9 **Q.** Absolutely, but you, of course, Dr Shoilekova, had seen
10 VC when he was in the PICU?
11 **A.** Yes.
12 **Q.** So you had seen him at a time when care was most
13 necessary?
14 **A.** Mm-hm.
15 **Q.** It's an intensive care unit, isn't it?
16 **A.** Sure.
17 **Q.** So you would have been able to get an impression of him
18 before he was medicated and/or had only had a short
19 period of medication --
20 **A.** Yes.
21 **Q.** -- having been transferred from Cassidy Ward *(sic)*.
22 **A.** Yes.
23 **Q.** So would your view at that time, how you felt, having
24 assessed him at that time, be useful to a successor
25 practitioner, just so they could see what he was like

1 from the start?
2 **A.** Yes, of course, without any question. However, that
3 view was expressed in my evidence to the mental health
4 review tribunal.
5 **Q.** No, I don't suggest for one moment that it wasn't. I'm
6 only thinking about, as you say --
7 **A.** How to --
8 **Q.** You said, "I couldn't" -- if we look at the other end of
9 fragmentation, when Ms Langdale was asking you about
10 whether or not you could look at other notes earlier,
11 you said "I have only got three days a week and I can't
12 be digging into it", and, at the other end of that, when
13 the clinicians receive the person into the Priory it may
14 be that they don't have time, but the Discharge Summary
15 will be something that clinicians would look at, isn't
16 it?
17 **A.** If gets on to his or her desk, yes.
18 **Q.** Can I move on to my second topic, please, and it's
19 a related topic but you have told the Chair this
20 afternoon that on 3 September, when VC was admitted into
21 Cassidy Ward, that then he was being treated with
22 aripiprazole. On 11 September, when you took over his
23 care, then you moved him on to haloperidol?
24 **A.** Can I expand on that? He was prescribed aripiprazole
25 following his second discharge, which was in 2020.

1 **Q.** Can I not ask you to expand on it, because we've got
2 limited time --
3 **A.** Yes.
4 **Q.** -- and, for this reason --
5 **A.** So, in that case, can I just clarify, he was on
6 haloperidol, and haloperidol was started on the
7 136 Suite in Nottingham.
8 **Q.** Right, and then when you had him on -- and did you -- so
9 you treated him with haloperidol from 11 September and
10 we know he went to the Priory on 1 October, didn't he?
11 **A.** Correct.
12 **Q.** Absolutely. So you had VC on haloperidol for about
13 three weeks, just around three weeks, and then you saw
14 that -- or you said that, really, you would need
15 somebody on the optimal dose, ideally, for some four
16 weeks to really see the impact --
17 **A.** Yes.
18 **Q.** -- of a drug. But, you said that, after a couple of
19 weeks even, you saw improvements with VC --
20 **A.** Mm-hm.
21 **Q.** -- on that dose --
22 **A.** Correct.
23 **Q.** -- and so on. Ideally, if VC had stayed with you, how
24 much longer would you have had him on haloperidol before
25 considering other medication?

1 **A.** I would have kept him on haloperidol.
2 **Q.** You would have kept him on haloperidol. Can I ask you
3 to have a look at this document, please, and whilst --
4 it's PAGR0000159.
5 Whilst that's coming up, can I ask you, did you know
6 that VC's medication, when he's discharged from your
7 care, at an MDT on 7 October, once he got to the Priory,
8 his medication was changed at his own request back to
9 aripiprazole.
10 **A.** No, I didn't know that.
11 **Q.** Can we just have a look at page 3 of this document,
12 please. We see here this is an MDT conducted by
13 Dr Gurusinghe, who is going to be giving evidence to the
14 chair next week, and we see halfway down the page the
15 description of him -- ah, thank you very much -- and we
16 see, if we could just, above "Patient views/feedback":
17 "He did not agree he had a relapse on this
18 occasion -- said he was too stressed and he overreacted
19 when police got involved."
20 That's talking about 3 September 2021:
21 "He did admit to 3rd person auditory hallucinations,
22 thought intrusions and abnormal beliefs in the past, he
23 stated that they went away when he was on aripiprazole.
24 He preferred to be back on aripiprazole and come off
25 haloperidol -- he said it was making him salivate a lot.

1 "[The Responsible Clinician] agreed to cross-taper
2 and titrate aripiprazole."
3 Are you surprised by that?
4 **A.** I am not surprised.
5 **Q.** I appreciate you have to have deference to other
6 practitioners but would you consider that too early to
7 change medication after such advance?
8 **A.** As I said, I can't comment on what has happened after,
9 and his transfer but I think I clearly answered your
10 question: if it was for me --
11 **Q.** You would have kept him --
12 **A.** -- I would have kept him on haloperidol.
13 **MR MOLONEY:** That's all I ask. Thank you, Dr Shoilekova.
14 **THE CHAIR:** Yes, Ms Cartwright.
15 **Questioned by MS CARTWRIGHT**
16 **MS CARTWRIGHT:** Good afternoon, Dr Shoilekova.
17 Can we start just to clarify the prescriptions
18 because we know that VC was admitted to the Psychiatric
19 Intensive Care Unit on the 11 September but he had been
20 detained on the Cassidy Suite from 3 September.
21 **A.** Correct.
22 **Q.** It's right, isn't it, that he had been commenced on
23 intramuscular haloperidol from 6 September?
24 **A.** Even earlier than that, I believe, from the 3 September.
25 **Q.** Well, there or thereabouts.

1 **A.** Yes.
2 **Q.** But, certainly, he had haloperidol for a number of
3 days --
4 **A.** Correct.
5 **Q.** -- whilst awaiting the identification of a PICU.
6 **A.** Correct.
7 **Q.** So in that context, can we just briefly look at your
8 paragraph 2 because that length --
9 **A.** Paragraph 2 of?
10 **Q.** Paragraph 2 of your statement. I'm just going to ask it
11 to be displayed. WITN0188001 at page 1, please.
12 **A.** Yes.
13 **Q.** You tell us -- so bearing in mind, essentially, VC has
14 been receiving medication whilst he was on the
15 Section 135, you say:
16 "I have some recollection of VC because he was
17 floridly psychotic when he arrived at Albert Ward and
18 was in complete denial of his condition but by the time
19 he had left, his condition had significantly improved
20 ..."
21 **A.** Correct.
22 **Q.** So would you agree, for a patient who's already been
23 a number of days on a unit, been receiving haloperidol
24 intramuscularly, in seclusion --
25 **A.** Correct, correct.

1 **Q.** -- that that shows just how acutely unwell VC was when
2 he arrived at the PICU, still being floridly psychotic?
3 **A.** Yes, yes, I would say that but, also, by experience, the
4 improvement, even with the optimal or higher than
5 optimal doses, even with intramuscular application, does
6 not happen quickly. So it happens normally after
7 a couple of weeks, but sedation and calming down might
8 happen earlier than that. And, yes, he was floridly
9 psychotic when he arrived with us but there was no
10 agitation, there was no intention to attack or to harm
11 people, and he has responded, to a degree, remaining
12 symptomatic.
13 **Q.** So what I want to next deal with is just an aspect of
14 the evidence that you gave to the tribunal that's in the
15 report that you weren't briefly taken to. So can we
16 just display, please, CYGN0000056, please. Thank you.
17 If we can move forward, please, thank you, we can see at
18 paragraph 2, you give some context, and I think it
19 probably addresses the point you just raised then about
20 VC's behaviour -- sorry, just down a little bit, thank
21 you -- how he was. But he had not shown -- there had
22 been no aggression since transfer on to the PICU?
23 **A.** No.
24 **Q.** But you:
25 "... remained of the view that he suffers from

1 a psychotic disorder with persistent delusions of
2 persecution and ongoing auditory hallucinations although
3 it [was] ... 'a bit early' to give a definitive
4 diagnosis."
5 But you had arrived at the view that:
6 "... the illness was relapsing and remitting ...
7 [that] VC had not fully recovered since it began in
8 2020. [But you also] ... considered there may be some
9 negative symptoms, including a marginal but declining
10 functioning in social interactions and a lack of ability
11 to pre-plan."
12 **A.** Mm-hm.
13 **Q.** If you go over the page, you were then taken, I think,
14 to the next paragraph. And so essentially, his early
15 admissions had not got a grip of the first evidence of
16 a psychosis --
17 **A.** I would kindly ask you to repeat that.
18 **Q.** Sorry, so you had identified, in the evidence you gave
19 to the tribunal, that the early admissions had not got
20 a grip on his psychosis?
21 **A.** They might have. However, it's a rel -- a relapsing, or
22 that was the impression at that point: that it was
23 relapsing and remitting.
24 The earlier admissions might have been effective in
25 addressing and reducing the symptoms, but the nature of

1 the illness is such that it comes back.
2 **Q.** Can we then just look on an issue of danger that you
3 identified in paragraph 4, if we go a little further
4 down, thank you.
5 You say:
6 "There's no evidence of risk of him harming himself.
7 [But] ... that whilst [VC] was compliant and this was
8 encouraging it is difficult to judge whether the risk
9 has actually diminished without a transfer to a less
10 restrictive environment and trialling unescorted leave
11 etc."
12 And I think can we take as the "etc" what you've
13 given in evidence as well as that trialling unescorted
14 leave, the psychological therapies that you were of the
15 view needed to be implemented?
16 **A.** Yes. You've got to appreciate this is a summary --
17 **Q.** We completely appreciate that. Well maybe then --
18 **A.** -- *(overspeaking)* -- the mental health tribunal makes,
19 and this is a pretty good summary as to what has been
20 said.
21 So obviously this is monitoring of ongoing
22 compliance with medication, testing progress, or with
23 granting unescorted leave, overnight leave, a week's
24 leave in the community, reinstating involvement with the
25 Community Mental Health Team, and attempting further

1 engagement with occupational therapy and, as you
2 mentioned, psychological therapy, for psychosis.
3 **Q.** Thank you. Then we see essentially what you told the
4 tribunal: that:
5 "... on the basis of [VC's] current presentation
6 [the] PICU was still appropriate as his delusional
7 beliefs had recently caused behaviours which were highly
8 dangerous to others."
9 **A.** Yes.
10 **Q.** And you were clear about that?
11 **A.** Yes, yes.
12 **Q.** Then we know obviously there came the time when VC
13 was -- essentially the PICU is to stabilise, it's not an
14 ideal place to institute therapy because people are
15 acutely unwell. But essentially there's then step down
16 to the next placement for the therapy to stabilise and
17 ensure a long-term plan --
18 **A.** That's correct.
19 **Q.** -- for safety in the community.
20 **A.** That is correct.
21 **Q.** Then can we then just look, because I think you give
22 some helpful evidence in your paragraph 60 at page 23
23 about the nature and degree, well, specifically degree,
24 please. So back in your witness statement, please --
25 **A.** In my witness statement?

1 **Q.** Yes, WITN0188001. Thank you.
2 Now you have obviously for the statutory criteria
3 for continued detention it's essentially a patient
4 having a mental disorder of a nature or degree, or
5 nature and degree --
6 **A.** Mm-hm.
7 **Q.** -- that warrants the detention but also that appropriate
8 medical treatment is needed --
9 **A.** Yes.
10 **Q.** -- and there's issues of risk of harm to either the
11 patient or risk of harm to the public; would you agree?
12 **A.** Yes, I would agree.
13 **Q.** So I'm just going to ask about what you say about
14 degree, because this appears significant to continuing
15 issues for VC, you say this:
16 "The degree incorporates prominent symptoms of
17 suspiciousness, hostility, delusional ideas of
18 conspiracy and control, auditory hallucinations, ideas
19 of thought interference, some somatic hallucinations
20 ..."
21 **A.** Yes.
22 **Q.** "... and lack of insight."
23 So you'd identified those as relevant issues as to
24 the degree of his mental disorder --
25 **A.** Yes.

1 **Q.** -- that then, in conjunction with other statutory
2 criteria, required his detention?
3 **A.** Correct.
4 **Q.** And then --
5 **A.** Degree, just to clarify, and very briefly I will do so,
6 "degree" is a term which is used by the Mental Health
7 Act --
8 **Q.** Yes.
9 **A.** -- to identify the acuity of certain symptoms which
10 might be different in every specific case.
11 **Q.** Thank you. And then I'm just going to, because that's
12 plain you found it was satisfied on degree of the mental
13 disorder.
14 **A.** Yes.
15 **Q.** But can we then briefly just go back to the tribunal
16 decision, CYGN0000056. And paragraph, I think it's the
17 tribunal's paragraph 11 where they deal with nature.
18 **A.** Yes.
19 **Q.** And they say this:
20 "With regards to nature, whilst the clinicians are
21 cautious about prematurely labelling [VC's] illness, the
22 fact that he experiences psychosis is of relevance, and
23 the psychotic disorder is of a relapsing and remitting
24 nature -- it appears that there was only partial
25 remission following [VC's] earlier discharges from

1 hospital, as the voices continued, although he was able
2 to remain ostensibly fairly well in the community for
3 a period of time. Whilst [his] first contact with
4 mental health services was not until May 2020, he has
5 now experienced three severe relapses over a period of
6 16-17 months."
7 So would you agree that really the issue as to the
8 nature of VC's condition, particularly as time went on,
9 and these factors continued, it kept relapsing and
10 remitting --
11 **A.** Yes.
12 **Q.** -- and he continued to have no insight, the nature
13 aspect --
14 **A.** Yes.
15 **Q.** -- was also plainly going to be engaged, and certainly,
16 whilst the tribunal were cautious when they made their
17 decision, they were very much flagging that VC would
18 qualify under nature also?
19 **A.** Yes, yes.
20 **MS CARTWRIGHT:** Thank you.
21 **THE CHAIR:** Yes, Mr Straw.
22 **Questioned by MR STRAW**
23 **MR STRAW:** Dr Shoilekova, I represent VC's family.
24 I'd unlike to ask you about a few documents, please.
25 Could we have on screen first the CYGN0000047, please.

1 And page 3 of that, please.
2 Or sorry, can we start with page 1, please, just to
3 show Dr Shoilekova what it is. CYGN0000047, yes.
4 **A.** Can tell me what is it? I might remember.
5 **Q.** Okay, thank you. This is one of your Responsible
6 Clinician's reports dated 17 September 2021.
7 **A.** Yes.
8 **Q.** And you're asked there:
9 "Is the patient now suffering from a mental
10 disorder?"
11 And in the box answering that question, it says --
12 well, it includes this, so:
13 "The degree incorporates prominent symptoms of
14 suspiciousness, hostility, delusional ideas of
15 conspiracy ..." et cetera, et cetera.
16 And it carries on to describe the nature of the
17 hallucinations he's suffering:
18 "[They include] ... some somatic hallucinations (...
19 'pins and needles', tactile sensations caused by
20 'psychotronic' technology) ..."
21 **A.** Correct.
22 **Q.** Finally you say at the end of the box:
23 "... [he] does not believe [the] ... experiences are
24 contributable to mental illness, hence he stopped taking
25 his antipsychotic medication."

1 Do you recall that?
2 **A.** Yes, that was in my report for the tribunal hearing. As
3 I said, that report was prepared five or six days after
4 admission. That was hearing in relation to detention
5 under Section 2, I remember that.
6 **Q.** Just to summarise some aspects or some symptoms of his
7 illness, would you agree that the symptoms include
8 delusions that there's a conspiracy against him by the
9 NHS and other bodies?
10 **A.** Yes.
11 **Q.** And his symptoms also include delusions that he's not
12 ill?
13 **A.** That we normally would call lack of insight, but it is
14 very closely incorporated into the delusional system,
15 and at one point it might really give rise to delusions
16 of grandeur. So in broad terms, I agree with your
17 statement.
18 **Q.** And those two factors, the conspiracy, the lack of
19 insight, would you agree they led him firstly to stop
20 taking medication?
21 **A.** *(The witness nodded)*.
22 **Q.** You're nodding. If you don't mind saying "yes" or "no",
23 just so it picks up on the transcript.
24 **A.** I'm unsure for which timespan you are referring. Would
25 that be before his admission --

1 **Q.** Yes, before admission.
2 **A.** -- to Cygnet? Yes, I was left with the impression that
3 it was an elaborate delusional system which incorporated
4 the wrong idea that his experiences are not due to
5 mental disorder but due to other third-party
6 interference, hence medication would not alleviate the
7 symptoms in any way, therefore it had to be stopped.
8 **Q.** And the conspiracy in particular, the delusions that
9 there was a conspiracy by the NHS and others against
10 him, would you agree in the community, that also led him
11 to disengage, to be guarded, and to mask his symptoms?
12 **A.** It's a possibility, but I cannot comment. Most
13 probably.
14 **Q.** I mean you were aware, weren't you, that he was someone
15 who at times masked his symptoms?
16 **A.** Yes. Many patients do.
17 **Q.** I don't think we have the document up so I'm just going
18 to read a further section from it, please, page 7 where,
19 it's at the end of the document at paragraph 21, where
20 you talk about what happens when he's been discharged
21 from hospital, and I think this has been read out
22 already. You say:
23 "His mental health will deteriorate.... his actions
24 will be driven by the content of his delusional beliefs
25 and hallucinatory experiences ..."

1 Et cetera.
2 Do you recall that passage?
3 **A.** Yes, yes, that is a standard part of the tribunal report
4 from the Responsible Clinicians to indicate what the
5 immediate risks would be if the section were to be
6 rescinded on the day of the tribunal hearing, which the
7 tribunal has the powers to do. And the risks described
8 in this paragraph are more or less following the Mental
9 Health Act, not algorithm, but way of representing risk.
10 Risk to self, risk to his own safety, and risk to the
11 safety of others. So that is what I have written there
12 in the report.
13 **Q.** Was it your view that his risk was driven by his
14 psychosis?
15 **A.** At the time, yes.
16 **Q.** Another document, please, I'd like to ask you about,
17 it's back to the Mental Health Tribunal report, which is
18 CYGN0000056, please, page 3 of that. So paragraph 3
19 there, you've been referred to this already, there's
20 just one line I'd like to ask you about, please. It's
21 four lines up from the bottom of paragraph 3, where you
22 say:
23 "It is essential that treatment is given early to
24 give him far better chances of long term better
25 functioning."

1 Do you see that?
2 **A.** Yes.
3 **Q.** When you say "treatment" there, can you expand what you
4 mean by that?
5 **A.** A holistic approach combining psychotropic medication,
6 monitoring of response, psychological treatment and
7 support with social and psychological functioning.
8 **Q.** Thank you. Could we go, please, to page 5. This is
9 part of the reasons for the decision given by the
10 tribunal?
11 **A.** Mm-hm.
12 **Q.** (v) there, so paragraph Roman (v), at the end of it, the
13 tribunal say:
14 "Given the rapidity and severity of relapses in his
15 condition, it is essential that medication is maintained
16 and optimised."
17 Would you agree with that?
18 **A.** Yes, I would.
19 **Q.** To look at it another way round, would you agree that
20 a key warning sign of relapse would be if he's not
21 taking medication?
22 **A.** It was in this case, in the case of the current relapse,
23 it is normally associated with other signs of relapse,
24 which are different in different patients but, in
25 general, yes. I would agree.

1 **Q.** Thank you. Then a further document, please. It's
2 CYGN0000016 can we have page 1 of that first, please.
3 So this a "Social Circumstances Report" by Claudia
4 Birtles, for the purpose of the Mental Health Tribunal?
5 **A.** Yes.
6 **Q.** Did you see this report?
7 **A.** Yes.
8 **Q.** Can we go to page 7, please. About halfway down that,
9 the top box, she says:
10 "When asked why I would be involved if [VC] was not
11 unwell, [VC] said that he believed I continued to be
12 involved with the hospital in a cover up, stating that
13 he was unwell when he is not. [VC] said [he] is
14 currently taking haloperidol and that he would rather
15 not but will continue if he has to, he said he would
16 make a sacrifice if it meant he could be discharged.
17 [VC] said he feels like he doesn't have a choice but
18 [is] not taking it because he needs it."
19 **A.** Yes. I have read that.
20 **Q.** You have read that?
21 **A.** Yes.
22 **Q.** Okay, would you agree that this is someone you couldn't
23 rely on his assurances that he would take medication?
24 **A.** On that stage, yes, but that was early in the course of
25 his admission to Albert Ward. That report, at the top

1 of my head, was dated a week after his admission to
2 Albert Ward and things might have changed after that,
3 and I think they did.
4 **Q.** But putting it in context, there were a lot of similar
5 incidents, weren't there?
6 **A.** Yes.
7 **Q.** Where he said, "I'm taking medication, I will take
8 medication", and then he didn't.
9 **A.** I can't argue with that, yes. That is a repeating
10 pattern.
11 **Q.** Thank you. Then I think, at the point of transfer to
12 the Priory, is it right the diagnosis was paranoid
13 schizophrenia?
14 **A.** It is right. It is right.
15 **Q.** Can you briefly outline why? Could you briefly outline
16 why you came to that diagnosis of paranoid
17 schizophrenia?
18 **A.** Because we had specific symptoms known to be associated
19 with paranoid schizophrenia, called first-ranked
20 symptoms, for at least a period of time of at least one
21 month, which were persistent and were influencing the
22 patient's behaviour, and these symptoms were delusions
23 of control, associated delusions of conspiracy,
24 delusions of thought interference, and third-person
25 auditory hallucinations.

1 **Q.** Once it's established, is it right paranoid
2 schizophrenia is normally a lifelong condition?
3 **A.** It is a lifelong condition, given into consideration
4 where we are with the ability to treat it at the moment.
5 But many people do respond well to treatment.
6 **Q.** Different issue now. You fairly accept, in your witness
7 statement at paragraph 90, that communication with
8 Celeste Calocane, so VC's mum, was not as good as it
9 should have been?
10 **A.** Correct.
11 **Q.** Would you agree that there are two reasons why
12 communication with someone like Celeste Calocane is
13 important, firstly to inform her of VC's condition --
14 **A.** Yes.
15 **Q.** -- that's permitted -- and so she's in a better position
16 to judge, once he's released into the community, what
17 his mental state might be, how she has to respond, and
18 so on?
19 **A.** Yes, I would agree with that. I have always been an
20 advocate of ongoing contact with the relatives.
21 **Q.** The second reason: that she may be a useful source of
22 information for you?
23 **A.** Exactly.
24 **Q.** Then, finally, please, just one question about depot.
25 Is it right that you discussed depot with VC and he

1 didn't mention any concern about needles?
2 **A.** I cannot recollect any concerns about needles being
3 discussed or mentioned. That is not to say it didn't
4 happen; I just don't recollect anything like that.
5 I also know that, even if there were concerns about
6 needles and some medication needed to be implemented
7 intramuscularly, it would have been with dealt and
8 potentially overruled, if need be.
9 **MR STRAW:** Okay, thank you very much.
10 Chair.
11 **Questioned by THE CHAIR**
12 **THE CHAIR:** Yes.
13 Thank you, Dr Shoilekova. I just want to ask about
14 the transfer to the Priory and what information, at that
15 stage, Cygnet would send on to the Priory.
16 **A.** Yes, so there is bundles of *(unclear)* information, which
17 is normally is, at the top of my head, required to be
18 sent, or recommended to be sent. That would be the
19 discharge notification. That would be the current care
20 plan. That would be the current risk assessment. And
21 that would be, most importantly, maybe, every document
22 in relation with the Mental Health Act, including the
23 detention papers, which would be the medical
24 recommendations for detention, which would be
25 application from the Approved Mental Health

1 Professional, for detention, which would be the Approved
2 Mental Health Professional report and the authority to
3 transfer a patient under the Mental Health Act.
4 **THE CHAIR:** Would you send on a copy of the tribunal
5 decision or would you just --
6 **A.** Ideally, yes, because it would come under the big
7 umbrella of the Mental Health Act documentation.
8 **THE CHAIR:** Who would be responsible, at that time, for
9 sending on that -- physically sending on that material?
10 **A.** Physically, that would be the admin staff and the Mental
11 Health Act Officer.
12 **THE CHAIR:** Would you be --
13 **A.** But, ideally --
14 **THE CHAIR:** Sorry, would you be informed as to whether that
15 had gone or what had gone or shown it in advance?
16 **A.** I don't think I would have been informed. But I could
17 have asked.
18 **THE CHAIR:** Just one final question. I don't know whether
19 you knew but, when VC was accepted by Cygnet, did you
20 have any idea about how long he was going to stay with
21 you before moving on?
22 **A.** At the time of transfer?
23 **THE CHAIR:** To Cygnet.
24 **A.** To Cygnet?
25 **THE CHAIR:** Yes.

1 **A.** No. But PICUs are short-term admission wards. They
2 have a high patient turnover and average length of stay
3 between two and four weeks. There are exceptions.
4 **THE CHAIR:** Yes, thank you. Well, thank you for that and
5 we'll stop there and start again tomorrow at 10.00,
6 thank you.
7 **(4.34 pm)**
8 **(The hearing adjourned until 10.00 am the following day)**
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