Witness Name: Kalina Georgieva Shoilekova

Statement No: WITN0188001

Dated: 11 December 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF KALINA GEORGIEVA SHOILEKOVA

I, Kalina Georgieva Shoilekova will say as follows:

INTRODUCTION:

1. I am a retired Consultant in General Adult Psychiatry. My qualifications include Medical Degree from Medical School Sofia University, Bulgaria – 1980, and Specialist Psychiatrist from Neurology, Psychiatry and Neurosurgery Institute, Sofia Medical School Bulgaria – 1984. I am a Member of the Royal College of Psychiatrists UK from 2003. I retired from clinical practice in January 2023. I have been a medical member of Mental Health Tribunals since 2018 and continue with this role.

2. I was involved in the care of VC from 11/09/2021 until 01/10/2021 at Albert Ward, Cygnet Victoria House Hospital in Darlington being VC's Responsible Clinician ('RC'). I have some recollection of VC because he was floridly psychotic when he arrived at Albert Ward and was in

complete denial of his condition but by the time he had left, his condition had significantly improved and he was discussing re-starting his University course

3. This witness statement is made to assist the Nottingham Inquiry with the matters set out in Rule 9 Request dated 01/10/2025. I express my deepest condolences to the families of the victims.

BACKGROUND:

General Questions:

4. I have been asked to set out my evidence in relation to a number of general questions, and questions related to VC's treatment whilst under my care at Cygnet Victoria House Hospital, Albert Ward from 11/09/2021 until 01/10/2021.

5. Cygnet is a privately run organization comprising a number of mental health hospitals and social care services in the UK. The patient care they provide follows the same guidelines, rules and regulations as their NHS counterparts. Cygnet hospitals receive referrals from different NHS trusts; whilst some of these NHS trusts have beds commissioned to them at some Cygnet hospitals. Independent inpatient providers contribute to the Care Program Approach ('CPA') through communication with community mental health teams and provide assessment of the patients in the most acute phases of their illness. Albert Ward is a psychiatric intensive care unit (PICU) at Cygnet Victoria House Hospital in Darlington.

6. PICUs provide care for patients with mental disorders who are acutely unwell, and the risk to their own safety or the safety of others is considered to be high. These patients are detained under a section of the Mental Health Act ('MHA'). The PICUs are usually more restrictive as compared to the acute psychiatric wards, a seclusion suite is available in most of them, patients are not usually granted unescorted leave of absence, the staff to patient ratio is higher, and the average length of stay is lower - for a broad comparison, the average length of stay on a PICU is measured by weeks, on an acute ward by months, on a secure (forensic) ward by years. Usually, a stay on a PICU is followed by step-down to an acute or rehabilitation ward. Further details of the care provided to patients and the care pathway in the Acute/PICU and Older Adults Healthcare services are set out in Cygnet's 'Clinical Model of Care' policy as exhibited at [CYGN0000002].

7. Acute psychiatric wards provide care for patients whose needs can be managed in a less restrictive environment, they provide occupational therapy and psychological therapy, and some of their patients can be 'informal' (voluntary) patients.

8. Detained patients are subject to the provisions of different sections of the MHA, of which the mostly used are: section 2 — detention for assessment, up to 28 days, and section 3 — detention for treatment, up to 6 months. In these cases, patients are subject to a different level of restrictions — for example, they can be managed in seclusion, can be administered medication without their consent, can be restrained, cannot leave the

hospital unless leave of absence has been granted. The MHA also provides safeguards for the detained patients, for example they can appeal against their detention to the Mental Health Tribunal, after three months of detention for treatment, it must be approved by a second opinion appointed doctor if the patient does not consent or lacks capacity to consent to it.

9. MHA Assessments are detailed examinations of patients' available history and current mental state, conducted by three professionals — two doctors, and an Approved Mental Health Professional (AMHP). The assessment has to establish whether the so-called statutory criteria for detention (which are: presence of mental disorder of a nature or a degree so that the patient is liable to be detained in hospital for the purposes of assessment and treatment, and whether the patient is posing a risk to his own health, his own safety, or the safety of others) are made out.

10. Section 2 detentions are normally recommended when the 'nature' of the mental disorder is not well established, hence further assessment is necessary.

11. Section 3 detentions are usually recommended following an episode of section 2 detention, and better understanding of the characteristics of the mental disorder (for example diagnosis, associated ongoing risks, prognosis) is achieved, and further treatment in hospital is necessary.

12. The factors that indicate the presence of psychosis involve out of character behaviour and the presence of two types of symptoms — delusional beliefs and perceptual abnormalities. Psychosis is a broad

term used widely, but is not an accepted diagnostic category, and does not indicate the possible causative factors and prognosis of the disorder.

13. The diagnosis of Paranoid Schizophrenia is arrived at considering specific diagnostic criteria including the presence of specific groups of symptoms for certain periods of time (for example delusions of persecution and conspiracy alongside auditory hallucinations for at least one month) in the context of specific course of the illness, for example relapsing and remitting with progressive deficit of functioning.

14. Patients require a PICU when risks of violence or risk to their own safety are persistent and significant, and they cannot be managed in a less restrictive ward, for example an acute admission ward.

15. Cygnet Victoria House and Albert Ward (PICU) can refuse a referral when the risk of violence is described as severe, or there is not enough information to evaluate the risks even in a very preliminary manner, and there are not enough resources at the time to manage it, for example staff shortages.

16. On referral Albert Ward staff would expect to have copies of previous discharge summaries, case notes reflecting contacts with community mental health teams and Crisis Teams, alongside detention papers, which include medical recommendations and the AMHP (Approved Mental Health Professional) report. This is not a complete list, and in many cases given the urgency of the referral, some of these documents are not provided.

17. Further Information can be asked for from the referrer, the Police, or patient's GP. The nature of that information will depend on the individual clinical characteristics, or omissions in information already provided. Additional information about patient's psychiatric history is requested when on admission it transpires that important aspects of mental health history, for example previous admissions, have not been mentioned in the referring documents. Further information from Police can be sought in cases when we are made aware that there has been Police involvement, however the nature of that involvement is unclear. Lastly, requesting a GP summary helps with identifying any physical health issues or historical concerns in relation to mental health.

18. When a patient poses a severe and immediate risk to the safety of others, and has not responded to verbal de-escalation, or medication, be it oral or intramuscular, a brief period of seclusion might be recommended. This must be proportionate to the risks posed and must be used as a last resort.

19. The appropriate observation levels are determined by the patient's presentation and ongoing risk assessment on admission. These can be one-to-one observations or checks on the patient approximately every 15 min, 30 min, or every hour, conducted at irregular intervals. The observation levels are discussed daily with the multidisciplinary team ('MDT'). They can be increased when there has been a deterioration of symptoms leading to an increase in risk of violence or to own safety.

Alternatively, observation levels are usually decreased when patients improve, and risks are less severe.

20. As for the psychotropic medications mentioned bellow, I have been asked to give some additional information about their indications. These are as follows: Olanzapine, Haloperidol and Aripiprazole are antipsychotic medications, whilst Lorazepam and Clonazepam are tranquillizers (sedatives), Zopiclone is a hypnotic (sleep medicine).

21. Capacity assessments are conducted alongside mental state examinations at ward reviews. These mostly refer to capacity to consent to treatment and to informal (voluntary) hospital admission.

22. Similarly, risk assessments are conducted on admission and updated daily at MDT report-out meetings. The aim is to summarize and prioritize possible and potential risks and to reflect that in the care plan. The risk assessments are further discussed in more detail at ward rounds and are conducted alongside the mental state examination. Input to these assessments is provided by the nursing team, medical team, psychologist, and occupational therapist, and the observations of the health care assistants. Further details are set out in Cygnet Risk Assessment/Management Policy as exhibited at [CYGN0000114].

23. The purpose of the care plan is to agree and involve the patient in achieving specific therapeutic goals, and to review progress against these, i.e. establishing compliance with oral medication, reduction of challenging behaviours, improvement of engagement with staff, better engagement in

ward activities, period of successful leave of absence. Care plans are reviewed at formulation meeting, ward rounds and MDT in conjunction with the risk assessments. Leave off the ward is considered at these meetings as well, and approved by the RC. If successful, further periods of leave are granted. PICU wards very rarely care for patients who are stable enough to be granted unescorted leave. Care plans, risk assessments and leave would usually be reviewed on Albert Ward once weekly, but could be changed if required daily at the Report out MDT meetings.

24. I have been asked to give information about Rapid tranquillization (RT). RT refers to a sedative and/or an antipsychotic medication administered intramuscularly to address imminent and fast escalation of risks of violence or serious self-harm. The most widely used medicines for RT are Haloperidol, Lorazepam and Promethazine. Physical health parameters monitoring is required.

25. Detained patients have the right to appeal their section with the Mental Health Tribunal. They are provided with information about appointing a solicitor, and are supported by staff with any additional information they might require. Mental Health Tribunals' administration then will request reports from the professionals - RC, Nursing, and Social Circumstances Report, and a date for Tribunal hearing is given.

26. Before stepping down to a less restrictive ward there should be a period of gradual improvement in symptoms and engagement with staff, alongside reduction of risk. These are assessed by continuous

observation on the ward, lack of incidents and challenging behaviours, successful periods of escorted leave of absence, and monitoring medication compliance.

27. Non-compliance with antipsychotic medication, social isolation, disengagement from services, history of violence, are all considered to be risk factors for future relapse and escalation of potentially dangerous behaviours. As for 'masking' symptoms this is a common presentation for the majority of patients with psychosis and in my view its significance has to be considered in any specific case.

28. Assessment of insight and possible masking of symptoms is an important part of the on-going mental state examination. That consists of observation of patient's behaviour, and structured interviews touching on patient's mood, thought content and form, emotional responses, social interactions, perceptions and perceptual abnormalities, attitudes towards the illness and evaluation of perceived need of help or treatment. Lack of insight and persistence of psychotic symptoms are usually indicators of either current or potential risk of non-compliance with treatment.

29. Therefore, if a patient remains preoccupied with psychotic symptoms, guarded and hostile, does not engage with staff, is not compliant with his medication, has been involved in incidents on the ward (i.e. assaulting staff or peers) they should not be, at that stage, stepped down to a less restrictive ward.

30. A transition plan to an acute psychiatric ward is usually agreed and formulated by the MDT at ward review. Professionals involved are: the RC, nursing team, occupational therapist, psychologist, community key worker. Information provided to the receiving team includes care plans, risk assessments, detention papers, discharge notification and discharge summary, though this is not an extensive list. Further details are set out in Cygnet Transfer and Discharge Policy as exhibited at CYGN0000112.

31. Cygnet Victoria House will not be involved in the patient's care after transfer. The MDT of the receiving ward will formulate their own care plans and risk assessments.

32. A Community Treatment Order (CTO) is considered for patients detained on section 3 of the MHA, who can be managed in the community provided they receive treatment, and can be recalled to hospital if the conditions of the CTO are not adhered to, or there is a deterioration in their mental state. CTO is considered for patients who have a history of disengagement from services and poor compliance with treatment, whilst when on treatment the risks they pose have been reduced.

33. Depot medication will be considered for patients who have been consistently non-compliant with oral medication and that has triggered relapse and increase of challenging or potentially dangerous behaviours. There are no specific guidelines for patients with history of violence, disengagement, non-compliance or social isolation and masking symptoms, however all these are considered in each case, and

are known risk factors for future poor compliance and relapse. Some patients accept and consent to depot medication once they have regained insight (even if partial), and have acknowledged the benefits of treatment. Many patients do not consent to depot, but still accept it, under the provisions of the MHA.

VC's Treatment:

Referral to Cygnet:

34. Historically I have been involved in MDT discussions in relation to referrals to Albert Ward (PICU). Although I cannot specifically recollect a discussion about rejecting VC's initial referral from 03/09/2021, I believe that at the time, the reasoning behind it (high levels of risk of violence matched with perceived inability to cope with that given staff available) were well justified. Accepting the same patient several days later might indicate that the risks have been reduced (i.e. patient receiving treatment whilst in seclusion or seclusion being terminated) or the staffing situation has improved. It is not uncommon for referrals to PICU to be rejected, and subsequently accepted, for these reasons.

35. I have been asked to comment on the purpose of two referral forms received by Cygnet Victoria House Hospital, namely the PICU Gatekeeping referral form from the Nottinghamshire NHS Trust [CYGN0000085] and the Cygnet PICU referral form [CYGN0000070]. These give basic information about the patient and outline why a PICU

admission is necessary. I would have not received these forms directly but they would have been available in the case notes. They would initially be dealt with by the hospital manager or deputy manager in working hours and nurse in charge of the PICU out of hours. On admission to Cygnet detention papers under the MHA should have been received as well. These include two medical recommendations and application for admission by an AMHP.

Initial Assessment and Plans

36. I was not involved with VC during his initial assessment on admission (11/09/2021) and the risk assessment completed at the time [CYGN0000086]. However, these were discussed at the daily MDT Report Out meetings, and reflect my opinion at the time. The 'signature risk signs' mentioned in the initial risk assessment were reached on the basis of the available psychiatric history at the time and mental state examination on admission. VC's risk of non-compliance with medication and risk to the safety of others were assessed to be high based on the history of recent relapse of the florid symptoms of psychosis which was triggered by non-compliance with maintenance medication. In similar circumstances in the past VC's actions were driven by the content of his delusional beliefs and auditory hallucinations, and had caused significant distress to others. Non concordance with medication and poor engagement with community services alongside persistent lack of insight are known perpetuating factors of the mental illness (which could potentially become resistant to

treatment) and contribute to more challenging and potentially dangerous presentation.

37. The patient review' forms completed on 14/09/2021 [CYGN0000060], 21/09/2021 [CYGN0000061] and 28/09/2021 [CYGN0000033], are authored by the specialty doctor attending the ward round. I can only speculate as to why certain aspects of the forms were left blank. The feedback may not have been provided in written form on time. The daily observation notes were documented in the case notes and all involved in VC's care had access to them. Verbal feedback would have been provided, by the nurse attending the ward round.

38. The most significant aspects of the feedback of each nursing review was the presence of directly observed signs of mental disorder ('thought block, appeared thought disordered and perplexed') in the context of concordance with medication and lack of agitation and violence, and engagement in 1:1 sessions with nursing staff reported on 21/09/21. The persistence of directly observed signs of mental disorder at that stage was concerning. The reported concordance with medication and engaging with nursing staff are signs of gradual improvement, and therefore can be reassuring. However notwithstanding that VC had been sectioned since 3 September 2021, initially in seclusion at the Cassidy Suite, Highbury Hospital, Nottingham and had received treatment for nearly 2 weeks, his symptoms persisted such that they were visible to staff which would suggest that either he was not responding to that treatment or he had a

more persistent mental disorder. The latter was established during his admission to Victoria House

39. There were a number of action points included in each patient review form. As to action points for VC to receive input from psychologist and occupational therapist (OT) these are standard requests to these professionals who at that stage can provide valuable input to patient's initial assessment, formulating further therapeutic interventions if required and advising whether the patient has improved enough as to be able to engage and benefit from these. It is usually only the initial assessment stage that can realistically be undertaken on a PICU. More longer term objectives of increased engagement and improvement would usually be expected following step down from PICU.

40. The short-term objectives for the psychologist and occupational therapist to engage with VC were reported as achieved on the 21 and 28/09/21 patient reviews, since these professionals had reported engaging with VC for formulation and OT assessment. Their findings were available on the electronic case records. The impression that VC was engaging with OT and psychology was based on feedback provided at MDT meetings, ward reviews, and entries in the case notes. Whilst VC was initially spending most of his time in his bedroom, he did engage with staff when approached and encouraged. Around the last week of his stay at Albert Ward, VC's self-care had improved, he was spending more time in ward communal areas, was doing some learning on-line, and was engaging with staff better - for example initiating conversation.

41. I consider that VC engaged with his treatment on Albert ward. I have been asked to comment on what concerns would have been raised if that were not to be the case. These would include concerns of further deterioration in mental state and increased levels of agitation and violence. I was also asked to comment on what actions would have been taken if a patient was not engaging with some elements of their treatment. The first step would normally be identifying the reasons for that, offering psycho education, and working with the patient to explore ways to improve engagement. What practical steps will be taken will depend on the specifics of the case, for example in the case of OT and psychology consent and wish to engage is a prerogative of successful intervention. Therefore it might be that in such cases a patient would be approached at a later stage in their treatment when they may be more cooperative, or offered more informal engagement and psycho education.

42. I have been asked to comment on what my impression of VC's engagement with other members of staff was during his stay at Victoria House, and what was the basis of that impression. VC's engagement with staff improved gradually alongside the improvement of his symptoms. He was engaging with staff and that was never raised as a concern by any MDT members at the regular daily meetings and ward reviews. Similarly these engagements were recorded in the electronic case records and were available to all staff members, including myself.

43. Risk assessments were updated at VC's ward rounds by nursing staff. I would have had sight of these and they would have been discussed daily particularly if any change was required or there were any incidents of note, at the MDT meetings. The risk of violence and non-compliance were downgraded due to lack of threatening behaviour or violent incidents on the ward, successful escorted leave and (observed by the nursing team) compliance with oral medication, which I did not have reason to question since VC's mental state was improving. No significant changes were made, since whilst there was an improvement of some of his symptoms (reduction in intensity and frequency, less impact of behaviour), VC was still lacking insight and minimising the events leading to his admission at the time. I am unable to recollect what 'DRA' stands for, I can only speculate it stands for daily risk assessment.

44. In my view the risk assessments undertaken at the time of VC's three week admission to Victoria House appropriately captured, addressed and managed the risk he posed at the time. He was not involved in any incidents whilst on the ward and developed reasonable therapeutic relationships with staff, he was compliant with his treatment, his escorted leave periods in the local area were uneventful, and his mental state improved. For the reasons set out above, it is my view that Cygnet Victoria House risk assessments in the three weeks he spent at Albert ward appropriately captured the risk associated with his mental health at that time.

Care Plans on Admission

45. I was not involved in formulating the care plan for VC on admission, however that would have been discussed at MDT meetings and reviewed regularly, and at least once weekly, at ward reviews with the patient. I was asked to comment on the benefits of offering one-to-one sessions with nursing staff. These are to develop therapeutic rapport with the patient and to allow on-going and more in-depth assessment of patient's symptoms. Patients are encouraged to engage in one-to-one sessions with trained staff and if unwilling to engage they are approached by different professionals, i.e. psychologist to explore ways of how engagement can be improved. The views of the patients are sought and noted in their care plans; this is an integral part of their care. I was not involved in formulating and recording the care plan so am unable to comment on whether VC was likely to take his medication as he said he would when asked for the purposes of the care plan. In principle however, I recall the team were quite vigilant in monitoring compliance with medication, and VC was compliant throughout his hospital stay at Albert Ward. I cannot recollect any substantive changes being made to the care plan. I note that in the care plan dated 21/09/21 it is noted that '[*VC] had a MHA assessment on 24.09.21 and placed on section 3*' [CYGN0000028]. I was not the author of this care plan and cannot comment on why an event postdating the plan's date was included in it.

46. I have been asked to comment on Section 17 leave granted on admission. This is emergency leave granted to all new patients, in case

urgent physical health intervention is required, for example referral to the Accident & Emergency Department of the General Hospital.

47. I have been asked for clarification on what PRN stands for. It refers to 'as required medication'. Literally it comes from Latin: 'pro re nata' which means 'as the thing is needed'.

48. I have been asked to clarify what MAPA (an abbreviation used in VC's initial nursing assessment) stands for. It refers to Management of Actual or Potential Aggression. It focuses on person-centered approaches in management of aggression, for example verbal de-escalation, PRN medication, and restraint as a last resort.

Leave, Observations, and Family Contact

49. VC was initially granted emergency leave. Following MDT discussion escorted one time LOA (leave of absence) was granted on 13/09/2025; Further escorted daily Section 17 LOA was granted on 16/09/2021 - 30 min twice daily to the local area. There were no concerns raised by escorting staff. On 28/09/2025 further two hours escorted leave twice weekly to the local town was granted. For further information I refer to the Section 17 LOA forms as per exhibit [CYGN0000097].

50. Initially VC was nursed on 15 min welfare checks by staff, which was reduced to checks every 30 min on 17/09/2021, and soon after that

reduced further to hourly checks ('general' observations') on 20/09/2021 following MDT discussions.

51. VC's mother was contacted over the phone at the time of the MHA Assessment on 24/09/2021 in view of section 3, which she, in her role of Nearest Relative, did not oppose. I recall that telephone contact with VC's mother was attempted by the AMHP at that time however she was apparently unable to take the calls due to work commitments. VC's care coordinator was approached, and she helped by phoning VC's mother after hours, discussing the issue of detention with her, and coming back to the AMHP with the outcome. The contact is described in the AMHP's report from that day. I am unable to recollect any other contacts with VC's mother. The AMHP's report is included in exhibit [CYGN0000052].

Clinical Reviews:

52. Below is a narrative of my involvement with VC at his ward reviews. I was also asked to comment on a number of other issues, which I believe would be better addressed by other members of the MDT who were involved in VC's care. These include: 1) Were patient's review forms done at the ward rounds – these are normally done by a specialty doctor; 2) Feedback from nurses/support workers – I am unable to comment why the feedback given was identical at two of the ward reviews.

53. I first saw VC on 14/09/2021 at Ward Round. I recollect VC was guarded and suspicious and disclosed systematized delusions of persecution and conspiracy linked to auditory hallucinations and passivity phenomena

(thought insertion). He completely lacked insight. My initial diagnostic impression was of Paranoid Schizophrenia. The dose of his antipsychotic medication (Haloperidol tablets 5 mg) was increased to 15 mg daily. Medication as required (PRN) with oral Lorazepam and Promethazine was prescribed as well. His observation level was set to 15 min check by staff, which is standard for newly admitted patients. I refer to the Patient's review document as set out at exhibit [CYGN0000060] for further information.

54. 21/09/2021 — Ward Review - VC was guarded and suspicious, systematized delusions of conspiracy and persecution persisted, he lacked insight. He did disclose his symptoms, i.e. delusional beliefs and auditory hallucination at that review. There were no signs of aggression or violence. He had been compliant with his oral antipsychotic medication. The diagnostic impression was one of Paranoid Psychosis with differential diagnosis (second diagnostic possibility) of Paranoid Schizophrenia. The ward review was attended remotely by his care co-ordinator (based in Nottingham). This is a common practice and care coordinators are invited to attend ward reviews for the sake of continuity of care [CYGN0000061].

55. 24/09/2021 – MHA Assessment in view of Section 3 of the MHA. Admission for treatment was recommended. At that stage VC was presenting with persistent symptoms of psychosis and lack of insight. The assessing doctors agreed that this is a mental disorder of both

nature and degree to require treatment in hospital, and unless such treatment is provided the risks to his own health and safety and the safety of others will escalate. Further details are set out in detention papers as exhibited at [CYGN0000013].

56. I was asked to comment on 'what was the reasoning behind "converting" VC's section 2 to section 3 of the MHA (MHA)'. Based on my assessment of VC thus far (from 11/09/2021 till 24/09/2021) I was of the opinion that he suffered from a mental disorder both of a nature and a degree to require treatment in hospital, and that unless such a treatment is provided, the risks to his own health, to his own safety, and the safety of others would escalate, and such a treatment was available for him. Section 3 is applied for by an AMHP (approved mental health professional) and is based on formal MHA assessment by himself/herself, and two doctors who provide recommendations for detention. VC was initially detained on a section 2 of the MHA, which can last up to 28 days and aims mostly at assessment, whilst section 3 of the MHA can last 6 months and can be extended, and aims at treatment. I was convinced at the time that VC needed treatment in hospital for a period of time longer than 28 days and since he had not regained insight and was opposing admission, such treatment could not be provided in the community.

57. 28/09/2021 — Ward Review — MDT felt that VC's mental state had been gradually improving – though he still presented with blunted affect and

lacked insight, he denied delusional beliefs and perceptual abnormalities, had utilized LOA (leave of absence) without concern, had been compliant with his oral medication, and had engaged appropriately with staff on the ward. Antipsychotic medication in depot form was suggested and recommended, however VC would not consider that, and would prefer to remain on his oral medication. Additional escorted Section 17 LOA was granted — two hours in local area three times a week was added. Transfer to an acute ward was also recommended. Please refer for further information to patient's reviews in exhibits [CYGN0000061] and [CYGN0000033].

58. There had been gradual improvement in VC's mental state during his stay on Albert Ward — at the end of his stay he was less guarded, less suspicious, engaged better with staff (including occupational therapist and psychologist), denied immediate signs of psychosis (delusions and hallucinations), started making plans for the future, i.e. rejoining University and doing some of the courses on-line. The improvement was contributed to by the structured environment, professional support, MHA safeguards (i.e. detention) and compliance with antipsychotic medication. That was reflected in reduction of risk of violence (from high to moderate) which was in turn reflected in his risk assessments.

59. The reference to ward round on 28/09/2021 where I 'explained that he might not have a lengthy admission' most probably relates to a

standard discussion after commencement of section 3 where it is explained to the patients that detention on that section still does not mean they will remain in hospital for the whole 6 months, and can indeed be discharged earlier than that either by his RC or the Mental Health Tribunal.

MHA Detention and Tribunal Application

60. I note that on 15 September 2021, VC made an application to be discharged to the Mental Health Tribunal. As RC, I prepared a report for the Mental Health Tribunal on 17/09/2021 [CYGN0000011]. In this report I provide a brief description of VC's mental state at the time as follows: '*…It is my view that Mr. Valdo Calocane suffers from Paranoid Psychosis of relapsing and remitting nature. The disorder is also currently of a degree to require treatment in hospital. The degree incorporates prominent symptoms of suspiciousness, hostility, delusional ideas of conspiracy and control, auditory hallucinations, ideas of thought interference, some somatic hallucinations (some 'pins and needles' tactile sensations caused by 'psychotronic' technology), and lack of insight. Valdo believes that he is subject to harassment by the government through interference with his mind by inserting thoughts there which are not his, and by transmitting 'voices' to his head that run a commentary on his actions and abilities, and are generally unpleasant. Valdo believes that this harassment is done as a punishment for him breaking the lockdown rules. Valdo indicates he has done research on the matter and does not believe that these experiences are contributable*

to mental illness, hence he stopped taking his antipsychotic medication.' Unfortunately, I have no further recollection as to what research VC had said he had done on the matter of 'psychotronic harassment'.

61. I have been asked to clarify what evidence the comment that "…*a female neighbour was so scared, that she jumped off the window and sustained serious back injuries requiring surgical interventions*" was based on. This incident, which occurred in 2020, was described in the notes from the initial medical assessment at the time of admission to Albert Ward, Victoria House Hospital, on 11/09/2021. There was also information that similar incidents (VC entering or attempting to enter neighbours' properties) had occurred prior to, but not immediately before, his admission to Albert Ward on 11/09/2021, and on these occasions nobody had been physically hurt. Unfortunately, I cannot explain the inconsistencies between above statements and the comments in VC's care plans. [CYGN0000052].

62. As far as accessing information relating to previous admissions, the process is to request that information on the point of referral, and chasing up that request if the information had not been provided. I cannot recollect what specifically and by whom this had been done in this case, however I can recollect that relevant information was received (case notes from 2020 to 2021, GP summary) after the tribunal report had been prepared on 17/09/2021.

63. The statement in my Tribunal Report that VC had engaged in occupational therapy activities was based on my daily discussions at MDT morning meetings with the Activity Therapist, and this professional's report and or verbal feed-back at ward reviews. I was also reading this professional's entries in hospital notes.

64. As for the comments about strength and positive factors, these were mentioned in the Social Circumstances Report from the patient's care coordinator for the Mental Health Tribunal hearing. [CYGN0000016].

65. The basis of my statement that VC would not comply with medication and would not engage with community team at the point of the tribunal hearing was the fact that he was lacking insight (did not believe he needs treatment for mental disorder), was still symptomatic, (i.e. perceived mental health services as persecutors) and had a history of non-compliance in the community. At that stage discharge had not been planned. For a discharge to be successful VC should have reached a stable mental state when he is free of psychotic symptoms and regains at least partial insight.

66. At the time of the tribunal hearing (23/09/2025) I had read the Social Circumstances report by Claudia Britles. I cannot recollect any disagreements or controversies at the time.

Tribunal Hearing

67. The opinion in relation to VC's previous discharges being 'swift' was based on the collateral information provided by his care coordinator when she attended ward review to indicate that VC most probably experienced

residual symptoms of psychosis and never regained premorbid levels of functioning in the period after his first two admissions in 2020. Though we cannot expect symptoms to 'fully abate' for all of the patients, a fair trial of treatment (i.e. optimal dose of antipsychotic medication for optimal time — 4-6 weeks) should be attempted.

68. I agree with the tribunal's view that VC appeared to minimize the seriousness of the circumstances leading to admission. For further information I refer to Tribunal Decision 24/09/2021 exhibit [CYGN0000052], pp43- 48.

Diagnosis, Treatment and Medication

69. VC was detained under section 2 of the MHA for the purposes of assessment of his mental health. That is based on historical information, ongoing monitoring and assessment and evaluation of response to treatment. It is not unusual that a definitive diagnosis is not arrived at during that time, however working diagnosis and possible differential diagnoses have to be made. My initial diagnostic impression was one of Paranoid Schizophrenia, however to be certain, further monitoring of response to treatment, improvement or persistence of symptoms, improvement or persistence of functional deficit, was required. These two diagnoses are similar in a way that Paranoid Psychosis is a broader term to describe mostly symptomatology, which can have different causative factors (drug induced, organic, non-organic), whilst Paranoid Schizophrenia links specific symptoms' patterns with specific courses of illness — i.e. relapsing and remitting with progressive deficit. The

diagnosis on the point of transfer to acute ward (Priory Arnold Hospital) was Paranoid Schizophrenia. I cannot comment on the diagnosis in hindsight.

70. VC's treatment and management would not have been different depending on whether he was diagnosed with Paranoid Psychosis or Paranoid Schizophrenia.

71. I have been asked to comment on whether I was aware of the findings of Occupational Therapist (OT) assessment [CYGN0000083] and Formulation Meeting findings [CYGN0000029], and what I believe was the most significant information contained in these documents. I can confirm that at the time I was aware of these and would have discussed them with the professionals involved. The OT assessment indicated preserved relatively high levels of functioning, whilst the Formulation meeting findings were a very good summary of the case that followed an accepted outline reflecting the basics of risk assessment. Both documents' findings were in agreement with the findings of the mental state examination and were taken in consideration when clinical decisions were made.

72. In relation to the 'Formulation' document [CYGN0000029], this was shared and discussed with me. The formulation reflects a specific structure of information about the patient focusing on risk assessment. The document re-iterates the recommendation for depot injections in the future.

73. Similarly I was aware of the document and had discussions with the occupational therapist ('OT') who completed the Model of Human Occupation screening tool on 15/09/2021 [CYGN0000066]. In brief, the OT was of the view that VC had the potential to function at a high level. This was taken into account for VC's management whilst on Albert ward - for example he was encouraged to do some university course work on line in the last week of his stay.

74. At the initial assessment on admission the admitting doctor continued the medication VC had been on prior to transfer to Albert Ward. That was antipsychotic medication, Haloperidol, and the dose was 5 mg twice daily. That was indeed increased to 5 mg thrice daily at the first ward review on 14/09/2021. That was a dose which in VC's case was well tolerated (no side effects) and appeared to be effective. For a proper conclusion to be drawn as to whether an antipsychotic has been effective, a period of 4 — 6 weeks monitoring is recommended. That's why this prescription was continued during his admission on Albert Ward. [CYGN0000050].

75. VC's capacity to consent to treatment and voluntary hospital admission had been assessed during all his contacts with medical and nursing team, following the guidelines of the Mental Capacity Act. During his stay at Albert Ward, he lacked capacity to make these decisions, and that was based on his inability (due to lack of insight and presence of delusional beliefs) to weigh up the pro-s and the contra-s of receiving treatment in hospital in the context of his best interests. [CYGN0000008].

76. My evidence at the tribunal hearing was that VC lacked insight. However, in his evidence at the tribunal hearing VC stated he had been persuaded that he had psychosis after 'talking to family and staff'. I had assessed him two days before that when insight was lacking. My comments to the panel were that I had not seen insight 'starting to form' overnight. My view was that VC still lacked insight but made that declaration to improve his chances of discharge from section. I have been asked to comment on VC's statement included in his care plan from 14/09/2021, when he said: 'I believe medication has made no difference to the voices' [CYGN0000025]. That was VC's view recorded by the author of the document early in VC's admission. It reflected his lack of insight and risk of non compliance with treatment in the future. It was addressed by psycho education and achieving some relief of these symptoms (auditory hallucinations) after a period of treatment. However at the point of transfer from Victoria House to an acute ward, VC had not regained insight, the risk of non compliance if not detained remained substantial, and therefore starting a depot injection was discussed with VC. He refused that, assuring the team he would continue taking his oral medication.

77. At VC's last review at Albert Ward on 28/09/2021 he still had no insight, however there were signs of improvement in some of his other symptoms. I would have expected that with on-going treatment on an acute ward and engaging in psychological therapy, VC's insight would improve.

78. I have been asked to comment on whether in my view Cygnet Acute/PICU and Older Adults Mental Health Inpatient Services Pathway Policy [CYGN0000002] was adequately followed in VC's case. I believe it was.

79. I have been asked to comment on whether I was aware of 'VC having any objections or resistance to needles'. I was not aware of any such issue.

Violence and Aggression

80. I can recollect VC expressing some regret for the violent incident leading to admission, calling it 'an error of judgement' [CYGN0000060]. I was also aware of the comments he made to the psychologist that his admission was "based on an incident which has been taken out of proportion" [CYGN0000050]. VC was not involved in violent incidents, neither had he threatened any violence, during his stay at Albert Ward. However, I agree with the statement in Mental Health Tribunal Decision that he was 'downplaying' the severity of his violence. The risk of violence has gradually decreased with provision of treatment, but remained moderate. These concerns were reflected in the discharge summary when he was transferred to an acute ward in a hospital nearer to his home. He was still detained on a section 3 of the MHA on the point of transfer [CYGN0000012].

VC's Delusional Beliefs

81. I was asked to comment on VC's delusional beliefs, which were familiar to me – these were delusions of conspiracy, persecution and control described in detail in my report for the Mental Health Tribunal. I do not recollect whether VC expanded on what research he had done, and I am not aware of any websites connected to VC's delusional beliefs. In my previous experience 'researching' for information about mental health on the web is not helpful. I am unsure whether it has been a particular risk in VC's case.

Depot Medication

82. Depot medication was considered due to history of non-compliance and severity of risk when untreated. Depot medication was discussed with VC at the ward round on 28/09/2021. However, he declined depot injections and insisted he would continue with his oral medication. During his admission at Albert Ward VC had been compliant with his oral medication and we had no reasons to suspect otherwise. Administering depot in such a case could not be justified at the time since that would probably require restraint (which can be used only as a last resort, must be proportionate to the severity of the immediate risk posed, and should be the least restrictive option) to prevent any serious and imminent incident from happening. That was not the case at the time.

83. In relation to the transfer to Priory Hospital Arnold and ongoing treatment, the collateral information from VC's care coordinator had been taken into account [CYGN0000061]. The view that he never fully recovered since

his admissions in Nottingham was accepted. That might have been due to insufficient treatment and/or non-compliance. Her views about depot injections were shared by the team.

84. I agreed with tribunal's decision indicating the risks had to be minimized before discharge into the community [CYGN0000052, p47]. VC was not discharged from Albert Ward. He was transferred to an acute psychiatric ward whilst remaining detained on section 3 of the MHA. The decision to recommend transfer to an acute ward was based on VC's settled presentation on the ward, uneventful periods of escorted leave, concordance with medication, and gradually improving mental state. That is following the principle of managing the patient in the least restrictive environment which can address their mental health needs.

85. I was not involved in drafting the discharge notification and discharge summary done by the specialty doctor, however I had sight of them and agree with their content. Discharge notification is a brief note including diagnosis and treatment prepared on the day of discharge (or the first working day after); whilst discharge summary is a more detailed synopsis of patient's history, presentation, response to treatment, current care plans and risk assessments.

86. My expectations after transfer to an acute ward were that ongoing monitoring and assessment of VC's mental state will continue, that further periods of leave will be granted to test his progress, that his engagement

with psychology (psycho-education, insight) and occupational therapy would continue, and that at a point when patient regains at least partial insight, further therapeutic options, including depot medication, discharge on a CTO, will be revisited and considered.

87. I do not recollect having contact or conversation with the team at Priory Hospital Arnold. VC was transferred to an acute psychiatric ward, under the care of a trained MDT and new RC. The transfer policy, including providing a number of documents had been adhered to, and that is to the best of my recollection. Similarly, MHA documentation, including detention papers and AMHP's report/application have been provided as well. I personally did not phone Priory Hospital Arnold, though I presume members of the nursing team did, giving a verbal update on the point of transfer. I cannot recollect receiving a phone call from Priory Hospital Arnold.

88. I cannot recollect VC's family members being involved in the decision of transfer to a less restrictive ward. This is normally well accepted by relatives since it is seen as a sign of improvement. I personally was not in contact with VC's family at the point of transfer, whilst I would imagine and in accordance with standard practice the nursing team would have attempted contact by phone.

89. I did not have any further contact with VC following his transfer on 01/10/2021 to Priory Hospital Arnold.

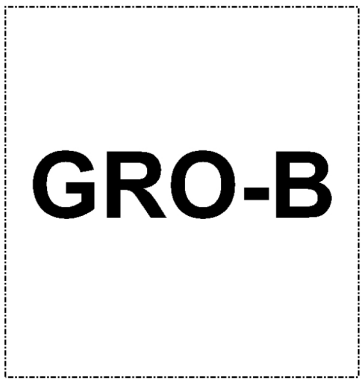
90. I was asked to comment on, if in my view, and in hindsight, any further action should have been taken by Victoria House MDT to address the risks associated with VC's behaviour when acutely unwell. I believe that communication between services generally was a problem, but I am unsure how Albert Ward could have addressed that. I am also of the opinion that mental health services have been fragmented and the continuity of care has suffered as a result. Once again, I am unsure how Victoria House MDT could have addressed that since it is a systemic issue. I accept that the communication with VC's nearest relatives was not as good as it perhaps should have been.

91. It is difficult for me to comment on what recommendations should the Inquiry make given the fact that I am not aware of all the evidence in front of it.

STATEMENT OF TRUTH

I believe the content of this statement to be true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth

Signed:



Dated: **11/12/2025**

Index to Witness Statement of KALINA SHOILEKOVA

No	URN	Document Description
1	CYGN0000002	Acute/PICU Cygnet Model of Care
2	CYGN0000114	Cygnet Individual Risk assessment and Management
3	CYGN0000112	Cygnet Transfer and Discharge Policy
4	CYGN0000060	Patient Review 14/09/2021
5	CYGN0000097	Cygnet Sec 17 LOA Form 14/09/2021
6	CYGN0000013	Detention papers 24/09/2021
7	CYGN0000061	Cygnet Ward Review 21/09/2021
8	CYGN0000033	Cygnet Ward Review 28/09/2021
9	CYGN0000052	MHA Documentation; Tribunal report; Tribunal Decision 23/09/2021
10	CYGN0000016	Social Circumstances Report
11	CYGN0000050	Cygnet Electronic Case Notes
12	CYGN0000008	Capacity Assessment 14/09/2021
13	CYGN0000012	Discharge Summary 11/10/2021
14	CYGN0000085	PICU Gatekeeping Referral Form 03/09/2021
15	CYGN0000070	PICU/Acute/Rehab Referral Form 04/09/2021
16	CYGN0000086	Risk Assessment Tool for Acute/PICU 11/09/2021
17	CYGN0000028	Care Plan 21/09/2021
18	CYGN0000011	Responsible Clinician's Report by Dr Kalina Shoilekova, dated 17/09/2021
19	CYGN0000083	Occupation Therapy Initial Assessment 15/09/2021
20	CYGN0000029	Formulation 22/09/2021
21	CYGN0000066	Occupational Therapy Assessment Feedback PICU 29/09/2021
22	CYGN0000025	Care Plan 14/09/2021