

Tuesday, 24 February 2026

1
2 (10.00 am)
3 Opening remarks
4 **THE CHAIR:** Yes, Mr Moloney. Just while you are on your way
5 to the lectern, I'm just going to say that all written
6 openings will be on the website later, including those
7 not speaking today.
8 We have a bit of an echo here, I think. Thank you.
9 **MR MOLONEY:** There did appear to be some feedback with your
10 microphone, Chair. I hope it is not the same for mine,
11 but in any event we represent the bereaved families. We
12 are very grateful for the opportunity you have given us
13 Chair to make these brief oral submissions.
14 **THE CHAIR:** Yes, Mr Moloney, just a moment. I think we will
15 just check the sound.
16 **MR MOLONEY:** Thank you.
17 **THE CHAIR:** I am told it is fixed but it is not.
18 **MR MOLONEY:** If those fixing it require me to speak at any
19 point to test whether or not it is fixed, I'm more than
20 happy to do that.
21 **THE CHAIR:** Perhaps if we can just keep going. Yes, I can
22 see right through the room there's a general feeling
23 that it is not working and I can hear that it is not.
24 Perhaps I should keep talking and see whether whoever is
25 fixing it backstage can actually make a difference.

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(Short Break)

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2 (10.11 am)
3 **THE CHAIR:** Try again, Mr Moloney.
4 Statement on behalf of the Bereaved Group by MR MOLONEY KC
5 **MR MOLONEY:** Thank you, Chair.
6 Chair, Barney Webber, Barney, Grace O'Malley-Kumar
7 and Ian Coates are names that the lawyers instructed in
8 this Inquiry should never have known.
9 Today, Barney and Grace ought to have been looking
10 forward to building successful careers and happy family
11 lives to make them and their families proud. Ian should
12 have been contentedly settled into his hard-earned
13 retirement. Instead, their names and their images are
14 forever tied in the public consciousness to the man who
15 so brutally ended their lives.
16 On 13 June 2023 life changed forever for each of the
17 families we represent. It changed for Emma, David and
18 Charlie Webber, for Sinead, Sanjay and James
19 O'Malley-Kumar; for James, Leigh and Darren Coates, for
20 Elaine Newton. No area of their lives has been
21 untouched. Their working and private lives,
22 relationships with family and friends, have all been
23 damaged in the most fundamental of ways. They live with
24 the raw horror of that day today and every day.
25 Whilst this Inquiry must necessarily and unavoidably

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(Pause)

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2 Do you want to try again, Mr Moloney, and just see
3 if yours works because it doesn't matter for the next
4 hour or so whether mine works.
5 **MR MOLONEY:** Thank you, Chair. If I speak as loudly as
6 reasonable it may be that people can hear me. I see
7 a shaking of the head towards the back, but
8 an encouraging few nods about ten feet away from me.
9 That's it, it's done. No.
10 **THE CHAIR:** Let's just keep speaking from time to time to
11 check because I know that there's work being done
12 backstage, as it were.
13 I think the important thing is that it is not only
14 in the room but also records properly as well.
15 **MR MOLONEY:** Indeed, Chair, thank you.
16 **THE CHAIR:** Do you want to have another go, Mr Moloney,
17 because I think it sounds better from my point of view
18 here.
19 **MR MOLONEY:** I think it is the carrying to the back which is
20 the -- I see shaking of the heads still.
21 **THE CHAIR:** Maybe I will rise for five minutes just to see
22 whether we can sort this out.
23 **MR MOLONEY:** Thank you, Chair.
24 **THE CHAIR:** Thank you.
25 (10.04 am)

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1 consider the circumstances in which Barney, Grace and
2 Ian were killed, the events of 13 June were not merely
3 ones of great personal loss and tragedy; they
4 represented the culmination of decades of unconscionable
5 but entirely predictable structural, systemic and
6 individual failures. These predictable failures were
7 repeated both in Nottingham and beyond, time and again.
8 Failures which echo down the years in the loss of life
9 in homicides linked to mental health. Repeated and
10 repeated and repeated in the decades since the Clunis
11 Inquiry in 1994 recognised that fundamental change was
12 required to better protect public safety in the face of
13 known risk.

14 Lives have been lost and families devastated again
15 and again and again. Last year it is believed that
16 about one in five homicides in this country were caused
17 by people suffering from psychiatric illness.

18 This is now the latest Inquiry to deal with the
19 issues the Clunis Inquiry tried to confront. We hope,
20 on behalf of the bereaved families, it is the last such
21 Inquiry because it succeeds. This Inquiry is only
22 happening because the families we represent refused to
23 just move along. They refused to accept that there is
24 nothing to see here and the issue of the role of poorly
25 managed and treated mental health in homicides is now

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1 back in focus for the umpteenth time because of their
2 refusal to move along. This Inquiry is not only about
3 Barney, Grace and Ian; it is also about each of the
4 countless other unnecessarily bereaved whose loved ones
5 were lost to the unmanaged risk of people who were known
6 to be ill and known to be a risk to public safety.

7 This Inquiry will consider afresh the complex
8 relationship between mental health and public safety,
9 the treatment, criminality and culpability, and must
10 grapple with significant questions of individual and
11 institutional responsibility when failure results in
12 tragedy.

13 These families recognise the Inquiry does not have
14 a simple task. It is, however, a crucial one. It is
15 an opportunity to change things for the better which
16 must be taken, we say. Any chronology of the subject
17 matter of this Inquiry is inevitably replete with missed
18 opportunities. It would be tragic if this Inquiry was
19 another missed opportunity.

20 In our written opening submissions we said that it
21 was not possible to cover, within the confines of that
22 document, the full breadth of the work that will be done
23 by the Inquiry over the coming months. To date 49,270
24 documents and many detailed and lengthy statements have
25 been disclosed following the work of your legal team,

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1 When he was eventually, some nine months later,
2 summonsed for that serious assault he failed to turn up
3 to court and a warrant was issued for his arrest. That
4 warrant was outstanding for ten months and
5 Nottinghamshire Police did not execute it for
6 ten months. They just left him out on the streets, and
7 whilst out on the streets he assaulted a man and a woman
8 while working in a warehouse in Leicestershire. In
9 simple terms, he committed an offence whilst wanted on
10 a warrant, and we heard yesterday that it may be that
11 there was another assault perpetrated by him that work
12 of the Inquiry legal team may have uncovered and we
13 await hearing more. But Leicestershire police never
14 arrested him. The warrant was never executed. It was
15 only five weeks after the Leicestershire assault that he
16 killed Barney, Grace and Ian.

17 Any attempt by the police to say arresting him would
18 have made no difference to what was to happen on
19 13 June 2023, sheltering behind some notion that he may
20 not have been convicted and may not have received
21 a custodial sentence, would be cowardly, highly
22 offensive and insulting to the intelligence of the
23 bereaved families. The Inquiry will need to examine
24 such a claim very carefully.

25 If he had been arrested, a number of different

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1 Chair. The process of disclosure continues as we write.

2 The task is all the more impossible in these short
3 oral submissions, but we would begin with a number of
4 basic overarching questions for the Inquiry's
5 consideration within its Terms of Reference.

6 First, was there a failure in both the healthcare
7 and criminal justice systems to learn the well-known,
8 ill-managed and oft repeated lessons of the past?

9 Second, were there tragic and predictable flaws in
10 the healthcare and criminal justice responses to VC's
11 deteriorating presentation from at least May 2020?

12 VC was known to mental health services in Nottingham
13 from 24 May 2020, that is to say over three years before
14 the events of 13 June 2023. VC was compulsorily
15 detained pursuant to the Mental Health Act four times
16 between May 2020 and February 2022. On each of those
17 four occasions he was detained following acts of
18 violence. On one occasion he had reacted with extreme
19 violence when being detained by officers. So violent,
20 attacking a large number of male and female officers,
21 punching, using the officers handcuffs to assault them,
22 headbutting, so violent that he had to be tasered,
23 pepper sprayed and had manacles placed on his ankles, as
24 well as his wrists, in order to be able to control and
25 detain him.

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1 things could have happened. Conviction aside, he could,
2 for example, have again been sectioned and could have
3 had a Community Treatment Order, when he could have been
4 given the depot medication everyone now agrees he ought
5 to have had, and then the chances of those horrible
6 killings happening on 13 June would have been
7 substantially reduced.

8 If the police do say that executing a warrant for
9 his arrest would have made no difference, then the
10 people of Nottinghamshire and Leicestershire have a lot
11 to worry about in relation to who's keeping them safe,
12 and depot medication could and should have happened much
13 earlier in his treatment by healthcare staff. It was
14 known -- known that he could not be relied on to take
15 his medication. It was known, known, that he became
16 violent when he did not take his medication. So
17 menacing was he, that healthcare workers were warned not
18 to visit him alone.

19 By this time, by the time depot was being
20 considered, he had attempted to break down the door of
21 a first floor flat where a woman was alone and became so
22 scared that she was forced to jump out of the window and
23 sustain serious injuries. He had assaulted flatmates,
24 imprisoned one of them. He had been so violent with
25 a large number of police officers, headbutting,

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1 punching, hitting with handcuffs, that he had to be
 2 sprayed, tasered, handcuffed too, hands and ankles. Yet
 3 that man, who had done all that, they did not require
 4 him to take depot medication when they could have done,
 5 and why? Well, one of the reasons was he was scared of
 6 needles. If they had bothered to check whether he was
 7 telling the truth about that they would have seen he had
 8 his COVID jabs.

9 Lots of people throughout the process this Inquiry
 10 will examine just accepted what he told them, took it at
 11 face value, when it was well documented that he wasn't
 12 telling the truth about things; he was masking, as they
 13 described it, but they just accepted that he was scared
 14 of needles and, worse, knowing that he could not be
 15 relied on to take his medication, knowing that he became
 16 violent when he did not take his medication, when he
 17 dropped out of contact with them, when they knew he was
 18 not taking his medication, they discharged him for
 19 non-cooperation. That man who was so dangerous that
 20 they couldn't visit him alone, they just let him go
 21 unsupervised on the streets for the ordinary public to
 22 deal with.

23 They discharged him the day after a warrant was
 24 issued by the court for his arrest, after he did not
 25 turn up to court to face a really serious allegation of

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1 The fourth question we ask is: did the emergency
 2 response adequately consider the continuing risk to life
 3 between the time of the first attacks on Barney and
 4 Grace being reported by callers to 999 and the arrest of
 5 their killer, 91 minutes later.

6 We suggest there was no coherent command and control
 7 of the search for VC after the attacks on Ilkeston Road.
 8 There could be no doubt for anyone attending the scene
 9 that this was an horrific attack by an unbelievably
 10 violent and dangerous individual. VC was armed and at
 11 liberty in a city centre in the early hours of the
 12 morning. The police had a window of time before the
 13 city would be up and about. Those we represent ask the
 14 Inquiry to consider whether there is any evidence of
 15 urgency or professional direction in the actions taken,
 16 whether in the Force Control Room or on the streets of
 17 Nottingham, between the attacks on Ilkeston Road and the
 18 killing of Ian Coates on Magdala Road, and for now we
 19 highlight three elements of concern.

20 Firstly, slow deployment of personnel including the
 21 armed response. The Inquiry will hear the frustration
 22 of armed officers waiting at Ilkeston Road for firearms
 23 authority which did not come. It will be a matter for
 24 the Inquiry but it appears that there may have been four
 25 police cars at the Ilkeston Road scene for an hour, and

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1 assault. Yet worse still, the Trust did this in
 2 circumstances when they did not know about the charge.
 3 Nobody was talking to each other when it came to the
 4 serious risk posed by this very dangerous man. It is
 5 a familiar and tragic story, and VC went on to kill
 6 three innocent people and tried his best to kill three
 7 more.

8 The third question we ask is: was the emergency
 9 response on the morning of 13 June 2023 adequately
 10 managed, coordinated and executed? First, there are
 11 significant questions over the tactical leadership
 12 afforded by the Force Control Room.

13 Second, those we represent are deeply concerned that
 14 the Inquiry does not yet have a full and clear picture
 15 of how instructions and information were being
 16 communicated across the force on the morning of 13 June.
 17 The Inquiry may hear evidence as to problems with talk
 18 channels, recordings of calls from the Force Control
 19 Room seemingly lost or unavailable. It is the evidence
 20 of Chief Inspector Mather that none of the outgoing
 21 calls from the Force Control Room are recorded. It's
 22 astonishing. The Inquiry may consider whether this lack
 23 of consistent contemporary record is reflective of the
 24 care with which Nottinghamshire Police approached the
 25 events of 13 June 2023.

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1 one was an armed response vehicle, and PC Speeden was
 2 asking in effect "Why am I sat here? Why am I not being
 3 told to go and search?"

4 Secondly, poor use of CCTV available to the
 5 authorities to track VC. They had a full and accurate
 6 description of him: a black man wearing black clothing
 7 and carrying a black rucksack. There were very few
 8 people on the streets at that time. The Inquiry will
 9 hopefully explore whether he would have been hard to
 10 find. We lawyers have seen already crystal clear
 11 footage of VC walking along the streets, matching the
 12 description the police had, on his way to the area where
 13 he brutally killed Ian Coates.

14 Thirdly, sending comparatively organised resources
 15 to reports of shouting near St Barnabus Cathedral when
 16 there hadn't even been a confirmed report of a crime
 17 committed there.

18 The fifth question we ask the Inquiry to consider
 19 is: did the steps taken by police and prosecutors in the
 20 investigation and prosecution which followed the
 21 killings adequately consider and scrutinise all lines of
 22 inquiry relevant to mental health and culpability?

23 We ask the Inquiry to consider whether the
 24 psychiatric reports prepared for the prosecution
 25 adequately considered all the available information

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1 about the killer's history and his intent before giving
2 an opinion on VC's culpability for the killings of
3 Barney, Grace and Ian.

4 Sixthly and finally, in the investigations which
5 followed, were the deceased and their families who were
6 seeking transparency and accountability about the events
7 of 13 June 2023 treated seriously and with respect? It
8 is just one example of our concerns around this. We say
9 it beggars belief that most of the bereaved family
10 members that we represent discovered through digital
11 media that their loved ones had died rather than through
12 a police-led death notification.

13 You will hear about how the families' individual
14 names appeared in police logs as early as 22 minutes
15 past 4 in the morning when Barney's driving licence
16 information was added and both Emma and David Webber's
17 names were logged and at 25 past 4 in the morning, when
18 a similar list was logged for Grace, namely Sinead and
19 Sanjay and Grace's grandmother, and yet you will also
20 hear how they were left to make frantic calls to the
21 police during the morning, and the Inquiry will hear
22 that the Coates brothers first found out from friends
23 through social media.

24 So to conclude, the families of the deceased over
25 the work of this Inquiry will prevent any other family

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1 for Grace, Barney and Ian. We acknowledge this
2 additional burden alongside your indescribable and
3 profound grief.

4 Many members of the public, when they hear about the
5 Nottingham attacks, do not appreciate that, as well as
6 the fatal stabbings, VC used a van as a weapon in
7 an attempt to kill Nottingham residents making their way
8 to work on the morning of 13 June 2023. Having carried
9 out the most brutal and barbaric attacks on Grace and
10 Barney at 4 am and then at 5.15 am having, brutally
11 killed Ian, VC then stole Ian's van and, just after 5.23
12 am, drove the stolen van at speed intentionally and
13 deliberately into Wayne, swerving and striking him from
14 behind as he crossed the road.

15 Wayne had been making his way to work on foot,
16 having commuted into Nottingham earlier by bus. Seven
17 minutes later at 5.30 am, and having driven past
18 Nottingham police station, VC drove at speed
19 deliberately into Sharon Miller and Marcin Gawronski.

20 The police officer now driving in pursuit behind VC
21 in the van with blue lights and sirens activated, Wayne
22 and Sharon have suffered appalling and life changing
23 injuries caused by VC.

24 Madam Chair, you and your team have worked
25 tirelessly since this Inquiry was announced in your

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1 from ever suffering again in the same way. They urge
2 you, Chair, please, to ensure that this is not just
3 another Inquiry with recommendations warmly welcomed
4 then forgotten, but instead it secures accountability,
5 responsibility and real change. They hope that
6 a future, where public safety is taken seriously in the
7 management of mental health in our communities, will be
8 a tangible outcome of this Inquiry and a lasting and
9 fitting legacy to honour Barney, Grace and Ian. They
10 and we stand ready to assist you, Chair, in that call.

11 **THE CHAIR:** Thank you, Mr Moloney.

12 Ms Cartwright.

13 Statement on behalf of the Survivors Group by
14 MS CARTWRIGHT KC

15 **MS CARTWRIGHT:** Madam Chair, this is the opening statement
16 made on behalf of the Survivor Core Participants, namely
17 victims Wayne Birkett and Sharon Miller, who VC
18 attempted to murder on 13 June 2023, and their
19 respective partners, Tracey Hodgson and Martin Read.
20 They have each instructed Rothera Bray of Nottingham.

21 At the outset, to the families of Grace, Barney and
22 Ian we offer our deepest sympathy to each one of you.
23 We thank you for your tireless and selfless campaign
24 seeking the establishment of this Inquiry, in the
25 pursuit of truth, accountability and to achieve justice

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1 preparations for a hearing of this magnitude. We are
2 grateful to you and your team for your considerable
3 efforts and for the volume of disclosure that has been
4 made to date. We welcome your confirmation that this
5 work will continue and those lines of inquiry, including
6 where appropriate drawing on expert opinion, will be
7 kept under review.

8 You have heard no evidence, had no analysis and
9 testing of the wealth of material disclosed to you and
10 have not yet seen witnesses forensically tested. Over
11 the next months that will happen. For now, we address
12 you with the survivors at the centre of what we have to
13 say.

14 Wayne was a hard-working forklift truck driver
15 working for ABB Furse. He is a loving partner, father
16 and grandfather. Wayne appreciates that he is lucky to
17 be alive. However, has said repeatedly he wished his
18 life had been taken rather than those of Grace, Barney
19 and Ian.

20 Tracey, his partner, feels that a large part of the
21 man he was before the attack did, in fact, die that
22 morning. VC's attempted murder of him has stolen
23 a lifetime of memories as a result of the fractured
24 skull and permanent brain injury caused.

25 Sharon is a mother to her much loved daughter and

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1 lives with her childhood sweetheart Martin. Sharon was
2 incredibly close to her own mother. She was making her
3 way to work as a cleaner for DTZ on the morning of
4 13 June 2023. This was a job she had done diligently
5 for over 27 years. She has not been able to work since.

6 Tracey took a year off work to care and support for
7 Wayne, first through his coma and then, when conscious
8 again, helping him with his ongoing rehabilitation for
9 his brain injury, every step of the way trying to help
10 Wayne remind him of the man he was and help him recall
11 his memories. Wayne did not even recognise or
12 understand what the tattoo on his arm to his beloved
13 Leeds United meant.

14 Martin has made so many sacrifices to nurse, care
15 and support Sharon for her physical and psychological
16 injuries, with their wedding put on hold until the
17 Inquiry is concluded.

18 Sharon now rarely leaves her home.

19 Our clients want to thank the medical professionals
20 who saved their lives and treated their injuries in the
21 hours, days and now years that have followed.

22 For the many individuals, members of the public, who
23 were nothing short of heroes in the aftermath of these
24 atrocities and who have not yet been recognised for
25 their compassion, courage and simple humanity, we thank

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1 participants of what Sir Brian Langstaff, Chair of the
2 Infected Blood Inquiry report, in his volume 1 report,
3 his sixth theme, which we submit equally applies to this
4 Inquiry, namely:

5 "... the damage that was done by that defensiveness
6 and the accompanying lack of transparency and candour to
7 the very people whose lives had been destroyed ... The
8 harms already done to them were compounded by the
9 refusal to accept responsibility and offer
10 accountability, the refusal to give the answers that
11 people fervently sought ... thoughtless repetition of
12 unjustified and misleading lines to take, and the lack
13 of any real recognition and of any meaningful apology."

14 The Public Office (Accountability) Bill, also known
15 as Hillsborough Law, currently making its way through
16 the House of Commons, has the objective to ensure that
17 public authorities, officials and those working for
18 public authorities at all times perform their functions
19 with candour, transparency and frankness. It will,
20 later this year, create a legal duty of candour, with
21 criminal sanctions for non-compliance.

22 Under this duty, public bodies and officials will be
23 required proactively and promptly, without fear or
24 favour of their own position, to make relevant
25 disclosure. Clause 11 will also create a new offence of

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1 you. Sharon in particular wants to thank a member of
2 the public who came to her immediately after she was
3 attacked, Melissa Austin.

4 Ms Austin's statement details how the incident she
5 witnessed has had a significant impact on her and how
6 her role and assistance has never been recognised by
7 the police. On behalf of the survivors, we acknowledge
8 and formally thank Ms Austin for all that she did, her
9 kindness and care. Sharon hopes one day to be able to
10 thank you in person.

11 Wayne wants to thank Headway Nottingham, the brain
12 injury association charity which has been invaluable in
13 helping him to adjust to his new life with an acquired
14 brain injury. Disclosure has revealed many other
15 victims of VC's violence and aggression failed by state
16 agents: Liam, Feven, Luke, Christopher, PC Pritchard,
17 Sebastian, the husband and wife team working at Arvato.

18 We ask that this Inquiry reminds the police of the
19 duty of candour as contained within the Code of Practice
20 for Ethical Policing which puts a responsibility on
21 chief police officers to ensure openness and candour
22 within their force. We ask health and social care
23 professionals, who are subject to the statutory and
24 professional duty of candour, to act in such a way when
25 coming to give evidence. We also remind all Inquiry

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1 misleading the public, which will apply where a public
2 authority or public official acts with the intention of
3 misleading the public and they know or ought to know
4 that their act is seriously improper.

5 To ensure that there is the fullest investigation
6 and understanding of all matters detailed in the Terms
7 of Reference of this Inquiry, we ask that you please,
8 Chair, make clear that you in your Inquiry expect
9 candour, transparency and frankness from all witnesses
10 and organisations at all times.

11 Tracey wants the police to be open and honest. In
12 her statement she details that in her first meetings
13 with DC Johal, the survivors' shared allocated Family
14 Liaison Officer, she was still extremely confused about
15 how these awful events caused by VC had been allowed to
16 happen. During an early meeting, she directly asked
17 DC Johal whether VC was known to the police prior
18 to June 2023 and was told he was not. Tracey now
19 clearly understands that this was not correct.

20 The acknowledgement in Nottingham Police's written
21 opening statement that there has been no dialogue with
22 the suspect -- with the survivors in respect of VC's
23 previous incidents is an acknowledgement that comes all
24 too late. It is also of concern to discover in the
25 disclosure that withholding of relevant information

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1 appears to be an issue considered at the highest level
2 of Nottingham Police. It is clear that by 15 June 2023
3 assistant Chief Constable Griffin had been provided with
4 a list of many previous police contacts with VC which
5 were on Nottingham Police's systems.

6 In January 2024, ACC Rob Griffin, in an email
7 exchange, can be seen approving what was to be
8 a timeline to be provided to journalists of police
9 contacts. It made no reference to the May 2020
10 incidents and adopted an approach regarding
11 the January 2022 incident which suggests a lack of
12 transparency and frankness.

13 He also approved, on 16 January 2024, an "only if
14 asked" press statement for the time of sentencing to
15 address if questions were asked about the warrant not
16 backed for bail issued by the court in September 2022,
17 which Nottinghamshire Police had failed to execute.

18 When read carefully, what is detailed in these
19 emails betokens an approach completely at odds with the
20 College of Policing's "Charter for families bereaved
21 through public tragedy" in many respects. We invite the
22 Inquiry to scrutinise this account provided during the
23 Inquiry with care, as the survivors believe this
24 suggests a force that was placing its own reputation
25 above that of the public interest and it misled the

1 policing response and regarding the events of
2 13 June 2023, which was said would constitute
3 an exhaustive examination of police processes, actions
4 and policies. This was suspended due to the IOPC
5 investigation.

6 Further still, the Theemis independent investigation
7 report details that the investigation tried on a number
8 of occasions to engage the Nottinghamshire Police, but
9 Nottinghamshire Police were unable to engage with the
10 review as they remained under investigation by the IOPC
11 in relation to the matters directly associated with the
12 Terms of Reference.

13 We encourage the Inquiry to read the Theemis Report
14 through that lense as it is clear that many of the
15 previous incidents involving the police are inadequately
16 addressed within the Theemis Report, including the
17 summaries in the report regarding the May 2020 incidents
18 and police involvement and contact.

19 Time must be taken during the Inquiry to examine
20 with care the command and control of the police response
21 on 13 June 2023. On Friday last week, the Inquiry
22 disclosed the statement of Inspector Peter Shaw who, on
23 13 June 2023, was on duty as the response policing
24 Inspector. His statement details that, where a serious
25 incident occurs, the RPI would be involved in

1 public. We look forward to the Inquiry examining what,
2 if anything, the police did do to execute the warrant
3 and locate VC after September 2022.

4 Throughout this Inquiry process, those who we
5 represent have had but one objective. That objective is
6 to achieve a thorough, fearless and critical examination
7 of all material which can answer the fundamental
8 questions of how VC, despite the knowledge and
9 information of so many individuals and organisations as
10 to his risk of violence and aggression and untreated
11 schizophrenia, failed to take actions to prevent the
12 attacks before 13 June 2023 and on the morning itself.

13 It will be for this Inquiry to find out why that did
14 not happen, for any organisation or person who fell
15 short of their duties and responsibilities to tell the
16 truth and share their knowledge and experience without
17 fear or favour, to ensure that every last drop of
18 learning is squeezed out.

19 Grace, Barney and Ian deserve nothing less.

20 On behalf of the survivors, we are concerned that
21 Nottinghamshire Police has not been subjected to
22 an independent and unbiased assessment of their response
23 on 13 June 2023. Crime Commissioner Caroline Henry
24 commissioned the College of Policing to conduct
25 an independent review into Nottinghamshire Police's

1 coordination of the initial response, liaising with and
2 tasking the sergeant to ensure key tasks are progressed,
3 liaison with colleagues in other police departments,
4 such as CID and crime scene investigation, to inform the
5 tasks. He became the Ground Bronze Commander. It is of
6 grave concern to read in his statement that at the time
7 of the incident there was a complete lack of training
8 for sergeants and inspectors in the role in general,
9 but, more pertinent to this incident, in major incident
10 training.

11 Further still, Inspector Shaw is not aware of any
12 set procedure or training in relation to who coordinates
13 the searches for suspects or high risk persons when they
14 are wanted in connection to an offence. He does not
15 remember any unambiguous direction or decision about who
16 would be coordinating the search for the suspect in
17 relation to this incident. This appears also to be the
18 position of Officer Speeden in his statement.

19 Inspector Shaw details that:

20 "the fact that all the incidents were being run on
21 different channels, as well as the firearm channel, was
22 a hindrance, but in my opinion one that is easily
23 avoided as to combine them would mean too much radio
24 traffic and updates would be missed. This is not ideal
25 for commanders but I cannot suggest a solution at this

1 time of writing." (As read)

2 Madam Chair, you will be aware that
3 Sir John Saunders, in November 2022, published the
4 second report in the Manchester Arena Inquiry in respect
5 of the emergency response that followed the terror
6 attack on 22 May 2017. All of the Inquiry reports
7 issued into this inquiry offer forensic analysis of what
8 went wrong in a way to inform all police forces and blue
9 light services of what is needed alongside clear
10 recommendations to be best prepared in critical, major
11 and Plato incidents.

12 From what has been seen and considered to date in
13 disclosure from Nottingham Police, they appear not to
14 have followed pertinent recommendations in respect of
15 every aspect of what is needed in a critical, major and
16 Plato incident, including recommendations as to
17 airwaves, talk group and communications, training,
18 control rooms and the requirements of command and
19 control needed to be undertaken by a force incident
20 manager or force duty officer. It is of grave concern
21 that Inspector Shaw, as the Ground Bronze Commander
22 tells you:

23 "If I had been made aware of the Operation Plato
24 declaration on the night, I do not think I would have
25 known my roles and responsibilities."

25

1 of significance.

2 Where VC attacked Grace and Barney was in eyesight
3 of Madison Court, Raleigh Park, at the junction of the
4 road. Here, in January 2022, VC had assaulted a student
5 called Christopher who he had shared accommodation with
6 and held him hostage.

7 VC was evicted from this accommodation but then
8 revisited it without permission and then trespassed
9 in February and April 2022. Ryan, another student who
10 was in the property at that time, describes one occasion
11 VC was caught by security trying to enter the building
12 dressed all in black and had a black backpack with him.

13 In VC's backpack on 13 June 2023 was a slip of paper
14 with the names of Christopher and two other students who
15 had been in the flat at the time. Christopher was
16 assaulted and taken hostage while inside. This piece of
17 paper suggests a worrying and potential motivation and
18 deep-seated resentment.

19 The survivors have always been concerned about VC's
20 trip to London over 11 and 12 June 2023. What is clear
21 from the sequence of events is that when VC travelled
22 back from his trip, having stayed at what is now known
23 to be a person of interest's accommodation, arriving
24 back into Nottingham just after midnight on
25 12 June 2023, VC, more likely than not, had the bag

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1 Madam Chair, this has significant implications for
2 Nottinghamshire Police's preparedness for a terror
3 attack. It is essential that this Inquiry forensically
4 examines this issue for the wider public protection of
5 the people of Nottingham.

6 Wayne wants to know why the police did not
7 neutralise VC's murderous rampage sooner. The police
8 should have realised, when they arrived on Ilkeston Road
9 at 4.08 am, and Grace and Barney were still fighting for
10 their lives, that their highly dangerous armed attacker
11 had only just left the scene and public protection
12 required every available police resource to be
13 strategically and tactically commanded, briefed and
14 utilised by way of a search strategy to find him.

15 Were police intelligence systems interrogated? The
16 survivors want to know if the police searched
17 intelligence systems quickly for any IC3 male with
18 a marker for unprovoked violence and with links to
19 addresses on Ilkeston Road, all of which VC had on his
20 police national computer record. Police systems show VC
21 had links to two addresses on 89 and 97 Ilkeston Road.
22 VC had also provided 209 Ilkeston Road as a discharge
23 address from hospital and his GP had recorded 109
24 Ilkeston Road. A search of police systems would also
25 have revealed VC's connection to other nearby addresses

28

1 containing the knives and scaffolding pole with him --

2 The survivors want to know who called VC at
3 01.56.48 hours and who called him less than ten minutes
4 before the attack at 03.51.25.

5 On 13 June 2023, having attacked Barney and Grace,
6 VC walked from Ilkeston Road to Brook Court, Player
7 Street, another address on the police systems. It is
8 clear also from the recordings that the police were
9 aware that he had turned left onto Hopedale Drive
10 heading towards that direction. Sharon wants to know
11 why the police did not block the van in before it was
12 used to strike her, and why the police did not take up
13 position in front of or blocking the van rather than, as
14 she witnessed, the blue lights and sirens in her opinion
15 encouraging VC's murderous attacks towards her.

16 Where were the firearms officers trained in driving
17 tactics and with firearms and special munitions, such as
18 tyre breaching rounds and CS gas? They could have been
19 there to protect Wayne and to stop VC long before he
20 used the van to hit Sharon again.

21 My Lady, the written opening statement on behalf of
22 the survivors details their view as to the failure to
23 follow the APP and the national decision model.

24 My Lady, for the interests of time, I will not go
25 through those matters, but the submissions make clear

28

1 that in the survivors' view there should have been
 2 an authorised firearm authority given far sooner.
 3 The statement that has now been disclosed by
 4 Officer Speeden, for which we thank him, now makes clear
 5 that he, too, believes that firearms authority should
 6 have been authorised. He details in his statement that
 7 he was asking for firearms authority even before his
 8 arrival on scene at 04.11 and after his arrival the
 9 Ilkeston Road at 04.12 he repeated his request. OC
 10 Speeden states that the foundation for a firearms
 11 authority was made out. He makes clear he wanted to do
 12 the job he was trained to do and his authorised firearms
 13 colleagues did too. He describes that:

14 "When deployed we are trained as a team in numerous
 15 tactics to safely deal with dangerous individuals."

16 He was annoyed on the day and tells us in his
 17 statement that he remains annoyed to this day as to why
 18 a firearms authority was not given at an early stage.

19 My Lady, our written submissions detail the factors
 20 that we ask in particular that this Inquiry has regard
 21 to. I will not go through these now, but I would
 22 encourage any of those to access the same through the
 23 website when they are published.

24 There are so many missed opportunities and failures
 25 revealed in the disclosure where, had individuals and

29

1 Inquiry, dated 17 February 2026, details that PC Johal
 2 now has no recollection of handing the letters. We hope
 3 this Inquiry establishes where the letters are, if there
 4 are in fact letters.

5 My Lady, finally, we thank the Inquiry for the
 6 arrangements made to create the pen portraits that will
 7 be played in court later today. These short videos
 8 capture the essence of the hard working, decent and kind
 9 people Wayne, Sharon, Tracey and Martin are. Each pen
 10 portrait provides a glimpse into the life changing
 11 injuries that have been sustained and the devastating
 12 ripple effects that have resulted to each one of them as
 13 a result of VC's murderous actions on 13 June 2023.

14 Participation in the Inquiry for the survivors will
 15 not be easy as a result of the physical, psychological
 16 and emotional impact VC's attacks have had on them.
 17 Attendance at the hearings comes with personal
 18 sacrifices. They are a long way from their homes in
 19 Nottingham, but Wayne, Sharon, Tracey and Martin are
 20 determined to participate in this Inquiry as they want
 21 the truth to come out. They want accountability for
 22 failings. They demand that all witnesses act with
 23 candour, transparency and frankness. Lessons must be
 24 learned. As residents of Nottingham they want to see
 25 meaningful change to ensure the police, healthcare and

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1 state agents followed appropriate processes and
 2 procedures, then each of the six attacks that VC carried
 3 out to kill and attempt to murder, we are clear, could
 4 have been prevented.

5 Aspects of disclosure have been very difficult for
 6 the survivors to read, with repeated insensitivities,
 7 references in documents to them as "walking wounded" who
 8 had second tier flow, victims who not only merit their
 9 own individual FLOs, but also were lucky to have one.

10 Wayne and Sharon want to know where the letters of
 11 condolence from the King, said by FLO Johal in her first
 12 statement to have been delivered on 3 July 2023, are.

13 The survivors are adamant these were never delivered
 14 and, for understandable reasons, they would like their
 15 letters from His Royal Highness King Charles III.
 16 Martin had been told by FLO Johal that the survivors
 17 would not be getting any letters from the King or any
 18 other member of the Royal Family, a comment at the time
 19 which she remembers, as it was particularly tactless.

20 If there were in fact letters, the insensitivity in
 21 not providing them with such significant letters, which
 22 would have given Wayne and Sharon great comfort, falls
 23 at the opposite end of the trauma-informed and
 24 victim-sensitive approach which FLOs are meant to
 25 deliver. A second statement now disclosed by the

30

1 mental health services make the necessary changes to
 2 ensure that a day like 13 June 2023 never happens again.
 3 The survivors want to see change so that these public
 4 services for the people of Nottingham are fit for
 5 purpose and operate always to keep the public safe.

6 Madam Chair, thank you.

7 **THE CHAIR:** Yes, Mr Straw.

8 Statement on behalf of VC's Family Group by MR STRAW KC

9 **MR STRAW:** Good morning.

10 Madam, these submissions are made on behalf of Valdo
 11 Calocane's mother and brother, Celeste and Elias.

12 This Inquiry arises from the horrific crimes
 13 committed by Valdo on 13 June 2023, when he killed
 14 Barney Webber, Grace O'Malley-Kumar and Ian Coates, and
 15 seriously injured Sharon Miller, Wayne Birkett and
 16 Marcin Gawronski.

17 Celeste and Elias wish to express their deep sorrow
 18 and condolences to the victims of Valdo's horrendous
 19 acts, the families of the victims and everyone else
 20 affected by those acts.

21 On the basis of the disclosure provided by the
 22 Inquiry so far, Valdo's family have a number of concerns
 23 about the conduct of the health services, the police and
 24 the University of Nottingham and the systems that were
 25 in place, and I will outline those concerns in a moment.

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1 However, his family remain open minded and would like to
2 explore all of this further in the oral evidence.

3 I will start with the health services and Valdo's
4 illness. Valdo had been diagnosed with paranoid
5 schizophrenia by numerous psychiatrists, starting on
6 31 July 2020. He had no history of mental health
7 problems earlier in life and had never been alleged to
8 be involved in crime.

9 He grew up in Portugal, having moved there from
10 Guinea-Bissau at the age of three, and has Portuguese
11 citizenship. He moved to the UK in 2007, aged 16, and
12 in 2020 was studying for a degree of mechanical
13 engineering at the University of Nottingham.

14 The triggers for him falling ill in or around 2020
15 appear to have been stress from university course work
16 and exams, sleep deprivation, isolation, the impact of
17 lockdown.

18 Expert psychiatrists considered it was not caused by
19 drugs. His blood was tested a number of times and was
20 always clear of illicit drugs.

21 Valdo's schizophrenia caused him to suffer from
22 a system of delusions, hallucinations and other symptoms
23 which led him to commit a series of acts of violence
24 against people or property. For example, on 24 May 2020
25 he twice tried to break down the door of neighbours'

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1 transmitting voices into his mind. This was apparently
2 one factor that led him to stop medication and to
3 disengage. Ms Birtles and Dr Sholiekova explained that
4 prior to the 3 September 2021 incident, Valdo suffered
5 "systemised delusions of conspiracy and persecution that
6 he was subject to psychotronic harassment orchestrated
7 by the health authorities." He said he knew the
8 clinicians would have to "feedback to higher powers", so
9 he was not willing to engage any further for treatment.

10 His illness also made him believe the delusions and
11 voices he suffered were real and he was not mentally
12 ill. This was another factor that led him to stop
13 medication. Dr Sholiekova explained: "He believed the
14 voices are transmitted to his mind by the authorities
15 and were not a symptom of mental disorder, hence he
16 stopped taking his antipsychotic medication."

17 There were a number of risk factors and signs that
18 his illness was relapsing that ought to have been
19 recognised. These factors arose before all or most of
20 each of the violent incidents and admissions to
21 hospital: first, not taking medication was considered to
22 be a critical risk factor; second, disengaging from the
23 health services; third, Valdo became particularly
24 guarded and suspicious; fourth, trespass and/or violent
25 behaviour; and a fifth factor may be strange or unusual

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1 flats, acting in response to hallucinatory experiences
2 of his mother screaming in pain, and voices telling him
3 she was being raped in those flats.

4 On 14 July 2020 he barged into a neighbour's flat
5 again because he heard unpleasant voices inside his head
6 coming from his neighbour's flat and believed someone
7 was in danger.

8 As to the 3 September 2021 serious assault, the
9 Mental Health Tribunal analysing the incident concluded
10 that:

11 "Valdo's delusions were sufficiently severe and
12 distressing so as to cause him to seriously assault
13 a police officer."

14 As a result, the Tribunal and others concluded that
15 when Valdo was unwell the risks to other people were
16 high.

17 The CQC explained that his risk of violence was
18 exclusively driven by his psychotic systems and
19 Dr Sholiekova noted that his actions will be driven by
20 the content of his delusionary beliefs and hallucinatory
21 experience, so it was very important that his illness
22 was properly treated and managed.

23 The symptoms of Valdo's schizophrenia included
24 paranoid and persecutory delusions that medical
25 professionals and others were conspiring against him,

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1 behaviour.

2 Valdo ought to have been placed on a Community
3 Treatment Order with a condition that he take depot
4 medication. Not taking medication was a critical risk
5 factor that led him to become psychotic and in
6 consequence to be a high risk of harm to others.

7 By late 2021 and 2022 it was clear that the symptoms
8 of Valdo's illness would lead him to stop taking
9 medication in the community unless compelled to do so.
10 The risks were such that a depot should have been
11 imposed whether or not Valdo liked it.

12 Dr Seedat had first explained the benefit of a depot
13 as long ago as 16 July 2020 to Valdo and Celeste and, in
14 reaction to this, on 20 July 2020, Celeste asked whether
15 the depot should be started. She did not raise the idea
16 of a depot herself independently.

17 It appears from the records that there was a failure
18 to provide other forms of treatment and management for
19 Valdo's schizophrenia, such as psychoeducation, contrary
20 to NICE guidelines. It was essential that this began
21 early when Valdo appeared more receptive. There is
22 evidence that this failure may have been due to systemic
23 problems, such as lack of resources and psychologists.

24 A linked problem is inadequate discharge planning
25 after hospital admission. It seems that there was

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1 a failure, particularly after the third and fourth
2 admissions, to bring together inpatient and community
3 teams with input from Valdo's family and identify
4 a robust plan to prevent him from relapsing. Again,
5 there's evidence that this was systemic. The Trust
6 discharge policy was vague and unfocused, for example.

7 Valdo's written risk assessment or crisis plans
8 should have clearly identified the risk factors, such as
9 the five that I identified earlier, and a plan for how
10 to respond to them. The purpose of this is perhaps
11 obvious, it was to ensure that it was clear to all staff
12 when he was relapsing. There was a failure to do this.
13 There were other flaws in the written risk assessments,
14 such as that it was not reviewed in July 2020 or prior
15 to discharge to the GP.

16 Further systemic problems are apparently linked,
17 including that the principles set out in the Royal
18 College of Psychiatrists 2016 guide to risk assessment
19 were not well integrated into the local or national
20 policy.

21 Madam, there were glaring signs that Valdo was
22 relapsing from early summer 2022. All of the risk
23 factors I mentioned were present. As to the crucial
24 risk factor, Valdo had stopped taking medication, he
25 disengaged, he was very guarded and suspicious and he

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1 his medication. She was heavily involved in his care
2 initially. She had around 100 separate contacts with
3 the health services about Valdo and gave them important
4 information about his condition on a number of
5 occasions. For example, she raised concerns of
6 a relapse shortly before both the 14 July 2020 and
7 3 September 2021 incidents, agreed the depot medication
8 and detention were appropriate and had an active role in
9 care planning.

10 Unfortunately, from October 2020, Valdo began to
11 disengage from his family and from September 2021, he
12 withdrew consent for medical staff to share confidential
13 information with them. This appears to have been driven
14 by his delusions that his family were under threat.

15 Valdo's family are concerned that they were not made
16 aware of important information about him until after
17 the June 2023 attacks. Examples are: (a) his diagnosis
18 of paranoid schizophrenia; (b) the risk he was
19 considered to pose to other people; (c) the extent to
20 which he was violent or aggressive, particularly in the
21 2021 and 2022 incidents; and (d) the decision to
22 discharge him after the third and fourth admissions, or
23 discharge to his GP; (e) a number of the worrying
24 incidents involving students at university; (f) the
25 warrant for his arrest issued in September 2022; and (g)

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1 exhibited strange or unusual behaviour. At least one
2 incident of trespass or violence, on 21 April 2022 at
3 Raleigh Park, was known by the health services. Key
4 protective factors had been lost, including that Valdo
5 had largely disengaged from his family and there was in
6 consequence a high risk of relapse into acute psychosis
7 with the associated high risk of serious harm.

8 There should have been an attempt to assess him and
9 if the team could not be satisfied that he was well and
10 genuinely taking his medication, he should have been
11 assessed for detention in hospital. Instead, the
12 opposite occurred. He was discharged to his GP. This
13 was disastrous as it meant that the assertive monitoring
14 and treatment, which his illness so clearly needed, was
15 entirely absent.

16 A number of other failures linked to discharge have
17 been identified by the CQC and others, including to
18 perform a face-to-face assessment and to liaise with
19 Valdo's family or the GP. Systemic failures have also
20 been suggested, including inadequate guidance about
21 disengagement and about discharge from the EIP team.

22 Valdo's family, particularly Celeste, were rightly
23 recognised by doctors to be an important protective
24 factor in Valdo's care. At times, in 2020, Celeste had
25 daily contact with Valdo, in part to prompt him to take

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1 the serious 5 May 2023 assault on his co-workers.

2 This all meant that Valdo's family were unable to
3 properly understand his illness, or his level of risk to
4 others, and to respond. Celeste explains that she had
5 no mental health training or experience, she was
6 a general nurse not a mental health nurse, but she says
7 that if she had known the full picture, the full risk,
8 she would have been much more vigilant for signs of
9 risk; for example, when he sent her the zip file of
10 documents in Christmas 2022.

11 Elias gives similar evidence. What Valdo said in
12 the zip file and to Elias on 12 June 2023 was, as far as
13 they understood it, the same sort of thing he had been
14 saying to them repeatedly for years and this is
15 illustrated by the messages from Valdo that Celeste sent
16 to Dr Seedat way back in May 2020.

17 In the absence of this further information, the
18 family could not have been expected to know the risk
19 Valdo posed to others at that time and perform any
20 protective role.

21 Valdo's refusal of consent to communication does not
22 constitute sufficient reason why his family were not
23 engaged with more, or indeed for other failures in
24 communication, both within health services and between
25 them and the other agencies. The schizophrenia

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1 diagnosis was first made in July 2020, long before he
2 declined consent, and should have been passed on at that
3 stage. Information can in any event be shared against
4 a patient's wishes, including where there is an
5 overriding public interest for sharing, or the patient
6 does not have capacity in respect of that issue.

7 This should have been assessed but was apparently
8 not. The CQC was right to criticise the level of
9 engagement with Valdo's family and to find that this was
10 a systemic issue.

11 Valdo's family are particularly concerned about
12 systemic flaws that have been revealed by the evidence
13 so far and to ensure that they are corrected, if
14 possible. I have touched upon some of them.

15 They also include chronic underfunding of
16 psychiatric services, lack of resources and staff and
17 insufficient in-patient beds in psychiatric hospitals.
18 More broadly, there appear to have been a failure by the
19 Trust to learn and make changes when flaws in their
20 services were identified by the CQC and in inquest
21 conclusions and we invite you, Chair, to investigate
22 why.

23 The next concern is communication between the Trust
24 and the University about Valdo. CTI rightly suggested
25 that there was an astonishing failure of information

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1 and to provide him with appropriate support and
2 management. So despite the tragic events of May
3 and July 2020, there was a period of about 17 months
4 between August 2020 and January 2022 when it appears
5 that there was little or no significant communication
6 between the University and Trust about Valdo.

7 In addition, with the exception of one email
8 in November 2020, there was apparently no attempt by
9 the University's mental health services to try to engage
10 Valdo. Although information between the University and
11 Trust resumed following the assault by Valdo on
12 Christopher in 2022, it was short-lived, yet Valdo
13 continued to study up until June of that year.

14 Valdo's family had very limited contact from the
15 University of Nottingham when Valdo was a student and
16 they had virtual actually no contact from any police
17 force about Valdo. There was a great deal of
18 information about Valdo's violence and other concerning
19 behaviour known by the police or university which was
20 not passed on to the family.

21 There are also concerns in respect of internal
22 communication within the University. So between
23 June 2020 and January 2022, it appears that there was no
24 communication between the University Mental Health
25 Advisory Service and Valdo's personal tutors and the

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1 sharing in this respect. It is inexcusable that
2 the University were unaware of the serious assaults by
3 Valdo on 3 September 2021 and his subsequent admission
4 until 18 January 2022.

5 You may think, Chair, that communication between the
6 two bodies was sporadic and reactive at best in response
7 to Valdo's risk when it presented rather than being
8 consistent and capable of properly managing his illness
9 and avoiding a relapse in mental health over the
10 longer-term.

11 The Inquiry will hear that university witnesses were
12 critical of the Trust's failure to share information
13 with them about Valdo. We invite you to examine these
14 criticisms but also to consider whether there was
15 a failure by the University to proactively seek out
16 relevant medical information about Valdo and whether
17 there were adequate systems in place to ensure proper
18 communication.

19 These inadequacies were problematic for a number of
20 reasons. They meant that the Trust did not become aware
21 of information known to the University about Valdo's
22 illness and risk which could have impacted upon his
23 treatment and management, but it also meant that
24 the University did not have the information it needed to
25 keep other students safe, to understand Valdo's illness

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1 first time that academic staff supervising Valdo were
2 given any information that he was seriously mentally
3 unwell and posed a risk was on 31 January 2022, so far
4 as the documents indicate.

5 As a result, Valdo's tutors were apparently not in
6 a position to identify signs that he was becoming
7 unwell.

8 Chair, I refer in particular to the comments made by
9 Valdo's tutor, Dr McWilliam, in his witness statement.
10 He states:

11 "In general, I think I should have known about the
12 severity of the situation. The reason I think I should
13 have been given this information is so that I could have
14 supported Valdo in the best way possible."

15 We invite you to consider, Chair, whether
16 the University's Mental Health Advisory Service was
17 sufficiently involved in Valdo's care. For example,
18 no one seems to have properly considered whether Valdo
19 returning to university and study in 2021 was advisable,
20 given his illness and risk, nor what protections and
21 support should have been put in place.

22 In October 2021, Valdo moved into accommodation at
23 Raleigh Park with other students. If the Trust and
24 University had been properly working together, would
25 this really have been considered appropriate?

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1 Ellie Turner recognised in 2020 that when Valdo
2 first became unwell that it was important for
3 the University to think about his wellbeing alongside
4 his studies, but when Valdo disengaged from that service
5 there does not appear to have been consideration of
6 whether this was because he was unwell, nor any attempt
7 by the University to obtain further information or
8 assistance from the Trust.

9 The evidence before the Inquiry suggests that stress
10 from university coursework and exams may have
11 exacerbated Valdo's mental health. It is not clear that
12 this was properly appreciated by the University or, if
13 it was, whether appropriate steps were put in place to
14 respond to it.

15 There were various difficulties during Valdo's time
16 at university, such as the interruption of studies
17 between November 2020, September 2021, transfer from
18 masters to a bachelors and finishing his degree. This
19 was clearly a time of high stress and communications
20 with his tutors recognised he was struggling, but it
21 does not appear that any thought was given to what
22 impact this would have on his illness.

23 The University apparently set up the report and
24 support platform in September 2021 to allow students
25 off-campus to report incidents of harassment, abuse and

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1 on his way by officers who knew nothing about his mental
2 health history, apparently, and the Trust remaining
3 ignorant of this incident?

4 We ask you, Chair, to examine whether
5 the University, the Trust and the various police forces
6 involved should have worked together in a more joined up
7 way so that they all had a holistic understanding of
8 Valdo's illness and risks. The family ask you to
9 consider whether there should have been robust means of
10 information sharing, including multi-disciplinary
11 discussions within and between the various bodies
12 involved.

13 Chair, in conclusion, at this stage it appears that
14 this tragedy was preventable. Valdo's risk came
15 exclusively from his schizophrenia and the evidence
16 suggests that effective treatment and management could
17 have controlled his illness and addressed his risk. To
18 try to prevent it happening again, Celeste and Elias
19 invite you, Chair, to do all you can to obtain
20 a complete and accurate understanding of what went wrong
21 and on that foundation to identify what changes should
22 be made to try to avoid something like this happening
23 again.

24 **THE CHAIR:** Thank you. Ms Patry.

25

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1 assault, yet it appears that some of the incidents, when
2 Valdo behaved in a worrying or aggressive way towards
3 other students, were not reported through this and we
4 invite you to explore if this could have worked better.

5 Turning to the police, it appears that there was
6 a failure to link ongoing criminal complaints about
7 Valdo together and to put them in the context of his
8 mental illness. There should have been a system which
9 ensured that police dealing with each new complaint were
10 aware of previous instances and of Valdo's mental
11 illness and dealt with each incident properly in that
12 context. There appears to have been an almost complete
13 breakdown in any such system.

14 It is of major concern to Valdo's family that
15 several violent or concerning incidents involving Valdo
16 in 2021, 2022 and 2023, the existence of the warrant
17 issued in September 2022, were not communicated by
18 the police to the Trust, the University or to Valdo's
19 family.

20 The 5 May 2023 assault was very serious and should
21 have led to an assessment by clinicians for detention
22 under the Mental Health Act. Instead, there was no
23 medical input at all.

24 Similarly, how was it that Valdo could turn up and
25 ring the bell at MI5 asking to be arrested but be sent

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1 Statement on behalf of the University of Nottingham by
2 MS PATRY KC

3 **MS PATRY:** Madam Chair, I make these submissions on behalf
4 of the University of Nottingham.

5 The University wishes to begin this opening
6 statement by offering its profound sympathy and
7 condolences to the families and friends of
8 Grace O'Malley-Kumar, Barney Webber and Ian Coates as
9 well as the survivors of the tragic attacks of
10 13 June 2023, Sharon Miller, Wayne Birkett and
11 Marcin Gawronski, and to their families and friends.

12 The University of Nottingham appears before this
13 Inquiry both deeply saddened by the events which took
14 place and in a unique position, given that it has been
15 affected in more than one capacity by the offence that
16 the Inquiry must consider.

17 As the Inquiry will know, the University lost two
18 members of its own community, Barney and Grace, two
19 students whose lives were taken in the most tragic and
20 senseless circumstances.

21 Wayne Birkett's partner, whose life as well as his,
22 has changed irrevocably, is also a valued member of the
23 university staff. At the same time, it is also a matter
24 of fact that the perpetrator, VC, had previously been
25 a student of the university.

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1 The University recognises the gravity of that
2 duality. It acknowledges the pain experienced by the
3 survivors, family, friends and its wider community and
4 it approaches this Inquiry with openness and
5 a commitment to assist fully. The University's aim is
6 to ensure that the Inquiry has a full, clear and
7 accurate understanding of the chronology of its material
8 interactions with or about VC while he was a student, to
9 reflect candidly on these and to contribute
10 constructively to any learning arising out of the
11 Inquiry.

12 The University has worked tirelessly to provide the
13 Inquiry with all the information and evidence it can to
14 assist in achieving its aims.

15 This week the Inquiry will hear from several
16 witnesses on behalf of the University of Nottingham,
17 starting tomorrow, and those witnesses are here to
18 assist you in any way that they can.

19 I am going to deal first with the University of
20 Nottingham community, if I may. As the Inquiry will be
21 aware, both Grace and Barney were first year students at
22 the University. The loss of two of our students at
23 a formative time, just as their independent lives were
24 only just beginning to take shape, was and remains
25 devastating to the University. The University of

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1 both yesterday and today.

2 As its name suggests, the University's Mental Health
3 Advisory Service is that, just that, an advisory
4 service. It does not diagnose, assess or treat mental
5 illness. The University of Nottingham does not hold
6 risk or formally assess risk. That is for the statutory
7 services.

8 Turning to the chronology, VC was a student at the
9 University of Nottingham between September 2017
10 and July 2022. That means that VC left the University
11 and had no further contact with it approximately a year
12 before the tragic events took place. In very summary
13 terms only, with detailed chronologies appearing in the
14 witness evidence, the relevant facts relating to VC and
15 his time at the University are as follows.

16 Firstly, VC started studying at the University for
17 a Bachelor of Engineering in September 2017. During the
18 summer between his second and third years, he
19 transferred to a Master of Engineering course, but, as
20 far as the University is aware, VC did not have any
21 academic or pastoral issues in his first two years of
22 university at all.

23 In March 2020, as a result of the COVID pandemic,
24 teaching across the University moved online. Most
25 students returned home, VC did not.

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1 Nottingham community continues to be very significantly
2 affected by their deaths. The Inquiry is asked to note
3 that some contemporaries of Grace and Barney's are still
4 at the University or have connections with
5 the University. As has been explained, the partner of
6 one of the victims is employed at the University.

7 As a result, the Inquiry will no doubt recognise
8 that many people at the University, both students and
9 staff, will be significantly affected by the fact that
10 the Inquiry is starting its important work and as
11 a result the University has offered ongoing wellbeing
12 support to all its staff and students. That support has
13 been offered both in the immediate aftermath of the
14 attacks and on an ongoing basis.

15 The University seeks to support those who continue
16 to grieve and be affected both by what occurred and also
17 by the rehearsing of events that will follow as a result
18 of the Inquiry commencing its work. The University
19 remains, Madam Chair, a community in mourning.

20 I will deal, secondly, with the background and
21 chronology. The University's statutory and practical
22 function is educational, to deliver higher education and
23 to support students in the pursuit of learning.

24 If I may, I will say a word about the University's
25 Mental Health Advisory Service, which has been mentioned

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1 On 29 May 2020, VC's mother contacted the University
2 to inform two of VC's academic tutors that he had been
3 admitted to a mental health ward as a result of a
4 psychotic episode and would therefore not be able to
5 take an online exam on 2 June 2020. This was the first
6 time, I make it clear, that the University was aware of
7 VC having any mental health problems.

8 The University was not made aware that in the days
9 preceding his admission a number of concerning incidents
10 related to VC's mental health had occurred at his
11 accommodation, Brook Court. Brook Court is privately
12 owned, is unconnected to the University and did not, as
13 far as the University is aware, house any other
14 university students. The University did not become
15 aware of an incident at Brook Court until 3 June 2020,
16 and then only because the University's Mental Health
17 Advisory Service, MHAS, upon becoming aware of his
18 admission contacted the hospital proactively and spoke
19 to VC's doctor. When VC was eventually discharged on
20 17 June 2020 the University was simply not made aware of
21 the date or the details of that discharge.

22 On 13 June 2020 VC was detained by the police after
23 a further incident at Brook Court and was re-admitted to
24 hospital. Again, the University was not aware of that
25 contemporaneously. MHAS liaised continuously with the

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1 NHS once it became aware of VC's admission, expressing
2 concerns in due course about the discharge plan, given
3 what it knew at the time of the incidents which had
4 taken place at Brook Court. VC was discharged on
5 31 July 2020 and was reluctant to engage with support
6 offered by the University.

7 In early November 2020, the University signed off on
8 a Voluntary Interruption of Study requested by VC
9 himself, and VC was accordingly not a registered student
10 at all between 4 November 2020 and September 2021.
11 During his Voluntary Interruption of Study, further
12 incidents took place in private accommodation
13 in July 2021 involving a university student studying for
14 a PhD, Sebastian. The police did not disclose these
15 incidents to the University contemporaneously, and in
16 fact the University did not become aware of the full
17 detail of these incidents until the University received
18 disclosure as part of this Inquiry.

19 As the Inquiry is aware, prior to his return from
20 his Voluntary Interruption of Study in September 2021,
21 VC had assaulted a police officer who attended his
22 accommodation on 3 September 2021 in order to execute
23 a warrant for a Mental Health Act assessment.
24 The University did not become aware of the details of
25 this incident until, this is important, 18 January 2022

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1 reported by the students, the University remained
2 completely unaware of the fact that VC had relatively
3 recently been sectioned, in September and October 2021,
4 that the assault on the police officer had taken place
5 in September 2021, and that he was currently disengaging
6 from community treatment, simply unaware of those
7 factors.

8 Further, despite attending the incident on
9 15 January 2022 as described, the police did not inform
10 the University of either that incident or the
11 police officer assault, or VC's sectioning, despite the
12 fact that it appears they had flagged him, prior to
13 attending the incident, as capable of being extremely
14 violent.

15 After the University's MHAS became aware of the
16 accommodation incident it put two and two together and
17 contacted the NHS and became aware of the police officer
18 assault and VC's admission. The NHS also informed
19 the University's MHAS that they had concerns about VC
20 because his engagement was poor. He had not attended
21 five appointments and had run out of medication, and
22 immediately on becoming aware of this information
23 the University took the decision that VC's flatmates
24 must be moved from their private accommodation.
25 The University worked with the third party accommodation

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1 and even then they were not aware of the full details.

2 VC was subsequently sectioned on that same date and
3 remained in hospital until 22 October 2021.

4 The University simply did not know contemporaneously of
5 VC's admission, only discovering limited details of this
6 on 18 January 2022.

7 During his time in hospital, VC was periodically in
8 correspondence with the University regarding the
9 resumption of his studies and even visited
10 the University on one occasion whilst on section 17
11 leave from the hospital. He told the NHS that it did
12 not need to contact the University on his behalf and he
13 did not disclose his admission to the University before
14 restarting his studies.

15 VC moved into Raleigh Park in late October 2021. It
16 should be noted that Raleigh Park is third party
17 non-university off-campus student accommodation,
18 although some residential experience services are
19 provided to it, and VC's flatmates were university
20 students.

21 On 15 January 2022, a Saturday, an incident occurred
22 at a flat in Raleigh Park during which VC placed
23 a student flatmate in a headlock and subsequently
24 prevented him from leaving, prompting him to call
25 the police twice. At the time when this incident was

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1 provider and within hours VC's flatmates had been
2 removed from the accommodation.

3 On 11 March 2022, VC confirmed to the University
4 that he would like to transfer to the BEng degree which
5 would allow him to graduate that year while only
6 completing one final report.

7 Between May and June 2022 he liaised with academics
8 to finalise his report, and in July 2022 he graduated
9 and left the University. The University had no further
10 contact with or about VC after providing him with
11 a transcript in August '22.

12 This summary is simply that, a summary. However,
13 the University has comprehensively reflected on the
14 actions it took and, as the Inquiry is aware, has now
15 provided to the Inquiry a very detailed chronology of
16 events which I understand will be published on the
17 Inquiry website today. It has disclosed to the Inquiry
18 all relevant documents which it has been able to obtain,
19 and overall, having undertaken that period of
20 reflection, it is satisfied that its members of staff
21 within the University community acted proactively within
22 the frameworks available to them and in line with the
23 information available to them at the relevant times, and
24 were always motivated by a desire to support student
25 welfare.

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1 In fact, as I hope we will see, in many cases
2 members of staff worked tirelessly to obtain relevant
3 information to query decisions made by statutory bodies
4 and to receive and provide as much information as
5 possible, with the twin aims of supporting
6 the University community and within the confines of its
7 powers supporting VC who was plainly very unwell at
8 times.

9 The Inquiry is also asked to note the context of all
10 this. Universities were operating during COVID which is
11 a unique and highly challenging period that had
12 a significant impact on the University community,
13 marked, as it was, by public health restrictions and
14 rapid, enforced changes to provision among other things.

15 The University has observed in the evidence
16 submitted by other parties to the Inquiry that VC
17 experienced distress as a result of isolation during the
18 pandemic period and that in many respects, in fact, his
19 attendance at the University provided a protective
20 influence for at least part of that time.

21 I deal, thirdly, with the changes made.
22 The University has made some changes since VC was
23 a student at the University and you will hear all about
24 those. In accordance with good governance and its aim
25 of always improving student experience, it has continued

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1 not made aware of incidents involving VC, including
2 periods when he was in hospital, or of relevant
3 discharge dates. At times, this reflected gaps in
4 information sharing by the statutory authorities or
5 agencies, and at other times it was due to VC's own
6 decision not to disclose information to the University.

7 As such, we have concluded that it would be
8 beneficial to have mechanisms where national information
9 sharing so that agencies like the NHS and police could
10 have standardised information sharing processes across
11 Trusts and universities. There have been discussions
12 between the University and the local NHS Trust, but any
13 agreement reached as a result would not be
14 a comprehensive solution given that it would not apply
15 to other NHS Trusts or to private providers, and it is
16 noted that VC spent at least some time also in private
17 hospitals.

18 It would also be beneficial for there to be a better
19 understanding about the respective roles of NHS
20 community services and university support services. As
21 I said earlier, the University's role is limited. Its
22 purpose is to deliver higher education and to support
23 students in the pursuit of learning, it is not
24 a statutory service.

25 There are also legal restrictions and complexities

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1 to refine and adapt its policies and processes, but any
2 changes have not been made as a direct result of the
3 attacks themselves. The University has set out the
4 details of changes in the evidence of
5 Professor Katherine Linehan, but the university does not
6 take the view that any of the changes made would have
7 had an impact on the devastating attacks which took
8 place.

9 The University has not, on the basis of the
10 information it has at present, identified anything
11 related to the University's dealings with VC which could
12 have altered the course of his subsequent relapse and
13 extreme violence.

14 I deal, finally, with preliminary thoughts for
15 recommendations.

16 In the aftermath of the attacks and throughout the
17 process of preparing for this Inquiry, the University
18 has undertaken careful reflection on its interactions
19 with VC as well as its interaction and engagement with
20 the NHS and the police, all of whom had contact with him
21 during his time as a student. The reflection has
22 encompassed both the actions taken at the time and the
23 wider context in which the decisions were made.

24 As set out in the witness evidence provided on
25 behalf of the university, the University was frequently

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1 around what information the University support services
2 can and should share with other university services,
3 including academics and the families of students,
4 particularly given data protection requirements, privacy
5 considerations and the need to avoid any potential
6 stigmatisation of students with mental health
7 difficulties.

8 As we made clear in witness evidence, the central
9 concern is around obtaining clarity as to the various
10 roles and responsibilities of various bodies, what
11 information can and should be shared, both externally
12 and internally, to universities. At the moment, we are
13 being asked to navigate a relatively ambiguous framework
14 around information sharing with all relevant
15 statutory bodies.

16 In broad terms, we would welcome recommendations
17 with clear national protocols and guidance endorsed by
18 the Information Commissioner's office to enhance both
19 multi-agency collaboration and information sharing, as
20 well as the sharing of relevant information within
21 the University, particularly in relation to student
22 mental health.

23 It is acknowledged that this is a complex area and
24 may have significant resource implications. However, as
25 noted, following a detailed review of all the actions of

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1 all staff that had material interactions with VC,
2 the University is satisfied that the staff acted
3 proactively and with positive intent. It is proud of
4 the professionalism demonstrated by its staff, many of
5 whom went beyond the requirements of their roles, by
6 asking questions, challenging decisions, requesting
7 relevant documents and seeking information whenever
8 necessary to support VC and the wider university
9 community.

10 With the benefit of hindsight, Madam Chair, the
11 Inquiry is well placed to examine in detail what
12 occurred and why. It is of the utmost importance to
13 the University that this process identifies lessons that
14 can and will be learned. The University's overriding
15 aim in taking part in this Inquiry is to obtain clarity
16 and to learn all the lessons it can from such scrutiny
17 and to make changes where appropriate.

18 This Inquiry offers all of us the best chance to
19 approach the issues before the Inquiry with an open mind
20 and the best information possible. We, therefore remain
21 steadfast in our dedication to supporting the Inquiry's
22 vital work. Thank you.

23 **THE CHAIR:** Thank you, Ms Patry. I think we will take
24 a break now -- a short break -- until quarter to 12.
25 Thank you.

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1 their reasonable best to manage VC's interactions with
2 law enforcement between those dates. Nottinghamshire
3 Police had 10 to 11 such interactions, depending on how
4 you count them, mostly responding to relatively
5 low-level complaints of anti-social behaviour by VC
6 and/or requests to support the NHS at section 135
7 warrants.

8 Two incidents involved injury to third parties, that
9 is the second incident on 24 May 2020 and 15 months
10 later to PC Pritchard in September 2021. Even those two
11 incidents, though unpleasant and anti-social, did not
12 reasonably herald to Nottinghamshire Police that VC
13 would become a triple killer.

14 We do not seek to diminish VC's behaviours, but
15 language and precision is important.

16 There is no evidence that VC intended Feven's
17 undoubtedly serious injuries. They were caused by her
18 understandable fear as to what the unknown male on the
19 other side of the door might do to her, but not by VC
20 applying any force directly to her. But may I make
21 clear that Nottinghamshire Police ought to have
22 investigated that offence properly and to have provided
23 a file to the CPS.

24 PC Pritchard's injuries, though unpleasant and
25 unjustified, were minor and sadly not unusual for

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1 (11.32 am)

2 (Short Break)

3 (11.46 am)

4 **THE CHAIR:** Yes, Mr Beggs.

5 Statement on behalf of Nottinghamshire Police by MR BEGGS KC

6 **MR BEGGS:** Madam Chair, as you know, I appear for
7 Nottinghamshire Police.8 I repeat on behalf of my client sincere and
9 heartfelt condolences to the families and the friends of
10 Grace O'Malley-Kumar, Barney Webber and Ian Coates, and
11 sincere sympathies to Wayne Birkett, Sharon Miller,
12 Marcin Gawronski and their families and friends.13 Our approach to this Inquiry. Nottinghamshire
14 Police has endeavoured earnestly from the very
15 announcement of the Inquiry to adhere to the spirit and
16 letter of the Charter for Families Bereaved through
17 Public Tragedy and to ensure maximal disclosure to the
18 Inquiry.19 All Nottinghamshire Police personnel who give
20 evidence understand the importance of candour and
21 assisting the Inquiry rather than trying to defend
22 themselves or the constabulary.23 Nottinghamshire Police interactions with VC
24 between May 2020 and August 2022. The provisional view
25 of Nottinghamshire Police is that its personnel did

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1 police officers in the course of their ordinary duties.
2 Sadder still, it is the experience of frontline
3 police officers that the courts generally do not
4 imprison such assailants.5 VC's flatmates were not injured by him, nor did he,
6 in any conventional sense, hold anyone hostage. Sadly,
7 these incidents were not in any way unusual or
8 remarkable for the police to have to deal with, but may
9 I underscore that Nottinghamshire Police is open minded
10 as to recommendations concerning an accumulation of such
11 incidents and relevant information sharing flowing
12 therefrom.

13 The failure to appear warrant.

14 Nottinghamshire Police should have executed that
15 warrant issued by the magistrates on 22 September. They
16 should have done so in a timely manner, but they failed
17 to do so at all.18 The Temporary Deputy Chief Constable Griffin
19 described that failure in his statement as "a serious
20 systemic, operational failure on the part of
21 Nottinghamshire Police". He recognised the seriousness
22 of what happened, or rather what didn't happen, and the
23 distress it caused. He offered, and we repeat,
24 an unreserved apology to the families of the deceased
25 and the survivors. It was Mr Griffin's intention that

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1 this particular information be shared with the families
2 quickly, and until January of 2024 he thought it had
3 been. That it had not was another failure.

4 However, we invite the Inquiry to tread carefully on
5 the counterfactual of what might have happened had the
6 fail to appear warrant been executed in a timely manner.

7 Given VC's illness at the time of the index offence,
8 we ask is it realistic to suppose that the CPS would
9 have maintained the prosecution, that the courts would
10 have refused bail, that VC would have been convicted, or
11 imprisoned? We respectfully suggest not, but we
12 understand why the bereaved and survivors are concerned
13 by the failure to execute the warrant, and I repeat: we
14 do not seek to defend that failure.

15 Nottinghamshire Police's response to the attacks.
16 As is plain, we hope, from the harrowing body-worn video
17 footage from responding officers, police personnel did
18 their best to render first aid to Barney, Grace and Ian.
19 The deployment of higher trained ARV officers in
20 Ilkeston Road for that purpose was, with respect,
21 appropriate. When officers attended on Ian Coates, they
22 provided constant and appropriate CPR until the
23 paramedics took over his management.

24 Tragically, the evidence considered to date
25 indicates that all three victims of these stabbing

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1 The responses of Nottinghamshire officers ensured
2 the arrest of VC on Bentinck Road at 05.35, thereby
3 preventing further death or injury.

4 Communications with the bereaved and the survivors
5 after the attacks.

6 In relation to three matters: first, the extent of
7 previous interactions between the police and VC; second,
8 the fact of the long outstanding fail to appear warrant;
9 and third, that a number of Nottinghamshire Police
10 personnel misconducted themselves after the attacks, the
11 bereaved and the survivors were entitled to clear,
12 consistent and timely briefings from Nottinghamshire
13 Police and for different reasons they did not receive
14 this. Nottinghamshire Police does not seek to defend or
15 justify those communication failures for which sincere
16 and unreserved apologies are proffered.

17 However, it is simply not correct to suggest or
18 imply that Nottinghamshire Police tried to cover these
19 matters up, whether to the bereaved, the survivors or
20 indeed the general public.

21 The failure of Nottinghamshire Police to advise the
22 bereaved and survivors in a coherent, clear and timely
23 manner of the relevant misconduct by PC Gell, Special
24 Constable Skenderaj and Sarah Rutherford(?) was
25 a serious and unacceptable failure by Nottinghamshire

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1 attacks were beyond salvation, "unsurvivable" as
2 Mr Justice Turner said in respect of Grace and Barney.

3 What about Nottinghamshire Police's efforts to
4 apprehend VC after the attacks on Grace and Barney?
5 Whilst lessons always can and must be learned, this is
6 an example where hindsight reasoning as to how VC might
7 have been caught can be unsafe.

8 Given what we now know about VC's movements, and
9 given the resources then available, it is not, with
10 respect, realistic to suppose that Nottinghamshire
11 Police could have prevented the killing of Ian Coates,
12 or the terrible attacks upon Wayne, Sharon or Marcin.

13 Members of the public reported VC making towards the
14 city after the Ilkeston Road attacks. That proposition
15 was apparently reinforced by the reports of a female
16 screaming in the cathedral area. In fact, we now know
17 VC did not continue towards the city but took an
18 apparently random route towards Seely Hirst House and
19 then Magdala Road.

20 At the time, Nottinghamshire Police couldn't know
21 what mode of transport he was using. It may be that
22 you, Madam Chair, will wish, with CTI, to retrace VC's
23 steps via the fixed camera sightings so as to better
24 appreciate the density of the housing and the number of
25 junctions, blocked off roads and alleyways.

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1 Police for which again sincere and unreserved apologies
2 are proffered through me, the then Chief Constable
3 having done so herself in correspondence in February of
4 2024.

5 However, it is equally clear that Nottinghamshire
6 Police took the misconduct of PC Gell, Rutherford and
7 Special Constable Skenderaj very seriously, since all
8 three faced gross misconduct proceedings. Indeed, the
9 officer and the civilian were arrested by my client.
10 The special constable was subject to fast-track
11 proceedings, and on 11 December a declaration made that
12 he would have been dismissed had he not already resigned
13 and he was placed on the barred list.

14 Rutherford was dismissed and the police constable
15 was given a final written warning by a panel chaired by
16 an independent legally qualified chair.

17 The decision by the CPS to accept pleas to
18 manslaughter on the grounds of diminished responsibility
19 was for them and their counsel. As you know, Madam,
20 Nottinghamshire Police has no direct role in that
21 decision, but we do not suggest that it was the wrong
22 decision given the state of the expert evidence.

23 The failure of the SIO to require VC to give head
24 hair samples is an oversight that he has admitted in his
25 statement, but this is not, we say with respect,

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1 an error that made any material difference to the
2 appropriateness of the manslaughter pleas.
3 Can I turn please to the risks to society from some
4 paranoid schizophrenics. Nottinghamshire Police share
5 the concern of the bereaved and the survivors that
6 32 years after the Clunis Inquiry things do not seem to
7 have changed or improved. Paranoid schizophrenia is not
8 a condition that police officers or staff are trained or
9 equipped to manage. The police service can only manage
10 sufferers of this dreadful condition on a case-by-case
11 basis as manifestations of illness present, sometimes as
12 anti-social behaviour or criminality.

13 Society's answers to these public safety risks posed
14 by some paranoid schizophrenics lies principally not
15 with the police but with the NHS and other clinical
16 services where judicious use of the mental health
17 legislation may be required, but the police service and
18 Nottinghamshire Police recognises that it may have
19 a useful function to perform in sharing information to
20 better inform psychiatrists' risk assessments.

21 It will be for the treating psychiatrist and other
22 healthcare witnesses in this Inquiry to explain why they
23 repetitively released VC between May 2020
24 and September '22 without depot injections or adequate
25 monitoring. Something plainly went wrong with the

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1 ill away from ill-equipped and undertrained
2 police officers, to the expert domain of mental health
3 practitioners who are better equipped and skilled to do
4 so.

5 "Right Care, Right Person" was launched by the
6 National Police Chiefs Council in July 2023 and is one
7 of the main manifestations of that effort. It is a very
8 necessary protocol if the police are not to be drawn
9 away from their core functions of the prevention of
10 crime, apprehension of criminals, maintenance of public
11 safety.

12 Right Care, Right Person was not launched because
13 the police seek to evade their responsibilities to save
14 life and limb, but because the police are plainly not
15 the correct agency to manage and treat the mentally ill,
16 save in circumstances of imminent risk to life.

17 Madam, may I conclude by identifying that from
18 herein after our involvement in this Inquiry is designed
19 first and foremost to assist you and your counsel
20 discharge the Terms of Reference and answer the
21 legitimate questions of the bereaved and the survivors,
22 and is designed not to cause any further distress to the
23 victims of VC's appalling crimes.

24 Madam, thank you.

25 **THE CHAIR:** Thank you. We will rise now and start again at

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1 psychiatric risk assessments, and Nottinghamshire Police
2 respectfully queries whether the balance between the
3 personal autonomy of those suffering serious mental
4 illness and wider public safety has shifted too far in
5 the direction of the former.

6 Hindsight wisdom.

7 It is always difficult at inquests or Public
8 Inquiries into tragic events to avoid hindsight
9 reasoning, but the endeavour is required. Any
10 counterfactual, such as what would have happened had
11 Nottinghamshire Police executed the warrant, must be
12 examined with forensic and factual rigour and on the
13 basis of evidence rather than speculation.

14 Information sharing.

15 Nottinghamshire Police will welcome any
16 recommendations from the Inquiry which improves
17 information sharing between relevant public bodies.

18 The Police Service, especially in its junior ranks,
19 is often inhibited by perceptions or fears as to
20 possible breaches of Article 8 or GDPR, but any such
21 recommendations from you, Madam Chair, must not, we
22 respectfully ask, draw the police away from its core
23 duties of preventing crime and apprehending criminals
24 and you will know that in the last few years the Police
25 Service has sought to refocus the care of the mentally

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1 2 o'clock, please. Thank you. Sorry, I thought it was
2 5 past 1. Time does pass quickly, doesn't it?

3 Thank you. We will have Mr Davies.

4 Statement on behalf of Leicestershire Police Officers by
5 MR DAVIES KC

6 **MR DAVIES:** Madam Chair, on behalf of Police Constable
7 Libbie-Mae Taylor, Police Constable Connor Amos-Perkins
8 and Police Sergeant Mark Read, all officers with
9 Leicestershire police, to the families of those that
10 died, to those that survived VC's murderous attacks, to
11 their friends and families, we say sorry, sorry for what
12 you have endured, sorry for what you are enduring and
13 most importantly in terms of the recognised operational
14 failures by each of these three officers I represent in
15 the narrative of events, sorry for that.

16 Where do they fit in the long narrative of events?
17 In the early evening of 5 May 2023, two Leicestershire
18 police officers were on routine patrol in a response
19 car. One was PC Connor Amos-Perkins, an officer with
20 approximately three years' experience. The other was PC
21 Libbie-Mae Taylor, an officer on the fast-track
22 detective programme but who was only on her 12th
23 operational shift as a probationary constable. PC
24 Amos-Perkins was her tutor constable and had performed
25 this role before with success.

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1 At 17.55 the two officers were assigned to attend
2 a reported incident at the Arvato warehouse in Kegworth.
3 They responded as an emergency and arrived at 18.13. In
4 headline terms, the allegation was that two members of
5 staff had been assaulted by an agency worker. No one
6 matching that agency worker's physical description was
7 seen as the officers travelled to the warehouse, and he
8 was reported to have been escorted from the premises
9 when they arrived at the address.

10 The detail of what was reported to the officers at
11 the scene and the actions they took will be of course
12 explored in evidence.

13 Applying the national charging standards and
14 recognising how unpleasant the assault would have been
15 for those suffering it, objectively the level of injury
16 suffered by the two victims was consistent with assault
17 by battery, or assault occasioning actual bodily harm at
18 most. No weapon had been used. The agency worker's
19 identity was not fully known to any member of staff at
20 the warehouse. The name "Val Mendez" was provided.
21 Checks had been made on police systems under this name
22 prior to the officers' arrival. No history was shown.

23 A decision was taken by the officers to obtain
24 witness statements at a later date using independent
25 interpreters. Basic details were taken. CCTV was

1 did not click through or review the pages on NICHE to
2 see what other information was known about VC. As you
3 are aware, we are awaiting the attempted reconstruction
4 of the NICHE database, an important piece of evidence.

5 Had she done so, the fact he was subject to an
6 arrest warrant by Nottinghamshire Police for an alleged
7 assault of an emergency worker, namely a police officer
8 acting under section 135 of the Mental Health Act, on
9 3 September 2021, would have been evident. She will
10 accept that this was an operational mistake. Why it
11 occurred will be a matter of evidence. It may be due to
12 inexperience, it may be due to her having been
13 distracted by something else as she used the system.

14 PC Amos-Perkins, her supervisor, will say that he
15 did not realise that those extra pages on NICHE had not
16 been viewed by PC Taylor. Whether she had or not,
17 nothing about VC that was on the system was reported
18 back to him, PC Amos-Perkins. As a more experienced
19 officer, this interrogation of NICHE was to him a basic
20 operational expectation from any officer. He accepts
21 that he made an operational error not double checking
22 that it had been done on this occasion.

23 For his part, Sergeant Read will say that he should
24 have reviewed the investigation log at 28-day intervals
25 and identified what was missing. Equally, the fact he

1 viewed.

2 These response officers were called to another
3 emergency at 18.56. This emergency was a Grade 1 call,
4 ie one requiring the fastest emergency police response
5 and involved a male reportedly walking on the A6.

6 The Arvato investigation was allocated to PC Taylor
7 under the supervision of her tutor constable, PC
8 Amos-Perkins. Such delegation is necessary for any
9 probationer officer to graduate to independent patrol
10 status.

11 The history of it is documented on the dedicated
12 electronic investigation log and will be explored in
13 evidence. It was procedurally subject to periodic
14 review by Sergeant Read. That didn't happen.

15 Against a wider background of her seeking the
16 identity details of Val Mendez, through Arvato and the
17 employment agency, and other operational duties, the
18 full identity of VC was first provided to PC Taylor on
19 24 May 2023, in other words 20 days before VC's criminal
20 conduct in Nottingham.

21 PC Taylor entered this information to the police
22 NICHE database at PC Amos-Perkins' direction on 24 May,
23 starting at 23.46. While she did enter this information
24 and linked the entry with the correct electronic
25 investigation log, the existing evidence suggests she

1 did not do so was attributable to the relentless volume
2 of work he describes having responsibility for at this
3 time. The consequence was that the information as to
4 Arvato was not provided to Nottinghamshire Police.

5 Similarly, and whilst other investigative steps were
6 taken, the facts giving rise to the warrant and any
7 other information about VC on NICHE were not known to
8 the Leicestershire officers. His background was not in
9 their minds, in other words.

10 On 13 June 2023, VC committed the crimes he did. If
11 I can be forgiven for speaking in personal terms for
12 a moment, even after some 35 years of professional
13 practice in criminal law, the detail of what occurred is
14 deeply harrowing. In human terms and whilst the effects
15 on the victims and the survivors and their families and
16 friends have been described powerfully and eloquently by
17 them in witness statements, it must be recognised, and
18 we do, that the reality will ultimately remain
19 incomprehensible to anyone who is not experiencing it
20 directly.

21 It is challenging enough mentally to transpose our
22 own family members into the shoes of the victims that
23 after all were chosen at random, as I and I'm sure many
24 others in this room have done, and this of course does
25 not begin to compare with the reality for many who

1 either knew or were themselves the victims of his
2 crimes.

3 In offering profound sympathy, as we do, to borrow
4 from Mr Moloney's written opening, we recognise that
5 many are living daily with the raw horror of what
6 occurred and it can only be imagined.

7 From this bleak starting point, this Inquiry must
8 explore and address a significant number and range of
9 questions. The answers should identify what happened
10 and why it happened and what changes are required to
11 minimise the risk of anything equivalent happening
12 again.

13 As has been described, it is simply not accurate to
14 suggest that homicides associated with mismanaged mental
15 illness are isolated events. Change is needed. No
16 other response officers want to find themselves in the
17 position of those I represent.

18 These questions self-evidently engage fundamental
19 principles of information sharing by different
20 organisations and sectors, including academia, the
21 mental health services and the police. The quality of
22 information sharing across organisations is a familiar,
23 repetitive and recurring theme in Public Inquiries and
24 inquests, and indeed pretty much every serious case
25 review in multiple safeguarding contexts.

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1 opening statement, the written and oral statements from
2 other Core Participants, reflect the context, nature and
3 purpose of the other questions you must address.

4 Addressing the purposes of this Inquiry from the
5 narrower perspective of the three officers I represent,
6 we suggest the real question is not whether some
7 operational errors were made, they were, but their
8 effects. No offence is intended by raising these
9 counterfactual questions. They are just that:
10 questions.

11 What would have happened assuming the correct
12 operational expectations were followed and met? Had
13 VC's warrant and/or wider accessible history, insofar as
14 available, become known to the investigating
15 Leicestershire police officers? Would they have had
16 grounds to justify arresting him or, rather, have simply
17 required him to attend a police station for voluntary
18 interview by appointment?

19 Was his address or whereabouts known such that he
20 would have been arrested even if that decision had been
21 taken? Would he have been granted bail after interview
22 and, if so, what, if any, information would have been
23 made known to the police as to his mental health history
24 to inform bail conditions?

25 Given the Arvato conduct, would Nottinghamshire

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1 In terms of Public Inquiries, an obvious example is
2 the Ritchie review, another the 2004 Bichard Inquiry
3 report, ten years after Ritchie, following the murders
4 of Jessica Chapman and Holly Wells. Again, at the heart
5 of it, failures in organisational information sharing.

6 Are organisations paralysed more than they should
7 be, more than the law says, from sharing information
8 that may promote public safety?

9 In the immediate Inquiry questions include whether
10 organisations with information about VC shared it as
11 they could have done under the law and, if not, why not
12 and with what effect? Should such organisations be
13 entitled or even mandated to share more information with
14 each other in future, to ensure appropriate mitigation
15 of risk from those with recurring mental disorder is put
16 in place. If so, according to what criteria?

17 Should much discretion be removed from the process?
18 Is there a risk that the centrality of patients' rights
19 in the 2025 Mental Health Act legislation will relegate,
20 as a matter of clinical culture, if not the law itself,
21 the importance of the protection of the public from the
22 significant risk of serious violence if a specific
23 mental health condition is not adequately gripped by the
24 assessing mental health clinicians?

25 The Terms of Reference, Ms Langdale's comprehensive

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1 Police have taken more proactive steps than it
2 previously had so as to execute the long-standing
3 outstanding warrant? But again, with what practical
4 results?

5 Given that the warrant related to an alleged assault
6 of a police officer during a section 135 Mental Health
7 Act remittal, and the conduct dated back to
8 3 September 2021, would it have been addressed, as
9 previous equivalent violent conduct consistently had
10 been, through mental health services rather than
11 requiring a criminal prosecution?

12 What additional information from previous decisions
13 not to prosecute was available and to whom?

14 Does the public interest element under the Code for
15 Crown Prosecutors require revision specifically to
16 address the public interest in prosecution even where
17 conduct is explicable by reference to an underlying
18 mental health disorder? Is that needed to drive a shift
19 in culture?

20 What would have been known about his medical history
21 to those conducting such decision-making? What was VC's
22 mental health condition on the date of the Arvato
23 incident and how would he have presented day-to-day
24 until the fatal events on 13 June?

25 Given the history to June 2023, is there any

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1 forensic basis safely to conclude that, based on the
2 Arvato incident, he would have been made subject to
3 a Community Treatment Order or equivalent mandated
4 intervention 20 days later following his identity being
5 established?

6 Given the documented reality of previous community
7 management when VC had acted violently when suffering
8 an acute phase of paranoid schizophrenia, is the
9 probability not that this objectively flawed approach
10 would have been repeated again such that there would
11 have been no form of assertive outreach, that he would
12 have been left to self-medicate, probably
13 non-compliantly and without any accountability up to
14 13 June? Probably still discharged simply to his GP on
15 the basis of non-cooperation.

16 We do not attempt to answer these questions today.
17 That would be presumptuous and, in any event, the
18 answers are for the Inquiry; but they are questions that
19 each of the officers I represent invites the Inquiry to
20 explore in evidence, such that if the evidence justifies
21 it, and avoiding speculation, objective answers are
22 provided at the conclusion of the Inquiry's work.

23 The Inquiry will of course approach this according
24 to what was a reasonable and proportionate expectation
25 at the time operationally, and will not reverse engineer

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1 recognition of the suffering of Wayne Birkett, Sharon
2 Miller and Marcin Gawronski. Our client also
3 acknowledges the terrible impact on all those whose
4 lives have been so profoundly affected by the events of
5 13 June 2023.

6 The evidence your Inquiry has gathered, and is soon
7 to receive, makes plain the tragic and ongoing
8 consequences of VC's horrific offending on that day.

9 Leicestershire Police's involvement in the events
10 within the scope of your Inquiry is in relation to
11 the police investigation following an incident on
12 5 May 2023. Mr Davies KC has set out the background.
13 I will not repeat what he has said.

14 In the briefest of terms, Leicestershire Police
15 received a 999 call reporting that a "Val Mendez" had
16 assaulted two co-workers at the Arvato warehouse.
17 PC Taylor and PC Amos-Perkins were dispatched to the
18 premises. VC had already left. The investigation was
19 allocated to PC Taylor.

20 While some steps had been taken to investigate the
21 matter by 13 June 2023, statements had yet to be
22 obtained from the victims or witnesses and VC had not
23 yet been spoken to.

24 The Chief Constable makes six headline points by way
25 of opening. First, your Inquiry has the full support of

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1 unrealistic operational standards back from the horrific
2 events of 13 June 2023.

3 In conclusion, in their witness statements to this
4 Inquiry, each of the three officers has made appropriate
5 concessions as to their performance of operational roles
6 and mistakes that were unquestionably made. In that
7 these mistakes have contributed to the wholly
8 understandable concerns, frankly anger, of affected
9 victims, their friends and families, survivors, they
10 offer, again through me, a simple but genuine public
11 apology from the outset and they wish to continue to
12 assist this Inquiry by providing evidence in public as
13 to what occurred and establishing objective answers as
14 to what consequences any such mistakes produced.

15 Those directly affected deserve no less and the
16 answers may well have wider implications for operational
17 policing. Thank you, Madam.

18 **THE CHAIR:** Thank you, Mr Davies. Mr Berry.

19 Statement on behalf of Leicestershire Police by MR BERRY KC

20 **MR BERRY:** Madam Chair, I represent the Chief Constable of
21 Leicestershire Police, along with Ms Joanne Kane. We
22 are instructed by East Midlands Police Legal Services.

23 I begin by repeating the Chief Constable's deepest
24 condolences to the families of Barney Webber,
25 Grace O'Malley-Kumar, and Ian Coates, and his

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1 Leicestershire Police. Leicestershire Police has given
2 this Inquiry its full assistance from the outset and is
3 committed to doing so throughout the Inquiry process.
4 It has assisted the Inquiry with candour and will
5 continue to assist the Inquiry with candour.

6 Second, there is an outstanding misconduct process
7 in respect of PC Taylor, PC Amos-Perkins and Temporary
8 Police Sergeant Read. That is unfortunate for all
9 concerned that this process has not yet concluded. That
10 it has not been means that the officers are separately
11 represented in this Inquiry by Mr Davies KC, and it also
12 means that the representations that the Chief Constable
13 is able to make at this stage are limited for two
14 reasons: the investigation is being carried out
15 independently by the Independent Office for Police
16 Conduct rather than by Leicestershire Police and,
17 moreover, the Chief Constable will have a statutory role
18 at the next stage of the misconduct process once the
19 IOPC's investigation has concluded. That includes being
20 responsible for bringing any misconduct proceedings that
21 the officers may face.

22 The Chief Constable would welcome the opportunity to
23 make more detailed submissions once the misconduct
24 process has come to an end.

25 Third, notwithstanding the ongoing misconduct

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1 process the Chief Constable is able to recognise the
2 shortcomings that have already been accepted by the
3 officers themselves. They are as follows.

4 PC Taylor not saving her body-worn video footage of
5 the police attendance at Arvato's premises as
6 evidential, meaning that it no longer exists, and PC
7 Amos-Perkins, who is PC Taylor's tutor constable, not
8 directing PC Taylor to do so or checking that she had.

9 Temporary Police Sergeant Read not conducting the
10 required 28-day supervisor's review of PC Taylor's
11 investigation.

12 PC Taylor not searching on the NICHE database for
13 VC's offending history and any outstanding criminal
14 matters, and not conducting searches for VC on
15 the Police National Computer, PNC, or the Police
16 National Database, or PND systems, and PC Amos-Perkins
17 for not reminding PC Taylor to do so, or double checking
18 that she had.

19 That is significant because on 24 May 2023, the
20 recruitment agency that had placed VC at Arvato provided
21 PC Taylor with VC's actual name. PC Taylor entered that
22 name and its details onto NICHE and has said that she
23 did not view the records for VC's previous encounters
24 with the police, so-called NICHE occurrences. Had she
25 done so, or performed the PNC check, she would have been

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1 individuals knew or reasonably ought to have known at
2 the material time.

3 Fifth, it will also be important for the Inquiry to
4 explore any counterfactuals rigorously and on the basis
5 of evidence. Other Core Participants have properly made
6 suggestions as to what might have happened if the
7 Leicestershire police officers had done things
8 differently between 5 May and 13 June 2023.

9 A number of things could and should have been done
10 differently, including PC Taylor identifying that there
11 was an outstanding warrant for VC's arrest, but there is
12 at present no evidence as to what difference these
13 actions would have been likely to have made in terms of
14 VC's opportunity to carry out the attacks on
15 13 June 2023. Not what difference these actions could
16 have made, not what difference these actions should have
17 made if all the relevant systems were operating as
18 intended, but what difference these actions would have
19 been likely to have made.

20 The need for evidence on that question becomes more
21 acute where the Inquiry is being invited to consider
22 multiple counterfactuals and the actions that multiple
23 agencies would have taken. We say this not to
24 presuppose what the answer to the counterfactuals is,
25 but to emphasise that the answer will need to be founded

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1 able to discover that VC had an outstanding warrant for
2 his arrest.

3 This warrant had been issued by Nottinghamshire
4 Magistrates' Court on 22 September 2022 for the offence
5 of assault by beating of an emergency worker. That
6 offence had occurred on 3 September 2021 and was in the
7 context of an attempt by Nottinghamshire police officers
8 to execute a warrant issued under section 135 of the
9 Mental Health Act 1983 for VC's removal to a place of
10 safety.

11 The officers have accepted these shortcomings
12 candidly. They are right to have done so and on behalf
13 of Leicestershire Police, the Chief Constable apologises
14 for these shortcomings.

15 The Chief Constable fully acknowledges that the
16 Inquiry is being invited to consider and will consider
17 other shortcomings by his officers. The Chief Constable
18 makes no observations as to those shortcomings at this
19 stage due to the outstanding misconduct process.

20 Fourth, in order to assist your Inquiry, it may be
21 necessary to emphasise the need to avoid the risk of
22 hindsight. When scrutinising the actions of the
23 Leicestershire police officers and the many other
24 individuals whose actions are under scrutiny, the
25 Inquiry will no doubt take care to focus on what the

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1 in evidence.

2 Sixth, Leicestershire Police has already made
3 changes which the Chief Constable has described in his
4 witness statement and will give oral evidence about. If
5 the Inquiry identifies shortcomings in Leicestershire
6 Police's actions or policies or processes, or indeed in
7 national guidance and processes that apply to policing
8 as a whole, Leicestershire Police is keen to understand
9 and to implement that learning.

10 Leicestershire Police is also keen to contribute to
11 the work of the Inquiry that touches upon the police
12 services' role in respect of members of the public with
13 mental illness. The regrettably familiar themes are
14 likely to include risk assessment and management and
15 information sharing.

16 As for risk assessment and management, the figures
17 for those with mental illness who have committed
18 homicide offences are of real concern. It is important
19 to observe that those figures represent a very small
20 proportion of people who suffer mental ill health, but
21 those with mental ill health who commit homicide
22 offences must be a fraction of those with mental illness
23 who harm others non-fatally and who harm themselves,
24 including fatally.

25 Whether the NHS's tools for risk assessment or its

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1 models for managing assessed risk are fit for purpose is
 2 an important matter for this Inquiry to consider. The
 3 result of inadequate risk assessment and management, be
 4 it systemic or operational, is that the police are often
 5 required to deal with incidents involving those with
 6 mental illness in the community and a good number of
 7 those incidents are inevitably beyond officers'
 8 capability.

9 As for information sharing, this perennial issue is
 10 also being considered by the Southport Inquiry whose
 11 phase 1 report is being published on 13 April this year.
 12 Whether through legislative change or common national
 13 guidance which breaks down wariness of data protection
 14 legislation, there is a need for better information
 15 sharing between relevant agencies, including the Police
 16 Service.

17 That need is most acute in respect of those who have
 18 been assessed as posing a serious risk of harm to the
 19 public or to themselves, including as a result of mental
 20 illness.

21 With respect to this category of individuals you
 22 might consider that ad hoc information sharing is
 23 insufficient and enhanced multi-agency information
 24 sharing on a common platform would lead to better
 25 informed decision-making by the organisation best placed

1 and other bodies in England and Wales. All prosecutors
 2 are required to follow the Code for Crown Prosecutors.
 3 The Code makes clear that prosecutors must always act in
 4 the interests of justice and not solely for the purpose
 5 of obtaining a conviction and those same principles
 6 apply to prosecution counsel.

7 In this regard I know you, Chair, will be familiar
 8 with many of the things that I need to say to you this
 9 morning. It is important that all those following these
 10 hearings understand the role of the CPS and the legal
 11 framework that applied in the prosecution of VC.

12 Just as juries are routinely directed to try the
 13 case only on the evidence and not allow themselves to be
 14 influenced by emotion or sympathy for those affected,
 15 the CPS must make decisions based solely in line with
 16 the legal test for commencing and continuing
 17 a prosecution, and must not and cannot be swayed by
 18 sympathy and emotion, no matter how strong those
 19 feelings are.

20 Before a prosecution can commence, the CPS must
 21 apply the Code for Crown Prosecutors and that sets out
 22 the two tests that can be applied prior to charging
 23 a suspect depending on the circumstances of case. It is
 24 either the Full Code Test, or the Threshold Test. In
 25 VC's case initially the Threshold Test was applied, as

1 to assess and manage risk.

2 Madam Chair, these are but two of the many issues
 3 that the work of your Inquiry is considering and in that
 4 vitally important work you and your team have
 5 Leicestershire Police's full support.

6 **THE CHAIR:** Thank you. Ms Carey.

7 Statement on behalf of the CPS by MS CAREY KC

8 **MS CAREY:** Chair, I along with Ms Brewer appear on behalf of
 9 the Crown Prosecution Service, or CPS for short.

10 I am grateful to Ms Langdale KC for covering
 11 a number of the matters that are also contained within
 12 the CPS's written submissions, and it has enabled me to
 13 shorten the submissions I make to you today. I shall
 14 try to keep repetition to the minimum but there are
 15 a few matters that I would wish to draw to your
 16 attention.

17 Before I do so, can I extend the CPS's condolences
 18 to Barney, Grace and Ian's families. The CPS's thoughts
 19 remain with them, along with Wayne, Sharon and Marcin
 20 and their loved ones. Nothing that I say or that is set
 21 out in these submissions is intended to, nor indeed
 22 does, detract from their enduring pain and utter
 23 devastation that VC has caused to their lives.

24 By way of introduction, the CPS is the independent
 25 prosecutor for criminal cases investigated by the police

1 the infancy of the investigation meant the Full Code
 2 Test could not be met at that stage, and the reviewing
 3 lawyer, Mr Murphy, correctly applied the Threshold Test
 4 and on Friday 16 June 2023 advised the police to charge
 5 VC with the murders of Barney, Grace and Ian, and the
 6 attempted murders of Wayne, Sharon and Marcin.

7 Our written submissions set out a chronology of the
 8 key dates of CPS decisions, in VC's case post that
 9 charge and, as is required by the Code, the Full Code
 10 Test was subsequently applied in his case.

11 As we heard yesterday, the two-stage test requires
 12 the evidential test to be met, namely there to be
 13 a realistic prospect of conviction against the suspect
 14 on each charge, and the public interest test. Chair, in
 15 VC's case there can be no doubt, given the seriousness
 16 of what he had done, that providing the evidential test
 17 was met the public interest test was also met.

18 One of the matters within your Terms of Reference is
 19 to consider the CPS's decision-making in respect of the
 20 acceptance of pleas. At the first hearing in the Crown
 21 Court on 20 June 2023 the defence indicated they would
 22 be seeking a psychiatric report. Now, that report from
 23 Dr McSweeney was not in fact served until the beginning
 24 of October, but by December of 2023 four psychiatric
 25 reports had been obtained and the evidential position in

1 respect of the three murder charges was reviewed.
 2 The experts all concluded that because of his
 3 psychiatric condition the partial defence of diminished
 4 responsibility applied in VC's case and, as such, the
 5 Crown Prosecution Service concluded that pleas to
 6 manslaughter on the grounds of diminished responsibility
 7 were acceptable.

8 It may be helpful, therefore, for me to summarise
 9 briefly the framework in relation to diminished
 10 responsibility. As you know, partial defences only
 11 apply in cases of murder. Diminished responsibility is
 12 one of the statutory partial defences available. It is
 13 for the defence to raise and for the defence to prove on
 14 the balance of probabilities, or, put another way, to
 15 prove that it is more likely than not. It reduces what
 16 would otherwise be a conviction for murder to
 17 a conviction for manslaughter and, as Ms Langdale
 18 outlined yesterday, the test for diminished
 19 responsibility is set out in section 52 of the Coroners
 20 and Justice Act 2009 and, in VC's case, section 52 was
 21 met because the psychiatrists were all of the view that,
 22 firstly, VC was suffering from an abnormality of mental
 23 functioning arising from his psychotic state at the time
 24 of the killings; secondly, his psychotic state arose
 25 from a recognised medical condition, namely paranoid

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1 you will be aware that he stopped his attempt to enter
 2 Seely Hirst House when a car drove past. Once in Ian's
 3 van he slowed down for speed bumps. Dr Blackwood
 4 explained those matters in this way, he said:
 5 "People in the grip of a psychotic episode do not
 6 necessarily lose all aspects of their rationality. Thus
 7 despite VC's psychosis he remained capable of seemingly
 8 rational behaviours, such as the slowing down for the
 9 speed bumps, even modifying his breaking and entering
 10 behaviours when he considered he may be observed by
 11 others."

12 On 24 November 2023, the defence served a second
 13 psychiatric report which also concluded that the defence
 14 of diminished responsibility was available.

15 Now, diminished responsibility as a concept is
 16 complex and the application of the legal test is often
 17 far from straightforward. The CPS has legal guidance
 18 which, in accordance with the case law, makes clear that
 19 where there is unchallenged medical evidence of
 20 diminished responsibility and no other evidence which
 21 when looked at in the round is at least capable of
 22 rebutting the defence, then a charge or charges in this
 23 case for murder cannot continue.

24 In this case there was a lack of other evidence
 25 rebutting diminished responsibility. Dr Blackwood had

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1 schizophrenia; thirdly, that psychotic state
 2 substantially impaired his ability to form a rational
 3 judgment and exercise self-control; and fourthly, the
 4 experts all agreed that VC's abnormality of mental
 5 function provided an explanation for his conduct.

6 It was apparent in his case, given his prior history
 7 with mental health services since 2020, that issues
 8 relating to VC's mental health might result in
 9 diminished responsibility being raised, and so the day
 10 after his arrest the CPS retained Dr Blackwood,
 11 a Professor of Psychiatry at King's College London, as
 12 the prosecution psychiatrist who would be able to
 13 respond to any defence expert report if the defence of
 14 diminished responsibility was raised on VC's behalf.

15 Experts instructed in criminal cases are
 16 independent. Their primary duty is to the court and not
 17 to the party instructing them and it means they are
 18 required to give unbiased and objective opinion on
 19 matters within their expertise.

20 Independently of each other, both Dr McSweeney and
 21 Dr Blackwood concluded that VC had the partial defence
 22 of diminished responsibility available to him.

23 In the instructions to Dr Blackwood, the CPS
 24 specifically asked Dr Blackwood to address VC's apparent
 25 ability to exercise self-control. For example, Chair,

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1 explained why VC was able to demonstrate some seemingly
 2 rational behaviours, a conclusion which was supported by
 3 Dr Latham, the fourth expert instructed to consider VC's
 4 case. The circumstances in which Dr Latham came to be
 5 instructed are set out in our written submissions, but
 6 in due course he, too, concluded that the partial
 7 defence of diminished responsibility was the proper
 8 conclusion reached in the experts' reports.

9 Chair, as you will hear from the CPS witnesses, once
 10 the psychiatric reports were available, the CPS
 11 conducted a number of reviews of the evidence, written
 12 advices were provided by prosecution counsel and the
 13 case was discussed at length in conference between the
 14 CPS and prosecution counsel.

15 At the conclusion of that work, it was agreed that
 16 the weight of the psychiatric evidence was such that
 17 there was no longer a realistic prospect of conviction
 18 for murder and therefore the evidential test in the Code
 19 for Crown Prosecutors was no longer met in respect of
 20 the three murder charges.

21 As you know, the code states that a case which does
 22 not pass the evidential stage must not proceed no matter
 23 how serious or sensitive and accordingly it was
 24 determined that the pleas to manslaughter on the grounds
 25 of diminished responsibility were acceptable.

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1 This was not, therefore, a case where the defence
2 sought to negotiate a lesser plea for their client,
3 perhaps sometimes more colloquially referred to as
4 a plea deal, it was a careful analysis of all of the
5 evidence in the case to ascertain whether the legal test
6 to prosecute VC was met.

7 Chair, I know that one of the matters the Inquiry
8 will wish to consider is what the legal position would
9 have been had there been evidence that VC was
10 intoxicated, whether through alcohol or drugs or both,
11 at the time of the killings. In due course the CPS will
12 set out the myriad pieces of evidence that demonstrate
13 an absence of evidence to suggest that VC's paranoid
14 schizophrenia was linked to or exacerbated by voluntary
15 intoxication of drink or drugs.

16 As explained by Dr Blackwood, VC's mental state
17 abnormalities continued for many months after any such
18 substances would have left his system. Even if
19 substance misuse, to quote Dr Blackwood:

20 "Had obtained in the weeks before or on the day in
21 question, VC's illness was not/is not reducible to
22 a drug induced psychosis".

23 The clinical picture, according to Dr Blackwood, is
24 of a major mental illness, namely paranoid
25 schizophrenia, with an onset and cause unrelated to

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1 organisations such as the CPS.

2 FLOs play a vital role in both investigating and
3 providing support and information to victims of crime
4 and the Bereaved Families Scheme makes clear the
5 circumstances in which the CPS should offer to meet with
6 bereaved families, either prior to or after charge,
7 where charges are discontinued and importantly in this
8 case, you may think, where charges are substantially
9 altered.

10 CPS communication by letter should be sent via the
11 FLO, and in this case there were five sets of FLOs
12 working under the Family Liaison Advisor, DCI Claire
13 Gould. There was a FLO for the injured victims, FLOs
14 for the Webber family, FLOs for the O'Malley-Kumar
15 family, FLOs for Ian Coates' partner Elaine and an FLO
16 for Ian's sons. In accordance with the Bereaved Family
17 Scheme, the four bereaved families were written to
18 and/or had meetings with the CPS.

19 Our written submissions set out a summary of the key
20 dates relating to those communications and you will know
21 that it is supplemented by a fuller chronology in the
22 HMCPSI report that was published subsequently.

23 In VC's case the CPS decided that the enhanced
24 rights would be offered to the injured victims as well
25 as the bereaved families and on 16 July 2023, the CPS

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1 substance abuse.

2 Chair, it is important for those listening, however,
3 to understand that even if VC had consumed alcohol
4 and/or drugs just before or on the night of 13 June,
5 case law makes clear that it does not follow that this
6 would have deprived him of the defence of diminished
7 responsibility.

8 The CPS appreciates that the decision to accept
9 pleas to manslaughter on the grounds of diminished
10 responsibility may be difficult for the public to
11 understand, but from the legal perspective there was
12 clear evidence that statutory tests for diminished
13 responsibility was met.

14 VC's case was properly and fully reviewed and let me
15 make it clear, had there been an evidential basis for
16 challenging the psychiatric reports' conclusions, the
17 CPS would not have hesitated to do so and would have
18 prosecuted VC for murder.

19 Chair, I turn next to communications with the
20 bereaved families and the victims of VC's crimes. Under
21 the Victims' Code, as you know, the bereaved families
22 have the right to have a Family Liaison Officer or FLO
23 assigned by the police and the Victims' Code
24 specifically states that the FLO will normally act as
25 the single point of contact between the family and

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1 was informed that none of the injured parties wished to
2 meet with the CPS and were content to receive updates
3 from the FLO. They were made aware that if that
4 position changed the families could always contact the
5 FLO and those meetings would have taken place.

6 Chair, communicating with victims and bereaved
7 families necessarily requires a case-specific approach
8 which adapts and responds to the views and wishes of
9 each victim or bereaved family member. In VC's case the
10 individual circumstances of each bereaved family
11 demonstrates why there is not a one-size-fits-all
12 approach.

13 In VC's case the needs of each of the bereaved
14 families and the injured victims were very different and
15 we submit that the CPS tried to balance how best to
16 communicate with each family and when, cognisant of the
17 fact that each family had been through the most
18 traumatic and devastating events.

19 Chair, unless I can assist you further, that is all
20 I propose to say on behalf of the CPS at this stage.

21 **THE CHAIR:** No, thank you Ms Carey.

22 **MS CAREY:** Thank you.

23 **THE CHAIR:** It is now 1 o'clock so we will break now until
24 2. Thank you.

25 **(12.55 pm)**

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1 (The lunch break)
 2 (The Inquiry continued in the afternoon)
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