Questions to be addressed by the Inquiry

This list of questions which will be addressed by the Inquiry is not part of the Terms of Reference and is non-exhaustive.

Timeline

1. In relation to each occasion when VC interacted with health or social services:

    a. What information was provided and/or available to those interacting with him, including the circumstances giving rise to police involvement or complaint to Nottingham University.

    b. What information was recorded about the interaction with him.

    c. What decisions were made, by whom and on what information and criteria.

    d. Whether information about a-c above was shared, if so to whom, and was it available to those next interacting with VC.

2. In relation to each occasion on which law enforcement/the police (from any force including Nottinghamshire and Leicestershire) came into contact with or monitored VC prior to June 2023:

    a. What information was provided to the police which gave rise to attendance.

    b. What information was recorded and in what form about the attendance

    c. What decisions were made, or action taken, and on what criteria.

    d. Whether, and if so when, were details of the attendance and/or decisions or actions taken communicated to

        - Health, social services or multi-agency.

        - VCs family

        - Nottingham University

- Others who might be affected by VC's actions.

3. What action was taken and/or record made by the police and the wider criminal justice system prior to 13 June 2023 in relation to an allegation of assault on police officers who attended VC's home on 3 September 2021 to assist with executing a warrant under section 135 Mental Health Act 1983 and/or a bench warrant without bail issued by Nottingham Magistrates Court on 22 September 2022 in relation to VC's failure to attend court to answer that charge? Was the existence of the bench warrant known to police, health services, social services or others in the wider criminal justice system prior to 13 June 2023?

4. What was VC's engagement with medical services, students and staff at Nottingham University during the timeline period? In relation to significant events which occurred during the timeline period, how were those events investigated and/or addressed by Nottingham University and when communicated to them, by the police, health or social services?

5. What engagement was there between health, social services and/or Nottingham University, and VC's family throughout the timeline period ? Was information they gave and were concerns they expressed recorded? Were they taken into account by decision makers?

6. In relation to the period between VC's discharge to his GP on 22 September 2022 and the attacks on 13 June 2023 what is known about VC's location, mental health and conduct? What contact was there between VC and his family? Where was he living? What were the circumstances of VC's employment in Kegworth in May 2023?

7. Were opportunities missed during the timeline period to take action which would have reduced the risk of or prevented any or all of the attacks on 13 June 2023?

Events and response on 13 June 2023

8. What was the sequence and timing of events on 13 June?

9. In the light of the sequence of events and timing:

a. Could anything more have been done which was not done to locate and arrest VC, and/or prevent the attacks or any of them?

b. Could anything more have been done which was not done by the emergency services in the provision of care and treatment to the victims of the attacks?

Unauthorised access and disclosure of case files and evidence

10. When did sensitive data, information and/or CCTV footage in respect of this high profile case come into the possession or access of departments or agencies (including but not limited to):

    a. Nottinghamshire Police (officers and staff)

    b. Nottingham City Council (including the Community Protection Service)

    c. HM Courts and Tribunals Service

    d. HM Prison and Probation Service

    e. Nottingham University Hospitals NHS Trust

11. What guidance did the department or agency have on the holding and viewing of such sensitive data, information or material?

12. What steps were taken in this case to ensure that information generated as a result of the events of 13 June was restricted only to those with a legitimate need for access?

13. How many people within the department or agency accessed sensitive data, information or material held, and/or referred to it in inappropriate telephone messaging with others?

14. What steps could or should have been taken to protect the integrity of the sensitive data, information or material and the dignity and privacy of victims and survivors, including the bereaved families?

15. What steps were taken and when to ensure that the survivors and bereaved families were appropriately informed concerning any data breaches and the

actions taken? What improvements could or should be made to the process for communication with victims and families in such circumstances?

16. What protocols govern the management of video footage and evidence in the investigation and prosecution of high profile cases? Should any changes be made?

Understanding, assessment and management of risk

17. Was VC's history and the detail of incidents which led to police attendance or complaints by others accurately recorded and consistently interpreted in decision making? What was the factual historical basis used for each risk assessment?

18. On each occasion when VC was detained, what factors were taken into account in decisions as to whether he was detained under s.2 or s 3 of the Mental Health Act? Was lack of compliance on medication taken into account and the potential for a Community Treatment Order ("CTO") considered? What aftercare services were provided?

19. On each occasion when VC was discharged how, and if so to what extent, were risks of failure to take medication, lack of engagement and relapse when not taking medication identified and considered in relation to discharge, and care after discharge? On each occasion were the risks of violence/ escalation of violence to others and risk of offending as a result also identified and assessed?

20. Was VC's capacity to make decisions about his care and medicine regime considered? Was insight or lack of insight considered in relation to capacity to make such decisions? If so, when and what criteria were used? Would assessment of capacity under the regime of the Mental Capacity Act 2005 have provided alternative approaches to ensuring compliance with medication?

21. In relation to each occasion on which depot medication was considered, what were the reasons for not pursuing this method of ensuring compliance?

22. What part did any or all of the following factors play in risk assessment and decisions on the management of the risk of violence and risk of offending in the care and treatment of VC? If so, what weight were they given? What effect did

they have on the treatment of VC and management of risk of violence to others and risk of offending?

a. The principle of treatment in accordance with the least restrictive option.

b. Consideration of VC's presentation during each period of hospital care separately, rather than against a background history of previous presentations in hospital and in the community after discharge;

c. VC's expressed wishes as to his care, including where those conflicted with views of clinicians and his family;

d. Treatment on positive risk management principles including reluctance to use diagnostic labels because of the potential adverse impact on VC's long term prospects and finishing his degree.

e. Avoidance of restrictive practice and approach in the context of concerns about disproportionate overuse of Mental Health Act restrictive measures with black African and black Caribbean patients publicised in the context of Mental Health Act reform during the timeline period.

f. Resourcing of mental health provision including forensic assessment of risk.

23. Are there further measures required to address failings other than those identified in the reviews undertaken by Nottinghamshire Healthcare NHS Foundation Trust, The Care Quality Commission and National Health Service England?

Multi Agency working and information sharing

24. What systems were in place for sharing of relevant information? Were those systems operated in this case? What information was shared between the police, health services, social services and Nottingham University concerning VC's health and relevant conduct? To what extent did the sharing of information impact treatment of VC? Would the sharing of any additional information have had an impact on the decisions taken?

25. Are there any barriers, legal or otherwise, to the sharing of information relevant to clinical treatment and risk assessment which limit the effectiveness of multi agency working?

26. In addition to those identified by the reviews, are there any additional weaknesses in systems and processes, both within organisations and across systems, which may have influenced the responses to VC?

27. What improvements could be made locally and nationally to multi agency working to increase effectiveness in preventing similar outcomes in the future, including by the gathering and analysis of data in relation to cases involving homicide by those in contact with mental health services, the revision of existing guidance (including that provided by the Royal College of Psychiatrists), and the enforcement of recommendations made by previous reviews and reports?

Adequacy and appropriateness of care, monitoring and risk of VC prior to 13 June 2023

28. Was the care and monitoring of VC prior to 13 June 2023 adequate and appropriate, including as to risks posed by him? The reviews by Nottinghamshire Healthcare NHS Foundation Trust, the Care Quality Commission and National Health Service England, have identified failings in care and monitoring against local and national standards and guidance. Are these the only respects in which the care and monitoring of VC was inadequate?

29. What factors contributed to the failings in care and monitoring?

30. Do the recommendations made in the reviews address and provide sufficient safeguards against perpetuation or recurrence of the failings which led to the dreadful events of 13 June 2023? Are there any further recommendations which would prevent similar outcomes in the future?

31. Would any changes to existing standards and guidance reduce the risk of similar incidents in the future?

Care in custody, actions policy and procedures after arrest

32. What procedures were in place as to assessment of medical and mental health issues and drug testing, and provision of appropriate medical support after VC was arrested? Were those procedures followed?

33. What was the procedure employed and basis of decisions taken as to VC's fitness to be interviewed and detention? What assessments of his mental health were carried out?

34. What strategy and procedures were followed for toxicology? Were attempts made to take samples? What actions were taken?

35. Should or could any further investigations have been carried out?

36. How did the police handle communication with other agencies, the media and the bereaved families and survivors of the attacks? Could or should any improvements be made to such communications in similar circumstances in the future.

Crown Prosecution Service Handling of the case

37. Does the HMCPSI review accurately set out the history, the basis of decision making, and fully address the concerns raised by families in respect of the CPS analysis of and reliance upon expert evidence, and decision-making as to charging and acceptance of pleas? If not, in what respects? What else could or should have been done?

38. Did the process adopted by the CPS comply with applicable guidelines and good practice? If not, in what respects? What other steps could or should have been taken?

39. Does the HMCPSI review accurately set out the history and fully address the concerns raised by families about the handling of and communications with the survivors and bereaved families? If not, in what respects? What else could or should have been done?

40. What steps could or should be taken to improve communication with and treatment of families and survivors in similar circumstances?

Provide Recommendations

41. What recommendations are required to prevent similar attacks?

21.05.25