THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DR TANIA ENGEL

I, Dr Tania Engel, of Cygnet Newham House, Hemlington Village Rd, Middlesbrough TS8 9DE will state as follows:

INTRODUCTION

1. I am a Speciality Doctor in Psychiatry currently working at Cygnet Newham House. I qualified with an MBChB (University of Cape Town 1998); MMed (Family Medicine) (Stellenbosch University 2009). I initially worked in South Africa in a variety of settings including general practice, general and teaching hospitals and clinical research. I moved to the UK in November 2020 and commenced work at Cygnet Victoria House as a Speciality Doctor (Psychiatry). In October 2023 I took up my current placement as a Speciality Doctor (Psychiatry) at Cygnet Newham House (Neuropsychiatric Rehabilitation).

2. I make this witness statement following a request by the Nottingham Inquiry, by letter dated 1 October 2025. The Inquiry Team require me to produce a witness statement, setting out my interactions with Mr. Valdo Calocane ('VC'), along with the matters as set out in the Annex to the Inquiry's request.

3. The facts and matters set out in this statement are within my own knowledge, unless otherwise stated, and I believe them to be true. Where necessary I have referred to those records made by myself and others which form part of the medical records for VC. Where I refer to my own notes I do so on the basis that they were made contemporaneously with the events I describe and to refresh my own recollection of events. Where I refer to records made by others, I do so on the basis that I would have referred to the relevant records as is my usual practice, whenever I had any clinical involvement with VC. Where I refer to information supplied by others, the source of the information is identified; facts and matters derived from other sources are true to the best of my knowledge and belief.

4. At the outset I wish to express my sincere condolences to the families of VC's victims, and every sympathy to all those effected by the tragic events on 13 June 2023.

Inpatient Mental Health Services

5. In broad terms an acute mental health unit refers to a secure psychiatric ward managing patients who are acutely mentally unwell with a risk to their own health and/or safety or the safety of others. A psychiatric intensive care unit ('PICU') (such as Albert ward, Cygnet Victoria House, where VC was admitted) is a secure unit for patients experiencing a very severe mental health crisis and are at their most unwell with significant and serious risk to own health and safety and/or the safety of others.

6. A patient who is detained under the Mental Health Act ('MHA') means that the patient is an involuntary patient hospitalised for assessment and / or treatment due to the risks to their own health and/or safety and/or the safety of others as a result of a mental disorder.

7. A patient may be detained under section 2 of the MHA which can last up to 28 days and allows for assessment of a mental health condition and necessary treatment during this time. It cannot be extended. Section 3 is a MHA section lasting up to six months; it provides a longer period for treatment of a mental health condition. Patients discharged from Section 3 have a statutory right to free aftercare services under Section 117 MHA.

8. Cygnet receives referrals from numerous NHS hospitals across the country. Cygnet Victoria House receives information in written form and also on occasion verbally to identify suitable placements for patients. Likewise if a patient is transferred to/from another independent provider, referral documents and records are provided and forms completed to ensure that all necessary information is conveyed.

9. The treatment, care and management depends on the level of service. Cygnet Victoria House offers a PICU service as well as an acute ward. NHS inpatient mental health services and inpatient mental health services at other independent providers provide services which include PICU and acute wards. Crisis Resolution Teams (CRTs) offer brief, intensive home-based support during a mental health crisis to prevent hospitalisation. Community Mental Health Teams (CMHTs) provide

ongoing, non-crisis support in a community setting, often through a range of services like therapy, medication management, and social support.

10. A PICU as compared to an acute unit is a more secure and highly controlled locked unit with higher staffing levels and is usually for patients who are severely unwell. PICU is mainly to stabilise the patient to a point where they can be transferred to a less restrictive and more appropriate setting which is usually an acute unit.

11. Inpatient service providers, including independent providers should partner with other role players ensuring continuity of care and contributing their specialised resources to meet the complex needs of individuals supported by the Care Programme Approach ('CPA'), a framework for care for people with mental health problems.

12. Psychosis, usually assessed by a clinician, is not a diagnosis but a mental state describing loss of touch with reality. Symptoms usually include hallucinations, delusions and disordered thinking. Schizophrenia is diagnosed by a specialist psychiatrist usually using the International Classification of Diseases-11 (ICD 11) or Diagnostic and Statistical Manual of Mental Disorders (DSM 5) criteria. Symptoms need to be present for most of the time for a month or more, which would include persistent hallucinations, disorganised thinking, delusions that are culturally inappropriate and delusions of control. NICE guidelines Psychosis and Schizophrenia [URN WITN0342002].

Treatment, care and management of patients experiencing psychosis

13. A PICU bed (as in VC's case) is required when a patient experiencing a mental health crisis poses an imminent and significant risk to self or others and needs a more secure environment. The main factor taken into account in assessing whether a PICU bed is required are the risks posed.

14. There are many factors to consider when accepting a patient. Reasons for Albert ward, Cygnet Victoria House (PICU) refusing a referral may include but are not limited to inappropriate referrals for example where someone's risk profile indicated that they are better suited to a forensic service, where PICU is not the least restrictive environment, where there is a primary diagnosis of learning disabilities or dementia; when patients are likely to require seclusion where the seclusion unit is in use; if the ward is full/nearly full; and if staff are finding it challenging to cope with the existing patients.

15. When a patient is referred or transferred to Cygnet Victoria House, I would expect to receive information on past psychiatric history, current circumstances, past and current medication, name and contact details of people involved in the patient's care and mental health act paperwork. If necessary further information can be sought from the referrer, previous services involved in the care/treatment of the patient or the police where appropriate. The aim is to secure all necessary

information to inform whether Cygnet Victoria House is an appropriate placement for that patient.

16. Where a patient is detained under s2 or s3 MHA, the decision to use seclusion is usually a professional clinical judgement. Seclusion is reserved as a last resort for those who pose an immediate risk of physical harm to others. It should be a reasonable and proportionate response to the level of risk posed.

17. There are multiple factors to consider when determining appropriate observational levels. The main factors are risks which needs to be balanced with the principle of proportionate and least restrictive environment. The risks include the risk of suicide and self-harm; the risk of harm to others; the risk of deterioration in physical health; the risk of vulnerability to harm from others; risk of absconding (in a larger acute ward rather than PICU), strong substance misuse history. Usually a change in observation level happens when there is a change in the risks. The risks are assessed together with the whole clinical picture and other factors considered include changes in mood, severe anxiety and irritation, paranoia, command hallucinations (hearing voices which instruct), poor engagement and social withdrawal, problems with substance misuse.

18. I set out below the medical differences between prescription medications in the treatment and management of psychosis:

a. Olanzapine is a second generation antipsychotic medication used for the long-term management of psychosis. This directly manages the underlying psychotic symptoms.
b. Clonazepam is a benzodiazepine used for managing acute agitation and anxiety. This is a short-term medication for agitation and anxiety.
c. Lorazepam is a benzodiazepine similar to Clonazepam used for acute agitation. In intramuscular form it is used for rapid tranquilisation. This is a short-term medication for agitation and anxiety.
d. Zopiclone is a hypnotic medication used for insomnia.
e. Haloperidol is a first generation antipsychotic medication used for acute and long-term treatment of psychosis. This directly manages the underlying psychotic symptoms.
f. Aripiprazole is a second generation antipsychotic medication, a partial D2 agonist used for long-term management of psychosis. This directly manages the underlying psychotic symptoms.

19. Following a patient's admission, the overall presentation, relevant behavioural changes and risk-related behaviour are observed as well as the physical health of the patient. Capacity assessments are undertaken which are specific to a particular decision at a particular time. They are necessary when there are concerns about a patient's ability to make a specific decision due to an impairment of the mind.

20. A 'mental state examination' is an ordered summary of the examining doctor's observations as to the patient's mental experiences and behaviour at the time of

the interview. The broad categories include appearance and behaviour, speech, mood and affect, perception, thought form and context, cognition and insight. As referenced in pages 117-119 of the Oxford Handbook of Psychiatry 4th Edition, chapter 2 (Psychiatric Assessment) [WITN0342003].

21. The main aim of conducting risk assessments is to provide informed good quality patient-centred care. They are conducted for all psychiatric patients and are repeated regularly and especially when there is a change in the presentation. All members of the Multi-Disciplinary Team (MDT) are expected to provide input to risk assessments. Risk assessments are reviewed at the daily morning meetings and at the patient ward rounds.

22. When I worked at Cygnet Victoria House, the current presentation was discussed by the MDT during the daily morning meeting and at the patient's ward round. The team would then note the historic risks and voice their opinions about the current risks. At ward rounds at Cygnet Victoria House the MDT would openly discuss the risk assessment with the patient and the opinion of the patient would also be sought. The purpose is to develop strategies to reduce the risks and enhance protective factors as noted in the risk assessment. The risk reduction plan is formulated initially by the MDT recorded on the daily risk assessment.

23. The care plan is formulated to take into account the comprehensive needs of the individual patient as each care plan should be individualised. When I worked at Cygnet Victoria House, the care plans were reviewed at each ward round however some aspects, where there was a change in circumstances were reviewed

between ward rounds usually at the morning meetings. Each plan point of the care plan usually contains a detailed account of the background, patient and MDT views, as well as the working strategy. The plan points usually include but are not limited to risks, physical health conditions, community access, engagement and observation, section (MHA) rights; reducing restrictive practice usually falls within the categories of managing my risks, my treatment and support and my discharge plan.

24. Where a patient has had multiple admissions, this would usually be captured in the background section of the plan point listed. The inpatient care plans are usually forwarded when patients are discharged. The service providing the care e.g. local community mental health team, together with the patient, creates an individualised care plan which is specific to the patient as well as the service. Risks which are moderate or high on the risk assessment would usually have a care plan.

25. The leave plan is authorised by the responsible clinician but developed in collaboration with the MDT as guided by the MHA Code of Practice (chapter 27) [NHFT0008520]. The factors which are considered include the patient's current clinical presentation; risk assessment and management (the risk to self or others, conditions of leave, contingency plans); therapeutic and recovery benefits, patient's views. Section 17 leave is reviewed and amended if there is a change in the clinical presentation or risk assessment.

26. In terms of reviewing risk assessments and care plans, at Cygnet Victoria House all staff are encouraged to and are provided with opportunities to voice their

opinions which they can either do in meetings or by speaking to a senior nurse, speciality doctor or the consultant psychiatrist. There is always at least one nurse (sometimes more) in morning meetings and ward rounds; and support staff are welcome and do attend ward rounds and morning meetings when feasible.

27. The term 'rapid tranquilisation' is defined by NICE as "use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed" [NICE0000023].

28. Prior to a PICU patient with psychosis being stepped down to an acute ward, the clinical treatments carried out include an up-to-date risk assessment, mental state examination, physical health assessment, medication assessment. According to Cygnet's Transfer and Discharge Policy – All Services (03/21) 4.16 [CYGN0000112] "the individual's Responsible Clinician is responsible for the discharge of the individual. The Responsible Clinician must be satisfied on the basis of the current risk assessment and corresponding plan for discharge that discharge is in all the circumstances, safe."

29. In terms of transitioning an inpatient experiencing psychosis from PICU to an acute mental health unit, the principle of proportionality requires that the treatment of mental health patients be given in the least restrictive manner and in a place which can safely and effectively manage the patient and his/her risks. The patient's clinical presentation and risks are usually carefully considered by the responsible clinician when the decision to "step down" a patient between PICU and an acute

mental health unit is made. Where there is a history of violence and aggression there is usually a focus on this, as well as the risk of non-concordance with medication in patients considered by clinicians to be at risk of becoming violent in the absence of treatment. In addition there is usually a focus on the risk of non-concordance with medication in patients with a history of non-concordance with medication, social isolation and disengagement from treatment.

30. All PICU patients but especially patients who have a history of masking psychotic symptoms should have a mental state examination by an experienced psychiatrist as part of the overall assessment to assist with the decision to transition to an acute unit.

31. The types of behaviours and/or observations to consider when making the decision as to whether to step down a PICU patient to an acute mental health unit include the current clinical presentation, concordance with medication and the risk to own health and safety and the safety of others.

32. According to the National Minimal Standard for Psychiatric intensive care in General Adult Services (updated 2014), chapter 10 [CQCM0028985] when a PICU patient is transferred to an acute mental health unit, information from all disciplines within the MDT outlining problems, needs, progress and recommendations specific to each of the disciplines and current management plans and treatment details to facilitate smooth handover of care to receiving unit or team should be provided.

33. With patients who have a history of, or are experiencing psychosis, the term 'insight' according to the Oxford Handbook of Psychiatry can be defined as having the correct attitude to morbid change in oneself. Insight in psychiatry involves recognising the illness, understanding its cause and significance, and accepting the need for treatment. Assessing insight is part of a mental state examination. The term 'masking' (of symptoms) means concealing symptoms whether doing so consciously or unconsciously. Factors and information to be included when considering whether there is masking include objective medical findings, direct observation of behaviour in different settings and compliance with assessments. If a patient is engaging on a "needs led" basis it means that the patient is only initiating interaction with staff when he/she needs something.

34. When psychiatric patients become acutely unwell, it may result in an increased risk to self and/or others. A history of violence, a substance misuse history and non-compliance with medication are the most relevant to consider to identify risks.

35. According to the Cygnet transfer and discharge policy (07/24) [CYGN0000112], when planning a transfer from PICU to acute units, a discussion should occur between the placing authority, the carer, clinical professions from the community, PICU and acute units. This discussion should be held either at the next patient review meeting or a special meeting. The responsibilities would be agreed upon but care of the patient would fall on the team who are currently caring for the patient.

Community Treatment Orders ('CTOs')

36. In some circumstances a patient experiencing psychosis and/or diagnosed with paranoid schizophrenia cannot reasonably be discharged without a CTO in place. A CTO is an option only for patients who meet the criteria set out in the MHA (as below). A decision as to whether a CTO is the right option is taken by the responsible clinician and requires the agreement of an approved mental health professional. In assessing that risk the responsible clinician should take into consideration the patient's history of mental disorder, previous experience of contact with services and engagement with treatment. A tendency to fail to follow a treatment plan or to discontinue medication in the community, and then relapsing may suggest a risk justifying use of a CTO rather than discharge into community care (Chapter 29.9-13 Mental Health Act Code of Practice).

37. The criteria for a CTO set out in the MHA for patients detained under section 3 are:

- the patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment
- it is necessary for the patient's health or safety or for the protection of others that the patient should receive such treatment
- subject to the patient being liable to be recalled as mentioned below, such treatment can be provided without the patient continuing to be detained in a hospital

- it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) of the MHA to recall the patient to hospital, and
- appropriate medical treatment is available for the patient.

38. Regarding patients with a history of aggression in the community and inpatient settings, the responsible clinician must be satisfied that the risk of harm arising from the patient's disorder is sufficiently serious to justify having the power to recall the patient to hospital for treatment. Regarding those who are considered by clinicians to be at risk of becoming violent in the absence of treatment and/or with a history of violence, the responsible clinician must be satisfied that the risk of harm arising from the patient's disorder is sufficiently serious to justify having the power to recall the patient to hospital for treatment.

39. Similarly in relation to patients with a history of non-concordance with medication, and/or a history of social isolation, disengagement from treatment, and/or a history of masking psychotic symptoms, the responsible clinician must be satisfied that the risk of harm arising from the patient's disorder is sufficiently serious to justify having the power to recall the patient to hospital for treatment.

Non-concordance and depot medication

40. Predicting non-concordance with medication may be complex and the determinants of non-adherence as listed by The Maudsley Prescribing Guidelines in Psychiatry include illness-related factors like lack of motivation, poor insight,

grandiose delusions, cognitive deficit and thought disorder; treatment-related factors like side effects and dysfunctional beliefs; clinician and organisational-related factors like poor therapeutic alliance, lack of follow-ups, limited consultation time; patient-related factors like denial, insight, co-morbidity, physical impairments/barriers; environmental-related factors like family's beliefs, cultural beliefs, religious beliefs and unintentional non-adherence due to forgetfulness and disorganised lifestyle. Exhibited is The Maudsley Prescribing Guidelines in Psychiatry 14th Edition by David M Taylor, chapter 14 (pages 918-924) [WITN0342004].

41. It is estimated that approximately 50% of people on chronic medication (for physical and mental disorders) do not take their medication as prescribed. Ten days after discharge, 25% of patients with Schizophrenia are non-adherent; 50% by one year and 75% by two years. The relative and absolute risk of relapse with depot medication maintenance is 30% and 10% lower, respectively than with oral medication. Switching from oral to depot does not address the determinants of non-adherence. Prescribing depot medication does not cure non-adherence but prevents the sudden cessation of medication and its consequences (all depots provide a slow decline in plasma levels) and it provides certainty about the level of adherence. The Maudsley Prescribing Guidelines in Psychiatry 14th Edition by David M Taylor, chapter 14 [WITN0342004].

42. The responsible clinician considers many factors when deciding whether depot medication is an option. These include:

    a. a history of aggression in the community and inpatient settings

b. considered by clinicians to be at risk of becoming violent

c. in the absence of treatment

d. a history of violence

e. a history of non-concordance with medication

f. a history of social isolation

g. a history of disengagement from treatment

h. a history of masking psychotic symptoms.

Interaction with VC

43. I note that VC was admitted to Cygnet Victoria House on 11 September 2021. Given that this was over 4 years ago I have only a limited recollection of VC. Accordingly this statement is predominantly based on the records and my standard practice at the time.

44. I was not involved with the admission on Saturday 11 September 2021 as he was admitted over a weekend and I was not on-call when he arrived. His notes indicate that his ECG (electrocardiogram) had been done on Sunday, 12 September 2021 and was reviewed by me on Monday, 13 September 2021. ECGs are routinely taken on new admissions to check for cardiac issues given that PICU patients are at higher risk of heart problems possibly due to, for example, lifestyle factors or psychiatric medications. I do not recall whether I met VC on Monday 13 September 2021, however I attended his ward round on Tuesday 14 September 2021.

45. I attended a number of MDT meetings throughout VC's admission. The MDT consists of a group of professionals who function together to provide the care needed by the patient: usually in the context of a PICU patient at Cygnet Victoria House this includes but is not limited to consultant psychiatrist, speciality doctors, medical secretary, MHA administrator, nursing team, occupational therapist, psychologist, psychology assistant and social worker. Speciality doctors play a supportive role working under the consultant psychiatrist. Major decisions and plans regarding the patient's care are made by the consultant who considers the views of the rest of the MDT which includes speciality doctors. Speciality doctors also support with the physical health of admitted patients which includes ensuring that ECGs and blood tests are performed and results reviewed.

46. Daily MDT meetings are essential to discuss various aspects of patients' care: this includes but is not limited to feedback since the previous MDT meeting on psychiatric and physical condition and any other relevant information; discussion regarding restrictions in place to keep the patient and others safe – like observation levels, section 17 leave, access to items on the ward; and management plan including medication.

47. I have no recollection of the MDT's perspective on VC generally or how he was discussed in the daily MDT meetings. I have a limited recollection of how VC presented and communicated during the meetings. I elaborate further on this below. I cannot recall any indication of violence or aggression during VC's admission to Cygnet Victoria House. In relation to medication, I note from the medical records that VC preferred oral medication and with previous medication

he had experienced side effects but he said that he did not have side effects with Haloperidol. From the notes it appears that over the course of his admission, VC stopped voicing delusional beliefs, there was improved interaction with staff and he showed an interest in continuing his studies.

Clinical reviews and ward rounds

48. I attended the ward rounds on 14 September 2025 and 21 September 2025. As we were two speciality doctors covering PICU (Albert ward, Cygnet Victoria House), the other speciality doctor attended the ward round on 28 September 2025. Usually we would take turns attending PICU ward rounds so each would attend every other week. I cannot recall exactly why I attended two weeks in a row.

49. From what I can remember of his first and second ward rounds on 14 September 2025 and 21 September 2025 respectively, his tone was neutral and unemotional and his speech content consisted of systematised delusions of persecution. He seemed guarded and suspicious. There was no specific concern during the first two ward rounds that he was masking his symptoms as he was talking about his delusional beliefs. There was no indication that he showed insight into his illness. The delusion shared with the team was that he had been targeted by the authorities / judiciary because he had broken COVID lockdown rules; he had been subjected to "psychotronic" thought interference for over six months but that it was coming to an end because they did all they wanted to and decided to leave him alone. The voices (auditory hallucinations) were reportedly dissipating. He denied that this improvement was as a result of taking his medication and stated that he did not

feel he needed to be in hospital. There was no indication of aggression or violence during the two ward rounds attended.

50. VC lacked insight into the need for medication during the ward round on 14 September 2025 but during the ward round on 21 September 2025 he indicated that he was satisfied with the oral Haloperidol, that he was happy with an increased dose and that he had not experienced side effects. Over the course of his admission, VC admitted to a reduction in auditory hallucinations, showed improved interaction with staff and he showed an interest in continuing his studies.

51. I note that the ward round on 21 September 2021 was attended remotely by VC's care coordinator, Claudia Birtles. Generally care coordinators are encouraged to attend the ward rounds of their patients, for a number of reasons which include continuity of care, obtaining information from a professional, obtaining the opinion of a professional who knows the patient well. This was usually done remotely.

52. Usually the care plan and risk assessments would be reviewed at ward rounds. I do not specifically recall doing this but note the updates are dated on ward round days of 14, 21 and 28 September 2021 therefore it is most likely that the updates were completed during the ward rounds. Patient review forms are completed by various members of the MDT prior to, during and just after the ward round (also known as patient review meeting).

Risk assessments

53. The risk assessment on 14 September 2021 [CYGN0000001, p185] assessed VC's risk of harm to others and risk of non-compliance as moderate, downgraded from high on admission [CYGN0000001, p189]. I believe this would have been the collective opinion of the MDT; reflecting VC's current risk. The conclusions as to risk at that stage would have been based on information available in the referral documentation, VC's presentation since admission and a current assessment of risk. At that stage VC had taken his medication without any issues, there had been no signs of verbal or physical aggression and accordingly it appears that the risk had reduced at that time. At the initial risk assessment on admission, VC was unknown to the team and the information given was that prior to admission there had been a very serious incident resulting in seclusion. The downgrade was the result of no incidents of physical or verbal aggression since admission. The key concerns arising from risks of non-concordance, lack of insight and non-engagement were risk to health, safety of self and others.

54. The 'Risk Reduction Plan' on the 12 September 2021 risk assessment [CYGN0000001,p188] included observations at 4 checks an hour, meaning that VC would be checked on intermittently, about every 15 minutes. This was fairly standard for new admissions. In addition the plan included S17 emergency leave currently for a period of assessment and reduction in risk behaviour, meaning that VC was only to leave the hospital in cases of medical emergencies and that there was to be a period of assessment first before he is allowed to leave the hospital for other reasons. This is also fairly standard practice for new admissions where

prior to allowing leave off the hospital premises that the patient had to undergo a period of assessment of risk.

55. The Risk Reduction Plan referenced restrictions of supervised access to blades or glass. Furthermore the Risk Reduction Plan permitted PRN 1st line Lorazepam, 2nd line Promethazine, meaning that if VC required medication for agitation, the guidance to nursing staff who would administer the medication which is prescribed as needed would be that the first option would be Lorazepam and the second option would be Promethazine. PRN is an abbreviation for the Latin term pro re nata which means "as the thing is needed". PRN medication is prescribed so that nurses who are on-duty 24 hours a day can administer medication if needed. VC's PRN Lorazepam (both oral and intramuscular) was prescribed for agitation (and severe agitation). I do not consider that there were other measures needed to reduce risk that could have been included in this plan.

56. The risk assessment of 14 September 2021 also refers to the use of MAPA as a last resort if VC was displaying behaviour likely to cause harm to himself or others. MAPA is an acronym which in this context refers to Management of Actual or Potential Aggression, a training program for de-escalation and crisis management. All PICU clinical and support staff are trained in these techniques to safely manage an agitated patient.

57. In the risk assessments of 21 and 28 September 2021 [CYGN0000001, p181 and p72 respectively] the reference to DRA means daily risk assessment. I note that

risk of harm to others and risk of noncompliance with medication remained at moderate. I cannot recall any changes to the risk assessment over this period.

58. I consider that VC's risk assessments whilst at Cygnet Victoria House appropriately captured, addressed and managed the risks that VC posed to himself and others whilst acutely unwell and based on the available information.

Care plans

59. I note that VC's care plan was updated on 14 September 2021 [CYGN0000025]. I cannot recall if I was directly involved in updating the care plan. I note in the 'Background' section relating to violence and aggression, it was noted that historically when VC had been unwell, he had forced entry into neighbours' houses under the influence of psychotic experiences '*...though no violence has resulted*'. I do not know what the basis was for the comment that no violence had resulted. I also note that in the care plan section dealing with violence and aggression, there is reference to VC assaulting police and his comment of regret and that it was a lack of judgement. I cannot recall VC making any comments about previous violence and/or aggression, any expression of regret or whether VC sought to downplay the severity of his violence and aggression.

60. I note that the care plan includes a 'Working Strategy' in relation to VC's risk of violence and aggression. The first point on the strategy is that staff would observe the patient for changes so that intervention can happen expeditiously and if there is any change then verbal de-escalation techniques may be used (second point).

1:1 time is a prevention strategy which gives a person space to express themselves so frustrations do not build up. Engagement is encouraged but cannot be forced on patients. If patients refuse, staff members would try again and would use different ways to try to engage patients. If verbal de-escalation techniques do not work, oral medication is offered and on the Kardex it is clearly stated what the first line medication and second line medication would be. If the patient refused oral medication and if it is clinically needed (risk to safety), the medication should be administered intramuscularly (rapid tranquilisation). The last point involves documentation and discussion of any violent incidents.

61. Under the '*Views*' section of the care plan, comments attributed to VC include that he would take his medication but also that on 14 September 2021, he believed that medication had made no difference '*...whatsoever for the voices'*. I cannot recall VC making either of these comments. It is standard practice to include the patient's views in the care plan and I consider it is good practice to include verbatim quotes. I cannot recall whether at the time I considered that VC would take his medication as he had indicated and I cannot recall whether I addressed his belief that the medication had made no difference. VC was prescribed an oral antipsychotic medication, however if he refused this, he could be given the same medication in intramuscular form. This would be reviewed daily in the morning meeting. Intramuscular medication for agitation (rapid tranquilisation) was also prescribed if needed (details on a separate care plan) and if MAPA (Management of Actual or Potential Aggression) was used, it should be used for the least possible time.

62. There were no substantive changes to VC's 14 September 2021 care plan when it was updated on 21 September 2021 and 28 September 2021. Generally speaking, changes to the care plan are only made as required and the changes made were decreasing observation levels and increased access to escorted section 17 leave.

63. It is noted that in the care plan dated 21 September 2021 there is reference to the MHA assessment on 24 September 2021, when VC was placed on a section 3 (background section). Care plans are updated when there are changes affecting the care of patients. As this happened between 21 September 2021 and 28 September 2021, the care plan would have been updated between ward rounds. The reading of VC's section 3 rights need to be included in the care plans hence the inclusion of this point prior to the next update of the care plan on 28 September 2021.

Patient Reviews

64. At each patient review, feedback from nurses/support workers are included in the review forms. On reviewing the forms, the most significant aspects of the feedback on 14 September 2021 included his settled presentation; his current clinical picture (thought block and isolation; good sleep; good self-care); and compliance with medication. The clinical picture of a patient with thought block or thought disorder not engaging were to be expected at that time and so these symptoms were not a surprise or a concern at this stage in his admission. On 21 and 28 September 2021, the most important aspects of the feedback in my view included his ongoing settled presentation with no signs of agitation, aggression or violence; his current clinical picture (thought disorder; improved engagement and interaction; successful

escorted section 17 leave; good sleep and dietary intake; good self-care); and, again ongoing compliance with medication. The feedback was mostly reassuring: he did not display aggression or violence; he was settled and he was taking his medication. I note that the feedback on 21 and 28 September was identical. I do not know why this was and cannot recall if I questioned it at the time. Furthermore I do not know why some of the sections of the forms were left blank. Whilst the risk formulation was not included on any of the patient review forms it would be recorded in the psychology folder.

65. 'Action points' were included at the end of each patient review form. These included for VC to receive input from and engage with occupational therapy and psychology. The occupational therapy and psychology teams would be best placed to elaborate on their input as a result of these action points and the extent to which VC engaged. I am unable to recall the extent of VC's engagement with occupational therapy and psychology. When patients do not engage with elements of their treatment such as occupational therapy and psychology, there are risks which include the deterioration of their mental health with resulting increased risks to the safety of the patient as well as the safety of others. VC was compliant with his prescribed medication and showed improvement in psychotic symptoms, with improved engagement with staff and displayed no aggression. He was starting to make plans for his future including re-joining University and was considering a career in Engineering. He was therefore discharged from Albert ward, Cygnet Victoria House to an acute ward when this was clinically appropriate.

Leave, observations and family contact

66. VC's first section 17 leave form dated 13 September 2025 only allowed him emergency leave for healthcare appointments / hospital visits / medical emergencies. Over the course of his admission his section 17 leave was increased to escorted leave (required to have a member of staff with him) to two hours on three occasions weekly to the local town.

67. According to the notes on admission VC was checked four times per hour (intermittent 15 minute observation); on 17 September 2025 his observation level was reduced to two checks per hour (intermittent 30 minute observation); and on 21 September 2025 his observation level was further reduced to the least restrictive level which is general observation (one check per hour). His observation level was reduced when clinically appropriate and in accordance with the least restrictive principle.

68. I do not recall having any conversations with VC's mother or wider family during his stay at Cygnet Victoria House. Neither can I recall whether other staff spoke with them. However I note that in the Approved Mental Health Professional's (AMHP) report for the purposes of the MHA assessment on 24 September 2021, VC's mother was contacted in view of the proposed section 3 detention and it appears that she did not oppose the section [CYGN0000013].

Diagnosis, treatment and medication

69. In the Notification of Discharge/Transfer completed by me following VC's transfer to Priory Hospital Arnold (CYGN0000015), I refer to the diagnosis of 'Paranoid Schizophrenia'. This was a diagnosis which had been made prior to VC arriving at Cygnet Victoria House. VC's responsible clinician and specialist psychiatrist at Albert ward, Cygnet Victoria House was in agreement with this diagnosis. VC's clinical presentation was consistent with this diagnosis. VC's short-term management whilst at Cygnet Victoria House may not have been affected depending on whether he was diagnosed with psychosis or paranoid schizophrenia however it would have had implications for future care. Schizophrenia is a lifelong condition requiring ongoing management whereas psychosis is a symptom, from which a patient may make a full recovery (depending on the cause).

70. In VC's 11 September 2021 care plan on admission, it was noted that he was prescribed oral Haloperidol 5mg BD. I was not present when VC was admitted but note that he was commenced on this in the days prior to his admission to Cygnet Victoria House. The admitting doctor likely continued the medication at the same dose he had just been commenced on as it would be necessary for him to be on this antipsychotic for a few weeks to assess its effectiveness. I note that at the first ward round on 14 September 2021, the dose of Haloperidol was increased to 5mg 3 times daily [CYGN0000060]. It appears that VC had remained symptomatic but was tolerating Haloperidol and this was having an effect and so his dose was increased. VC needed antipsychotic medication to manage his condition and he showed improvement with Haloperidol.

71. Under the 'Key checks' section of the patient review forms dated 14 and 21 September 2021 [CYGN0000060 and 61 respectively], I noted that VC did not have capacity to consent to treatment. VC's capacity was assessed based on his answers to questions during the ward rounds where it was clear that he lacked insight into his illness and did not accept that he needed treatment. He was not able to weigh up whether receiving treatment was in his best interests. This capacity assessment was specific to treatment including medication for his mental health condition. During his short time at Cygnet Victoria House, he was not assessed as having the capacity to consent to treatment. VC was prescribed IM Haloperidol if he refused to take his oral medication.

72. The care pathway set out in Cygnet's policy '*Acute/PICU and Older Adults Mental Health Inpatients Service*' [CYGN0000002] was followed in so far as necessary.

Transfer to Priory Hospital Arnold and ongoing treatment

73. On the 28 September 2021 patient review [CYGN0000033] it was noted that VC still lacked insight. There was no evidence that VC gained insight regarding the need for treatment of his mental illness prior to his transfer to Priory Hospital Arnold. While admitted he was encouraged to engage in treatment; he was prescribed intramuscular medication in case he did not take his medication orally; and he was discharged to an acute ward for further care. It is not unusual for patients admitted to a PICU to lack insight into their illness and the need for treatment at the time of transfer to an acute ward. Lack of insight in Schizophrenia,

once the patient is stabilised requires a multipronged approach which includes psychological therapies and medication.

74. VC held delusional beliefs, as noted in the 14 September 2021 patient review where there is reference to '*... a conspiracy with the judiciary because there is an electronic harassment which he calls 'psycotronics' ... he had not done research on it'* [CYGN0000060]. I am familiar with the delusional belief of a conspiracy from experience with other patients with delusional beliefs. I do not recall if I asked VC whether he had conducted any research and if so what this research was.

75. I can confirm that VC was not aggressive or violent at any time during his admission to Cygnet Victoria House. From the ward round notes on 14 September 2025 under Patient Feedback [CYGN0000060]: "We asked why he was violent to the police officers and he said it was because he did not feel the hospital was polite and respective enough to him but right now he feels regretful for that and it was a lapse of judgement." I believe that this may be a typographical error and that it was the police not the hospital who VC felt were not '...polite and respective enough to him...'. As VC had not shown any aggression or violent behaviour for the duration of his time at Albert ward PICU, this risk at the time of transfer, was considered to be reduced.

76. In the patient review dated 21 September 2021 [CYGN0000061] there was reference to considering depot antipsychotic medication if detained on section 3, and given VC's history of non-compliance. However by 28 September 2021 [CYGN0000033], it was noted that VC would not consider depot antipsychotic

medication injections. Depot medication is usually considered as it is thought to improve compliance and reduce risks. It was increased during VC's admission on the PICU at Cygnet Victoria House. He was at Cygnet Victoria House for a very short time and the main goal of management was to stabilise his condition prior to transfer to an acute ward nearer his home that could liaise with his community mental health team regarding the treatment plan after discharge. During his time at Cygnet Victoria House, he was taking his medication orally, with a plan to administer intramuscularly if he should refuse; however he never refused his medication and so using a depot against his wishes at that point would not have been proportionate in his management, or the least restrictive option. I do not recall any specific discussions with the Priory Hospital Arnold. Depot medication was mentioned in the discharge summary [CYGN0000015].

77. In the patient review dated 21 September 2021, comments from Claudia Birtles, VC's care coordinator were noted and reference to depot being considered given that in Claudia's view, VC had never recovered to the premorbid levels of functioning following his previous discharge. This was of concern and accepted. This information was included in the discharge summary [CYGN0000012].

78. I do not recall whether I was involved in the decision on 23 September 2021 that VC should be transferred to an acute ward and that he no longer required management on a PICU [CYGN0000050, p11]. After two weeks of settled presentation with no aggressive or violent behaviour and accepting oral medication, a PICU, which often has many violent and aggressive patients, would

not have been the most appropriate environment and would not be the least restrictive environment for VC.

79. I produced a discharge notification on 4 October 2021 [CYGN0000015] and discharge summary on 11 October 2021 [CYGN0000012] in relation to VC's transfer to Priory Hospital Arnold. The notification was a shorter document notifying of the discharge and mainly would contain information about risks and medication usually completed at the time of discharge. The intention was to provide summarised information regarding VC's presentation, risks and current treatment for the next hospital to consider when planning his ongoing care. The discharge summary is usually a more comprehensive document completed about a week later. By the time of VC's transfer to Priory Hospital Arnold, his clinical presentation had improved: There were no signs of agitation, aggression or violence; he had improved engagement and interaction; he had successful escorted section 17 leave; good sleep and dietary intake; good self-care; and ongoing compliance with medication.

80. Following step down to an acute ward, the expectation is that the acute ward would manage him in an appropriate manner and that when he was ready for discharge, they would liaise with his community mental health team and care co-ordinator regarding his future care. Given the time that has elapsed since VC's admission at Cygnet Victoria House, I do not recall any conversations or other communication in relation to VC's transfer to Priory Hospital Arnold. I note from the discharge summary that relevant information was included [CYGN0000012]. Similarly I am

unable to recall if VC's family were involved in planning arrangements for VC's transfer.

81. I do not recall having a view on how long an admission VC may need in an acute ward and I was not aware of a settled view in this regard. The length of VC's admission in the acute ward would be a matter for the clinicians and staff caring for him in that ward. I am also unable to recall any discussions regarding a CTO or whether I had a view on it at the time.

82. I do not consider that any further action should have been taken to address risks whilst VC was admitted to Cygnet Victoria House. VC displayed no signs of violence and aggression, was compliant with his medication, had a settled presentation on the ward, had uneventful periods of escorted leave and his mental state had improved.

83. I had no further contact with VC after he was transferred to Priory Hospital Arnold.

84. I do not consider that I am in a position to make recommendations to the Inquiry.

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 GRO-B

Dated: 4 December 2025

Index to First Witness Statement of Dr Tania Engel

No.	Inquiry URN	Document Description
1	CYGN0000012	Discharge summary of VC
2	CYGN0000001	Section 17 leave form and photo consent of VC
3	CYGN0000025	Care plans for VC
4	CYGN0000013	Forms H3, A7 and A6 of VC
5	CYGN0000015	Notification of discharge/transfer for VC
6	CYGN0000060	Patient review – Adult Acute/PICU for VC dated 14 September 2021
7	CYGN0000061	Patient review – Adult Acute/PICU for VC dated 21 September 2021
8	CYGN0000002	Clinical model of care for Acute/PICU and Older Adults
9	CYGN0000033	Patient review – Adult Acute/PICU for VC dated 28 September 2021
10	**CYGN0000050**	Pink notes for VC
11	CYGN0000112	Cygnet Health Care - Transfer and Discharge Policy – All Services
12	WITN0342002	NICE Guidelines - Psychosis and Schizophrenia
13	NHFT0008520	Mental Health Act 1983: Code of practice
14	NICE0000023	NICE Guidelines – Violence and aggression: short term management in mental health, health and community settings
15	CQCM0028985	National Minimum Standards for Psychiatric Intensive Care in General Adult Services – Updated 2024
16	WITN0342003	Oxford Handbook of Psychiatry 4th Edition

17	WITN0342004	Maudsley Prescribing Guidelines in Psychiatry (14th Edition) by David M Taylor