

Monday, 23 February 2026

(10.00 am)

Opening by THE CHAIR

THE CHAIR: Good morning and welcome to the first day of the hearings in the Nottingham Inquiry.

I know this is a deeply emotional and momentous day for those closest to and most affected by the events of 13 June 2023. In getting to this point they have climbed mountains only to find that they had reached false summit after false summit and each time another arduous climb lay ahead. Over the next few months I and the Inquiry team will ensure as far as we are able that we reach a summit with a clear view of both the past and the way ahead.

So with that in mind I want to set out how we have approached the Inquiry and how we intend to proceed over the next few months.

As you are all aware, whilst we begin the hearings today, the Inquiry has been gathering, analysing and preparing a great deal of evidence with a wider and deeper scope than has been undertaken in relation to previous reports into these incidents. Shortly, Counsel to the Inquiry, Rachel Langdale KC, will set out an overview of the evidence. Tomorrow counsel for Core Participants will make their opening statements. We

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You will shortly hear from Ms Langdale about how the Inquiry will address the terms of reference, the detailed evidence to come, the questions which will be addressed and the issues that the Inquiry must determine.

Over the period of the oral hearings, evidence will be heard from well over 100 witnesses but I want to make it clear at the outset that that is not all of the evidence. I can assure you that all of the statements which have been received have been read and form part of the Inquiry evidence on which I will be able to draw in it preparing a report. I, with the Inquiry legal team and taking into account additional views expressed by Core Participants, have decided which witnesses need to be called to give oral evidence to the Inquiry. In addition, there are thousands of underlying documents obtained by the Inquiry and disclosed to Core Participants. Again, all of these will be read and analysed. Some have been summarised and tabulated in Inquiry legal team documents and shared with Core Participants. So be assured that, in addition to the witnesses called and the documents referred to during their evidence, there will be a much larger body of underlying evidence which I will also consider.

In the event that it becomes necessary to obtain

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will end the hearing day tomorrow with profound and moving film portraits of Barney Webber, Grace O'Malley-Kumar and Ian Coates prepared by their families, and films made by Wayne Birkett and Sharon Miller, survivors of the attacks on 13 June 2023. Then we will start on Wednesday with the first witness.

From the start of this Inquiry I have made clear that the Inquiry expects prompt assistance and cooperation and adherence to deadlines. For the most part, Core Participants and material providers have taken that message seriously and have done their best to assist the Inquiry in providing statements, documents and submissions on time, avoiding unnecessary delay. So I thank you for your assistance to date and expect that cooperation and keeping to schedule to continue.

The Inquiry will use the time allocated to these hearings to the full and that will mean that we will start promptly in the morning and after breaks. Where it is necessary to sit later to finish off a witness' evidence, we will generally do so, but pace shouldn't be mistaken for superficiality. All necessary questions will be asked by Counsel to the Inquiry, by Core Participants, where they have been granted permission for time to do so under the rule 10 procedure, and where required, and I think it appropriate, by me.

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further evidence I have no doubt that that can be obtained during the course of the hearings without disruption or delay to the timetable.

The public will be able to follow the Inquiry on live stream where witnesses are live streamed and, for those witnesses who are live linked, by reading transcripts provided daily on the Inquiry website. Also, should they wish to do so, by reading statements and documents which will be put onto the website in due course.

This rigorous approach to evidence gathering has therefore allowed us to focus in these hearings on extracting and testing the evidence necessary to establish a detailed understanding and history in the case of Valdo Calocane, who will be referred to as VC during the Inquiry, of his actions, what was done or not done by individuals, by agencies singly or agencies which could or should have worked together. We will examine what was, could and should have been done, why it was or was not done and the effects of key actions, omissions and decisions.

This Inquiry will hear all the evidence in one continuous set of hearings. There are two main reasons for this approach. Firstly, so that the families and survivors don't have to wait any longer than necessary,

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1 and, secondly, rather than looking at the factual  
2 background in isolation, it is important to set what  
3 happened in relation to VC in the context of a wider  
4 canvas: the principles and practice applied in treatment  
5 of those with serious mental illness in relation to  
6 health and criminal justice; the evidence of the  
7 treatment of, actions taken and reports on other similar  
8 cases involving homicides by mental health patients; the  
9 history of, resourcing and changes in mental health  
10 provision and what's been done in the past; and the  
11 community as a concept and as a reality when considering  
12 the provision of VC's and others' mental healthcare.

13 This Inquiry comes at an inflection point, a moment  
14 of change in areas to be covered by the evidence: the  
15 changes made by the Mental Health Act 2025; progress  
16 towards the Hillsborough duty of candour; recent  
17 extensions of the rights of victims of crime and in  
18 mental health tribunals; and proposals for more joined  
19 up policing. In that context we will look at complex  
20 questions: what more can be done in the understanding  
21 and treatment of serious mental illness to identify and  
22 manage risk of violence to others so as to protect the  
23 public; to look at what more can be done for those  
24 closely affected by the serious mental illness of  
25 others, and how to ensure clear understanding of how

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1 Participants for this Inquiry to change that pattern by  
2 addressing underlying and immediate causes and to act  
3 positively with recommendations to achieve necessary  
4 change. Words of condolence, sympathy and apology can  
5 be given substance by a commitment to establishing the  
6 detailed facts and bringing clarity to what happened and  
7 how it may be prevented from happening again.

8 It is therefore important that all recognise that  
9 the engine of change is powered by frankness, by  
10 reflection rather than deflection, by insight and by  
11 acceptance of both personal and collective  
12 responsibility where required. Ms Langdale.

#### 13 **Opening statement by Counsel to the Inquiry**

14 **MS LANGDALE:** Thank you, Chair.

#### 15 Introduction

16 On 13 June 2023 in the city of Nottingham, Valdo  
17 Calocane, who we will refer to as VC throughout in this  
18 Inquiry, brutally stabbed and killed Barney Webber,  
19 Grace O'Malley-Kumar and Ian Coates and then attacked  
20 and injured Wayne Birkett, Sharon Miller and Marcin  
21 Gawronski by deliberately driving the van he had stolen  
22 from Ian Coates into collision with them.

23 Whilst we refer to the Nottingham attacks  
24 collectively, each attack was on an individual and each  
25 attack is a personal tragedy for the victims, their

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1 agencies should work together to share information and  
2 address risks of violence and homicide.

3 I have had the advantage of being informed in  
4 advance what Core Participants will address in their  
5 opening statements. With different perspectives and  
6 emphasis, the same concerns and criticisms are raised.  
7 These themes and the detailed evidence relied on come as  
8 no surprise. It is apparent that all Core Participants  
9 recognise the wide public concern they have attracted.  
10 That concern reflects their importance, not only for  
11 those so grievously affected in this case, nor only for  
12 the people of the city of Nottingham, but also for many  
13 other families and members of the public across the  
14 country who have suffered over the years in similar  
15 cases and who have tried to seek more information or  
16 greater understanding of how and why their tragedy  
17 occurred.

18 Each case of this kind has devastating effects on  
19 individuals, families and communities. Over the  
20 30 years since the last Public Inquiry addressing the  
21 same issues as this Inquiry, many cases have created  
22 a splash when they hit the public consciousness through  
23 the media, have created ripples which at best led to  
24 some change but then sank below the surface.

25 There is a desire universally expressed by Core

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1 families and those close to them. We will hear more  
2 about each of them in films to be shown tomorrow and  
3 they will be at the forefront of our minds during this  
4 Inquiry. The bereaved families and survivors will give  
5 oral evidence in the week of 23 March.

6 Nottingham University friends Barney Webber and  
7 Grace O'Malley-Kumar were celebrating the end of exams  
8 and the end of the summer term. They were 19 years of  
9 age, hugely loved and admired and on the threshold of  
10 their adult lives with everything to live for.

11 Grace spent the afternoon on 12 June with friends  
12 from the university hockey team. A few of them decided  
13 to go to a club that evening. They went to Barney's  
14 house first to socialise for a while and to the club at  
15 around 11.30 pm. After leaving the club and eating  
16 pizza in town during the early hours of the morning, at  
17 around 3.10 am, Barney and Grace headed back towards  
18 their student accommodation. CCTV footage demonstrates  
19 that they were chatting, relaxed and happy.

20 On the night of 12 and 13 June VC travelled from  
21 London, where he had been staying with a friend, to  
22 Nottingham. At 11.50 pm VC called his brother Elias.  
23 During this call VC said to Elias that he was not  
24 mentally ill but his mind was being controlled. He  
25 referred to files he had sent his parents over Christmas

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1 2022, and then sent them over email to Elias at  
 2 11.52 pm. I will return to their contents later.  
 3 At 3.03 am, VC turned off his mobile phone as he  
 4 walked towards the area of Ilkeston Road. He did not  
 5 turn his phone back on again until he left the Ilkeston  
 6 Road area. He had a history of violence and mental  
 7 health problems. Although it was a summer night, he was  
 8 dressed in a black top, trousers and a beanie hat pulled  
 9 down so as to cover the top half of his face. He was  
 10 carrying a rucksack of weapons: a Boker dagger, a Gerber  
 11 survival knife, a large pointed knife and a metal  
 12 scaffolding pole.

13 At about 3.56 am Barney and Grace crossed Ilkeston  
 14 Road and Radford Boulevard junction. Footage recorded  
 15 what happened next at 4 am. VC was waiting in a shaded  
 16 area on Ilkeston Road. After Barney and Grace passed by  
 17 he came out and followed them. VC suddenly stabbed  
 18 Barney with the dagger repeatedly. The brutal ferocity  
 19 of the attack forced Barney to the ground immediately.  
 20 He was fatally wounded. Grace responded instinctively  
 21 and bravely to try and help her friend and push the  
 22 attacker away into the road. She tried to fight him off  
 23 for over 30 seconds during which time VC stabbed Grace  
 24 repeatedly. VC then walked back to where Barney was  
 25 lying on the ground, returning to his relentless attack

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1 look at the route he took in the evidence. He was still  
 2 wearing the same black clothes and carrying a rucksack.  
 3 He tried to gain entry by opening a ground floor window  
 4 and was told by a caretaker he should leave. VC did  
 5 leave, only to return two minutes later when the  
 6 caretaker had gone back into the house. He tried to  
 7 gain entry again until he was pushed away by the  
 8 occupant of the room he was trying to enter.

9 Over an hour after Barney and Grace were killed, at  
 10 5.10 in the morning, Ian Coates, a greatly loved  
 11 partner, father and grandfather, was driving his white  
 12 Vauxhall van on Magdala Road. He was on his way to work  
 13 at a nearby school. It is not known how Ian Coates came  
 14 to stop his van in Magdala Road. The attack on him was  
 15 not captured on footage. However, one witness reported  
 16 that they heard blood curdling screaming and someone  
 17 shouting "Leave me" at around 5 am. Meanwhile, a couple  
 18 driving a car slowly along the road noticed a white van  
 19 in the road and at first thought two men were arguing.  
 20 As they drove closer they noticed VC making a stabbing  
 21 motion towards Ian Coates and realised he was bleeding  
 22 heavily and had been attacked.

23 They saw VC get into the van. VC looked hard at  
 24 them and they carried on driving for fear of him hurting  
 25 them too.

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1 upon him. Although seriously wounded, Barney showed  
 2 great fortitude and attempted to fend him off by kicking  
 3 his legs. Grace walked towards them again but her  
 4 injuries were too severe and she subsequently collapsed.

5 Leaving Barney and Grace grievously injured,  
 6 two minutes after he began his attacks VC returned to  
 7 his rucksack which he had left on the road nearby. He  
 8 picked it up and then calmly walked off, initially  
 9 towards the city centre. The first 999 call to  
 10 the police was made at 4.03 am, reporting: "I think  
 11 someone has been robbed or attacked, I don't know if  
 12 stabbed, a girl and a guy, I think they have been robbed  
 13 or something".

14 We will explore in evidence the reports and calls  
 15 that came in and the response of the emergency services;  
 16 also how long it took to find and arrest VC.

17 VC turned his phone back on at 4.47 am and phoned  
 18 his brother Elias Calocane at 4.52 am. During this  
 19 short conversation with his brother, VC said: "This will  
 20 be the last time we will speak. Take the family out of  
 21 the country." Elias asked VC if it he was going to do  
 22 anything stupid. VC replied, "It's already done". This  
 23 conversation will be explored in oral evidence.

24 At 5.01 am VC appeared at Seely Hirst house,  
 25 a hostel for adult males on Mapperley road. We will

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1 VC made no comment when subsequently interviewed by  
 2 the police but later told the psychiatrist Dr Blackwood  
 3 that he came across Ian Coates in his van, stabbed him  
 4 in the drive seat and continued to stab him after he had  
 5 taken him out of the van.

6 At 5.30 am a site manager drove down Magdala Road  
 7 and noticed Ian Coates lying on the edge of the curb.  
 8 He stopped and phoned the police. Ian Coates had  
 9 suffered multiple stab wounds to the chest and abdomen  
 10 and when emergency services arrived he was declared dead  
 11 at the scene.

12 Having killed three people thus far, VC attempted to  
 13 kill three more before he stopped and was apprehended by  
 14 the police. After killing Ian Coates he drove along  
 15 Magdala Road, back onto Woodborough Road and towards the  
 16 city centre. He arrived at Milton Street just after  
 17 5.20 am. At this time Wayne Birkett, a hard working,  
 18 self-sufficient sociable man got off a bus on  
 19 Mansfield Road and was walking along Milton Street. VC  
 20 deliberately swerved onto the wrong side of the road and  
 21 hit Wayne Birkett from behind, throwing him six feet  
 22 into the air before landing on the ground. Wayne  
 23 Birkett was assisted at the scene and taken to intensive  
 24 care. He has suffered serious and life changing  
 25 injuries from the attack. His partner Tracey, upon whom

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1 he now depends, provides him with devoted care and daily  
2 support.

3 VC continued to drive the van through the city  
4 centre. He eventually arrived at the junction of  
5 Market Street and Upper Parliament Street where Sharon  
6 Miller and another pedestrian, Marcin Gawronski, were  
7 standing. Sharon Miller had worked hard as a cleaner of  
8 office buildings for 27 years and was on her way to  
9 work. She noticed a van and a police car behind it. As  
10 captured on police dash cam at 5.29 am, VC deliberately  
11 drove across the pedestrian island and into Sharon and  
12 Marcin, his last two victims, giving them no chance to  
13 avoid his vehicle.

14 Sharon Miller was taken to the major trauma ward at  
15 the Queen's Medical Centre. She has been physically and  
16 psychologically injured by the attack and Martin, her  
17 long-standing partner, supports her in her daily life.

18 Marcin Gawronski was also injured and taken to  
19 hospital. He has chosen not to take part in the Inquiry  
20 and the Inquiry has respected that choice.

21 In November 2023, VC pleaded guilty to manslaughter  
22 by reason of diminished responsibility in relation to  
23 the killings of Barney, Grace and Ian Coates. The  
24 partial defence of diminished responsibility does not  
25 apply in cases of attempted murder, and VC pleaded

1 psychiatric report obtained by the prosecution.

2 The psychiatric reports obtained in respect of VC  
3 resulted in the prosecution accepting pleas to  
4 manslaughter rather than murder. The bereaved families  
5 disagreed with the acceptance of the pleas of  
6 manslaughter, and you will hear evidence, Chair, about  
7 how communication with the bereaved families, survivors  
8 and the prosecution unfolded.

9 On 25 January 2024, and in respect of each offence,  
10 VC was made subject to a hospital order and restriction  
11 order under sections 37 and 41 of the Mental Health Act  
12 1983. The effect of a restriction order is that the  
13 patient cannot be discharged or released on licence  
14 unless either the Secretary of State for Justice or the  
15 Mental Health Tribunal orders this. The bereaved  
16 families and survivors in this case have expressed  
17 concern that there was no punitive element on sentence,  
18 that is to say a prison term, to reflect VC's  
19 culpability.

20 By the terms of reference this Inquiry cannot  
21 consider the judicial decision-making in this case and  
22 cannot determine matters of criminal or civil liability.

23 The terms of reference also expressly exclude  
24 consideration of reform of the law relating to homicide,  
25 which is currently the subject of a Law Commission

1 guilty to attempted murder in respect of each of the  
2 three driving attacks.

3 The partial defence of "diminished responsibility"  
4 was introduced by the Homicide Act 1957 as an exception  
5 to the mandatory death sentence which then followed  
6 a conviction for murder. The definition was amended by  
7 the Coroners and Justices Act 2009, which now provides  
8 that "an offender who kills shall not be" convicted of  
9 murder if suffering from an "abnormity of functioning"  
10 which: (a) arose from a recognised medical condition;  
11 (b) substantially "impaired the offender's ability to do  
12 one or more of the following three things" -- understand  
13 the nature of his conduct; to form a rational judgment  
14 or to exercise self-control; and (c), provides an  
15 explanation for the acts in it doing or being a party to  
16 the killing.

17 The "abnormity of mental functioning" provides  
18 an explanation for the offender's conduct if it causes,  
19 or is a significant contributory factor in causing, the  
20 offender to carry out that conduct.

21 The 2009 Act provides that the burden of  
22 establishing diminished responsibility lies on the  
23 defendant in a criminal case. In practice, it cannot be  
24 established without experienced psychiatric evidence,  
25 and in nearly every case there will be an independent

1 review. Consequently, Chair, whether an offender who  
2 kills and is charged with committing murder should have  
3 a plea accepted to manslaughter by reason of diminished  
4 responsibility is not for you to consider.

5 However, the Inquiry can and will examine the  
6 underlying factual material in the case of VC relating  
7 to the psychiatric evidence obtained for the sentencing  
8 hearing and whether or not all factual information now  
9 known was known at the time.

10 The Inquiry is able to examine other concerns of the  
11 bereaved families and survivors, including the adequacy  
12 of the response of the police when VC was in custody  
13 following the attacks and the Crown Prosecution Service  
14 handling of the case. What was the procedure employed  
15 and basis of decisions taken as to VC's fitness to be  
16 interviewed and detention? What strategy and procedures  
17 were followed for toxicology? Were attempts made to  
18 take samples and should further investigations have been  
19 carried out? How did the police handle communications  
20 with other agencies, the media and the bereaved families  
21 and survivors of the attacks? Could or should any  
22 improvements be made to such communications?

23 As you are fully aware, Chair, the purpose of this  
24 Inquiry is to build a clear understanding of the events,  
25 attacks, acts and omissions that led up to VC carrying

1 out these brutal attacks. Within the terms of reference  
2 you have been required to provide a report and  
3 recommendations by May 2027, so that lessons can be  
4 learned to prevent similar attacks in the future. Over  
5 a four-month period oral evidence will be heard and,  
6 Chair, you have of course an enormous amount of written  
7 evidence for review as well.

8 Before focusing on the Nottingham attacks, I want to  
9 step back for a moment and take a longer view of the  
10 place of this Inquiry in the context of a history of  
11 Inquiries and recommendations following homicides by  
12 those receiving mental health treatment.

13 The Ritchie Report 1994.

14 This is not the first Public Inquiry which has been  
15 invited to examine the delivery of mental healthcare in  
16 the context of a homicide with a view to making  
17 recommendations to avoid harm to others. The Ritchie  
18 Inquiry was set up as long ago as July 1993, and tasked  
19 with reviewing the killing of Mr Jonathan Zito by  
20 Christopher Clunis. In December 1992 Jonathan Zito and  
21 his brother were standing on a platform at Finsbury Park  
22 tube station, when Christopher Clunis struck Jonathan  
23 Zito fiercely in the face with a knife. Christopher  
24 Clunis pulled the knife from Jonathan Zito's head, and  
25 without any sign of remorse or concern, walked away.

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1 We observe at this point that the Ritchie Inquiry  
2 made the following general observation:

3 "We do not single out just one person, service or  
4 agency for particular blame. In our view it was  
5 cumulative; it was one failure or missed opportunity  
6 after another."

7 The Ritchie Report resulted in increased investment  
8 in mental healthcare. The Inquiry has received evidence  
9 about the setting up of specialist teams following its  
10 recommendations, Assertive Community Treatment teams,  
11 with a cap of 12 patients per worker in the team. The  
12 approach was targeted and intensive, and the evidence at  
13 the time from other countries was that this was both  
14 effective and cost-effective compared with in-patient  
15 care.

16 The Ritchie Report recommended that every  
17 psychiatric service should identify patients as part of  
18 a special supervision group. A nationally based  
19 Supervision Register should be set up. Chair, you will  
20 hear evidence in due course in respect of how those  
21 recommendations were implemented.

22 The cases of VC and Christopher Clunis are 30 years  
23 apart. In the interim, there have been numerous  
24 internal review and inquiries into homicides by persons  
25 with mental illnesses. As the website "Hundred

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1 When the next tube train stopped and the doors opened,  
2 Christopher Clunis was seen to board the last carriage  
3 and sit down.

4 Christopher Clunis pleaded not guilty to murder but  
5 guilty to manslaughter. That was accepted by the  
6 prosecution in the light of his previous and continuing  
7 serious psychiatric condition. In imposing hospital  
8 orders with a restriction order under section 37 and  
9 section 41 of the Mental Health Act, the judge said that  
10 the orders were in the public interest but there must be  
11 no question of Clunis being released while there was the  
12 remotest chance of him being a danger to fellow human  
13 beings. In February 2021, 30 years after the killing of  
14 Jonathan Zito, Christopher Clunis died in a secure  
15 mental health hospital.

16 The Ritchie Inquiry identified a string of failures  
17 by mental health professionals, including failure to  
18 assess Clunis' past history of violence and propensity  
19 for violence, or to note and act upon warning signs and  
20 symptoms to prevent relapse in the community. The  
21 Ritchie Inquiry found that hospitals and social services  
22 failed to contact Clunis' family or GP, repeatedly  
23 treated admissions as separate incidents and discharged  
24 Christopher Clunis from hospital because of pressure on  
25 beds or to save money.

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1 Families" and other statistical evidence makes clear,  
2 mental health related homicides are far from one in  
3 a generation, and many recommendations made in the  
4 intervening years cover issues which will be revisited  
5 in this Inquiry. By way of example, in 2002 qualitative  
6 analysis of recommendations in 79 inquiries after  
7 homicide committed by persons with mental illness was  
8 undertaken. The analysis found that the reports  
9 contained numerous recommendations regarding a range of  
10 issues: care programme approach, assessment, care  
11 planning, risk assessment and management, history  
12 taking, the need for improvements in communication  
13 between different professional groups and between  
14 agencies, improvements to police procedures and liaison  
15 between healthcare agencies and the police, mental  
16 healthcare and treatment guidelines, evidence-based  
17 practice, monitoring of the use of guidelines or  
18 protocols, audit and training. Time has moved on but  
19 these fundamental issues remain.

20 I will turn later to the evidence of Julian Hendy  
21 who set up Hundred Families, and the evidence from other  
22 research and analysis about the wider canvas when  
23 outlining how you may consider this, Chair, in the  
24 context of making recommendations.

25 I turn now to previous reviews in the case of VC.

20

1 A number of reviews into the handling of VC's case have  
 2 already been completed by various agencies. The terms  
 3 of reference for your Inquiry, Chair, require us to take  
 4 account of the work of the Independent Office for Police  
 5 Conduct into the actions of the police, and any existing  
 6 reviews in respect of the CPS, and the Trust, and to  
 7 avoid duplication of such work. The Inquiry is required  
 8 to use and build upon the work undertaken in those  
 9 reviews. With that in mind, and before turning to the  
 10 details of the evidence the Inquiry has obtained and  
 11 will call, I will set out briefly what previous reviews  
 12 have found.

13 The Independent Office for Police Conduct is the  
 14 body responsible for overseeing the police complaints  
 15 system. It investigates the most serious and sensitive  
 16 incidents in respect of police conduct. It is  
 17 conducting a number of investigations relevant to this  
 18 Inquiry.

19 Operation Penhallow is an investigation into the  
 20 handling by Leicestershire Police of an allegation of  
 21 assault by VC on 5 May 2023, considering both the  
 22 investigation into the assault and the supervision of  
 23 the relevant officers. The IOPC report had been  
 24 finalised in September 2024 but the investigation was  
 25 reopened in March 2025. The IOPC are carrying out

1 They met with the families to understand their concerns.  
 2 The inspection considered whether the decision not to  
 3 proceed to trial for murder and to accept pleas for  
 4 manslaughter was correct, and whether the approach taken  
 5 by the CPS engaging with the families during the case  
 6 met the standards and expectations set out in the  
 7 Victims' Code and the CPS Bereaved Family scheme.

8 HMCPSI noted that three psychiatric reports on VC  
 9 were prepared, two on behalf of the defence and one on  
 10 the part of the prosecution. Each of those reports  
 11 concluded that VC was suffering from a serious mental  
 12 illness, namely paranoid schizophrenia, which led to  
 13 abnormality of mental functioning and substantially  
 14 impaired his ability to form rational judgments and  
 15 exercise self-control. As a result, the psychiatrist  
 16 concluded that the partial defence to murder of  
 17 diminished responsibility was available. A fourth  
 18 psychiatric report was commissioned by the prosecution  
 19 and this too agreed with the conclusion of the first  
 20 three.

21 The HMCPSI report found that the CPS and prosecution  
 22 counsel considered the relevant law as to the acceptance  
 23 of the pleas and applied it correctly. Accepting pleas  
 24 of not guilty to murder but guilty to manslaughter was  
 25 correct on the evidence and as the law currently stands.

1 further inquiries.

2 Operation Astwell is an investigation into the  
 3 actions of Nottinghamshire police prior to, during, and  
 4 following the attacks on 13 June, following complaints  
 5 about their contact with VC and handling of the murder  
 6 investigation.

7 Operation Copthorne is an investigation into  
 8 complaints by the families of the victims against the  
 9 Chief Constable of Nottinghamshire police, Kate Meynell.

10 Operation Longdale is an investigation into  
 11 complaints by the families that a briefing given by  
 12 Nottinghamshire Police to the media on 22 February 2024  
 13 was an improper attempt to hide information.

14 A date for the publication of final reports is not  
 15 currently available. The Inquiry is required to and  
 16 will avoid any action that could prejudice any criminal  
 17 or police misconduct investigations or proceedings.

18 At the request of the Attorney General  
 19 in January 2024, His Majesty's Crown Prosecution Service  
 20 Inspectorate examined concerns of the bereaved families  
 21 that justice let them down and had failed them and their  
 22 loved ones. HMCPSI had access to all of the material  
 23 relating to the case are were able to interview all who  
 24 had dealt with the case on behalf of the prosecution  
 25 including the first prosecution psychiatric expert.

1 The report noted:

2 "It is easy however to understand why the bereaved  
 3 families find the decision difficult ... to accept.  
 4 Their loved ones were killed by an offender who knew  
 5 what he was doing was wrong and intended to kill them."

6 The report made the observation that if Parliament  
 7 had implemented the recommendations made by the  
 8 Law Commission in 2006 -- that there should be three  
 9 tiers of homicide -- the deaths of Barney, Grace and Ian  
 10 Coates would have been categorised as second degree  
 11 murders. Elsewhere in the report it acknowledged that  
 12 the term "manslaughter" has the perception to underplay  
 13 the gravity of what has taken place.

14 In terms of communication with the bereaved  
 15 families, the report noted that the CPS used the word  
 16 "Consult" on a number of occasions when referring to  
 17 engagement with the families about the legal  
 18 decision-making in the case. It found that this may  
 19 have contributed to a misunderstanding of the CPS's  
 20 obligations to victims when decisions are taken on  
 21 evidential grounds. There is no obligation on the CPS  
 22 to "consult" victims when making a decision on the  
 23 evidential test of the Code for Prosecutors, but rather  
 24 to "inform" and "explain" their decision.

25 The report recommended that by October 2024 the CPS

1 undertake a review of all guidance to ensure that staff  
 2 are aware when the use of the term "consult" or  
 3 "consultation" is appropriate.

4 Whilst the report said that it was regrettable that  
 5 the bereaved families were only told four days prior to  
 6 the plea and trial preparation hearing that the  
 7 prosecution intended to accept pleas to manslaughter, it  
 8 found that the timing was dictated by the receipt of the  
 9 psychiatric reports. The CPS could not have  
 10 communicated this information sooner than they did.  
 11 Nevertheless, it found there were some areas where the  
 12 quality of engagement could have been better. It found  
 13 that the guidance on diminished responsibility should  
 14 have been provided to the three family liaison officers  
 15 working directly with the bereaved families, which would  
 16 have enabled the families to understand the implications  
 17 of diminished responsibility at an earlier stage in the  
 18 case.

19 James Coates, the designated point of contact in  
 20 respect of the CPS's engagement with Ian Coates' three  
 21 sons, was not made aware of the issues being raised by  
 22 the other bereaved families and was not therefore in  
 23 a position to make an informed decision about attending  
 24 a key meeting. He was not made aware of meetings the  
 25 CPS had with the other bereaved families either.

1 Dr Joanne Perry.

2 The Panel had access to VC's clinical records and  
 3 the Trust's policies and procedures. Seven members of  
 4 Trust staff were interviewed. It did not have VC's  
 5 primary care notes, or the notes of the independent  
 6 hospitals involved in his third admission, the Priory  
 7 and Cygnet. The Panel did not meet with VC or his  
 8 family.

9 The report, dated 15 March 2024, found that there  
 10 were areas of good practice. It noted good  
 11 communication and handover between the crisis team and  
 12 the Early Intervention in Psychosis team. It found that  
 13 the community and in-patient staff communicated  
 14 "extremely well" with VC's family and the university.  
 15 It described the Early Intervention in Psychosis team as  
 16 being mature and thoughtful.

17 It concluded that VC's risk of violence to others  
 18 was moderate, not high, and was driven by  
 19 a deterioration in psychotic symptoms. It asserted that  
 20 no reasonable risk formulation in September 2022, that  
 21 is the point when VC was discharged by the Trust to the  
 22 GP, would have anticipated an attack of the type that  
 23 occurred in June 2023.

24 Paragraph 29 of the report summarised VC's  
 25 presentation as follows:

1 The report stated that this highlighted "the  
 2 importance of a proactive and probing approach being  
 3 taken by both the CPS and [Family Liaison Officers] ...  
 4 when communicating with each other."

5 The report suggested that in future cases involving  
 6 more than one bereaved family, the CPS should ensure  
 7 that, where it is providing information about the case  
 8 to one family, either directly or via a Family Liaison  
 9 Officer, where appropriate it updates the other family  
 10 or families at the same time.

11 Immediately following the attack, the Nottingham  
 12 Health Foundation Trust undertook an initial management  
 13 review. The review was based on information taken from  
 14 VC's medical records and in anticipation of the Trust  
 15 commissioning a more comprehensive so-called level 2  
 16 investigation. The management review set out a timeline  
 17 of VC's interactions with the Trust, but did not make  
 18 any significant findings about the care he received.

19 The Trust commissioned an organisation called  
 20 "Psychological Approaches" to appoint an independent  
 21 chair and undertake a comprehensive investigation.  
 22 Dr Jackie Craissae, a consultant clinical and forensic  
 23 psychiatrist, chaired the three-person panel. The other  
 24 two members of the panel were a mental health nurse,  
 25 Rachel Lees, and a consultant forensic psychiatrist,

1 "In summary, VC appeared to recover quickly from  
 2 each episode/relapse of psychosis when an inpatient,  
 3 resuming work or attendance at university on discharge.  
 4 In our view, discharge planning reflected an inpatient  
 5 focus on VC's presentation in the present as a snapshot  
 6 view of someone with a recent relapse and relatively  
 7 quick short-term recovery, rather than taking  
 8 a longer-term view of VC's pattern of behaviour, risks  
 9 and needs with consideration of what might be required  
 10 for successful community management."

11 The report identified ten learning points, grouped  
 12 principally into three areas: Clinical Records,  
 13 Discharge and Risk Management.

14 In relation to clinical records, it was observed  
 15 that whilst contacts with VC were recorded and core  
 16 standards were often though not always adhered to, there  
 17 was a failure to make records in a way that reflected  
 18 professional thinking.

19 The second area was in respect of the discharge  
 20 process. It would have been particularly helpful, the  
 21 report observed, to include a clear mandate for the use  
 22 of depot medication if VC were discharged and became  
 23 unwell.

24 In respect of the discharge of VC from hospital care  
 25 to the GP in September 2022, the report concluded that

1 there was significant learning. Prior to the discharge  
 2 to the GP, the view of the panel was that VC's care plan  
 3 should have been reviewed, there should have been a cold  
 4 call to his new address, and there should have been  
 5 a face-to-face review to determine VC's mental state.  
 6 A risk formulation and future crisis plan should have  
 7 been shared with the GP.

8 In relation to managing risk, the report found that  
 9 the decision to detain VC for his fourth admission under  
 10 section 2 of the Mental Health Act, rather than  
 11 section 3, was not in keeping with the fundamentals of  
 12 the Act. The report caveated this conclusion with  
 13 an acknowledgement that it was a finely balanced  
 14 decision and an area of clinic at judgment, where  
 15 different professionals may reach different conclusions.  
 16 The panel's view was that there was sufficient criteria  
 17 for detention pursuant to section 3, as VC had a known  
 18 mental health disorder, had been admitted three previous  
 19 times, with the essential elements of the treatment plan  
 20 to be followed in place.

21 The Panel consider that there was sufficient  
 22 evidence to place VC on a Community Treatment Order and  
 23 to instigate depot medication, but too much emphasis was  
 24 placed on complying with VC's priorities for his  
 25 education, with insufficient weight given to the risks

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1 provided by the Trust, as well as an assessment of  
 2 progress made at Rampton Hospital.

3 In this report it was noted that over the last  
 4 five years the CQC had raised ongoing concerns about the  
 5 quality of community and in-patient mental health  
 6 services at the Trust. All services, except forensic  
 7 in-patient services, had been rated as "requires  
 8 improvement or inadequate".

9 The March 2024 report concluded that there were  
 10 enduring areas of concern at the Trust. Three areas of  
 11 concern were demand for services, staffing and  
 12 leadership. Particular issues identified were: care  
 13 planning and risk assessment was inconsistent; discharge  
 14 planning across community mental health and crisis  
 15 services was not robust -- there were concerns around  
 16 people being discharged too soon or leaving in-patient  
 17 services in a worse state than when they arrived; there  
 18 were not enough staff to keep patients safe across  
 19 community mental health and crisis services, and some  
 20 in-patient services; people struggled to access the care  
 21 they needed when they needed it, putting them and  
 22 members of the public at risk of harm; the quality of  
 23 care and treatment across the Trust varied and did not  
 24 always meet the needs of individuals; there were issues  
 25 with communication between services which affected

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1 associated with non-concordance.

2 For those unfamiliar with the term "concordant", in  
 3 everyday language it means taking medication as  
 4 prescribed; non-concordant means not taking the  
 5 medication prescribed.

6 The Care Quality Commission, the CQC hereafter, was  
 7 commissioned by the Secretary of State for Health and  
 8 Social Care to carry out a rapid review of  
 9 Nottinghamshire Healthcare NHS Foundation Trust under  
 10 section 48 of the Health and Social Care Act 2008.  
 11 Section 48 imposes an obligation on the CQC to conduct  
 12 a special review or investigation when the Secretary of  
 13 State so requests, and to publish a report when  
 14 undertaking such an investigation.

15 The CQC was asked to look at three specific areas:  
 16 first, a rapid review of the available evidence related  
 17 to the care of VC; second, an assessment of patient  
 18 safety and quality of care provided by NHFT; and,  
 19 thirdly, an assessment of progress made at  
 20 Rampton Hospital since the most recent CQC inspection  
 21 activity.

22 On 26 March 2024, the CQC published the first of two  
 23 reports: "A special review of mental health services at  
 24 Nottinghamshire Healthcare NHS Foundation Trust". This  
 25 report considered patient safety and the quality of care

30

1 continuity of care for people; senior leaders did not  
 2 appear to have a clear oversight of risks; action taken  
 3 to address safety concerns was predominantly reactive --  
 4 leaders did not obviously prioritise engagement with  
 5 people using services.

6 In August 2024, the CQC published its second report,  
 7 which was a review of the care and treatment provided to  
 8 VC. The scope of the report was as a rapid review and  
 9 was intended to complement NHS England's Independent  
 10 Mental Health Homicide Review, undertaken by Theemis and  
 11 to which I will turn shortly.

12 As to the CQC's methodology, it had VC's records  
 13 containing his interactions with the Trust, Trust  
 14 policies and national guidance. The CQC also engaged  
 15 with the families of the victims and VC. In addition to  
 16 VC's case, the review considered ten other cases for  
 17 benchmarking involving patients of the Trust's Early  
 18 Intervention Psychosis service between April 2020  
 19 and February 2024.

20 Four experts were commissioned. Two consultant  
 21 psychiatrists considered VC's records, and two senior  
 22 community mental health nurses reviewed the ten  
 23 benchmarking cases. We have obtained statements from  
 24 these experts.

25 As the report recognises, the CQC did not speak to

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1 any members of the Trust staff involved in VC's care,  
2 and did not look more widely at how agencies such as  
3 the police and social services work together. We  
4 suggest, Chair, that both are necessary to understand  
5 the factual background and circumstances of VC's case,  
6 and to make recommendations for the future.

7 The report concluded that in respect of VC, there  
8 was no single point of failure but a series of errors,  
9 omissions and misjudgments, all of which were compounded  
10 by the symptoms of VC's illness. It acknowledged that  
11 the scope of the review did not allow for further  
12 exploration of these failures. This Inquiry will do so.

13 Key amongst the errors, omissions and misjudgments  
14 identified by the CQC were: the decision to discharge VC  
15 back to his GP in September 2022; inconsistent  
16 approaches to risk management; and, to some extent in  
17 contrast to the level 2 internal investigation, poor  
18 care planning and engagement with VC and his family.

19 The CQC's second report observed that the review of  
20 VC's case and the ten benchmarking cases supported the  
21 findings in the first report in respect of concerns with  
22 the assessment and management of risk in the community,  
23 the quality of care planning, the engagement and  
24 involvement of families and poor quality discharge  
25 planning.

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1 would relapse into distressing symptoms and potentially  
2 aggressive and/or intrusive behaviour. The decision to  
3 discharge VC back to his GP in September failed to  
4 consider or mitigate adequately the risks of relapse and  
5 violence.

6 The report made nine recommendations to the Trust  
7 and seven to NHS England. The Trust accepted all of the  
8 recommendations and developed an action plan which has  
9 been disclosed to the Inquiry and which will be explored  
10 in oral evidence.

11 Theemis review.

12 I turn now to NHS England's Independent Mental  
13 Health Homicide Review. NHS England commissioned  
14 Theemis Consulting Limited to carry out the  
15 investigation into the care and treatment provided to VC  
16 by NHS services prior to the 13 June.

17 The terms of reference were agreed with NHS England  
18 and representatives from the families of the victims.  
19 They included: compiling a full chronology; reviewing  
20 VC's interactions with services; describing the approach  
21 to the communication of risk across the healthcare  
22 system for patients with severe mental health problems;  
23 considering the adequacy of risk assessments and risk  
24 management processes, and how NHS services identified  
25 and managed the risk relevant to VC; determining whether

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1 In terms of VC specifically, findings included that  
2 risks around VC's capacity and consent may not have been  
3 managed adequately, as not all opportunities to assess  
4 his capacity to consent to treatment in the community  
5 were taken.

6 The report found that care planning was not always  
7 approached in a holistic manner. There was no real  
8 change to his care and treatment, despite multiple  
9 hospital admissions and the evidence that VC was  
10 symptomatic. There were large gaps between visits to  
11 VC. Information provided by VC's families was not  
12 consistently acted upon. There was an obvious pattern  
13 of VC not taking his medicine while in the community.

14 The CQC found that there was no evidence of  
15 a discussion around the value of depot medicine or  
16 a Community Treatment Order until the fourth admission  
17 but, as VC was admitted under section 2 of the Mental  
18 Health Act, that was not then an option.

19 There was no updated risk assessment prior to VC  
20 being discharged back to the GP in September 2022, with  
21 no evidence that VC's family, the GP, police or  
22 university were consulted.

23 This CQC report concluded that the evidence over the  
24 course of VC's illness, and his contact with services  
25 and the police, indicated beyond any real doubt that VC

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1 there were missed opportunities to engage, listen to and  
2 support VC and his family.

3 The methodology adopted by Theemis was to review  
4 publicly available documents, national policies,  
5 legislation, mental health review reports, national  
6 professional guidance and academic papers. In addition,  
7 VC's medical records from the Trust, the private  
8 providers and primary care were obtained by Theemis.

9 The investigation was undertaken by  
10 a multi-disciplinary team including those with expertise  
11 in psychiatry and nursing. The report was primarily  
12 authored by Amber Sargent, a healthcare consultant and,  
13 at the time, director of Theemis, with contributions and  
14 peer review from the rest of the team.

15 Staff from the Trust involved in VC's care and the  
16 author of the internal investigation report were  
17 interviewed by Theemis, as were primary care staff,  
18 members of the Integrated Care Board and two providers  
19 of acute mental healthcare services. VC was interviewed  
20 by a psychiatric qualified member of the team.

21 The report made 27 key findings. It identified two  
22 areas for improvement at national level and ten areas  
23 for improvement at local level where recommendations  
24 were made.

25 The key findings included: VC lacked insight; he did

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1 not consider himself to have a mental health condition;  
 2 his insight did not seem to increase even if he  
 3 clinically improved as an in-patient; he did not  
 4 demonstrate retrospective insight; his lack of insight  
 5 which limited his ability to understand fully the  
 6 implications of his mental health condition may have  
 7 meant he lacked full capacity to make decisions relating  
 8 to his care and treatment, particularly in the  
 9 community; capacity did not appear to inform all  
 10 assessments of risk across different settings.

11 Early Intervention in Psychosis staff were working  
 12 with caseloads beyond the recommended level. The  
 13 complexity and acuity of service users was not reflected  
 14 in the allocation of workload.

15 The majority of dedicated assertive outreach teams  
 16 had been disbanded a decade previously. The approach to  
 17 assertive outreach, that is supporting service users who  
 18 are not engaging, varied. In VC's case "there was  
 19 an element of an assertive approach", but it was  
 20 constrained by the service model and workload Early  
 21 Intervention in Psychosis team.

22 Pausing there, we will question what is meant by  
 23 "assertive approach", Chair, as opposed to "assertive  
 24 outreach" and whether this is a misguided term.

25 The report found the approach to risk assessment did  
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1 not the community team. Whilst the community team fed  
 2 into discussion about VC's care, shared decision-making  
 3 was missing.

4 When VC was discharged from the Early Intervention  
 5 in Psychosis team to the GP, there was an absence of  
 6 robust process enabling engagement with primary care and  
 7 the family and a lack of meaningful communication and  
 8 planning to manage recognised risks. Non-engagement had  
 9 been an accepted reason for discharge.

10 As to oversight at Trust and Integrated Care Board  
 11 level, Trust process and approaches to managing incident  
 12 data and reports of specific harm to others did not  
 13 support effective oversight and provide opportunities to  
 14 learn. Effective follow-up actions to improve the  
 15 approach to the management of risk were absent.

16 There were limitations in the assurance and  
 17 oversight arrangements at the ICB; the ICB were aware of  
 18 concerns regarding risk and safety at the Trust but were  
 19 not fully assured of the ability of the Trust to make or  
 20 sustain the requirements.

21 The report recommended discussion and debate at  
 22 a national level amongst NHS England and others, as to  
 23 how the needs of people similar to VC were being met and  
 24 how they were to be supported to thrive safely in the  
 25 community. It was recommended that NHS England consider  
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1 not fully consider all potential hazards in different  
 2 treatment settings. By failing to consider community  
 3 risks, the approach to risk assessment was not dynamic.

4 A positive risk management approach, which is  
 5 essentially making choices that involve some level of  
 6 risk in favour of patient autonomy, may have impacted  
 7 the ability to achieve medication concordance and  
 8 engagement, and to increase VC's insight.

9 VC's third admission, which involved an out of area  
 10 placement in the North East, came at an important point  
 11 in his mental illness. With out of area placements,  
 12 something is lost with not keeping care delivery local.

13 There was an opportunity during each hospital  
 14 admission to consider putting in place arrangements for  
 15 depot medication. During VC's third admission, which  
 16 was pursuant to section 3 of the Mental Health Act,  
 17 there was an opportunity to discharge VC on a Community  
 18 Treatment Order, including a condition that he comply  
 19 with depot medication.

20 By the time of the fourth admission there was  
 21 a pattern of concordance in hospital and non-concordance  
 22 in the community. The in-patient team was trying to  
 23 treat VC in the least restrictive way. The decision to  
 24 discharge from hospital was ultimately the  
 25 responsibility of the in-patient Responsible Clinician,  
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1 how mental health and social care understand, assess and  
 2 manage risk and the mechanisms in place to communicate  
 3 risk across multiple agencies.

4 Again, the Trust accepted the report recommendations  
 5 and we will explore the action plan for their  
 6 implementation in evidence.

7 Common themes and building on the reports.

8 Chair, we suggest some key themes emerge from these  
 9 investigations and reports and whether described  
 10 currently as "learning points", failings or criticisms,  
 11 they provide a baseline critique upon which we will  
 12 build. Unlike the reports which anonymise those  
 13 involved, evidence will be given by named individuals in  
 14 this inquiry who have provided detailed written  
 15 statements in advance.

16 The approach to risk assessment, the dynamic nature  
 17 of risk and the need to have a clear and accurate  
 18 history are all key themes. When should the risk VC  
 19 presented in the community have been recognised and what  
 20 should have been done about it? Was there any attempt  
 21 to reduce the risk? Was there any attempt at assertive  
 22 outreach? If not why not?

23 Whilst depot medication, a long-lasting injection of  
 24 medication, was considered in relation to VC's known  
 25 non-concordance, it was never instituted. VC's  
 40

1 antipathy towards it was given priority over its  
2 benefits in risk management. This, and the failure to  
3 consider depot medication as a condition of a Community  
4 Treatment Order on discharge from VC's third admission,  
5 will be examined in detail.

6 That VC was discharged from the Trust of the GP on  
7 the grounds of non-engagement, which had become an  
8 accepted reason for discharge, requires further  
9 scrutiny. There was no face-to-face review of VC prior  
10 to discharge, no engagement with the GP, police or VC's  
11 family, and no assessment or communication in respect of  
12 management of the risk. Unlike the reports cited, this  
13 Inquiry will take a holistic approach when examining the  
14 handling of VC's case to identify where and why  
15 information fell through the gaps.

16 The Inquiry has analysed a great deal of information  
17 about VC himself, including in respect of his time at  
18 the University of Nottingham and his interactions with  
19 the police. We have obtained over 60 statements from  
20 the police. The Inquiry has sought written evidence  
21 from all those mental health professionals who had  
22 interactions with VC, obtaining witness statements from  
23 the vast majority of them. We have received 169  
24 statements from those working at the Trust, 19 from the  
25 Priory Hospital and 29 from Cygnet. We have obtained

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1 integrated Master's degree in engineering at the  
2 University of Nottingham. You will hear from Nottingham  
3 University witnesses in relation to the University's  
4 knowledge of and interactions with VC.

5 Upon beginning his degree and moving to Nottingham,  
6 he registered with the University of Nottingham Health  
7 Service GP, based at the Cripp's Health Centre on the  
8 University Park Campus in September 2017. The GP  
9 records contain two entries prior to his first mental  
10 health admission in May 2020, neither of which concerned  
11 mental health issues.

12 VC had previously been registered at a GP practice  
13 in Wales from September 2007 to September 2017. Despite  
14 the Inquiry's efforts, it appears scant records survive  
15 from that GP practice. There is no electronic sharing  
16 of records between NHS practices in England and NHS  
17 practices in Wales. Dr Timothy Baker, the senior GP  
18 partner at VC's GP practice, explains that this means  
19 there is a limited transfer of medical history in  
20 respect of patients previously registered in Wales. All  
21 that was received was a summary print-out showing two  
22 entries from 2014 and 2015, neither mental health  
23 related.

24 On the basis of all of the evidence the Inquiry has  
25 received therefore, it appears VC has no documented

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1 nine statements from Nottingham City Council who  
2 employed Approved Mental Health practitioners.

3 Chair, you are required to produce and review  
4 a detailed multi-factorial timeline of VC's interactions  
5 with health services, social services, Nottingham  
6 University, the police and the wider criminal  
7 justice system between 2019 and the attacks on  
8 13 June 2023.

9 1. Chronology and prior events leading up to the  
10 attack.

11 We will turn now to set out the chronology of events  
12 prior to 13 June and the involvement of police and  
13 health services.

14 The treatment VC received for mental health problems  
15 was provided predominantly by the Nottinghamshire  
16 Healthcare NHS Foundation Trust, which I will simply  
17 refer to as "the Trust" henceforth.

18 Additionally, there was involvement from Nottingham  
19 City Council Approved Mental Health Professionals, VC's  
20 General Practitioners and the University of Nottingham  
21 Mental Health Services.

22 VC's interactions with the police involved  
23 essentially two police forces, Nottinghamshire Police  
24 and Leicestershire Police.

25 In September 2017, VC began studying towards an  
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1 mental health issues prior to his presentation  
2 in May 2020.

3 At the University of Nottingham there was a Mental  
4 Health Advisory Service. This was headed by Eleanor  
5 Turner, a mental health social worker who had worked as  
6 a community psychiatric social worker. She explains  
7 that the Mental Health Advisory Service was a specialist  
8 referral only service for students experiencing  
9 significant mental health difficulties. It offered  
10 advice, not diagnosis or treatment, liaising with  
11 external services when needed to ensure support and risk  
12 were communicated. VC was one of the students on  
13 Ms Turner's caseload and she provided support to him  
14 between 1 June 2020 and April 2022, albeit she had no  
15 contact with him between November 2020 and January 2022.  
16 Ms Turner will be the first witness in this Inquiry.

17 The Trust provided care to VC from 24 May 2020 until  
18 he was discharged by them to his GP on  
19 22 September 2022. In that period of time, VC had seven  
20 Mental Health Act assessments leading to four  
21 detentions, one of which, the second, was pursuant to  
22 section 3 of the Mental Health Act, and another, the  
23 third, which commenced as a section 2 detention but  
24 which was converted to a section 3 during the admission.  
25 The remaining two were pursuant to section 2.

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1 Each of the detentions was preceded by incidents of  
2 violence committed by VC and the involvement of  
3 Nottinghamshire Police. Each of the assessments  
4 involved City Council Approved Mental Health  
5 Professionals.

6 The Trust provides both in-patient mental health  
7 services and community mental health services. Between  
8 VC's in-patient admissions and when in the community, he  
9 received mental healthcare in the community primarily  
10 from the Trust's Early Intervention in Psychosis  
11 service, referred as EIP throughout the evidence. The  
12 EIP is a multi-disciplinary community mental health  
13 service that provides care for those with a first  
14 episode of psychosis during the first three years of  
15 psychotic illness, with treatment commencing during  
16 within two weeks of referral. It provides support and  
17 treatment concluding a range of pharmacological, social,  
18 occupational and educational interventions in accordance  
19 with NICE guidelines.

20 It was originally set up in the early 2000s as  
21 a stand-alone team. In 2018 it was integrated into  
22 local mental health teams before being uncoupled from  
23 local mental health in 2021, when care coordinators were  
24 released from local mental health teamwork. However,  
25 the consultants undertaking Early Intervention in

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1 the EIP team also had interactions with VC over the  
2 course of his treatment from that team.

3 VC also received treatment from the Crisis  
4 Resolution and Home Treatment team. This team provides  
5 short-term intensive community-based treatment for  
6 a period of up to six weeks. The aim is to reduce the  
7 risk of an individual being admitted to hospital.

8 VC never received treatment from the Trust forensic  
9 care group. No referral to them was ever made and they  
10 were not involved in his care. Forensic services have  
11 specialist expertise in assessing the risk of violence  
12 and associated treatment interventions to manage future  
13 risks. It was the Trust's forensic services that  
14 primarily used a tool, called the HCR-20, in order to  
15 assess and manage the risk that a person might become  
16 violent.

17 Forensic psychiatric services fall broadly into two  
18 categories: those provided in secure units and those  
19 provided in community settings. Community forensic  
20 mental health services in Nottingham were provided by  
21 the Nottinghamshire Community Forensic Team. This team  
22 ordinarily worked with patients who had contact with the  
23 criminal justice system but it could accept patients  
24 without criminal charges or convictions where there was  
25 clear evidence of an emerging danger to others, or if

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1 Psychosis work remained part of the local mental health  
2 team, although there was no dedicated Early Intervention  
3 in Psychosis consultant.

4 VC's Early Intervention in Psychosis team was the  
5 City South team based at Stonebridge Centre. His  
6 community consultant was Dr Tuhina Lloyd. As we will  
7 describe, in the period of over two years that the Early  
8 Intervention in Psychosis team were involved with VC,  
9 Dr Lloyd only saw him once, on 14 March 2022. VC had  
10 several appointments with Dr Bilal Burri, who was  
11 Dr Lloyd's Speciality trainee in the  
12 period September 2020 to March 2021. COVID restrictions  
13 were relevant during this time and we will explore  
14 whether and how they impacted.

15 VC had a care coordinator from the EIP team  
16 allocated to him. The care coordinator is the main  
17 key worker for a patient, coordinating their care and  
18 supporting them to develop and implement their care  
19 plan. Care plans ought to cover a number of domains  
20 such as housing, employment and welfare support, need  
21 for medication, psychological therapy, physical health  
22 and family intervention.

23 Claudia Birtles was VC's care coordinator  
24 from June 2020 to April 2022 when Gary Carter took over  
25 until VC's discharge in September 2022. Other nurses in

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1 there was a pattern of assaults and escalating threats.

2 The Inquiry will explore the circumstances in which  
3 referrals are and should be made to forensic services,  
4 and when treatment advice from forensic services should  
5 be sought. Should it have been sought in VC's case?

6 In our chronology, we begin in the academic year  
7 2019/2020, the third year of VC's degree. VC completed  
8 a group design project with four other students. Chair,  
9 you will hear from William and Joel, two of VC's group  
10 members. They will tell you how, in their experience,  
11 VC was quiet and calmly mannered. They will say that  
12 whilst VC did not contribute to the project in the same  
13 way as the other group members, as Joel puts it, "would  
14 always pull through" when it came to work at that time.

15 We note that his personal tutor, Stewart McWilliam,  
16 did not receive any direct contact from VC during the  
17 academic year 2019-2020 and was not aware of his arrest  
18 and detention in May 2020. We will ask why he was not  
19 aware of this. Were there barriers internally to  
20 information sharing?

21 Not long after the group project finished in the  
22 very early hours of 24 May 2020 officers were called to  
23 attend 11 Brook Court, an address in the Radford area of  
24 Nottingham. Brook Court houses some students but is  
25 primarily a general residential building. It is not

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1 owned by the University. VC was at that time one of its  
2 residents living at number 7 Brook Court.

3 You will hear from Liam, a neighbour of VC's, who  
4 heard a loud banging noise and found VC repeatedly  
5 kicking and punching a door. He will describe VC as  
6 doing whatever he could to get into the flat. He asked  
7 VC if he was okay but couldn't understand what VC was  
8 saying in response. The VC was, according to Liam, just  
9 saying "scattered words". VC is said to have turned on  
10 Liam who had to restrain him alongside a second  
11 resident.

12 Inspector Eustace as was one of the officers  
13 attending the scene. You will hear that when she  
14 entered the building she could hear shouting coming from  
15 the floor above. She describes VC shouting that his  
16 mother was inside the flat. He was trying to push his  
17 way into number 11 and was placed into handcuffs by the  
18 officer. He had caused significant damage to the door  
19 of number 12 Brook Court and was saying someone was  
20 inside that flat trying to harm his mother. The officer  
21 formed the view that he was suffering from some sort of  
22 hallucination. She arrested him on suspicion of  
23 criminal damage at 12.20 am.

24 Inspector Anthony Wilde was the Custody Sergeant on  
25 the night of 24 May. He authorised VC's detention and

1 custody by a Community Psychiatric Nurse from that team,  
2 Dominic Lloyd. Mr Lloyd noted that VC had kicked the  
3 door in to another flat causing damage. VC was noted to  
4 be presenting with mental health issues, hearing voices,  
5 appeared vacant, and had not slept for five days.

6 Mr Lloyd does not recall feeling uncomfortable in VC's  
7 presence. Mr Lloyd was unclear as to his mental health  
8 needs and VC did not engage fully with the assessment.  
9 Mr Lloyd was under the impression VC was suffering  
10 a psychotic episode given his short answers and delayed  
11 responses, and that he appeared to be responding to  
12 stimuli. He considered VC lacked capacity about his  
13 mental health. In view of his assessment and VC's  
14 behaviour Mr Lloyd referred VC for a mental health  
15 assessment.

16 That mental health assessment, VC's first, was  
17 undertaken by Dr Gandhi, Dr Malik, Approved Mental  
18 Health practitioner Ben Williams, and Annette Palmer,  
19 a psychiatric nurse in the Trust's crisis team. Their  
20 assessment obtained a history that VC had heard his  
21 mother screaming and other people screaming that his  
22 mother was being raped and in pain. He described  
23 hearing two voices talking to each other. The  
24 impression was the first episode of psychosis which was  
25 attributed to sleep deprivation and stressors or

1 carried out a risk assessment. During that assessment,  
2 VC informed the officer that he had been at the Queen's  
3 Medical Centre the previous day due to chest pain but he  
4 had been discharged. He said he had been hearing voices  
5 over the last five days and had not been sleeping. The  
6 custody record noted that he appeared to have been  
7 having a mental health episode and appeared distant. VC  
8 was placed on "level 3 observations" which involves  
9 constant observations via CCTV and a physical check  
10 every 30 minutes.

11 According to Inspector Wilde, the relevant Health  
12 Care Professional made contact with the NHS Crisis Team  
13 who had no record of any mental health issue for VC and  
14 he was to go to the Queen's Medical Centre to rule out  
15 any issues. VC was taken to the Medical Centre by  
16 officers and brought back to custody by 4.04 am. A note  
17 on his custody record observed that he had been seen by  
18 the senior consultant who stated that "his actions may  
19 be more mental health" than a physical concern. VC does  
20 not appear to have received any mental health treatment  
21 at that stage.

22 Inspector Wilde completed a referral to the Liaison  
23 and Diversion Team, based in custody, for them to  
24 conduct a mental health assessment later in the morning.

25 On the morning of 24 May, at 9.54 am, VC was seen in  
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1 university work and exams. The assessing team noted  
2 that VC presented with limited insight. They agreed  
3 that the least restrictive option needed to be offered  
4 instead of in-patient admission. VC agreed to home  
5 treatment and a prescription of Olanzapine and  
6 Zopiclone. The plan was for the Crisis Team to visit VC  
7 that evening and to undertake twice weekly visits to  
8 assess him and his risk, and to consider a referral to  
9 the Early Intervention in Psychosis team.

10 VC was interviewed in the presence of an appropriate  
11 adult later that afternoon. You will hear from the  
12 interviewing officer, PC Gail Collins, who will say that  
13 VC asserted in that interview that he had no real  
14 recollection of the incident. He was then released from  
15 custody pending investigation at 6.21 pm and formally  
16 released at 7.17 pm.

17 You, Chair, may ask why VC was released at that  
18 stage and whether release straight into the community  
19 was appropriate in view of Dr Gandhi's assessment. The  
20 Inquiry will also explore the appropriateness of the  
21 decisions made in this Mental Health Act assessment and  
22 its consideration of risk.

23 When Dr Gandhi was interviewed by the Trust on  
24 13 June, he commented that he had been leaning towards  
25 a section 2 admission given it was a first presentation

1 of psychosis and a lack of information on risk history,  
2 but:  
3 "the team of professionals considered the research  
4 evidence that shows over representation of young black  
5 males in detention. [He recalled that] Anna Palmer was  
6 able to persuade us that [the Crisis Team] could provide  
7 a safe and reasonable alternative ... with the option to  
8 admit if the community treatment plan failed."

9 Ms Palmer's evidence is that it was not her job to  
10 persuade the medical doctors and Approved Mental Health  
11 Professional, she simply agreed it was right to consider  
12 home treatment for VC. She notes that he had no prior  
13 mental health history and was willing to receive support  
14 from the crisis team. Dr Gandhi explains in his  
15 evidence that it is part of his role to be aware of  
16 research evidence and data, including patient  
17 demographic and health inequalities, but it would not  
18 have affected the decision to admit or treat VC in the  
19 community which would have been based purely on his  
20 current needs, acuity of the symptoms, and the risks.

21 The incident at 11 and 12 Brook Court, which I have  
22 already described, was not the only incident on 24 May.  
23 In fact, an even more serious incident occurred shortly  
24 after VC's return from custody. You will hear evidence,  
25 Chair, from a former resident of Brook Court who heard

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1 address with the intention of observing him taking his  
2 medication as part of the plan made following the first  
3 mental health assessment. In light of VC's arrest she  
4 did not see him. She spoke to VC's mother and noted  
5 that "she would prefer that her son goes into hospital  
6 for treatment as he is a risk to others in his current  
7 mental state". Ms Palmer completed the first of VC's  
8 risk and safety assessments. The box for "Risk to  
9 others" was ticked. The risk formulations noted that he  
10 had no past history of mental health difficulties, no  
11 past history of illicit substance use or forensic  
12 history, and no history of violence or aggression.

13 The second mental health assessment was undertaken  
14 the following evening, on 25 May, by Dr Sadraei,  
15 Dr Malik and AMHP Eleanor Cullen. The assessment noted  
16 that the neighbour jumped from a window due to being  
17 frightened. VC was described as perplexed, very  
18 distracted and appearing to be psychotic. He explained  
19 that he had broken the neighbour's door after hearing  
20 a woman screaming. He denied taking drugs. The  
21 impression was first episode psychosis due to sleep  
22 deprivation and stress, with a risk to VC's own safety  
23 and others. It was concluded that he did not have  
24 capacity to agree to hospital admission, detention  
25 pursuant to section 2 was recommended.

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1 a knock-on her door soon after she had returned from  
2 work at around 8 pm. It was VC. She asked who it was  
3 and he said "It's me, open please". She repeated the  
4 question but he just knocked louder and louder. He  
5 began kicking. She was alone in the flat and describes  
6 her fear at this point. She was so frightened that she  
7 jumped out of a first floor window, causing serious  
8 damage to her spine.

9 You will hear evidence from PC Marsden, who was the  
10 first to arrive and who took photographs of the scene,  
11 and similarly from PC Smith who arrested VC at  
12 approximately 9.14 pm. You will hear oral evidence from  
13 the custody officer, PS Swift. VC was again placed on  
14 Level 3 observations. Police Sergeant Swift attempted  
15 to contact the Mental Health Crisis Team.

16 The Mental Health Crisis Team responded at around  
17 11.01 pm. They confirmed that VC had been seen earlier  
18 that day and was assessed as having a first episode of  
19 psychosis and sleep deprivation. He hadn't been  
20 detained under the Mental Health Act and the Crisis Team  
21 would visit that evening.

22 Shortly after 1 am the nurse had referred the matter  
23 to an Approved Mental Health Professional who was booked  
24 in to assess VC at 9 am on 25 May.

25 In the meantime, Ms Palmer had arrived at VC's

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1 **THE CHAIR:** Ms Langdale, is that a convenient moment to take  
2 a break?

3 **MS LANGDALE:** It is, Chair, thank you.

4 **THE CHAIR:** We will rise now and we will start again at 20  
5 to 12. Thank you.

6 (11.18 am)

(Short Break)

8 (11.40 am)

9 **THE CHAIR:** Yes, Ms Langdale.

10 **MS LANGDALE:** Chair, I turn then to VC's first admission,  
11 25 May 2020 to 17 June 2020.

12 VC was admitted to Rowan 1 ward of the Trust's  
13 Highbury Hospital at 11.30 pm on 25 May. He remained an  
14 in-patient there until his discharge on 17 June. His  
15 consultant during this admission was Dr Seedat,  
16 consultant psychiatrist.

17 Initially it was noted that VC did not verbally  
18 engage with staff, was suspicious and seemed to be  
19 responding to unseen stimuli. On 26 May he consented to  
20 staff speaking to his mother.

21 Also on 26 May there was a multi-disciplinary team  
22 meeting. In addition to Dr Seedat this was attended by  
23 Dr Ludvigsen, a ward doctor, Dr Ibrahim, a junior  
24 doctor, and Esmee Ryder, a nurse. It was noted that the  
25 admission was to assess psychosis and due to expire

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1 22 June 2020. It noted an arrest for criminal damage  
2 and did not expressly refer to two arrests or the  
3 serious injury to VC's neighbour. We will ask why not.

4 The review was that VC was presenting with an acute  
5 psychotic picture and required a period of observation.

6 Later that day it was noted that VC was seen kicking  
7 a glass door. He refused to stop when asked by staff  
8 and had to be physically restrained by the response team  
9 after an alarm was triggered. He was forcibly  
10 administered 2 milligrams of Lorazepam, a sedative. VC  
11 said he wanted to leave and appeared to have no insight  
12 he was being detained.

13 VC's mother, Celeste Calocane, visited the hospital  
14 that evening and asked whether VC had been violent in  
15 any way. She was assured he had not been. She  
16 explained that VC's siblings had raised concern about  
17 the content of VC's conversation over the last few  
18 weeks. She described him as becoming a little more  
19 paranoid within his conversations. VC's brother had  
20 kept a journal of conversations which he offered to pass  
21 on to the staff.

22 A ward review on 28 May was attended by VC's mother  
23 by telephone. The nursing feedback was that he was very  
24 unwell but less chaotic, aggressive and hyperactive.  
25 VC's mother said that he had for some time been telling

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1 NHS mental health services in relation to VC and the  
2 challenges they encountered. You will also receive  
3 written evidence from Stuart Croy, the University's  
4 Associate Director of Security Services, who was  
5 contacted by Ms Turner on 10 June to give a "policing  
6 perspective" on the incident.

7 At a ward review on 2 June 2020, VC disclosed that  
8 since October 2019 he had thoughts that people were  
9 following and watching him. He had moved home to get  
10 away from the voices but they continued to follow him.  
11 He became angry, which is the reason he went to the  
12 neighbouring flat to get the people he thought were  
13 invading his mind.

14 That account is of course different from that given  
15 at his arrest when he said that he was responding to  
16 fears for his mother. This disclosure suggested he in  
17 fact attacked neighbouring properties with an angry  
18 intention to confront those he believed were following  
19 and watching him.

20 The notes for this ward review on 2 June recorded  
21 that VC now realised that, in order to safeguard his own  
22 safety and the wellbeing of others, he had to ask for  
23 help if he found himself hearing voices or becoming  
24 paranoid. Consideration will need to be given as to  
25 whether this was an early example of what would become

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1 his brother he had been hearing voices  
2 since January 2020. Dr Seedat's view was that he had  
3 suffered a psychotic breakdown most likely caused by  
4 sleep deprivation and stress. VC told the meeting he  
5 had never taken illicit drugs. It was noted he had  
6 insight into his current condition.

7 On 29 May his mother emailed academic staff,  
8 Alastair Campbell-Ritchie and Donald Giddings at the  
9 University of Nottingham on behalf of VC. She told them  
10 that he had "recently been admitted to the mental health  
11 ward, due to a psychotic episode and will remain there  
12 for the time being."

13 His mother sent the same email to the engineering  
14 faculty's Student Support and Wellbeing email address on  
15 1 June. This was picked up by Paige Smith, who was at  
16 the time an officer in the Support and Wellbeing team.  
17 Ms Smith notified Claire Thompson, the Head of Student  
18 Wellbeing, who then notified Eleanor Turner, the Head of  
19 the Mental Health Advisory Service.

20 You will hear evidence from Ms Turner and  
21 Ms Thompson, and written evidence from Ms Smith, about  
22 the steps taken by the University during this time, and  
23 following VC's subsequent admissions into mental health  
24 care and incidents with other students. They will tell  
25 you about their experience working with the police and

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1 a recurring theme: VC saying essentially the "right  
2 things" and appearing compliant whilst an in-patient,  
3 which accelerated his discharge.

4 It was also noted, in respect of risk, that VC had  
5 entered a neighbour's flat to confront those he believed  
6 were trying to spy on him and torment his mind. It was  
7 stated that there had been "no incidents of violence  
8 yet, [but] it would be a potential concern if it acutely  
9 unwell."

10 Chair, you will no doubt consider whether "no  
11 incidents of violence yet" was correct, in circumstances  
12 where doors had been forcibly kicked and damaged and  
13 a victim was seriously injured having jumped from  
14 a window in fear as a consequence of VC's actions.

15 The ward review concluded that more clarity around  
16 VC's mental health and insight was needed prior to  
17 discharge.

18 That same day, 2 June, Dr Seedat emailed PC Marsden,  
19 following a request from the police about VC's capacity  
20 at the time of his arrest at Brook Court.

21 Dr Seedat reported that VC "presented with clear  
22 symptoms and signs suggestive of an acuter psychotic  
23 illness". Dr Seedat stated that VC had informed him  
24 that he had no recollection of the events prior to his  
25 admission. VC had, of course, given two accounts of the

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1 incidents prior to this. In Dr Seedat's view VC was  
2 "not in touch with reality around the time of his  
3 admission nor around the time of the incident causing  
4 damage to someone's door". Dr Seedat explained that in  
5 his view "it was more likely that he did not have the  
6 capacity to be responsible for his actions as this was  
7 not done in a clear conscious state."

8 You, Chair, will hear how Dr Seedat's opinion fed  
9 into the police's decision not to pursue these two  
10 incidents further. You will hear from Police Sergeant  
11 Katie Sparkes who on 9 June filed the incident when the  
12 neighbour jumped out of the window as "unable to be  
13 detected", having formed the view there was a lack of  
14 evidence in the case. She will say that this was based  
15 primarily on the information provided by Dr Seedat  
16 stating that VC did not have capacity for his actions.

17 Chair, you will consider whether providing a view  
18 that VC lacked capacity to form sufficient criminal  
19 intent was something that Dr Seedat should have done or  
20 should have been expected to do in the circumstances;  
21 furthermore, whether the police should have simply  
22 accepted Dr Seedat's email as the final say about the  
23 matter. Was Dr Seedat even aware of the extent of the  
24 injuries the victim suffered? Would it have made any  
25 difference if he was?

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1 extent of VC's psychotic symptoms was not volunteered to  
2 medical practitioners by VC, but rather was revealed in  
3 his communications to his brother. VC's mother provided  
4 Dr Seedat with the text messages VC sent, and Dr Seedat  
5 summarised them in VC's notes on the evening of  
6 3 June 2020. VC said he believed he was being monitored  
7 in his previous flat, he heard voices and believed some  
8 of the people had followed him to the new flat. He  
9 heard voices in his head and at times it was like  
10 someone was speaking to him outside of his head. He  
11 wanted to hurt the people he was hearing. He believed  
12 he was being watched. He queried whether there was  
13 technology or artificial intelligence that could map his  
14 thoughts accurately. He believed the people next door,  
15 who he had confronted, used advanced technology.

16 Dr Seedat concluded that these messages clearly  
17 showed psychotic symptoms starting and developing over  
18 time, with evidence of auditory hallucinations and  
19 persecutory delusional beliefs suggesting more of  
20 a functional illness rather than it being precipitated  
21 by stress or isolation.

22 The result, however, was that the day after giving  
23 his opinion to PC Marsden, Dr Seedat had this  
24 information, including that VC wanted to hurt the people  
25 he was hearing.

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1 You will be aware of CPS guidance "Mental Health:  
2 Suspects and Defendants". It makes clear that mental  
3 health conditions do not provide a carte blanche for  
4 criminal culpability or an automatic exception from  
5 liability. In the case of serious offending, the  
6 relevance of mental health may be to sentencing and  
7 disposal rather than the decision to prosecute. 2023  
8 guidance refers to the fact that "a thinking approach is  
9 required when considering what information is required  
10 and in explaining the purpose ... for which it is  
11 sought."

12 No formal capacity assessment was undertaken in  
13 respect of VC at this time. As you will be aware,  
14 Chair, a caution or criminal conviction would have been  
15 highly relevant within any risk assessment from this  
16 point onwards. You will consider whether there was  
17 a failure to consider the risk VC posed to the public at  
18 this point; furthermore, to adequately address whether  
19 he should be prosecuted or not in respect of his  
20 actions.

21 By the next day, 3 June, some degree of discharge  
22 planning was in motion. A referral to the EIP team had  
23 been made. There would also be a referral to the Crisis  
24 Team on discharge.

25 It is clear that a fuller picture of the nature and

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1 On 4 June Dr Seedat spoke to Eleanor Turner to  
2 explain VC's situation. Her advice was that VC should  
3 not return to his flat in Nottingham but instead return  
4 to his family in Wales where he could undertake online  
5 learning and avoid social isolation. The University  
6 could support him with his studies. This option was  
7 discussed with VC the same day, but VC described going  
8 back to Wales as undesirable. He wished to stay in  
9 university accommodation and did not want to be on any  
10 medication.

11 On 5 June, VC was pacing the ward. He reported to  
12 staff that he could hear a woman in distress. He led  
13 a member of staff to where the voice was coming from.  
14 It was in fact a linen cupboard.

15 Later that day Dr Seedat explained to VC and his  
16 family that VC was suffering a first episode of  
17 psychosis. VC agreed that things were not right and  
18 agreed to start medication. Dr Seedat explained he  
19 would start him on aripiprazole, a low dose to be  
20 increased as required. He was to be started on  
21 5-milligram daily tablets.

22 Thereafter VC was described as keeping a low profile  
23 on the ward. He largely kept in his bed space. He  
24 declined occupational therapy input, he declined  
25 escorted leave. There was concern he was not eating.

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1 At ward review on 9 June he reported he had no  
2 paranoia, suspiciousness, and was not hearing any  
3 voices. He reported he had not had thoughts about  
4 hurting himself or others and no side-effects from  
5 aripiprazole. Dr Seedat was concerned by VC's social  
6 isolation and how he would manage on discharge. VC was  
7 considered to have capacity. The aim was for discharge  
8 on 16 June but more clarity around his mental health,  
9 insight and safety planning was required prior to  
10 discharge.

11 On 10 June VC reported that he was feeling  
12 brilliant. He wanted to live independently on discharge  
13 and finish his degree. However, in a telephone  
14 conversation with VC's mother that day she expressed  
15 concern about the discharge plan. She felt it was too  
16 early and wanted to speak to Dr Seedat. By the time of  
17 the ward review on 11 June 2020, VC had been on leave  
18 around the hospital grounds and had spoken to Eleanor  
19 Turner who repeated her advice that the best outcome was  
20 to go back to Wales.

21 The University were not keen on him returning to  
22 university accommodation. VC wished to go back to it  
23 and then to Birmingham and he agreed to continue to take  
24 medication.

25 There was a meeting with the Crisis Team on 15 June  
65

1 to be a risk to himself and others. Following  
2 assessment, it was determined he had suffered a first  
3 episode of psychosis. It was unclear if this formed  
4 part of a greater illness or was isolated. Community  
5 follow-up would be crucial in this regard. On the ward  
6 there were no further incidents of risk to others and  
7 there was clear remorse for his actions. The GP was to  
8 ensure his medications are prescribed on his repeat  
9 prescriptions.

10 VC was in the community for just under a month until  
11 his second admission. This raises questions in respect  
12 of the assessment and discharge planning at the first  
13 assessment and the care in the community that followed  
14 it.

15 The Crisis Team spoke to VC by telephone on 18 and  
16 20 June. VC didn't raise issues on either call. On  
17 22 June Dr Seedat sent the Crisis Team an email asking  
18 that VC be seen face-to-face as he was likely to  
19 downplay any symptoms or problems, that is he was likely  
20 to mask them.

21 Daisy Coleman from the Crisis Team carried out  
22 a home visit on 23 June. She noted that VC appeared  
23 distracted at times and was staring for long periods.  
24 He said his mental state had improved since being  
25 admitted. He was able to manage the voices he was  
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1 attended by Samantha Woodings of that team. Dr Seedat  
2 advised a three-day follow-up on discharge with  
3 continuing follow-up until the proposed move to  
4 Birmingham when there should be a referral to an EIP  
5 team in Birmingham; alternatively, a referral to  
6 a Nottingham EIP team. It was noted that Dr Seedat had  
7 no concerns as VC, who was described as largely keeping  
8 a low profile, had been very settled on the ward and had  
9 no issues with alcohol or illicit substances. It was  
10 noted that there was a risk of aggression.

11 VC was discharged by Dr Seedat on 17 June. The  
12 diagnosis was first episode psychosis, the plan to take  
13 medication for at least six to nine months and seek  
14 medical advice if he wished to stop. He was given  
15 14 days of medication with further supplies to be  
16 provided by the GP. A letter was sent to VC's GP  
17 practice putting them on notice that VC had been  
18 admitted after being arrested by the police after  
19 gaining unlawful entry into a neighbour's flat. The  
20 neighbour jumped out of the flat's first floor window  
21 from fear and had to be taken to the emergency  
22 department "for minor injuries". VC was hearing voices  
23 and responding to unseen stimuli. He was admitted under  
24 section 2 for assessment, as it was his first  
25 presentation to mental health services. He was deemed  
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1 hearing. He said he was taking his medication. His  
2 intention was to stay in Nottingham until at least the  
3 end of July.

4 Ms Coleman noted that VC had the ability to mask his  
5 symptoms, a history of violence and aggression when his  
6 mental health deteriorates, and there was a risk of  
7 deterioration in his mental state if non-concordant.  
8 The plan was to conduct a joint visit with Nottingham  
9 Early Intervention in Psychosis.

10 On 26 June, Ms Coleman spoke to VC by telephone. He  
11 said he was doing well and that the voices were at  
12 a manageable level and dying down. The same day Claudia  
13 Birtles spoke to VC for the first time by telephone in  
14 order to introduce herself. He denied any concerns  
15 about his mental health. Ms Birtles noted that his  
16 responses appeared delayed.

17 Subject to the attacks Claudia Birtles would say of  
18 VC that her relationship with him was superficial from  
19 the start, she never really knew him, he was hard to  
20 engage and determined to keep EIP at a distance.

21 The joint visit to VC by the Crisis and Early  
22 Intervention in Psychosis teams was on 30 June, attended  
23 by Claudia Birtles and Daisy Coleman. From this point  
24 on the EIP team took over his care. VC was provided  
25 with written information on Early Intervention in  
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1 Psychosis and recovery. He was described as well kempt  
2 during the visit. Ms Birtles noted that he appeared  
3 distracted and some of his responses were delayed. He  
4 denied auditory hallucinations, contending that they  
5 hardly happened anymore. He denied any concerns  
6 regarding his mood. He said he was happy to continue  
7 taking medication but wasn't clear about how he would  
8 get a further supply.

9 On 3 July Claudia Birtles spoke to VC. He had no  
10 medication remaining and had not taken any steps to  
11 contact his GP. The Inquiry will explore what steps if  
12 any had been taken by the GP to facilitate his  
13 prescription and whether there ought to be active steps  
14 taken by General Practices in these circumstances.

15 The failure of VC to make any arrangements to obtain  
16 medication, despite stating only days later he was happy  
17 to continue with it, may have been an early indication  
18 or warning that whilst VC said he would take medication,  
19 he did not have an intention to do so.

20 Arrangements were made for the local mental health  
21 team to take VC a four-week supply of medication later  
22 that day. The local team then took over the  
23 responsibility for prescribing his antipsychotic  
24 medication.

25 There was no face-to-face meeting the following week  
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1 from PC Michael Plant who arrived on the scene at  
2 approximately 10.16 pm to find three residents having  
3 detained VC on the floor. The Street Triage Team  
4 attended and spoke with VC. A Street Triage Team  
5 includes both a police officer and a Community  
6 Psychiatric Nurse. You will hear from PC Jamie Severn  
7 who was the officer in that team.

8 PC Severn and the Community Psychiatric Nurse were  
9 able to consider information from the electronic patient  
10 record system and from officers at the scene. They were  
11 aware from the electronic patient record system that  
12 there had been a similar incident in May which resulted  
13 in VC being detained and assessed under the Mental  
14 Health Act. CPN Nigel Wade advised that VC needed to be  
15 detained under section 136 of the Mental Health Act, as  
16 he was felt to be a significant risk to himself or  
17 others requiring immediate care and control.

18 No further police action was taken in respect of the  
19 incident and we will return to this later. Suffice to  
20 say that this was the third display of violent and  
21 aggression at Brook Court within three months, a pattern  
22 which appears to have eluded the police.

23 Dr Seedat, along with Dr Manzar and Approved Mental  
24 Health Professional Geoff Culpin, carried out a mental  
25 health assessment of VC on the afternoon of  
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1 but Claudia Birtles spoke to VC by telephone on 9 July  
2 and he said everything was good. However, on 11 July,  
3 VC's mother contacted the Trust as she believed VC's  
4 mental state might be deteriorating. In recent  
5 discussions he was not making much sense. She thought  
6 he was not taking his medication as prescribed. Andrew  
7 Jackson, the nurse who spoke to VC's mother, felt unable  
8 to discuss VC's care without VC's consent. It will be  
9 recalled VC had previously given consent whilst an  
10 in-patient for his care to be discussed.

11 Mr Jackson passed a message on to Claudia Birtles  
12 who tried unsuccessfully to call VC's mother back but  
13 did not in fact speak to her until three days later on  
14 14 July. During the conversation VC's mother told  
15 Claudia Birtles that she had noticed red flags and was  
16 unsure he was taking the medication despite her daily  
17 prompts. She believed he may mask his symptoms, having  
18 denied that he was experiencing auditory hallucinations.

19 In the meantime, on 13 July, VC had been taken by  
20 the police to a place of safety pursuant to section 136  
21 of the Mental Health Act, having again forced his way  
22 into a nearby property.

23 On the evening of 13 July, police were called by  
24 a resident of Brook Court who reported VC had broken  
25 into the property and assaulted someone. You will hear  
70

1 14 July 2020. It transpired during the assessment that  
2 VC had stopped taking his medication two weeks after his  
3 discharge from hospital, believing that he was well, did  
4 not have mental health problems and would be fine.

5 It was noted, in contrast to the letter to VC's GP  
6 following his first discharge describing his remorse,  
7 that VC minimised the potential risk and did not  
8 acknowledge his actions or risk to others. He was not  
9 convinced he was unwell or needed to be in hospital.

10 VC was said to accept that he had made a mistake in  
11 not taking his medication and asserted he would now do  
12 so. The assessment concluded he had poor insight and  
13 required treatment and risk management; he was  
14 unsuitable for community treatment and needed work on  
15 concordance. The recommendation was for a section 3  
16 detention. He was restarted on his aripiprazole  
17 medication at an increased dose of 10 milligrams per  
18 day. He was transferred back to the Rowan ward at  
19 Highbury Hospital that night and remained detained until  
20 31 July, a period of two and a half weeks.

21 On 15 July, Dr Ackroyd completed a core assessment  
22 which documented a plan for VC to re-establish treatment  
23 and receive some "psychoeducation".

24 On 16 July, there was a ward review which described  
25 VC as settled on the ward. He had given, as his reason  
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1 for stopping medication in the community, the fact that  
2 he had read that it could slow the mind. He accepted  
3 that this may have made him "a little more paranoid".  
4 He was described as nonplussed when confronted with the  
5 effects of his recent behaviour on his neighbour on  
6 13 July, and the previous incidents, and demonstrated no  
7 signs of remorse or insight into how his actions had  
8 affected others.

9 Dr Seedat is recorded to have stated "that there  
10 seems to be no insight or remorse and that the danger is  
11 that this will happen again and perhaps VC will end up  
12 killing someone." VC responded: "It will not happen  
13 again". Dr Seedat's view was that it seemed  
14 increasingly likely that VC may have schizophrenia. VC  
15 did not accept he had an enduring illness and was hoping  
16 it would go away, that he could "power through it" with  
17 his will. It was concluded that given VC did not accept  
18 he had a mental illness, he lacked capacity.

19 There was, during this review, the first discussion  
20 of depot medication. It was recognised at this early  
21 stage that VC "takes medication while on the ward but  
22 then stops once discharged". Dr Seedat explained the  
23 pros and cons of depot. VC said he would think about  
24 it.

25 On 18 July, VC's mother contacted the hospital. She

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1 discharge or would prefer to stay on oral tablets. We  
2 will ask whether more work could have been done to  
3 convince VC of the benefits of depot. VC's mother was  
4 clearly supportive. Interestingly, there is no  
5 indication that Dr Seedat doubted VC's capacity to think  
6 about this decision.

7 Dr Seedat noted that whilst VC could remain in  
8 hospital for up to six months given it was a section 3  
9 detention, being in hospital made no difference to VC  
10 whilst he was well. The important thing was continuing  
11 to take his medication on discharge. It was noted that  
12 Claudia Birtles was happy with the plan of oral tablets  
13 "for now".

14 We note, Chair, that this turned out to be  
15 a relatively short section 3 admission. There was the  
16 option, not explored at the time, of discharging VC on  
17 a Community Treatment Order with the requirement that he  
18 received his medication by depot to ensure concordance.  
19 Given that it was expressly recognised during this  
20 admission that VC took medication whilst on the ward but  
21 stopped once discharged, we will ask why this was not  
22 done.

23 At the multi-disciplinary team meeting on 27 July it  
24 was noted VC was polite and pleasant on the ward,  
25 appeared to be remorseful and said he would take his

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1 was planning a visit and wanted to be involved in his  
2 review. A multi-disciplinary team meeting was held on  
3 20 July. It was noted that VC had been keeping a low  
4 profile, spending most of his time in his room. He had  
5 been settled, calm, with no aggression or hostility. He  
6 had not disclosed psychotic symptoms.

7 The plan for VC was to have occupational therapy and  
8 psychological interventions to work on insight and  
9 concordance. An occupational therapist met with VC but  
10 in fact he declined Occupational Health input.

11 A ward review held on 21 July was attended by VC's  
12 mother and brother as well as Claudia Birtles. Based on  
13 VC's discussion with Ms Purdue, Acute Psychological  
14 Interventions Practitioner, the feedback was that VC  
15 appeared to have developed good insight into his  
16 condition. Dr Seedat explained the importance of VC  
17 taking his medication. VC was noted to say he felt  
18 better since starting his medication, was not hearing  
19 voices on the ward, understood his condition well and  
20 recognised the importance of taking his medication after  
21 discharge.

22 VC's mother suggested starting VC on a depot. VC  
23 said he did not think he needed to make the decision on  
24 depot at that stage and Dr Seedat said that VC had time  
25 to think about when he wanted to take a depot on

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1 medication on discharge. There was no overt sign of  
2 psychosis.

3 At a ward review on 28 July, however, Dr Seedat  
4 explained that although VC was saying the right things,  
5 Crisis Team follow-up was needed to ensure what he was  
6 saying was actually the case. Dr Seedat advised VC that  
7 he would need to take medication for two years. VC  
8 agreed that he had difficulties with his mental health  
9 again and acknowledged the importance of taking his  
10 medication when discharged. He was discharged on  
11 31 July 2020.

12 Returning now to the police investigation of the  
13 events at Brook Court, the first, VC kicking the door  
14 and trying to gain entry to Liam's flat, was  
15 investigated by PC Gail Collins. You will hear from  
16 PC Collins that she did not progress the case  
17 significantly until January 2021, eight months after the  
18 incident. She spoke with Dr Seedat ten months after the  
19 incident, in March 2021, and Claudia Birtles around the  
20 anniversary of the incident in May 2021. By then, of  
21 course, the police knew of three incidents at Brook  
22 Court between May and July 2020.

23 Nevertheless, on 29 July 2021, PC Collins met with  
24 VC to discuss whether the first case could be resolved  
25 by a community caution. VC refused to agree to the

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1 caution and you will hear about the discussions that  
2 took place with VC on that occasion and subsequently.

3 It was only on 29 July that PC Collins read  
4 the police notes from the second incident, when the  
5 victim was seriously injured jumping out of the window,  
6 and the email from Dr Seedat from 2 June. PC Collins  
7 was not previously aware of the diagnosis of acute  
8 psychotic illness. You will hear of the circumstances  
9 that led to the first incident being closed. In  
10 particular, you will hear from Sergeant Powar who  
11 decided that the incident should be marked as "Outcome  
12 12 -- too ill to prosecute". In what Sergeant Powar  
13 accepted was an error, there was also reference to the  
14 case being well over the six-month statutory time limit,  
15 but that time limit did not in fact apply to the case.

16 On 4 October 2021, almost a year and a half after  
17 the incident, the case was closed.

18 Why was it not immediately clear to the officer  
19 investigating the first incident that the second  
20 incident, which after all happened on the same day, had  
21 been discontinued on the basis of an email from  
22 Dr Seedat on 2 June? Why were the two incidents not  
23 linked? What was the barrier to the sharing of the  
24 medical information? As a matter of law and policy, we  
25 know that mental health information can be shared when

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1 contact with VC following his first admission. As well  
2 as the discharge summary from the first admission, the  
3 practice had also received the discharge summary of  
4 31 July from the second admission. In August 2020 the  
5 practice had sent VC three text messages asking him to  
6 arrange an appointment.

7 During the telephone appointment with Dr Murphy, VC  
8 said he had been doing well since leaving hospital and  
9 was compliant with his medication. He reported no  
10 further intrusive voices or thoughts. Dr Murphy  
11 described VC as calm, well spoken, and focused. His  
12 impression was that VC was stable.

13 Following the appointment, Dr Murphy sent VC a text  
14 message asking him to make an appointment with the  
15 practice nurse for his weight, height and blood pressure  
16 to be measured. It does not appear such appointment  
17 ever occurred. It does not appear he was seen or spoken  
18 to subsequently in respect of mental health by his GP.  
19 He had a telephone consultation on 10 September 2020 for  
20 an ear infection.

21 We will return to the role of primary care when  
22 considering the period following VC's discharge from the  
23 EIP team to the GP in September 2022, but note at this  
24 stage that VC did receive COVID 19 vaccinations by way  
25 of injection at his GP practice on 14 July 2021 and

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1 it is proportionate, necessary and lawful for a specific  
2 policing purpose. The College of Policing APP on  
3 information management includes such purposes as  
4 protecting life and property, preserving order,  
5 preventing and detecting offences and bringing offenders  
6 to justice.

7 With the information provided by Dr Seedat, was it  
8 right that the second incident was simply closed? With  
9 the addition of a third similar incident in July 2020,  
10 when VC broke into another flat and assaulted the  
11 occupant, was this an identifiable pattern of behaviour?  
12 Did it provide a clearer picture for the police and  
13 mental health authorities of psychosis and repeated  
14 violence? Was there sufficient liaison between  
15 the police and mental health services, in particular in  
16 relation to risk of violence? Should the cases have  
17 been referred together to the CPS?

18 There was a period of just over 13 months that VC  
19 spent in the community after his second admission.  
20 Immediately following discharge, VC was followed up by  
21 the Crisis Team with a number of visits up until  
22 15 August 2020 when he was described as seeming well,  
23 and said that he was compliant with his medication.

24 On 17 August VC had a telephone appointment with GP  
25 Dr Craig Murphy. This was the GP practice's first

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1 13 December 2021.

2 We highlight this because one of the reasons VC  
3 would subsequently give for not agreeing to depot was  
4 that he did not like needles.

5 In this 13-month period between the second and third  
6 detentions, VC's care was predominantly provided by the  
7 EIP team and, in particular, his care coordinator  
8 Claudia Birtles and Dr Bilal Burri. He was not seen by  
9 the consultant Dr Lloyd at all during this period.

10 One of the limitations in the evidence available in  
11 this period is that whilst the EIP team had weekly  
12 multi-disciplinary meetings, notes of these meetings  
13 were not routinely made and entries appear rarely to  
14 have been made in VC's record about what was discussed  
15 and decided, despite evidence suggesting that he was  
16 regularly discussed. As the Trust have accepted, that  
17 is a significant shortcoming in practice.

18 A summary care plan was created by Claudia Birtles  
19 on 1 September 2020. This named Dr Lloyd as being  
20 responsible for mental health actions, risk and safety  
21 actions, physical health, activities of daily living,  
22 medication, social and occupational needs and therapy.  
23 The Inquiry will explore whether and how Dr Lloyd could  
24 discharge that responsibility in the absence of seeing  
25 VC.

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1 On 7 September 2020 VC saw Dr Bilal Burri for the  
2 first time. VC requested a medication-free trial. This  
3 request may be thought to conflict with his assurances  
4 just prior to discharge from hospital on 31 July when he  
5 was told he must continue to take medication and he  
6 recognised the importance of this. The Inquiry will  
7 explore why, a month later, VC was asking to be  
8 medication-free and whether this was evidence of  
9 an ongoing lack of insight on his part, an indication of  
10 intended non-concordance and should have been recognised  
11 as such.

12 Dr Burri appeared to think so, as he observed that  
13 VC had tried being medication-free in the past and ended  
14 up in hospital, so it was not a good idea, and advised  
15 him that he needed to be on antipsychotic medication for  
16 at least six months to a year. Dr Burri considered VC  
17 showed only superficial insight. Dr Burri was not very  
18 confident VC had a deeper grasp of his illness and  
19 noticed there could be some element of minimisation. He  
20 was unsure about VC's long-term commitment to taking  
21 antipsychotic medication and considered there might be  
22 compliance issues on the horizon.

23 In the weeks that followed, no concerns about VC  
24 were detected by the EIP team, but on 9 October VC's  
25 mother contacted them as VC had told her not to speak to

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1 VC contacted his previous in-patient consultant,  
2 Dr Seedat, on 5 November. Dr Seedat was surprised to be  
3 contacted by VC, given he was not involved in his care,  
4 and advised him to contact his community team.  
5 Dr Seedat recorded in the notes that he felt, based on  
6 the interaction, VC needed "more close monitoring and  
7 regular visits otherwise he will end up in hospital".

8 In light of VC's call to Dr Seedat and Dr Seedat's  
9 note, nurses Gary Carter and Abigail Parsonage visited  
10 VC the following day. VC asked if he may contact  
11 Dr Burri or the medical team for advice. He was  
12 reluctant to explain what advice he needed. Gary Carter  
13 had taken a month's supply of medication with him as  
14 VC's medication was at this point overdue. The Inquiry  
15 will explore why medication had not been provided prior  
16 to it becoming overdue.

17 However, VC reported he had ten tablets left which,  
18 given his repeat prescription was overdue, was a clear  
19 indication that VC was not compliant with his  
20 medication. An appointment was arranged with Dr Burri  
21 to determine a possible deterioration in his mental  
22 state.

23 On 10 November 2020 Claudia Birtles spoke to VC. He  
24 wanted an appointment that day, saying he had something  
25 very important to discuss that he was hesitant to speak

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1 him for two months. She had been unable to contact him.  
2 She requested a visit to VC. Abigail Parsonage and  
3 Anthony Walthall went to VC's address that afternoon but  
4 he was not in. A housemate said he was in the city  
5 centre and was okay; she had no concerns.

6 There were no further entries in the record until  
7 almost a week later on 15 October when VC's mother asked  
8 if someone had made contact with VC. Four days later,  
9 on 19 October, VC's father told Gary Carter VC had said  
10 he was fine.

11 On 24 October VC's mother spoke to Gary Carter as  
12 she was worried about VC. He visited VC two days later  
13 on the 26th and asked him to consider giving his parents  
14 a ring. VC said he would but "then went back into his  
15 room without another word". This was the first time VC  
16 had been seen or spoken to by the Community Mental  
17 Health Team since his mother first raised concerns more  
18 than two weeks earlier.

19 Meanwhile, on 4 November, VC met with  
20 Dr Stewart McWilliam, his personal tutor at the  
21 University of Nottingham, to discuss troubles he was  
22 experiencing with his studies. By this time VC was in  
23 the fourth year of his degree. He decided to interrupt  
24 his studies and this was formally signed off six days  
25 later. He left the University until September 2021.

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1 about over the phone. Dr Burri and Ms Birtles carried  
2 out an urgent home visit that afternoon. There were  
3 noted to be no signs of self-neglect, VC described as  
4 pleasant and cooperative and looking more engaging than  
5 he had previously.

6 VC told them whilst he told the in-patient doctor,  
7 just prior to discharge from the second admission, that  
8 he could no longer hear voices, that was not the case  
9 and he had only said that because he was tired of being  
10 in hospital. In fact, he disclosed that "the voices  
11 that I hear can see other people as well and he don't  
12 want that other people get into the trouble".

13 He described auditory hallucinations from a group of  
14 people, men and women, that he did not recognise. They  
15 were from a variety of institutions, including  
16 the police and MI5, telling him he should be punished  
17 for crimes he had committed in the past. His previous  
18 crimes were his violation of lockdown rules. They did  
19 not command him but suggested to him that he "prove his  
20 power". The voices were telling him that since he had  
21 the power to challenge the lockdown rules he should do  
22 to something to prove to people his powers. He believed  
23 the voices were really experiences, not the result of  
24 mental illness. He said he was taking medication  
25 regularly apart from missing a couple of odd days. He

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1 denied any thoughts of harm to himself or others.

2 Dr Burri's impression was that VC came across as  
3 psychotic with escalation of symptoms. The risk was  
4 described as currently contained, with a need to  
5 optimise antipsychotic treatment. His dose of  
6 aripiprazole was increased to 15 milligrams per day.

7 The Inquiry will ask whether there was greater  
8 significance to these disclosures beyond an escalation  
9 of symptoms. Did they confirm that VC was misleading  
10 when reporting that he was taking medication and had  
11 only missed a couple of days, and that he had misled  
12 when an in-patient to obtain a swifter discharge? Was  
13 it an opportunity to engage in more detailed  
14 understanding of the role of the voices in VC's  
15 behaviour?

16 Following the increased dose of medication, VC  
17 reported that the voices were quieter, though he  
18 remained unsure that they were a symptom of psychosis.

19 On 7 December he was seen by Claudia Birtles after  
20 he had secured a job working in a warehouse. He  
21 described his work colleagues as okay to work with and  
22 his mood and sleep as good. He was able to keep calm  
23 and carry on through the auditory hallucinations.  
24 Ms Birtles' impression was slow but steady progress.  
25 She could not identify any acute risk VC posed to

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1 VC stated if he became unwell again he would like  
2 people not to be overly judgmental and would like to  
3 avoid hospital with the use of the least restrictive  
4 practice. We will explore with Ms Birtles whether this  
5 was a rehearsed or learned response on the part of VC.  
6 Was it, in any event, an appropriate relapse plan?

7 On 1 February 2021 VC was seen by Dr Burri, when  
8 slow but steady recovery was noted. VC agreed in  
9 increasing his aripiprazole to 20 milligrams a day.  
10 There was noted to be no acute risk of self-harm,  
11 suicide or risk to others. VC's complaint in respect of  
12 his short-term memory were attributed to the cognitive  
13 deficit of psychotic illness.

14 On 22 February VC reported being much better. The  
15 voices were quieter, in the distance, he was able to  
16 ignore them. Ms Parsonage, who saw him on this  
17 occasion, considered he was low risk to himself and  
18 others.

19 On 15 March Dr Burri administered memory tests which  
20 were not particularly concerning. Again no acute risks  
21 were identified.

22 On 13 May, visited by Ms Birtles, VC was found to be  
23 relaxed and well presented. Voices remained much of the  
24 day but were much more in the background and did not  
25 cause distress. He denied any command hallucinations.

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1 himself or others, and there was no self-neglect.

2 VC confirmed he was not keen on CBT therapy.  
3 I pause to note, Chair, that at various stages of  
4 treatment VC was offered different non-pharmacological  
5 treatments all of which, as in this case, he refused.  
6 Should more have been done to pursue these treatments?

7 On 17 December VC reported both that he had plenty  
8 of medication left and that he had been taking it daily.  
9 This inconsistency was attributed to him potentially  
10 using his previous lower 10-milligram dose of  
11 aripiprazole before starting the 15-milligram dose. If  
12 correct, that would have been further evidence of him  
13 not properly complying with advice on medication.

14 During a home visit on 21 December, Ms Birtles  
15 witnessed VC taking his dose of aripiprazole, one of the  
16 relatively few times in the record that VC was actually  
17 observed taking his medication in the community. There  
18 were ongoing daily auditory hallucinations but despite  
19 this VC was continuing to function and was said to be  
20 keen to get on with his life without too much  
21 interruption.

22 On 4 January 2021 VC raised concern about defects in  
23 his memory. On 18 January Ms Birtles worked with VC to  
24 identify early warning signs and relapse prevention,  
25 developing a relapse plan.

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1 He was unconvinced the medication had improved the  
2 hallucinations but said he remained concordant.

3 Therefore, in summary, Chair, on the basis of the  
4 medical records at least it would appear that VC was  
5 improving in the months following the appointment on  
6 10 November when he had disclosed more troubling  
7 hallucinations leading to an increase in his medication  
8 doses. But that is not the full picture when other  
9 sources are considered.

10 On 29 May 2021, VC's mother contacted the Crisis  
11 Team, speaking to Juliet Lopez, as she believed VC was  
12 becoming unwell. She felt he had not been taking his  
13 medication in the last few days and reported that VC had  
14 told his brother he had not been taking his medication  
15 for two to three weeks. She was concerned he would act  
16 on his paranoia, observing that previously he had  
17 attacked a neighbour and gone to a neighbour's house  
18 with intent. Ms Lopez contacted VC by telephone who  
19 said everything was fine and he was not hearing voices  
20 or having any visual hallucinations. He said, in fact,  
21 he was taking his medication daily and had no thoughts  
22 to harm himself or others. He described his mood as  
23 nine out of ten and peaceful. Ms Lopez did not see  
24 a role for the Crisis Team, there being no obvious signs  
25 of deterioration. She acknowledged she had not nursed

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1 VC before.

2 Just two days later, on 31 May, an incident occurred  
3 which adds support to VC's deteriorating psychiatric  
4 state and his mother's concern he was becoming unwell.  
5 On that day VC visited MI5 headquarters in Westminster.  
6 You will hear evidence read from an MI5 witness, witness  
7 G. He will explain that VC pressed the intercom  
8 claiming to have information regarding a case and  
9 wanting to be arrested. He made the request again at  
10 another entrance. Two police officers attended: PC  
11 Foster and PC Nash. You will hear oral evidence from PC  
12 Foster about their interaction with VC, and you will be  
13 able to see this via body-worn camera footage. VC told  
14 the officers that he didn't want to explain why he  
15 wanted to speak to a member of MI5 and stated he did not  
16 want to speak with the police. His demeanour in the  
17 video appears calm and compliant. He was awaiting an  
18 Uber taxi. Whether his behaviour was unusual or strange  
19 will be a matter explored in oral evidence and for you,  
20 Chair.

21 Police checks were completed at the time, and  
22 although he was identified as being known to police  
23 there were no warning signals or special checks against  
24 his name. It does not appear that the officers were  
25 aware that VC had been sectioned twice in the last

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1 put her mind at rest. She had spoken to VC a couple of  
2 times and she thought he was okay.

3 On 18 June Ms Birtles visited VC. She noted there  
4 was no overt evidence of psychosis. VC reported  
5 residual voice experiences but denied it caused him  
6 distress. He had a new job working in a warehouse for  
7 a medical distribution company.

8 In July 21, just over a month after VC's visit to  
9 MI5, two further incidents occurred. By way of  
10 background, in early 2021 VC had moved back to student  
11 accommodation at 48 Salisbury Street near the University  
12 campus in Ilkeston Road. He had lived there previously  
13 from September 2019 to September 2020. You will hear,  
14 Chair, from his former flat mate, Sebastian, who lived  
15 with VC between 2019 and 2020, and again when VC  
16 returned to the accommodation in 2021. Sebastian will  
17 describe two incidents in July 2021 which caused him to  
18 leave the accommodation.

19 The first of the two incidents occurred on 5 July.  
20 VC grabbed hold of Sebastian and forced him back against  
21 the wall. You will hear Sebastian recall that VC said  
22 to him "People are going to contact you. When they do  
23 tell them I will find them." Sebastian describes  
24 calling the police and later seeing PC Amy Pannell at  
25 Radford Police Station. They discussed placing a marker

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1 12 months.

2 No action was taken by the police at the scene,  
3 although information was passed on to the Fixated Threat  
4 Assessment Centre, FTAC. FTAC is a joint NHS and  
5 Metropolitan Police service team which manages threats  
6 posed to protected public figures and protected sites by  
7 fixated lone individuals. The Inquiry has obtained  
8 a statement from Superintendent Lorraine Busby-McVey,  
9 who holds responsibility for FTAC within the Royalty and  
10 Specialist Protection Command. VC's case did not reach  
11 the threshold for further FTAC involvement, but  
12 Superintendent Busby McVey and Dr Frank Farnham,  
13 consultant psychiatrist, will provide evidence as to how  
14 that centre works.

15 Abigail Parsonage and Adele Pinder, nurses at the  
16 Early Intervention in Psychosis team, visited VC on  
17 2 June '21. Ms Parsonage notes she describes VC as  
18 being well kempt, less monosyllabic than he had been in  
19 the past. He described voices as being faint. He was  
20 able to ignore them. He did not know why his mother was  
21 concerned. Ms Parsonage wrote that she didn't think VC  
22 had relapsed, he appeared well in himself.

23 On 17 June VC's mother texted the care coordinator,  
24 Ms Birtles, stating that the telephone call from Ms  
25 Lopez and the visit by Ms Parsonage and Ms Pinder had

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1 on VC for the appropriate agency to follow up. He was  
2 advised that, in the absence of injury, VC was unlikely  
3 to be arrested or taken away. The matter was then  
4 closed and filed as "undetected". It was marked as  
5 "outcome 16 Victim Declines/Withdraws Support".

6 You will hear from PC Pannell who will give her  
7 account. You will also hear from Police Sergeant Zoey  
8 Price, the reviewing sergeant. Through their oral  
9 evidence, we will seek to understand whether this was  
10 taken seriously enough by police at this stage and  
11 whether they should have taken further steps with mental  
12 health professionals or the Street Triage Team.

13 On 8 July 2021 Ms Birtles saw VC for a home visit  
14 after he missed an outpatient appointment. Dr Burri had  
15 left the Early Intervention in Psychosis team and the  
16 next appointment would be with the consultant, Dr Lloyd.  
17 VC described himself as being 100 per cent back to his  
18 normal self and denied any concerns about his mental  
19 health. He described the voices as barely noticeable;  
20 he did not register them any more. He reported taking  
21 his medication daily, and whilst he wished to be off  
22 medication he had no immediate wish to come off the  
23 tablets.

24 The second of the two incidents occurred just over  
25 a week later. On 14 July 2021, at around 5 am,

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1 Sebastian heard VC trying to get into his room which was  
2 locked. He was sufficiently worried to agree a plan  
3 with a friend to leave the flat. He also sent a message  
4 to PC Pannell informing her of the incident and asking  
5 whether it was something worth reporting to the police.  
6 No response was received.

7 On 6 August 2021 Gary Carter rang VC because his  
8 medication was due. He was going to deliver it. Gary  
9 Carter described VC as seeming abrupt and a little rude  
10 on the telephone. When he visited him he was short with  
11 Gary Carter and not as friendly as he had known him in  
12 the past.

13 On 9 August VC failed to attend an appointment with  
14 Dr Lloyd. Concern that he might be relapsing is noted,  
15 but when Ms Birtles spoke to him by telephone VC said he  
16 was unaware of the appointment. He said he was too busy  
17 for an appointment the following day.

18 Ms Birtles and Dr Sasidharan visited VC on  
19 10 August. He said the voices were faint, he wasn't  
20 distressed by them. He denied thoughts of harming  
21 others. He didn't believe he had mental health  
22 problems, said he would follow medical advice and  
23 continue to take his medication. The recorded  
24 impression was that his mental health was stable.

25 On 16 August, VC turned up at Highbury Hospital  
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1 was not psychotic and never had been, and had no  
2 intention of seeing the EIP any longer. They were  
3 working in collaboration with the judicial system and  
4 had created technology to cause his voice experiences  
5 and monitor him.

6 It was noted at this point that VC was relapsing,  
7 had no insight, there was a risk of further decline in  
8 his mental state and in respect of risk to others;  
9 previously when unwell he had broken a neighbour's door.  
10 Ms Birtles and Mr Carter did not feel it was not safe to  
11 continue to push the assessment.

12 VC was referred for a mental health assessment that  
13 day. His risk assessment was updated by Claudia  
14 Birtles, for the first time in over a year, identifying  
15 the risk of a further deterioration of his mental state.

16 A. He was visited twice: two days later on 2 September for  
17 the assessment, but he wasn't in; and on 3 September  
18 Ms Birtles spoke to VC's mother. The previous evening  
19 VC had spent much of a call to his mother talking about  
20 the government monitoring him. He told his mother he  
21 had stopped his medication and no longer wanted to see  
22 the EIP team.

23 On 3 September 2021 there was a further serious  
24 incident. VC assaulted a police officer, PC Barnaby  
25 Pritchard. A warrant had been obtained to detain VC  
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1 wanting to speak to Dr Seedat. Instead he spoke to  
2 Ms Amanda Smilie. He told her he wanted to discuss with  
3 Dr Seedat whether there was an alternative explanation  
4 for the voices he heard. He asked whether staff on the  
5 ward heard voices and whether they communicated with  
6 artificial intelligence.

7 Abigail Parsonage and Adele Pinder from the EIP team  
8 visited VC on 19 August. VC said he was not expecting  
9 them until Thursday, but it was in fact a Thursday. VC  
10 told them they could not come in and he didn't have time  
11 to talk. When asked if he was taking his medication he  
12 paused before responding "Yeah". He seemed guarded and  
13 less friendly and warm. He looked more unkempt. His  
14 impression was he was likely relapsing and, whilst no  
15 risks were noted, it was acknowledged to be difficult to  
16 assess because of VC's guarded presentation. The plan  
17 was to liaise with Claudia Birtles, the  
18 Care Coordinator, when she was back from leave.

19 Claudia Birtles and Gary Carter carried out a home  
20 visit on 31 August. The note of that visit describes VC  
21 as slightly confrontational and appearing suspicious of  
22 their intentions. He confessed that he was no longer  
23 taking his medication and stated he had no intention of  
24 continuing with treatment.

25 He said he had not been taking medication for days,  
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1 under section 135 of the Mental Health Act. Police  
2 attended to assist the medical professionals, Dr Lomas  
3 and Dr Manzar who were already at the address. VC was  
4 refusing to go with them. You will hear that PC Rachel  
5 Wakefield knocked on the door several times and VC  
6 opened the door. He refused to go. Dr Lomas explained  
7 to VC that he was required to go.

8 VC appeared calm and you may think, Chair,  
9 purposefully removed his glasses. He implied that he  
10 would use violence against the male officers but not  
11 female officers saying: "No one is going in an  
12 ambulance. I don't have a history of mistreating women.  
13 Gentlemen if you want to take me out ... I prefer you  
14 do."

15 He soon after attacked PC Pritchard and the Inquiry  
16 will hear evidence about what occurred. VC was sprayed  
17 and tasered twice to bring the attack under control.

18 The events are recorded on body-worn camera footage.  
19 Some people may find it distressing to watch. VC is  
20 seen congratulating the officer at the end of the  
21 encounter saying: "You did good, yeah. That was  
22 something [and] you didn't go down."

23 During the execution of the warrant, unused  
24 medication dating back to February 2021 was found at  
25 VC's flat.  
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1 VC was taken to the Queen's Medical Centre for  
2 treatment as a result of the taser deployment and then  
3 to the Cassidy Suite, a place of safety at Highbury  
4 Hospital. There a mental health assessment was  
5 undertaken that evening by Dr Lomas, Dr Manzar, and  
6 Approved Mental Health Professional Amy Staples. VC  
7 told the assessing team, politely it is noted, that "no  
8 assessment is going to happen" and they were "not going  
9 to admit him to any hospital or give him any  
10 medication".

11 VC would not be drawn on any discussion. The  
12 assessing team's view was that VC was experiencing a  
13 relapse of his psychosis, and it was clear from the  
14 assault on PC Pritchard that he posed a significant risk  
15 of violence to healthcare staff attempting to treat him.

16 The assessment concluded that the risk of serious  
17 assault to hospital staff was high and immediate. The  
18 team agreed to recommend his detention under section 2,  
19 with a referral to a psychiatric intensive care unit,  
20 a more secure form of psychiatric ward.

21 It was considered that he needed an intensive care  
22 unit bed to manage his mental health state and ensure  
23 the safety of others.

24 The Inquiry will explore in evidence the reasons why  
25 a section 2 rather than a section 3 detention was

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1 and in light of their predominantly female staff.

2 On 7 September VC's medication was given under  
3 passive restraint. The following day his seclusion was  
4 ended with VC assuring staff he would not attack other  
5 patients. He acknowledged an incident with the police  
6 but denied ever confronting neighbours.

7 On 9 September he accepted oral medication after  
8 a lot of prompting, but had been telling staff he didn't  
9 have mental health issues and didn't believe he needed  
10 it.

11 With VC no longer being in seclusion and accepting  
12 oral medication he was referred again to Cygnet for  
13 reconsideration, and this was accepted on the 10th. He  
14 was transferred there on the 11th. This was an out of  
15 area placement, being some distance away in Darlington,  
16 County Durham, the north east of England.

17 At Cygnet, VC accepted medication and was fully  
18 concordant. He was described as stable in mood,  
19 pleasant and polite. He kept a low profile. At ward  
20 review on 14 September, he expressed delusional thoughts  
21 and ideas about electronic harassment and a desire to  
22 stop aripiprazole whilst in the community. The  
23 diagnostic impression was paranoid schizophrenia, it  
24 being noted that he completely lacked insight. He  
25 wished to appeal his detention to the Mental Health

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1 recommended by the assessing team, albeit ultimately the  
2 detention was converted to a section 3.

3 From Nottingham Police, and in respect of VC's  
4 assault on PC Pritchard, you will hear, Chair, from PCs  
5 Pritchard and Wakefield. You will also hear from Police  
6 Sergeant Louise Ellis who addresses the subsequent  
7 police investigation and difficulties she encountered in  
8 obtaining information about VC's mental health from  
9 Dr Lomas, owing to patient confidentiality concerns.  
10 You will hear from the officer in the case, PC Matthew  
11 Johnson, and the investigating officer, PC David Myers.

12 We will ask why there was a difficulty in the police  
13 obtaining medical information about VC. As we have  
14 already noted, mental health information can be shared  
15 if it is proportionate, necessary and lawful for  
16 a specific policing purpose. Why wasn't it shared about  
17 VC?

18 VC was kept in seclusion at the Cassidy Suite whilst  
19 waiting for a psychiatric intensive care bed. He was  
20 guarded and suspicious, refusing medication. The Trust,  
21 having no such beds available, sought to refer VC to an  
22 independent healthcare provider. On 5 and 6 September  
23 it was necessary to give VC antipsychotic medication and  
24 a restraint. On 6 September Cygnet Victoria House  
25 declined the referral given the level of VC's violence

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1 Tribunal and appealed the following day.

2 On 17 September Claudia Birtles emailed John  
3 Laverick, a senior nurse at Cygnet, asking whether  
4 a depot was being considered. It was noted it was VC's  
5 third admission and concordance remained an issue.  
6 Mr Laverick replied the same day noting that VC was  
7 settled and concordant with his medication and there  
8 was, as far as he was aware, no plan to commence  
9 a depot. He suggested that was best discussed when he  
10 was being stepped down from psychiatric intensive care.

11 On the same day Ms Birtles spoke to VC ahead of the  
12 Mental Health Tribunal considering his detention. She  
13 prepared a social circumstances report. VC accused  
14 Ms Birtles of being involved with the hospital in  
15 a cover-up. He asserted he had no issues with his  
16 mental health, did not have a psychotic illness, he was  
17 not mentally unwell.

18 They discussed depot medication, with VC saying it  
19 would depend on the side-effects, but it might be easier  
20 than taking medication daily.

21 The Inquiry will explore with witnesses whether  
22 a depot can be justified in circumstances where  
23 a patient is clear that they are taking medication in  
24 order to be discharged.

25 Ms Birtles attended remotely VC's ward round on

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1 21 September, during which VC explained that he had,  
2 through his research, become aware of psychotronic  
3 harassment, a technology developed to transmit thoughts  
4 and voices into an individual's head. He believed he  
5 had been subjected to that harassment since the previous  
6 year, but it had ceased as he was no longer hearing  
7 voices. It was noted Ms Birtles did not believe VC had  
8 recovered to his pre-morbid level of functioning since  
9 his last admission.

10 On 23 September the Mental Health Tribunal decided  
11 that VC was to remain detained. VC participated in the  
12 hearing and told the Tribunal he had consistently taken  
13 his medication for 13 months up to August 2021.

14 The Tribunal meanwhile concluded:

15 "There is unequivocal evidence that the risk to  
16 others when [VC] is unwell are high and that relapse  
17 occurs rapidly and is difficult to manage. These risks  
18 eventuated very recently and it is important that they  
19 are minimised, so far as is reasonable, before [VC] is  
20 discharged into the community."

21 The same day Cygnet sent to the Trust a clinical  
22 update that VC was ready for step-down, there having  
23 been no incidents of violence or aggression and him  
24 being fully concordant and self-supporting. The Trust  
25 responded by insisting that any step-down be to a local

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1 that VC said this was because he was moving to a new  
2 house and needed to hang items. Dr Gurusinghe cannot  
3 recall whether he had concerns at the time, but was  
4 satisfied VC remained calm and cooperative.

5 We will pursue whether the question of retention of  
6 a hammer by a patient with a history of violence and  
7 aggression within the community was adequately explored.

8 Dr Gurusinghe describes VC's condition during his  
9 admission as improving consistently, with him  
10 demonstrating better insight. He was fully compliant  
11 with treatment and engaged at multi-disciplinary teams.  
12 Dr Gurusinghe says he did not have ongoing concerns  
13 about a risk of violence/aggression at the time of his  
14 discharge. He does not recall discussing depot  
15 medication with VC. He says:

16 "I would have considered the depot option if there  
17 was any evidence of non-compliance during the admission  
18 period, if he had expressed negative views of medication  
19 or if there was any evidence or suspicion of secreting  
20 medication."

21 On 18 October VC was released from his section. He  
22 remained at the Priory on a voluntary basis until  
23 22 October when he was discharged.

24 Whilst VC had been detained he had resumed his  
25 degree at the University of Nottingham. Indeed, in

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1 provider rather than an out of area one.

2 On 24 September a mental health assessment was  
3 undertaken which recommended that VC be detained  
4 pursuant to section 3 of the Mental Health Act.

5 On 28 September VC stated he wished to continue  
6 taking oral medication rather than being on a depot.

7 VC's mother spoke to Claudia Birtles telling her she  
8 had had no contact with Cygnet and they had not returned  
9 her numerous calls. Dr Sholiekova, from whom you will  
10 hear, consultant psychiatrist, reflects in her evidence  
11 to this Inquiry that communication between services was  
12 generally a problem and that communication with VC's  
13 nearest relatives was not as good as it perhaps should  
14 have been. We will ask why.

15 On 30 September VC was accepted by Priory Arnold,  
16 a local private hospital. He was transferred there on  
17 1 October. This was an acute ward rather than  
18 a psychiatric intensive unit. His consultant was  
19 Dr Gurusinghe, psychiatrist.

20 On arrival at the Priory it was noted that VC was  
21 happy to continue treatment as an in-patient, but was  
22 keen on discharge. A high risk of violence and  
23 aggression was noted.

24 On 10 October VC brought a hammer to the ward after  
25 a period of leave. The recollection of Dr Gurusinghe is

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1 September and early October 2021 VC liaised with  
2 academic staff at the university about his return to  
3 studies. The university was unaware of VC's admission  
4 at the time and remained unaware until 18 January 2022.

5 You, Chair, may wish to consider whether this  
6 represents an astonishing failure of information  
7 sharing.

8 There was a degree of confusion in respect of VC's  
9 discharge from the Priory which will be explored in  
10 evidence. VC was discharged on the morning of  
11 22 October, which was a Friday. Neither the EIP team  
12 nor VC's mother appeared to be aware of the discharge  
13 initially. The Crisis Team were too busy to carry out  
14 a follow-up appointment over the weekend. VC turned  
15 down an appointment with Claudia Birtles on Monday,  
16 25 October on the grounds that he was busy with a group  
17 project.

18 Ms Birtles did speak to him by telephone on the  
19 Monday. He was monosyllabic and could not recall when  
20 he was discharged. He reported he was back to normal  
21 and his mental health was perfect. He said he was  
22 taking medication.

23 The pattern that then followed was one of  
24 disengagement. VC did not attend the EIP as planned on  
25 1 November, although his mother spoke to Ms Birtles on

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1 that day reporting that he seemed okay and told her he  
2 was taking his medication.

3 On 4 November VC sent Ms Birtles a text message  
4 saying he had two weeks of tablets left, but she noted  
5 that the discharge summary indicated he had been  
6 discharged with a two-week supply which was due to run  
7 out on Friday, 5 November.

8 VC did not attend the EIP on 5 November to collect  
9 medication. This was the first time he had been seen  
10 following his discharge some two weeks earlier. He  
11 remained of the view the admission to hospital was  
12 unnecessary and did not agree he had been unwell. He  
13 said he was taking his medication but because he had to,  
14 but by oversight had been taking one 10-milligram tablet  
15 per day rather than the two prescribed.

16 VC failed to collect medication on 12 November 2021  
17 and didn't attend his appointment with Dr Lloyd on  
18 15 November. It remained the case at this stage that VC  
19 had still not been seen by Dr Lloyd.

20 VC attended the EIP on 19 November and was  
21 monosyllabic, hostile and unfriendly. He still appeared  
22 to be taking 10 milligrams of medication per day rather  
23 than 20 milligrams. Ms Birtles' view was that VC  
24 remained reluctant to engage with mental health services  
25 and was doing the minimum required. She wrote it was:

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1 and fixed in his staring and curt with the receptionist.  
2 He left the centre mid-conversation without a goodbye.  
3 He did not answer calls on 31 December, 6 January and  
4 was not present or did not answer for a home visit by  
5 Claudia Birtles and Abigail Parsonage on 6 January 2022.  
6 He missed an appointment with Dr Lloyd on  
7 10 January 2022.

8 Dr Lloyd noted in her entry that VC had missed four  
9 appointments, had disengaged from his Care Coordinator,  
10 Ms Birtles, and it was unknown if he was taking his  
11 medication. She noted that:

12 "We will discuss next steps at MDT on Thursday and  
13 maybe consider a final attempt at a home visit."

14 VC missed yet another appointment with Dr Lloyd on  
15 17 January. Dr Lloyd observed this was his fifth missed  
16 appointment and:

17 "... consideration will need to be given to  
18 discharge as VC has essentially disengaged and we have  
19 not been able to monitor him. Perhaps a conversation  
20 with his mum and course tutors to see if there are any  
21 concerns currently will be prudent before considering  
22 discharge."

23 The Inquiry will consider the appropriateness of  
24 discharge being contemplated in response to a patient  
25 who had not been seen by the consultant suggesting it,

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1 "... unlikely VC will ever open up about his  
2 experiences given this has led to an admission  
3 previously and [he] doesn't trust [mental health]  
4 services."

5 He didn't collect medication on 29 November and was  
6 not at home for a visit on 6 December 2021. He didn't  
7 answer a call on 14 December, but did contact Early  
8 Intervention in Psychosis in December 2021 when he was  
9 described as confrontational and angry throughout the  
10 call. His anger seemingly stemmed by attempts by  
11 Ms Birtles to contact his mother. VC demanded to know  
12 why Ms Birtles had tried to contact him via his mother  
13 and said under no circumstances was she to have contact  
14 with her, that he was cutting the contact off completely  
15 and she was never to speak to his mother again. He  
16 agreed that Claudia Birtles could contact his mother to  
17 say that he had requested no further contact.

18 Chair, you will be aware that up until this time  
19 VC's mother had raised concerns and provided information  
20 in respect of VC to treating doctors. We will explore  
21 in evidence the role of the next of kin, including when  
22 and how treating teams can receive information from  
23 them, irrespective of the views of the patient.

24 The following day VC attended EIP to collect his  
25 medication with his hood up and mask on. He was hostile

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1 was not engaging and potentially non-concordant, and in  
2 circumstances where he had previously displayed  
3 significant violence. Dr Lloyd saw VC once on 14 March  
4 and we will explore the nature of that single meeting in  
5 oral evidence.

6 In the meantime, following discharge in October 21  
7 VC had moved into private student accommodation at  
8 Raleigh Park with five other students. You will hear  
9 from two of VC's flatmates at this address, Christopher  
10 and Thomas. Thomas will tell you about VC's behaviour  
11 which deteriorated over time. Similarly, Christopher  
12 will tell you that while VC kept to himself in the  
13 beginning, his behaviour began to change around December  
14 2021 or January 2022. This was echoed by VC's group  
15 design partner, William, who saw him again at university  
16 around Christmas time of 2021 and noted signs of decline  
17 in VC's work.

18 Shortly after this, on the evening of 15 January  
19 2022, VC assaulted Christopher after he confronted him  
20 about the state of the shared bathroom. Christopher  
21 will give evidence as to how VC tried to punch him and  
22 how they started wrestling before VC put Christopher in  
23 a headlock. You will be shown a video of this incident  
24 recorded by another flatmate. You will hear how  
25 Christopher called the police twice that night, once

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1 when he was released from the headlock and a second time  
2 when VC prevented two flatmates from leaving the flat.  
3 You will also be shown a video that shows VC blocking  
4 their exit.

5 Officers PC Zacharia and Sergeant Faulkner were  
6 called to respond to the incident at Raleigh Park. You  
7 will hear from PC Zacharia, who spoke with Christopher  
8 on arrival, who he says was undecided about whether to  
9 pursue the matter. PC Zacharia will tell you that this,  
10 coupled with the view that the situation had calmed  
11 down, and it was supported by the other flatmates, led  
12 Sergeant Faulkner to make the assessment that an arrest  
13 was not necessary.

14 We will explore, Chair, whether it was right or fair  
15 to ask Christopher at this point and in these  
16 circumstances whether he wished to pursue the matter.  
17 There was video footage demonstrating VC's abusive  
18 behaviour. Was assessment of that behaviour and any  
19 risk posed a matter for the police and not the students?

20 At the request of PC Zacharia Christopher attended  
21 the central police station the following day. It was  
22 here that he confirmed the facts of the incident and  
23 advised PC Zacharia that he did not want to pursue  
24 action against VC, but only wanted him out of the  
25 property. You will hear from PC Zacharia that informed

1 health assessment would be arranged with the police in  
2 attendance. Claudia Birtles updated the risk  
3 assessment, noting VC had disengaged from community  
4 support, didn't have insight and was suspected to be  
5 non-concordant with his medication. Reference was made  
6 to the incident in his flat, though it was noted that  
7 details were unclear because the police declined to  
8 share information at that point.

9 The mental health assessment was undertaken by  
10 Dr Mike Skelton, Dr Manzar and an AMHP. The decision  
11 was not to recommend detention. The assessment team  
12 recognised that there had been poor engagement and  
13 a recent altercation, which suggested VC was relapsing.  
14 We will ask what they understood had happened in  
15 relation to Christopher and his fellow students. The  
16 university exams were thought to be a stressor. VC  
17 reported that he was taking aripiprazole but at  
18 10 milligrams per day rather than the prescribed  
19 20 milligrams. He denied symptoms of psychosis. His  
20 insight was thought to be relatively low.

21 Despite VC's history and the events of the previous  
22 night, it was concluded that there were no imminent  
23 risks to self or others. The plan was for VC to be  
24 monitored by the Crisis Team with admission being looked  
25 at if VC was not engaging. VC was referred to the

1 VC of this decision over the phone. PC Zacharia also  
2 asked VC if there was any help the police could provide,  
3 as he was aware of VC's mental health issues based on  
4 comments made by Christopher, but VC did not engage and  
5 no further action was taken.

6 The university were made aware of the incident when  
7 Christopher emailed the university's off-campus student  
8 affairs manager, Jamie Dickinson, to explain what had  
9 happened and to seek support. The information was  
10 passed to Christopher Hoskins, the university's  
11 residential experience manager and from whom you will  
12 hear.

13 You will hear from Mr Hoskins who explains his role  
14 in supporting VC's flatmates and coordinating next steps  
15 with the assistant scheme manager at Raleigh Park,  
16 Rebecca Patterson, and the university mental health  
17 support team, including Eleanor Turner. The Inquiry  
18 will look at what actually happened in the circumstances  
19 and the role of the university and ask more broadly what  
20 kind of a role a university should play in protecting  
21 its students in circumstances such as these.

22 On 18 January Eleanor Turner from the mental health  
23 support services contacted the EIP team reporting the  
24 assault by VC. It was decided, in light of VC's risk,  
25 a home visit would not be attended and instead a mental

1 Crisis Team. It was decided medication concordance  
2 meetings would be put in public places as VC didn't want  
3 to be visited at home. He missed one such meeting on  
4 20 January.

5 Eleanor Turner raised concern that VC was unwell and  
6 was not meaningfully engaging with support services.

7 VC did meet with two nurses from the Crisis Team on  
8 21 January 2022. He was observed taking two  
9 10-milligrams of aripiprazole tablets, but did not  
10 engage in conversation and as he walked away the nurses  
11 observed him putting his hand to his mouth and seemingly  
12 throwing his medication in the bin.

13 On 21 January Eleanor Turner expressed her view that  
14 a mental health assessment should be considered over the  
15 weekend if there was another failed medication  
16 concordance. VC met with nurses from the Crisis Team on  
17 22 January and was observed to take two 10-milligram  
18 tablets.

19 On 24 January Ms Turner reiterated her concern that  
20 VC was not fully engaging with community support and  
21 risks remained. We pause to note, Chair, what is meant  
22 by "community support" in this context and whether, and  
23 if so how, it was capable of mitigating any risk of  
24 violence and aggression VC posed?

25 On 25 January there was an attempted home visit to

1 VC and numerous attempted phone calls. Ms Turner  
2 informed the Crisis Team that VC had been asked to leave  
3 his accommodation and needed to leave. There were five  
4 students too scared to return to the flat who only had  
5 alternative accommodation available until the end of the  
6 month.

7 On 27 January 22 VC refused to engage in discussion  
8 with Crisis Team nurses. He wouldn't sit down. He  
9 walked off when receiving his medication. When asked  
10 about his accommodation predicament he denied that his  
11 flatmates had moved out, saying they were still living  
12 with him which was obviously untrue. It was decided to  
13 arrange a mental health assessment.

14 On 28 January 2022 PC Matthew Gell and PC  
15 Russell-Taylor assisted mental health professionals with  
16 detaining VC under section 135 of the Mental Health Act  
17 warrant. You will hear oral evidence from PC Gell who  
18 was aware that VC had previously assaulted an officer  
19 and had a warning marker for violence on the Police  
20 National Computer. PC Gell spoke with VC who agreed to  
21 go with officers on this occasion and did not display  
22 any violence.

23 **THE CHAIR:** Yes, thank you. We will stop there and we will  
24 start again at 2 o'clock. Thank you.

25 (12.56 pm)

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1 the assessors felt that further assessment was required  
2 given the lack of clear psychopathology currently, and  
3 the recommendation was detention under section 2.  
4 Chair, given that the assessment team had in mind VC  
5 commencing depot medication, should that not have  
6 pointed them towards a section 3 admission which would  
7 have allowed for discharge with a Community Treatment  
8 Order and depot being a condition of the order? The  
9 Inquiry will explore this question and whether, quite  
10 aside from the issue of depot, a section 2 rather than  
11 section 3 admission was appropriate in circumstances  
12 where VC's diagnosis and treatment needs appeared  
13 relatively well-established and it was a little over  
14 three months since his last admission.

15 Dr Manzar's witness evidence to this Inquiry is that  
16 the decision to detain under section 2 was because his  
17 psychopathology was not yet fully clear and although  
18 there was a diagnosis of a psychotic disorder there was  
19 uncertainty as to the exact nature of his symptoms and  
20 no clear definitions of his symptoms cluster. Quite why  
21 and whether this was a good reason not to detain under  
22 section 3 will be explored.

23 Dr Manzar does not recall any discussion during the  
24 assessment of the potential for a Community Treatment  
25 Order, albeit Dr Lomas recalls that there was some

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(The lunch break)

2 (2.00 pm)

3 **THE CHAIR:** Yes. Just before we start, Ms Langdale, I'm  
4 going to remind everybody in the room there are to be no  
5 photographs taken in the hearing room. There is a live  
6 stream and that's all that's possible in the hearing  
7 room. Thank you.

8 **MS LANGDALE:** Chair, may I turn now please to the fourth  
9 admission, 28 January 2022, to 24 February 2022.

10 VC was taken to the Cassidy Suite at Highbury  
11 Hospital where a mental health impact assessment was  
12 undertaken that evening. The assessment by Dr Lomas,  
13 Dr Manzar and Approved Mental Health Professional Fiona  
14 Parker, found that VC's engagement with the Crisis Team  
15 had been superficial. It was suggested during the  
16 assessment that VC have a long acting injection, that is  
17 depot, but VC flatly refused to accept this saying there  
18 was no need as he was taking the medication.

19 VC did not present as overly psychotic but it was  
20 decided that there was sufficient concern to suggest  
21 hospital admission for further assessment and to look at  
22 starting depot antipsychotic. The assessment team  
23 considered that VC required further assessment and  
24 treatment in an in-patient setting. An admission  
25 pursuant to section 3 was discussed but the balance of

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1 consideration of the fact that admission under section 3  
2 could result in a CTO.

3 VC was admitted to the Redwood Ward at Highbury  
4 Hospital on 30 January 2022. He was under the care of  
5 consultant Dr Thangavelu. He was reviewed by Dr Gibson  
6 on 31 January. VC told Dr Gibson that he had been  
7 taking medication consistently and the hostage-taking  
8 situation in the flat was in fact an altercation. He  
9 denied any current or recent mental health problems,  
10 claiming that his second and third admissions were  
11 misunderstandings. He refused consent for Dr Gibson to  
12 speak to his parents. He denied hallucinations. Other  
13 than being guarded, Dr Gibson did not consider that he  
14 presented with overt psychotic symptoms.

15 Dr Gibson spoke to VC's mother on 2 February 2022  
16 but was unable to share information with her. She  
17 informed him that VC did not at the time seem unwell to  
18 the family. He had a good recollection which had not  
19 been the case in the past when he was unwell. At the  
20 ward review the following day, VC's mother was described  
21 as being guarded during this telephone conversation, not  
22 giving much information. It is noted, however, that she  
23 was not being provided with any either.

24 Claudia Birtles, who attended ward review, reported  
25 that her relationship with VC had deteriorated.

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1 The police were not sharing information with her.  
 2 Ms Birtles asked whether there were alternative plans  
 3 for medication as she was not completely sure whether he  
 4 was concordant, and the EIP team considered he would be  
 5 better off on a depot.

6 VC claimed he had not heard voices for over a year.  
 7 He was asked about receiving depot but said he would  
 8 prefer not to. He did not like needles and would prefer  
 9 to continue with tablets.

10 In the afternoon following the ward review,  
 11 community consultant Dr Lloyd emailed Dr Thangavelu  
 12 asking that a depot and possibly a CTO be considered  
 13 given it was his fourth admission and he was becoming  
 14 a revolving door and to avoid poor engagement and  
 15 concordance at discharge. Dr Lloyd commented that VC  
 16 managed to conceal his symptoms well but his insight  
 17 remained very poor.

18 VC had been permitted unescorted leave twice a day  
 19 for 30 minutes but that was restricted on  
 20 4 February 2022 after the University reported that VC  
 21 had been seen at his old address by his former  
 22 flatmates. When asked about this, VC denied attending  
 23 University accommodation. In fact you, will hear from  
 24 Mr Hoskins and Ms Turner about VC returning to Raleigh  
 25 Park on more than one occasion after he was relocated by

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1 the same material over email to his brother at 11.52 pm  
 2 on 12 June.

3 After the attacks on 13 June, forensic analysis of  
 4 VC's phone was undertaken. Extraction records  
 5 demonstrated that VC researched "mind control  
 6 technology" and viewed online material concerning the  
 7 apparent scientific reality of this. Also VC watched  
 8 videos, including three of a shooting in Buffalo New  
 9 York, close to the time of those events. He viewed  
 10 documents with some content relating to the law on  
 11 police powers, including a document detailing how  
 12 body-worn footage video is used.

13 He also appears to have viewed a report titled "the  
 14 Public Inquiry into the shootings at Dunblane Primary  
 15 School", and a document "Estimating the Historical and  
 16 Future Probabilities of Large Terrorist Events".

17 When told during the fourth admission that he was  
 18 missing out on positive therapeutic engagements with  
 19 staff and peers, VC said he did not want to engage as he  
 20 did not agree with the admission. He wanted to engage  
 21 as minimally as he could, keeping out of people's way  
 22 and not being a problem until he could get back to his  
 23 life in education. He said he would try to engage and  
 24 participate in ward activities but in fact continued to  
 25 keep a low profile and did not do so.

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1 the University and not allowed to return. You will also  
 2 hear from Thomas and Christopher about how he entered  
 3 the flat on one of these occasions.

4 VC largely kept a low profile during his fourth  
 5 hospital admission, spending most of his time on his  
 6 phone. At the multi-disciplinary team meeting on  
 7 7 February 2022 his presentation was described as  
 8 guarded and withdrawn.

9 We will explore with treating clinicians whether  
 10 they ever asked VC what he was viewing on his phone; if  
 11 not, why not, and whether patients routinely have  
 12 unfettered access to their phone.

13 This is a convenient point to highlight the contents  
 14 of a collection of files VC sent to his parents over  
 15 Christmas 2022, along with a document explaining what it  
 16 was he was sending. VC sought to "clarify" what had  
 17 been happening during recent years. VC stated that he  
 18 had been hearing voices in his head all the time but  
 19 this wasn't the result of mental ill health. He  
 20 believed he had never had a mental health condition,  
 21 rather this was explained by mind control technology.  
 22 The files were the results of his research into this  
 23 technology. The contents have been summarised by the  
 24 Inquiry legal team in a document provided to all Core  
 25 Participants. VC sent the same material or essentially

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1 There was a ward review on 10 February 2022 which  
 2 noted that VC had been compliant with medication.  
 3 Claudia Birtles expressed her wish that VC had received  
 4 depot during his last admission, given the risk of  
 5 non-compliance. There was a discussion as to whether  
 6 a Community Treatment Order would be beneficial. VC  
 7 denied he had been non-compliant with his medication and  
 8 claimed he had been collecting his medication from his  
 9 GP practice weekly. That was a very obvious lie.

10 Dr Thangavelu explained that there was the option of  
 11 depot once a month and explained it may be a better  
 12 option to minimise confusion around taking tablets and  
 13 minimise the likelihood of symptoms restarting. VC said  
 14 he was satisfied with the medication he was on and when  
 15 he changed medication in the past there were  
 16 side-effects. It was explained to him that depot was  
 17 the same medication but VC reiterated his wish to stay  
 18 on tablets.

19 There appears to have been no capacity assessment to  
 20 establish whether VC was able to make this decision  
 21 about medication and to understand its consequences. We  
 22 will explore whether assessment of capacity was ever  
 23 issue specific and, if not, why not?

24 It was explained to VC that depot would need to be  
 25 considered if he did not engage with the team, and the

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1 plan formulated included consideration of depot were VC  
2 to relapse again.

3 In his statement to this Inquiry, Dr Thangavelu  
4 comments that he did not feel he could justify giving  
5 depot under physical restraint given VC's wishes and his  
6 anxieties about needles. He says after deliberation the  
7 decision swayed towards giving VC "another chance" on  
8 oral medication but with further relapse a depot would  
9 need to be given.

10 It is to be observed that depot as part of a CTO or  
11 otherwise in the community would not be given "under  
12 physical restraint". Where a Community Treatment Order  
13 is in place, discharge to the community is subject to  
14 conditions. If the patient fails to comply with the  
15 conditions of a Community Treatment Order they can be  
16 recalled to hospital with the possibility of  
17 readmission.

18 At a multi-disciplinary team meeting on  
19 14 February 2022 it was noted that VC had slammed the  
20 door in a nurse's face who was trying to undertake  
21 physical observations. There was discussion about  
22 a Community Treatment Order to keep VC engaged. The  
23 note does not set out the conclusion of that discussion,  
24 although we know that a CTO was not made and the  
25 admission was not converted to a section 3.

1 was still happening. He wished to get back to his  
2 studies and a normal life and said he had no issues with  
3 medication. He was discharged with 14 days medication.

4 I turn now, Chair, to the following fourth admission  
5 between 24 February 2022 and 23 September 2022.

6 The day after his discharge on 25 February 2022, VC  
7 attended the EIP team for follow-up. He denied having  
8 missed any medication prior to his recent admission.  
9 The view of Claudia Birtles was that VC would engage  
10 only superficially and had no intention of working to  
11 build a positive therapeutic relationship.

12 The plan had been for weekly contact with VC to be  
13 reduced if the issues and risks associated with his  
14 condition improved. VC was not, however, seen on  
15 a weekly basis.

16 On 28 February 2022, VC's risk assessment was  
17 updated for the final time prior to the attacks. It  
18 noted that given the history of violence and aggression  
19 there should not be home visits, and if a home visit was  
20 required it should be a joint visit, no lone working.  
21 We will ask why this assessment of the risk to the  
22 community medical team did not apply equally to other  
23 students and the wider public.

24 On 11 March 2022, VC attended to collect his  
25 medication but was given only a seven-day supply. He

1 Ultimately, it was decided that VC would not receive  
2 a depot, and given that he was not detained pursuant to  
3 section 3 it could not be made a condition of a CTO in  
4 any event. The in-patient team considered a move to  
5 section 3 could not be justified. VC assured the  
6 in-patient team he was willing to work with the  
7 community team and was not displaying active symptoms of  
8 psychosis.

9 In his statement to this Inquiry, Dr Thangavelu  
10 explains that imposing forced depot or a Community  
11 Treatment Order when there were no grounds for continued  
12 detention would only make VC further lose trust in  
13 mental health services and the least restrictive  
14 approach, given he was willing to engage, was discharge  
15 without a Community Treatment Order.

16 We will ask, firstly, on what grounds the assessment  
17 of his willingness to engage could be justified and  
18 where the risk VC posed to the public through not taking  
19 his medication featured in this reasoning.

20 VC was discharged on 24 February 2022. At the  
21 discharge meeting that day he said he was fine. He  
22 referred to research he had carried out into  
23 technologies that interfere and control the mind. He  
24 said he had felt that someone outside him was  
25 influencing him and controlling his mind but denied it

1 was unhappy to have to collect medication weekly.

2 On 14 March, he was seen by Dr Lloyd for the first  
3 and only time. It was agreed that he would collect  
4 medication fortnightly. Dr Lloyd considered VC appeared  
5 well with no evidence of psychosis and functioning at  
6 a high level. She did not consider CBT or a support  
7 worker was necessary. Dr Lloyd planned to see VC again  
8 in three months' time.

9 On 19 April 2022, VC contacted Ms Birtles requesting  
10 to see her in person as he wanted to get some  
11 information. He told her he had been doing some  
12 research and wanted to discuss his treatment but did not  
13 want to do it over the phone. Ms Birtles spoke to her  
14 team leader, Emma Robinson, and they agreed, given the  
15 historical risks of violence, aggression and hostage  
16 taking -- the descriptor used for the incident with  
17 Christopher -- home visits were not appropriate unless  
18 absolutely necessary.

19 On 28 April, a decision was made to transfer VC to  
20 a new Care Coordinator, preferably two. The Trust  
21 report found that the rationale for this change was  
22 primarily based on VC's prior history of violent and  
23 unpredictable behaviour when acutely mentally ill. The  
24 new Care Coordinator was Gary Carter. There is some  
25 suggestion that he was chosen, in light of the risks

1 around violence and aggression, because he was a male.  
 2 Claudia Birtles explains in her statement that by this  
 3 time her relationship with VC had broken down. He had  
 4 lost trust in her. Moreover, she was pregnant which  
 5 meant that she should be removed from working with  
 6 people with a known risk to others.

7 For his part, Gary Carter explains in his statement  
 8 to the Inquiry that he was not at the MDT meeting on  
 9 28 April when it was agreed to change VC's  
 10 Care Coordinator. He believes that none of his  
 11 colleagues were willing to work with VC unless they had  
 12 to and, as the only man on the team, he was made VC's  
 13 Care Coordinator. He describes his colleagues as  
 14 frightened of what VC could do. He feels VC was  
 15 delivered to him as a fait accompli, the decision being  
 16 made while he was on annual leave. He does not recall  
 17 any formal handover.

18 Meanwhile, VC's unusual behaviour on campus was  
 19 brought to the attention of Claudia Birtles. On  
 20 26 April the University forwarded an email to Ms Birtles  
 21 which described VC having attended his old university  
 22 accommodation, Raleigh Park, on 21 April, giving a false  
 23 name when approached by security. The email described  
 24 VC following someone into the block of flats, entering  
 25 his old flat and asking his former housemate about mail.

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1 whether the level of risk VC posed was addressed  
 2 adequately, or at all, in the circumstances.

3 On 12 May 2022 the case was assigned to PC  
 4 Beardsmore. According to the log, PC Beardsmore stated  
 5 that he offered advice on "how to handle the  
 6 circumstances should there be any further contact" and  
 7 that the "caller requests the matter to be logged only  
 8 and him [presumably VC] not be spoken to".  
 9 PC Beardsmore marked that the incident could be closed.

10 Three months later, on 28 July 2022, VC again tried  
 11 to follow Sebastian home. Sebastian called the police  
 12 once more and PC Sarah Barnes told him that she wanted  
 13 to talk to VC and asked for his consent, which he gave.  
 14 Sebastian heard nothing further. You will hear from  
 15 PC Barnes as to what steps she took in this regard. You  
 16 will also hear from Police Sergeant Ashleigh Small who  
 17 formally closed this incident as "Outcome 16 -- victim  
 18 does not wish to support a prosecution".

19 Once again, we will interrogate the apparent  
 20 reliance on a victim's response and the failure to  
 21 formally question VC.

22 You will hear evidence about the tools and policies  
 23 in place at both a national and local level within  
 24 Nottinghamshire which are intended to guide how  
 25 the police should investigate potential stalking

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1 He was not confrontational and VC left when asked.

2 It is here where we will turn to the evidence of  
 3 Sebastian, one of VC's former flatmates. You will  
 4 recall, Chair, that Sebastian was the flatmate VC  
 5 assaulted in July 2021. The fact that there had been  
 6 medical intervention in the summer of 2021 did not bring  
 7 to an end the pursuit of Sebastian by VC. There were  
 8 subsequent phone calls and, in 2022, VC approached  
 9 Sebastian at the gym. On another occasion, on  
 10 26 April 2022, Sebastian recalls VC trying to follow him  
 11 home. Sebastian went back to Radford Police Station and  
 12 spoke to an individual at the reception but they didn't  
 13 take a statement.

14 You will hear from the Neighbourhood Policing  
 15 sergeant, Police Sergeant Langham, who was first  
 16 notified of this on 9 May 2022. This was some 13 days  
 17 after the incident and it had not yet been allocated to  
 18 an officer to deal with it. Police Sergeant Langham's  
 19 evidence will be that he spoke with Sebastian but was  
 20 not completely convinced that the matter amounted to  
 21 stalking. His assessment was that it was low risk,  
 22 although he left the incident marked as remaining  
 23 "open". He was not aware of the previous incident  
 24 involving VC and had not checked the relevant system.

25 Chair, it will be a matter for you to determine

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1 incidents. This includes stalking screening tools,  
 2 a specific stalking procedure and guidance on what lines  
 3 of enquiry to pursue.

4 You, Chair, may wish to consider whether these  
 5 stalking incidents were taken sufficiently seriously by  
 6 the police and if not, why not? Why were they not  
 7 linked together to give a broader picture of VC's  
 8 actions towards Sebastian? What did they suggest about  
 9 VC's focus? What about VC's previous episodes of  
 10 violence? Did the police ask sufficient questions and  
 11 pursue all reasonable lines of enquiry to ensure they  
 12 understood the level of risk posed by VC? Could other  
 13 options, such as the completion of An Adult Concern  
 14 Public Protection Notice, which could have led to more  
 15 effective liaison between the police and other agencies  
 16 involved with VC at that time, have been explored?

17 On 13 and 27 May 2022 VC was seen by Mr Carter when  
 18 collecting his medication. Both appeared to be brief  
 19 interactions, certainly the note of the attendance is  
 20 short. On 27 May VC was described as seeming to be in  
 21 a good mood.

22 VC did not attend to collect his medication on  
 23 10 June and missed his appointment with Dr Lloyd on  
 24 13 June. VC did attend to collect his medication on  
 25 15 June, when he was described by Ms Parsonage as well

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1 kempt but with overgrown facial and head hair. He  
2 looked suspicious and walked off after collecting his  
3 medication.

4 On 24 June 2022, when he was asked to collect his  
5 medication, he reported he had enough medication until  
6 1 July 2022, which is unlikely to have been consistent  
7 with him being fully concordant. He collected  
8 a two-week supply of medication on 4 July. He was due  
9 to collect further medication on 18 July, but when  
10 contacted by text to see if he was coming to collect, he  
11 replied that he was not in the UK at the moment and  
12 would probably be back in Nottingham in October.

13 In response to the question "What about medication?"  
14 he replied "Still have some. Won't make much  
15 difference."

16 Gary Carter phoned VC's mother who said she had not  
17 heard anything to suggest VC was abroad. Attempts to  
18 contact VC were unsuccessful. On 27 July VC's mother  
19 spoke to Gary Carter confirming that she had spoken to  
20 VC and he was in Nottingham. VC missed an appointment  
21 with Dr Lloyd on 1 August 2022.

22 An attempted cold call by Gary Carter and Paul  
23 Williams, a Healthcare Assistant, on 4 August 2022 was  
24 to an address where the occupants told them VC did not  
25 live. Gary Carter noted that VC "has a history of

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1 limitations on the ability of community mental health  
2 teams to deliver assertive outreach and if so why?

3 Chair, you will hear evidence about the concept of  
4 assertive outreach and whether and how this can succeed  
5 in improving engagement. What skill mix is needed for  
6 it to be effective? We will explore whether and if so  
7 how the public and individual patients can benefit from  
8 it.

9 On 31 August Gary Carter spoke to VC's mother who  
10 said she had not seen VC face to face for many months  
11 but had spoken to him in the last week. Mr Carter noted  
12 that he would arrange a visit with a colleague to see  
13 VC. As I have said, no visit was carried out to this  
14 address.

15 Addresses for VC.

16 Before turning to VC's discharge we should say  
17 something more about known addresses provided for VC.  
18 VC's address history is not entirely clear and will be  
19 developed in oral evidence only to the extent that it is  
20 necessary to do so. VC's address on his UCAS  
21 application in 2017 was a Birmingham address. His first  
22 known address in Nottingham was student accommodation,  
23 Chatterley Court, Raleigh Park, from September 2017  
24 to May 2018.

25 On 1 August 2018, an Ilkeston Road address was

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1 giving false addresses". Gary Carter wrote that he  
2 would take the situation back to Dr Lloyd and Emma  
3 Robinson to consider "discharge to GP" or "report as  
4 a missing person". These appear to be two quite  
5 different routes. The Inquiry will explore the  
6 rationale for considering discharging a patient with  
7 VC's history and risk.

8 On 9 August it was noted that VC had requested  
9 access to his notes, giving a different address from the  
10 one the EIP team had. It does not appear a visit to  
11 this address was attempted. Gary Carter explains that  
12 he was too busy to visit. Instead, on 17 August, some  
13 eight days later, Mr Carter wrote to VC, failing to copy  
14 the GP, at the new address stating:

15 "It seems like a long time since we last met. Could  
16 I do something to help you? Do you still want to engage  
17 with our services at this time. Perhaps you could give  
18 me a ring ... and we could have a chat. I still have  
19 a supply of your medication here at Stonebridge if you  
20 want them. Can we have a chat and work something out  
21 together."

22 The Inquiry will explore the extent to which, upon  
23 receiving a new address for VC, who appeared not to be  
24 engaging, the timing and nature of these attempts at  
25 reengagement was likely to be effective. Are there

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1 entered on VC's Amazon account. From 27 August 2019,  
2 7 Brook Court was included on the account. 7 Brook  
3 Court is where VC was arrested in May 2020.

4 From September 2019 VC shared a tenancy for  
5 12 months at 48 Salisbury Street -- otherwise known as  
6 the Marquis of Lorne, 20 Middleton Street -- with  
7 Sebastian and others. This is where VC was discharged  
8 on 31 July 2020. It is unclear to the Inquiry when VC  
9 ceased to have a connection to Salisbury/Middleton  
10 Street. The address is included on a wage slip dated 18  
11 November 2021 and a tenancy agreement dated  
12 5 January 2022.

13 VC obtained a six-month tenancy in Sneinton Dale  
14 from 5 September to 5 March 2021 before returning to the  
15 Salisbury/Middleton Street property in early 2021. VC  
16 was seen by the EIP team at the Middleton Street address  
17 in August 2021, and was removed from this address in  
18 respect of his third admission.

19 In October 2021 is VC was allocated student  
20 accommodation at Madison Court, Raleigh Park, into which  
21 he was discharged by the Priory in October 2021.  
22 Meanwhile, the Early Intervention in Psychosis team had  
23 his address at Queens Road, Beeston, until they were  
24 told about his Madison Court address by Eleanor Turner  
25 on 18 January 2022.

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1 VC moved out of Madison Court following his assault  
2 on his flatmate in January 2022 and was discharged on  
3 23 February 2022 to an address in Ilkeston Road.

4 In July 2022 VC told Abigail Parsonage that he was  
5 abroad and would probably be back in Nottingham  
6 in October. As stated previously, his mother told Gary  
7 Carter in July 2022 that he was in fact in Nottingham.

8 On 19 October 2022 VC paid a rent deposit for an  
9 address in Burford Road, Nottingham, and was evicted  
10 from there on 11 June 2023 in respect of failure to pay  
11 rent.

12 Turning now to the decision to discharge on  
13 23 September 2022.

14 At a multi-disciplinary meeting on 22 September the  
15 decision was taken to discharge VC. That meeting was  
16 attended by Dr Lloyd, who had minimal experience of VC  
17 over the period in which she was the consultant  
18 psychiatrist in charge of his care. Neither  
19 Claudia Birtles for Gary Carter, who had the most  
20 experience in management of VC outside of in-patient  
21 care, were present at the meeting. In addition, and  
22 perhaps remarkably given discharge from services is  
23 a significant decision, no detailed note of this meeting  
24 was taken. There is simply a short entry within VC's  
25 medical records as follows:

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1 Discharging VC to the GP, the discharge letter  
2 written by Sharon Heath, stated:  
3 "Following a discussion in our [MDT] ... meeting on  
4 22 September ... the decision has been made to discharge  
5 VC from our services due to non-engagement. No contact  
6 has been made with VC for a period of time ...."

7 That not being specified, Chair:

8 "... despite attempts to make contact and having  
9 carried out cold calls. A letter was sent to VC dated  
10 17 August 2022 inviting him to contact the team if he  
11 still wanted support with his mental health. However,  
12 there was no response to this invitation. Therefore at  
13 this time we are closing his referral and transferring  
14 his care back to yourselves. If VC chooses to engage  
15 with services, or his mental health deteriorates, please  
16 re-refer back to our team in the future."

17 Dr Timothy Baker, the senior partner at VC's GP  
18 practice, fairly observes in it his statement that: "No  
19 information with regards to his current risk or risks  
20 when not taking medication was shared with the practice  
21 at the point of discharge." There was no explanation of  
22 any risk he posed, no advice on management, medication  
23 needs or concerns as to non-concordance. There was no  
24 explanation of any care plan.

25 I turn now to following discharge between

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1 "Discussion within MDT on 22.09.22, as no contact  
2 has been made with VC for a period of time despite  
3 attempts to make contact and having done cold calls,  
4 decision made within the team to discharge back to GP  
5 due to non-engagement with view for GP to refer back to  
6 services in the future if needed."

7 It will immediately be noted, chair, that the cold  
8 call, singular rather than plural, was apparently to an  
9 incorrect address and no attempt had been made to visit  
10 VC at the correct address. The last interaction with VC  
11 was some eight weeks earlier, on 18 July 2022.

12 The Inquiry will explore what consideration, if any,  
13 was given when discharging VC to whether the  
14 disengagement and probable non-concordance indicated  
15 a deterioration in mental health and a further increase  
16 in the risks he posed. It is not clear what, if any,  
17 risk assessment was undertaken.

18 Furthermore, the discharge process appeared to fall  
19 short of the Trust guidance contained in their "did not  
20 attend" policy. VC was not given a warning letter  
21 advising of the consequences of failing to make contact.  
22 Crucially, no other agency appears to have been  
23 contacted prior to discharge. No attempts were made to  
24 assess VC's capacity. VC's family were not involved in  
25 the decision to discharge.

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1 23 September 2022 until 13 June.

2 On 28 September 2022, a text message was sent to VC  
3 by the GP practice asking him to confirm his address.  
4 On 29th the message was sent to VC asking him to make  
5 an appointment with the GP for mental health review if  
6 this would be beneficial and providing him with the  
7 mental health crisis line number.

8 On 30 September he was asked to book in for his  
9 long-term condition annual review. A further two text  
10 messages were sent on 11 November 2022 and 21 November.  
11 It does not appear VC responded to any of these  
12 messages.

13 Sam Bailey, a local mental health team improvement  
14 worker, recorded in the GP records on 1 March 2023 that  
15 she had spoken to VC to book him in for a physical  
16 health check, but he declined saying he was all right  
17 and did not need any health checks.

18 In short, VC was not seen and was not provided with  
19 any medication. A senior partner of the GP practice,  
20 Dr Timothy Baker, comments in his statement that  
21 discharge by secondary services for non-engagement is  
22 a wholly Secondary Care decision and he would expect it  
23 only to be made after careful appraisal of the patient's  
24 safety, the safety of others, their capacity and mental  
25 stability. The Inquiry will explore the reasonableness

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1 of this expectation. The discharge letter appears clear  
2 that VC was being discharged for non-engagement.

3 While the discharge letter did not provide  
4 a detailed account of VC's risk or treatment needs, the  
5 GP practice had received correspondence from the Trust  
6 over the course of VC's treatment. We will consider in  
7 oral evidence if this was considered on discharge and  
8 whether it would or should have alerted them to the  
9 challenges of VC's presentation.

10 The Inquiry will consider the role of primary care  
11 services following discharge of non-engaging patients,  
12 especially where the non-engagement may be an indication  
13 of deteriorating mental health and increased risk. The  
14 Inquiry will explore whether the role of primary care  
15 services is appropriately limited to sending a text  
16 message. There certainly appears to be a lacuna in  
17 respect of provision of medication in that Dr Baker in  
18 his statement to the Inquiry appears to consider that  
19 monitoring concordance of medication provided by  
20 secondary care teams is the responsibility of those  
21 teams. It does not appear that the GP practice took any  
22 steps to manage VC's prescriptions, or make any efforts  
23 to ensure he received any. VC was essentially in the  
24 community, disengaged from any health service and  
25 unmedicated.

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1 VC attacked two people at work. Only four days earlier,  
2 on 1 May, VC had started work as an agency warehouse  
3 operative with a company called Arvato. He was based as  
4 a distribution centre in Derby. On the afternoon of  
5 5 May, VC approached a male colleague who was training  
6 another operative. According to the colleague VC said  
7 "Why are you talking to me?" to which VC was told that  
8 the operative was being trained. VC proceeded to  
9 assault the male, punching his face and head, and  
10 kicking a female colleague who had come to his defence.  
11 Both victims required medical care and sought hospital  
12 treatment. When questioned by fellow employees about  
13 the reason for the unprovoked assaults VC only said  
14 "I was pushed".

15 The police were called at around 5.50 pm and  
16 Leicestershire Police officers, PC Libbie-Mae Taylor and  
17 PC Connor Amos-Perkins arrived at the scene  
18 approximately 25 minutes later. By this time VC had  
19 been escorted from the premises.

20 Initial witness accounts and a recording of the CCTV  
21 footage covering the incident were captured on PC  
22 Taylor's body-worn video camera. You will hear from  
23 both PC Taylor and PC Amos-Perkins that this footage was  
24 automatically deleted due to an administrative error by  
25 PC Taylor in the recording of the video on the police

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1 Meanwhile, the preparation of the case against VC in  
2 respect of his assault on PC Pritchard was belatedly  
3 gathering some pace. PC Myers will describe the  
4 charging process and the CPS's decision to charge VC  
5 with what was classed as an "assault on an emergency  
6 worker". VC was summonsed to attend Nottingham  
7 Magistrates Court on 22 September at a time when he was  
8 in hospital. What does that say about inter-agency  
9 working?

10 He failed to appear and a warrant was issued for  
11 VC's arrest. The warrant was flagged to PC Myers, at  
12 least by 20 January 2023, but came through the NICHE  
13 computer system as a low priority. PC Myers will  
14 describe his belief that the warrant would be taken  
15 forward by another team.

16 Chair, you will no doubt want to consider in due  
17 course whether this was a significant opportunity  
18 missed, whether there are failures in the process by  
19 which warrants are acted upon by the police, a failure  
20 of liaison and what improvements can be made. Temporary  
21 Deputy Chief Constable Rob Griffin will address this in  
22 his oral evidence. He has described it as "a serious  
23 systemic operational failure on the part of  
24 Nottinghamshire Police".

25 On 5 May 2023 there was a further serious incident.

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1 system.

2 You will hear evidence from three employees of  
3 Arvato who were present in the warehouse at the time of  
4 the assault and intervened. From Louisa, the training  
5 coordinator who spoke to the police and provided  
6 first aid to the victims, you will hear her describe  
7 VC's behaviour as "extremely strange", with his eyes  
8 "glazed over" and "staring completely blankly" at the  
9 injured male.

10 Similarly you will hear from Matthew, the operations  
11 manager, and Volodimir, the operations supervisor, who  
12 both express concerns that the police did not take the  
13 incident seriously.

14 PC Taylor, at this time only a probationary  
15 constable, was put in charge of and responsible for the  
16 investigation. She was supervised by PC Amos-Perkins  
17 and the investigation was subject to review by Police  
18 Sergeant Read. You will hear how PC Taylor entered VC's  
19 details into the police database and, while doing so,  
20 failed to register that VC was already recorded on the  
21 system. Had PC Taylor done so it would have become  
22 apparent that there was an outstanding warrant for VC's  
23 arrest in relation to the assault on PC Pritchard.

24 You will also hear evidence from PS Read, the  
25 supervisor on duty at the time of the incident. Police

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1 Sergeant Read will describe how he was mandated to  
2 conduct a review of the incident at 28-day intervals but  
3 failed to do so. He will explain that had he conducted  
4 a review he would have provided PC Taylor with a more  
5 structured investigation plan and would have likely  
6 advised background checks be conducted on VC.

7 You will hear how PC Taylor progressed the  
8 investigation and attempted to contact the victims of  
9 the assault over the following month. She will describe  
10 how, on 10 June, she emailed the Arvato employees  
11 stating that if contact was not made by 15 June the  
12 investigation would be "submitted for filing",  
13 a decision that PC Taylor describes as being "taken by  
14 or in conjunction with supervising officers".

15 No contact was made with VC by the police in  
16 relation to the assault until the incident was taken  
17 over by Nottinghamshire Police following the Nottingham  
18 attacks on 13 June.

19 The actions of PC Taylor, PC Amos-Perkins and  
20 PS Read are the subject of an investigation by The  
21 Independent Office of Police Conduct and you will hear  
22 from Rachel Watson, the director general of the IOPC, on  
23 this in due course. As I said earlier, as of today's  
24 date the investigation remains ongoing.

25 David Sandall, the Temporary Chief Constable of  
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1 them and what should have happened if that information  
2 had been shared.

3 You may wish to consider, for example, when  
4 community care is being examined what account was taken  
5 within risk assessment, if any, of VC's community? When  
6 taken overall, do the incidents involving neighbours  
7 living close to VC, such as those in Brook Court, the  
8 incidents involving Christopher, Sebastian and other  
9 students living with VC, and VC's repeated return to  
10 university accommodation when excluded, indicate  
11 a pattern of risk to students who lived with VC? In  
12 short, did VC represent a risk to what might be seen as  
13 his immediate community at the time?

14 2. Mental Health Framework, Inquiry  
15 evidence/assessment of risk.

16 Chair, I turn now to Mental Health Framework and the  
17 Inquiry evidence in respect of assessment of risk.

18 Following the chronological approach we have taken,  
19 and therefore completing the consideration of VC's  
20 treatment prior to 13 June, we turn now to the law on  
21 Mental Health Framework before moving to the attacks and  
22 the response of the police. The Mental Health Act 1983  
23 contains provisions on the assessment, treatment and  
24 rights of those with a diagnosis or suspicion of a  
25 mental disorder, and its focus is the assessment and  
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1 Leicestershire Police, will give evidence to the Inquiry  
2 in relation to the policies and procedures governing the  
3 officers' conduct and lessons learned by the force.

4 You, Chair, may want to consider whether the assault  
5 at Arvato was a serious missed opportunity, whether an  
6 arrest of VC under the existing warrant or in respect of  
7 this assault might have triggered a different chain of  
8 events. The Inquiry will investigate how such errors  
9 can be avoided in the future and how best to ensure that  
10 all relevant crime and mental health information is  
11 available to those investigating offences.

12 Furthermore, the Inquiry has recently unearthed  
13 evidence of an earlier episode of violence on  
14 15 February 2023, and CCTV footage is said to have shown  
15 VC punching a man at another warehouse where he was  
16 working. The Inquiry is seeking to establish if the  
17 CCTV footage is still available and statements are being  
18 sought in respect of this matter. It does not appear  
19 that this episode was reported to the police.

20 Chair, as I have set out, we will be hearing  
21 evidence and reviewing decisions made by the police,  
22 health professionals and the University in the period  
23 leading up to the attacks on 13 June. You will wish to  
24 consider what information was available to those working  
25 with VC, what information should have been available to  
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1 treatment of detained patients. Its purpose is to  
2 ensure that those with severe mental illness receive  
3 necessary care and treatment, even in the absence of  
4 consent.

5 Accompanying the Act is a statutory guidance  
6 contained in a Code of Practice. This came into force  
7 on 1 April 2015. Doctors, clinicians, managers and  
8 staff, Approved Mental Health Professionals and local  
9 authorities must have regard to the Code.

10 The Code contains the guiding principles that should  
11 inform any decision under the Mental Health Act. There  
12 are five overarching principles and these are as  
13 follows.

14 First, least restrictive option and maximising  
15 independence. Where it is possible to treat a patient  
16 safely and lawfully without detaining them under the  
17 Act, the patient should not be detained.

18 Secondly, empowerment and involvement. Patients  
19 should be fully involved in decisions about care,  
20 support and treatment. The views of families, carers  
21 and others, if appropriate, should be fully considered  
22 when taking decisions.

23 Third, respect and dignity: patients, their families  
24 and carers should be treated with respect and dignity.

25 Fourth, purpose and effectiveness: decisions about  
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1 care and treatment should be appropriate to the patient,  
2 with clear therapeutic aims.

3 Five, efficiency and equity: providers,  
4 commissioners and other relevant organisations should  
5 work together to ensure that the quality of  
6 commissioning and provision of mental healthcare  
7 services are given equal priority to physical health and  
8 social care services.

9 When considering whether it is necessary for  
10 a person to be detained under the Mental Health Act,  
11 consideration needs to be given to whether the person  
12 has capacity to consent to or refuse admission and  
13 treatment in accordance with the Mental Capacity Act  
14 2005.

15 A person lacks capacity if they are unable at the  
16 material time to make a decision for themselves in  
17 relation to any issue because of an impairment of, or  
18 disturbance of, the mind or brain. They will be unable  
19 to make a decision where they cannot understand, retain  
20 or weigh the information relevant to the decision, or  
21 they cannot communicate their decision.

22 Where a patient lacks capacity to give or refuse  
23 consent to admission or treatment they are extremely  
24 unlikely to be admitted informally. A decision needs to  
25 be made as to whether detention ought to be pursuant to  
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1 a treatment plan, or to reach a judgment about whether  
2 the patient will accept treatment on a voluntary basis  
3 following admission; and if there is need to carry out  
4 a new in-patient assessment to re-formulate a treatment  
5 plan or reach a judgment as to whether a patient will  
6 accept treatment on a voluntary basis.

7 Section 3 of the Mental Health Act, meanwhile,  
8 allows for a patient to be admitted to hospital for  
9 treatment, initially for a period of up to six months,  
10 as set out in section 20 of the Act, but that period can  
11 be extended for a further six months and thereafter  
12 annually.

13 Section 3 should be used where the nature and degree  
14 of the patient's mental disorder, the essential elements  
15 of the treatment to be followed and the likelihood of  
16 the patient accepting treatment as an informal patient  
17 are already sufficiently established to make a new  
18 assessment under section 2 unnecessary.

19 When considering whether detention is necessary for  
20 the protection of other people, the Code of Practice  
21 explains that the factors to be considered are the  
22 nature of the risk to other people arising from the  
23 patient's mental disorder, the likelihood that harm will  
24 result, and the severity of any potential harm.

25 As we have set out, of VC's four admissions the  
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1 the provisions of the Mental Health Act 1983 or whether  
2 instead reliance should be on the Mental Capacity Act  
3 and deprivation of liberty safeguards.

4 We will consider the interaction of these pieces of  
5 legislation and their impact or otherwise in VC's case.

6 Two of the most significant legal powers relevant to  
7 the care received by VC are sections 2 and 3 of the  
8 Mental Health Act. Both of these sections provide for  
9 the detention of a mental health patient, even in the  
10 absence of consent, although the basis for detention and  
11 the implications of each differ.

12 Section 2 of the Mental Health Act provides for an  
13 admission to hospital for a period of up to 28 days for  
14 assessment, or for assessment followed by treatment.

15 The grounds for admission are that the patient is  
16 "... suffering from mental disorder of a nature or  
17 degree which warrants their detention for assessment for  
18 at least a limited period; and ... that [the patient]  
19 ought to be so detained in the interests of [their] own  
20 health and safety or with a view to the protection of  
21 other persons."

22 The Code of Practice states that section 2 should  
23 only be used if the full extent of the nature and degree  
24 of a patient's condition is unclear; there is need to  
25 carry out an initial in-patient assessment to formulate  
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1 final two were both commenced as section 2 detentions.  
2 The third admission converted, during detention, to  
3 a section 3. The fourth admission was under section 2  
4 throughout.

5 In 2018 the final report of the Independent Review  
6 of the Mental Health Act ("Modernising the Mental Health  
7 Act") expressed concern that section 2 was used too  
8 often for patients who were well known to services and  
9 who were not realistically in need of the full  
10 assessment required for someone not known to services.  
11 It was observed that the overuse of section 2 could  
12 disadvantage patients, in particular by denying them  
13 rights under section 117 of the Act, which imposes  
14 a duty on integrated health boards and social services  
15 to provide aftercare services following detention.

16 The Independent Review recommended that section 2  
17 should only be used where it is truly necessary to  
18 assess someone, not because it is perceived as the least  
19 restrictive option. It recommended change to the Code  
20 of Practice to make clear that section 3 should be used  
21 where there has been a section 2 detention in the last  
22 12 months. Where there has been a section 3 admission  
23 in the last 12 months, a material change should be  
24 demonstrated before an application under section 2 can  
25 be used.  
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1 If such an approach had been taken to VC, his fourth  
2 admission would certainly have been pursuant to  
3 section 3 given it was only three months following his  
4 third admission.

5 A significant difference between sections 2 and 3  
6 are the options available to treating clinicians upon  
7 discharge. Pursuant to section 17A of the Mental Health  
8 Act 1983, a patient admitted pursuant to section 3 can  
9 be discharged subject to recall under a Community  
10 Treatment Order.

11 As we have set out, VC was never the subject of  
12 a Community Treatment Order. The Inquiry will explore  
13 the reasons for this and consider whether and if so when  
14 there were grounds for making one in his case. Of  
15 particular significance, a Community Treatment Order  
16 could have been used to impose a condition that his  
17 medication be provided by way of depot injections,  
18 failing which he would be subject to recall.

19 During his third admission VC was repeatedly given  
20 intra-muscular treatment under active or passive  
21 restraint after he refused oral medication. This is  
22 because when a patient is detained under the Mental  
23 Health Act, part 4 of the Act allows for them to be  
24 provided with treatment non-voluntarily. Section 63  
25 provides that the consent of the patient is generally

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1 to the Inquiry and will give oral evidence on the work  
2 of the review, its conclusions and the reforms  
3 introduced by the government. Of particular relevance  
4 to the work of the Inquiry are the reforms to the  
5 threshold for detention and the use of other powers in  
6 the Act.

7 In the introduction to the final report of the  
8 Review, Sir Simon Wessely states that a substantial  
9 reason for the increase in detentions under the Mental  
10 Health Act is the issue of risk and risk aversion. The  
11 fear of making a faulty risk assessment influences many  
12 professionals who are increasingly risk averse. He  
13 states that there is no such thing as zero risk, and it  
14 would be absurd to detain every person with a mental  
15 disorder. Any probability judgment will be wrong  
16 sometimes, without being faulty.

17 The report notes that rates of compulsory detentions  
18 in psychiatric hospitals have more than doubled since  
19 1983, with the steepest rise in the last decade. The  
20 report finds that the basis for detention, that it is  
21 necessary and in the interests of the patient's health  
22 or safety or for the protection of others, sets the bar  
23 too low. A person could be detained to avoid any  
24 deterioration in their mental health or relapse even if  
25 there was no other risk which may have allowed

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1 not required to give medical treatment for mental  
2 disorder. The courts have interpreted this section to  
3 include the ability to use restraint, including physical  
4 force, in order to administer such medical treatment.

5 Where a patient is not detained, part 4 of the  
6 Mental Health Act does not apply. The circumstances in  
7 which a non-detained patient can be compelled to receive  
8 treatment, including medication, are limited. For  
9 a patient with capacity who is not in hospital and not  
10 subject to the Mental Health Act 1983, there is  
11 generally no power to provide non-voluntary medical  
12 treatment. Whilst a condition of a Community Treatment  
13 Order can be to take a certain medication, this does not  
14 provide a basis for compulsion or restraint. Instead,  
15 there is the power of recall for failing to comply, as  
16 I have stated previously.

17 The Mental Health Act 2025.

18 On 6 November 2024 the government introduced the  
19 Mental Health Bill in the House of Lords. The Bill  
20 received Royal Assent on 18 December 2025, becoming the  
21 Mental Health Act 2025. The Act is intended to  
22 implement the policy approaches in the Independent  
23 Review of the Mental Health Act chaired by Professor Sir  
24 Simon Wessely, and referred to above.

25 Sir Simon Wessely has provided a witness statement

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1 professionals to become risk averse and afraid of  
2 consequences that may never happen, and probably would  
3 not happen.

4 The report proposed new detention criteria requiring  
5 there to be a "substantial likelihood of significant  
6 harm to the health, safety or welfare of the person, or  
7 the safety of any other person". The intention of this  
8 increased threshold was to reverse the trend of raising  
9 detention rates and to give professionals the backing  
10 they need to take more risks. It is said in the report  
11 that the Act needed to be more explicit about how  
12 serious the harm has to be to justify detention and/or  
13 treatment, or how likely it is that the harm will occur.

14 The report does not, however, provide a definition  
15 of "substantial likelihood" or "significant harm", other  
16 than saying that the detention will only be permitted in  
17 the most serious cases.

18 The reform of the detention criteria in the Mental  
19 Health Act 2025 do not go as far as the Independent  
20 Review proposal. Instead the new threshold will be that  
21 "serious harm may be caused to the health or safety of  
22 the patient, or of another person and that it is  
23 necessary, given the nature, degree and likelihood of  
24 the harm, the patient ought to be so detained".

25 The Act does not explain what is meant by "serious

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1 harm" or the term "may be caused". Dr Lade Smith will  
 2 give evidence that the wording of this requirement is  
 3 ambiguous and may have a wide breadth of application;  
 4 "may be", she observes, is a highly inclusive verb  
 5 phrase. Her concern is that this may drive defensive  
 6 practice. She also highlights difficulties with  
 7 predicting the likelihood of harm and whether this  
 8 simply means greater than 50 per cent, which may be  
 9 difficult to quantify in individual cases and, in any  
 10 event, some serious harms may justify detention even if  
 11 the probability is lower than 50 per cent.

12 The explanatory notes to the Act explain that the  
 13 Code of Practice will provide guidance on what is meant  
 14 by serious harm. The Code of Practice is something upon  
 15 which you, Chair, may wish to make recommendations.

16 The period of detention provided for a section 3  
 17 admission is to be reduced from an initial period of six  
 18 months to three months, followed by renewal after  
 19 three months, then six months, then a year.

20 Reforms are also made to CTOs. There will be  
 21 a requirement that the community clinician, where they  
 22 are not the responsible clinician, state in writing that  
 23 they agree the criteria for a Community Treatment Order  
 24 is met and to be consulted by the responsible clinician  
 25 before a CTO is varied or suspended.

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1 coordinator, Claudia Birtles, having contact with family  
 2 members. He withdrew consent in a telephone  
 3 conversation on 16 December 2021. In the medical  
 4 records it is noted that VC was "very confrontational  
 5 and quite angry throughout the call" and that "he ...  
 6 went on to say that under no circumstances could I have  
 7 any contact with his mum as it was 'stressing her out'."

8 He went on to tell Ms Birtles that:

9 "... he was 'cutting this contact off completely'  
 10 and I was never to speak to her again."

11 Contact between mental health services and VC's  
 12 family thereafter was much more limited. The second CQC  
 13 report observes that it could be argued that the Trust  
 14 could have continued to engage with the family while  
 15 still maintaining his confidentiality.

16 The starting point is that information provided by  
 17 patients to clinicians is provided in confidence.

18 Clinicians owe a common law duty to maintain that  
 19 confidence. A breach of confidence is a breach of  
 20 a duty of care and potentially of the patient's  
 21 Article 8 rights and data protection legislation.

22 The Mental Health Act 1983 does not contain powers  
 23 or duties to disclose information about risk to third  
 24 parties. Whether there is a duty to disclose depends  
 25 upon whether there is a common law duty to disclose or

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1 The Independent Review report noted that controlled  
 2 trials looking at CTOs found very limited evidence that  
 3 they had achieved the goal of reducing the numbers of  
 4 people being re-admitted. They were experienced as  
 5 coercive and restrictive by people subject to them, but  
 6 there were a small number of people for whom CTOs  
 7 represent the least restrictive option. The report  
 8 wanted to see the use of CTOs at least halved.

9 What was described as the cornerstone of the  
 10 Independent Mental Health Review is the statutory care  
 11 and treatment plan to be developed soon after detention  
 12 and which would be the responsibility of the responsible  
 13 clinician. The recommendation was that it would be in  
 14 place within seven calendar days, signed off by the  
 15 responsible clinician and reviewed by a clinical  
 16 director or delegated officer at 14 calendar days. It  
 17 would be required to set out how the wishes and  
 18 preferences of the patient, their families, and carers  
 19 informed the plan.

20 The Act also replaces nearest relative, thought to  
 21 be outdated, with a nominated person and confers new  
 22 functions on them.

23 I turn now to the test for sharing information under  
 24 current law for the rights of the next of kin.

25 VC had initially consented to his community care

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1 the disclosure is necessary to discharge an obligation  
 2 imposed by the European Convention on Human Rights, such  
 3 as the duty to secure life pursuant to Article 2.

4 In accordance with General Medical Council guidance,  
 5 clinicians can, in appropriate circumstances, disclose  
 6 personal information which would include the risk that  
 7 the patient poses to themselves or others without  
 8 breaching duties of confidentiality.

9 In his evidence to the Inquiry, Chris Hart, who has  
 10 written extensively on the practice of risk assessment,  
 11 notes that risk overrides the patient's right to  
 12 confidentiality and, if the patient is unwilling for  
 13 information about their risk to be shared with others,  
 14 that must be acknowledged but the information shared  
 15 nonetheless with agencies if relevant. He notes  
 16 a history of public inquiries going back to the 1990s in  
 17 which poor inter-agency working and the sharing of  
 18 information have been identified as key failures.

19 The Royal College of Psychiatry has published  
 20 guidance on information sharing which sets out a number  
 21 of principles. These recognise that patients have  
 22 a right to the privacy and confidentiality of their  
 23 health information, but information can be disclosed  
 24 without breaching confidentiality where: the patient  
 25 consents; disclosure is of overall benefit to a patient

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1 who lacks capacity to consent; disclosure is required or  
2 permitted by law; or disclosure can be justified in the  
3 public interest.

4 This guidance will be considered in oral evidence.  
5 The guidance advises a discussion on confidentiality and  
6 information sharing with the patient at an early stage,  
7 ensuring that the patient understands the benefits of  
8 sharing healthcare information with their family or  
9 carers.

10 The Code of Practice provides that local  
11 authorities, NHS commissioners, police forces and  
12 ambulance services should have in place a clear joint  
13 policy for safe and appropriate admission of people in  
14 their local area. Furthermore, that it is good practice  
15 for the parties to that local policy to meet regularly  
16 to discuss its effectiveness and to decide what  
17 information about specific cases can be shared between  
18 relevant parties for the purposes of protecting the  
19 person or others.

20 For patients who are the subject of the use of  
21 powers under the Mental Health Act 1983 there is certain  
22 information that must be shared with the nearest  
23 relative. The Approved Mental Health Professional is  
24 required to attempt to identify the patient's nearest  
25 relative and to take practicable steps to inform them

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1 current and past status under the Act, if that will help  
2 to ensure properly informed risk management by the  
3 relevant authorities, families and carers."

4 It is important to note that the duty of  
5 confidentiality attaches to the health information of  
6 the patient. The Royal College guidance explains there  
7 is nothing to prevent mental health practitioners  
8 receiving information from family members and carers, or  
9 actively seeking information even without patient  
10 consent. Receiving information is different from  
11 disclosing information, albeit it is recognised that  
12 listening to the views or concerns of others might be  
13 a breach of trust where the patient has made a request  
14 not to listen to specific people.

15 Alexander Ruck Keene KC is a legal expert in mental  
16 health and mental capacity law. He lectures and has  
17 advised previous public inquiries on these topics. His  
18 evidence will provide the Inquiry with a clear and  
19 detailed understanding of the legal framework within  
20 which the mental health professionals that came into  
21 contact with VC operated.

22 He will explain the powers that clinicians have with  
23 respect to patients submitted under the Mental Health  
24 Act, or on a voluntary basis, as well as those being  
25 treated in the community under a Community Treatment

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1 that an application under section 2 is being made, and  
2 also to communicate the outcome of an assessment.

3 Before making an application under section 3, the  
4 AMHP must consult the nearest relative unless it is not  
5 reasonably practicable or would involve unreasonable  
6 delay. The nearest relative must be told of discharge  
7 from detention or a Community Treatment Order.

8 Paragraph 4.48 of the Code sets out the duty on  
9 hospital managers to ensure that nearest relatives of  
10 detained and community patients have been informed about  
11 their legal situation and rights, albeit this duty is  
12 not absolute and information should not be shared with  
13 relatives if the patient objects.

14 The Code of Practice provides that where the Act  
15 allows steps to be taken in relation to patients without  
16 their consent, it is implicit that confidential patient  
17 information can be disclosed to the extent necessary to  
18 take those steps. The Code also makes clear that  
19 professionals may need to share information to manage  
20 any serious risks which certain patients may pose to  
21 others. The Code recognises that even where there is no  
22 overriding public interest in disclosing detailed  
23 clinical information about a patient's health, "there  
24 may, nonetheless, be an overriding public interest in  
25 sharing more limited information about the patient's

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1 Order or otherwise. He will set out for the Inquiry the  
2 interface between the Mental Health Act and the Mental  
3 Capacity Act and the provision of treatment. He will  
4 give his legal opinion in respect of specific scenarios  
5 that the Inquiry may find clinicians who came into  
6 contact with VC were faced with, such as the treatment  
7 of patients who have schizophrenia and/or pose a risk of  
8 harm to the public, and in what circumstances  
9 information in respect of risk can be lawfully shared  
10 with third parties, including the police, probation or  
11 the patient's family.

12 Mr Ruck Keene's evidence will also assist you,  
13 Chair, with potential recommendations. He will give  
14 evidence on whether there are any legal impediments to  
15 extending the scope in which CTOs or CTO-like orders  
16 might be deployed. He will also consider the ways in  
17 which the Mental Health Act 2025 will impact treatment  
18 of patients, noting the Act's increased focus on patient  
19 choice in relation to the making of medical treatment  
20 decisions.

21 He will also explain his concern about the lack of  
22 "legal confidence" amongst clinicians and the need for  
23 them to better understand the interaction between mental  
24 health law and professional practice.

25 Amongst the published questions to be addressed by

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1 the Inquiry is whether, in respect of VC's treatment,  
2 there was an avoidance of restrictive practice given  
3 publicised concerns about the disproportionate overuse  
4 of Mental Health Act restrictive measures with black  
5 African and black Caribbean patients in the context of  
6 Mental Health Act reform during the timeline period.

7 The context of this question is:

8 (i) The terms of reference for the independent  
9 review of the Mental Health Act 1983 were published  
10 in October 2017. Those terms of reference note the  
11 Government's concern that the disproportionate number of  
12 people from black and minority ethnicities detained  
13 under the Act;

14 (ii) The independent review report was published  
15 in December 2018. It too expressed concern at the  
16 excessively poor experiences and outcomes of black  
17 people who were disproportionately more likely to be  
18 detained under the Mental Health Act. It noted that  
19 black African and Caribbean men were also seriously  
20 overrepresented in the use of community treatment  
21 orders.

22 VC's treatment postdates both of these, spanning the  
23 period 2020 to 2022. It pre-dates the Mental Health  
24 Bill, the first reading of which was in November 2024.

25 As to whether in general terms there is evidence of  
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1 evidence thus far received by the Inquiry does not  
2 suggest it was. It is to be observed that he was  
3 detained on four occasions, and five of his seven mental  
4 health assessments recommended detention.

5 Assessing risk (experts and professional opinion).

6 Following consultation with Core Participants, the  
7 Inquiry has instructed and will hear from two experts  
8 relating to the understanding, assessment and management  
9 of risk. Dr Seena Fazel, Professor of Forensic  
10 Psychiatry and Dr Ruth Tully, Consultant Forensic  
11 Psychologist.

12 Dr Fazel has provided an expert report based upon  
13 his academic and clinical experience on the relationship  
14 between mental illness, violence and risk assessment.  
15 He provides an overview of the literature in the area  
16 which suggests, he says, a clear relationship between  
17 mental illness, particularly schizophrenia, and the  
18 perpetration of violence.

19 Dr Fazel will address the Inquiry on the various  
20 risk assessment tools that exist in this area. In his  
21 view, the use of such tools should be strongly  
22 encouraged. He considers that standardisation of tools  
23 would improve risk communication between services. He  
24 will say that training for clinicians working in general  
25 adult psychiatry in the risk assessment of violence is  
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1 an avoidance of the use of restrictive practices due to  
2 publicity in respect of mental health reforms, Dr Lade  
3 Smith, President of the Royal College of Psychiatrists,  
4 explains in her statement that recent statistics show  
5 that black people are four more times more likely than  
6 white people to be detained under the Mental Health Act,  
7 and eight times more likely to be placed under a CTO.  
8 The Royal College of Psychiatrists is not aware of any  
9 evidence about concerns about the disproportionate use  
10 of restrictive measures in respect of black patients  
11 impacts the approach taken by practitioners. There is  
12 no evidence that psychiatrists are not admitting  
13 patients because they are black. The rates of admission  
14 are the same as at the time of the publication of the  
15 independent review, and recent evidence shows that  
16 detentions are going up.

17 As to whether specifically in VC's case there is any  
18 evidence that restrictive practices were not used  
19 because he was black, this question has, in accordance  
20 with the published questions, been put to a significant  
21 number of the professionals who were dealing with him.  
22 The Inquiry may wish to consider further in oral  
23 evidence whether race was a factor in restrictive  
24 practices not being used as a result of publicity about  
25 mental health reforms in the period 2020 to 2022. The  
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1 currently limited and should be improved via, in his  
2 view, the Royal College of Psychiatrists.

3 He will also give his opinion as a psychiatrist in  
4 respect of specific scenarios that may have been  
5 relevant to the clinicians that came into contact with  
6 VC, such as treatment of patients who have  
7 schizophrenia, and pose a risk of harm to the public,  
8 but do not want to engage with treatment or depot  
9 injections. In what circumstances can information about  
10 risk be shared with third parties such as the police,  
11 probation or the patient's family?

12 His evidence is that the public interest can  
13 outweigh the patient's interest and justify disclosure  
14 to protect individuals or society from the risk of harm.

15 Dr Fazel will tell the Inquiry that risk assessments  
16 should be undertaken in general adult psychiatry when  
17 people are first taken on by mental health services, and  
18 whenever there is a clear change or escalation in risk,  
19 such as when someone has been arrested by the police.  
20 Risk assessment should also be undertaken where there is  
21 uncertainty about violence risk, as it provides  
22 an opportunity for the clinical team to consider this in  
23 a more structured way.

24 In terms of how risk assessment should be done, he  
25 will highlight three main areas. First, taking  
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1 a comprehensive personal and clinical history that  
2 includes information about previous violence towards  
3 people, history of substance misuse, and triggers for  
4 any psychotic relapses. Such a history should aim for  
5 corroboration from informants and other sources where  
6 possible.

7 Second, this should be followed by a clinical  
8 examination that covers the main areas of mental state:  
9 appearance and behaviour, speech, mood, thought and  
10 perception, cognition and insight, and investigation of  
11 the presence of delusions and their impact on mood and  
12 anger.

13 Finally, the structured violence assessment tool  
14 should be administered to provide a baseline risk  
15 evaluation and to provide a means to communicate risk  
16 consistently within and between services.

17 Dr Fazel will identify the key risk factors that  
18 should be analysed in a risk assessment, in particular  
19 sex, age and any previous history of violence, as well  
20 as a lack of compliance with treatment plans, and  
21 co-occurring substance misuse issues.

22 Dr Ruth Tully has been instructed to provide an  
23 opinion on risk assessment tools, in particular the  
24 HCR-20, version 3, structured professional judgment  
25 violence risk assessment tool, which is recommended by

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1 It notes, similarly to the Independent Review, that risk  
2 is dynamic and requires regular review, particularly at  
3 times of transition between services, discharge or when  
4 clinical presentation changes.

5 The guide identifies factors likely to increase  
6 violence, including sex and age. Men in late  
7 adolescence and early adulthood have a higher  
8 statistical risk of violence than women or older adults.  
9 Substance misuse, personality disorder, previous history  
10 of violence, impulsivity and environmental stressors are  
11 also contributory.

12 The guidance outlines different approaches to the  
13 assessment of risk. One is unstructured clinical  
14 judgment, where the psychiatrists use their training,  
15 experience and intuition to weigh up information.  
16 Professor Morgan explains that this approach is prone to  
17 bias, inconsistency and limited reliability.

18 Chris Hart will provide a psychiatric nursing  
19 overview. He will outline the importance of nursing in  
20 the overall assessment and treatment of mental health  
21 patients. In his view, nurses are the core of mental  
22 health service provision. He will discuss the role of  
23 nursing in the community and in hospital settings.  
24 Because of the nature and frequency of their contact  
25 with patients he will say that nurses are expected to

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1 the Royal College of Psychiatrists in their 2016  
2 guidance.

3 Dr Tully will provide expert evidence on risk  
4 assessment approaches. She will walk the Inquiry  
5 through the HCR-20 version 3 tool and explain its  
6 design, use, benefits and limitations. She will assist  
7 with how training is given on the ground. She will  
8 suggest that every Trust should have a policy for  
9 non-forensic services with procedures for considering if  
10 a formal risk assessment tool is needed in a given case.  
11 Like Dr Fazel, she considers that the use of risk  
12 assessment tools should be strongly encouraged. She  
13 will agree with other witnesses that confidentiality  
14 concerns should not be a barrier to information sharing  
15 in high-risk cases.

16 We will also hear from Professor John Morgan, who  
17 has provided the Inquiry with evidence about the work of  
18 the Royal College of Psychiatrists Patient Safety  
19 Working Group. In 2016, the group published a report  
20 and good practice guide on the Assessment and Management  
21 of Risk to Other People.

22 The report emphasised that risk cannot be  
23 eliminated, but it can and should be rigorously assessed  
24 and managed. It stresses that most patients with mental  
25 illness pose a greater risk to themselves than others.

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1 assess the ongoing risk with the patient and note any  
2 changes in the patient's mental state, behaviour or  
3 overall situation over time. He advises on best  
4 practice.

5 Mr Hart will highlight in his evidence problems and  
6 limitations faced by professionals in this area. He can  
7 find few examples where NHS trusts adopt and implement  
8 the best practice for risk assessment and management.  
9 He considers that the time devoted to risk assessment  
10 training for nurses and other clinical staff and senior  
11 clinicians has declined over time. Nurses, he will say,  
12 do not receive detailed, coherent training or education  
13 in assessing risk to others during their  
14 pre-registration training, and few Trusts incorporate it  
15 in their post-registration programmes beyond a mandatory  
16 one-day training. Even fewer Trusts assess the  
17 competency of nurses in this area.

18 If it is clear, he suggests, that an individual  
19 nurse or team of nurses are struggling, it has to be  
20 incumbent on the organisation to analyse the problem and  
21 address it before there is a tragedy. It is unrealistic  
22 to imagine that services and nursing care can be  
23 improved without improving the knowledge, skills and  
24 experience of nurses. He notes a dramatic loss of  
25 clinical leadership roles in mental health nursing.

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1 A number of risk assessments were completed in  
 2 respect of VC between May 2020 and February 2022. The  
 3 Trust promoted positive risk-taking as a fundamental  
 4 principle in the best practice of managing risk. The  
 5 theory is that overly defensive practice is bad practice  
 6 because avoiding all possible risks is not good for the  
 7 patient or society in the long term and can be  
 8 counter-productive. Positive risk management identifies  
 9 that risk can never be entirely removed, and so  
 10 management plans will always involve choices that carry  
 11 some level of risk which should clearly be acknowledged  
 12 within the decision-making process. Positive risk  
 13 management involves encouraging clinicians to support  
 14 reasonable autonomy and community participation with  
 15 proportionate safeguards in place.

16 The report of the Independent Review of Mental  
 17 Health referred to earlier concluded that the way risk  
 18 assessments are carried out and how the concept is  
 19 framed requires a fundamental rethink. Risk changes  
 20 over time. Assessments need to be frequently redone but  
 21 are not carried out consistently. The report observed  
 22 that standardised assessment tools are not ideal because  
 23 they are designed to fit a generic patient rather than  
 24 being tailored to an individual and there is little  
 25 evidence to support their use.

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1 evidence-based and safety-critical mental health  
 2 interventions are implemented, maintained and monitored.

3 Professor Tim Kendall, NHS England National Clinical  
 4 Director for Mental Health from 2016 to 2023, and  
 5 Clinical Lead for New Models of Mental Health since  
 6 2023, will provide evidence in respect of new community  
 7 mental health schemes being piloted in England at the  
 8 present time.

9 Witnesses from the Royal College of Psychiatrists  
 10 and the Royal College of Nursing will be giving evidence  
 11 about learning, practice and training for clinicians in  
 12 their respective areas.

13 Witnesses from the relevant regulators, the GMC and  
 14 NMC, have also provided evidence in respect of their  
 15 roles in overseeing training.

16 Finally, Chair, Dr Nuwan Dissanayaka, Consultant  
 17 Psychiatrist for the Assertive Outreach Team for Leeds  
 18 and York Partnerships NHS Foundation Trust since 2003,  
 19 will give evidence as a national expert in Assertive  
 20 Outreach. He describes the clinical need for Assertive  
 21 Outreach, a whole team approach with a shared caseload  
 22 rather than individual case management. The keys to  
 23 engagement include consistency of contact and treatment  
 24 and practical support with issues such as housing and  
 25 finances. He explains constructive, as opposed to

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1 The Inquiry will hear from Professor Louis Appleby  
 2 in relation to his role as the Director of the National  
 3 Confidential Inquiry into Suicide and Safety in Mental  
 4 Health. He will inform the Inquiry of the systematic  
 5 collection and analysis of clinical and offence-related  
 6 data on all people convicted of a homicide offence in  
 7 the UK up until 2018, when funding was ceased save for  
 8 the collection of data on suicides. Funding for the  
 9 collection of data on homicides was later recommenced by  
 10 NHS England in 2025 following the Nottingham attacks.

11 Professor Appleby will summarise the key findings  
 12 from that extensive body of work, including from a study  
 13 in 2020 that 94 per cent of those convicted of homicide  
 14 had either a history of drug or alcohol misuse or were  
 15 not in receipt of planned treatment.

16 In his view, the key area for recommendations should  
 17 be maintenance of treatment in the community, the  
 18 response of services to signs of risk or relapse, and  
 19 the oversight of evidence-based safe care. He supports  
 20 the greater use of Community Treatment Orders and  
 21 outreach teams, and considers that patients' families  
 22 should have a right to request assessment and a second  
 23 opinion because they are often in the best position to  
 24 identify deterioration and risk. He also suggests a new  
 25 national oversight body is needed to ensure that

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1 restrictive, principles of support.

2 **THE CHAIR:** Yes, Ms Langdale, that seems a good point to  
 3 stop. We're going to take a shorter break this  
 4 afternoon and we will come back at half past 3. Thank  
 5 you.

6 (3.17 pm)

(Short Break)

8 (3.30 pm)

9 **THE CHAIR:** Yes, Ms Langdale.

10 3. Immediate period in the run up to the attacks,  
 11 the attacks on 13 June 2023 and the response of the  
 12 police.

13 **MS LANGDALE:** Having set out the legal framework and  
 14 evidence relating to treatment of VC prior to the  
 15 attacks, I turn now to the immediate period in the  
 16 run-up to the attacks, the attacks on 13 June and the  
 17 response of the police.

18 VC had graduated from Nottingham University in 2022  
 19 and, as we already set out, shortly before the attacks  
 20 he had been working at the Arvato warehouse in Kegworth.  
 21 He was dismissed by Arvato on 5 May 2023. We now know  
 22 that VC lived at 165 Burford Road in the Forest Fields  
 23 area of Nottingham until he was evicted on the weekend  
 24 prior to the attacks.

25 You will hear from the Senior Investigating Officer,

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1 retired Superintendent Leigh Sanders, about the  
2 investigation that he carried out in respect of VC's  
3 whereabouts, both before the attacks and after.

4 On Sunday 11 June, VC left his address in Nottingham  
5 and travelled to London. He left behind some property  
6 for a housemate to look after, including what turned out  
7 to be a wet stone knife sharpener. He stayed in London  
8 with a friend and attended a BBQ with him in Romford.

9 Shortly after 7 pm on 12 June, VC phoned his brother  
10 Elias on WhatsApp. He told his brother "this is the  
11 last time I will talk to you. After this I will leave  
12 you alone." He told him: "disassociate yourself from  
13 me. If anything happens don't come and see me in  
14 hospital [and] this is not mental illness, I am fine.  
15 I'm not ill but there is 2-way communication and 24/7  
16 voices in my head, they are intelligent people and they  
17 are making threats -- I will send you the files that  
18 I sent to mum and dad at Christmas, I know what is  
19 happening is real."

20 Later that evening, at 10.52 pm, he also telephoned  
21 his father, similarly telling him that if he were to end  
22 up in hospital he should not be visited or contacted.

23 VC arrived in Nottingham at around 11.20 pm on  
24 12 June. He is seen on CCTV at Nottingham train  
25 station, then travelling on a tram destined for

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1 is later seen at 1.30 am in Nottingham Road where he  
2 withdrew £10 from a Sainsbury's ATM. His movements can  
3 be seen to are a short period again, but then he cannot  
4 be found for a further 42 minutes.

5 This sequence raises obvious questions, namely where  
6 did VC change his footwear and leave his bag? Why did  
7 he change his footwear? How did he avoid detection on  
8 CCTV, and whether he knew where there were CCTV cameras  
9 and how to avoid them. VC eventually reached the  
10 Ilkeston Road area, returning once again to an area  
11 where he had lived and again disappears from view at  
12 3.30 am, possibly in a shrubbed green area.

13 As stated previously, for the attacks themselves,  
14 footage from a vehicle parked on Ilkeston Road captured  
15 the attack on Barney and Grace at approximately 4 am.  
16 We say approximately, because the information that the  
17 Inquiry will be looking at comes from a variety of  
18 different sources, each necessarily caveated as to the  
19 reliability of the precise timing of recording devices  
20 and other records.

21 Over the course of this Inquiry we will build up  
22 a picture of the sequence of events as accurately as is  
23 possible so that you, Chair, are able to make  
24 assessments as to whether the response of the police and  
25 emergency services was reasonable and whether any of the

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1 Wilkinson Street, before walking in the direction of  
2 Radford Road. He is captured at various locations such  
3 as Nottingham Road, then walking into the Radford area  
4 and ultimately heading to Ilkeston Road.

5 During his walk and other prior movements, at  
6 11.52 pm VC sent his brother the zip file of  
7 approximately 1,400 documents, many of which related to  
8 issues of mind control and state surveillance and which  
9 have been summarised by the Inquiry legal team.

10 There is a significant period during VC's prior  
11 movements that is unaccounted for. CCTV and other  
12 evidence has tracked VC making his way on foot from  
13 Wilkinson Street to Gladstone Street in the north west  
14 of the city at 29 minutes past midnight. His  
15 whereabouts for a 48-minute period thereafter are  
16 unknown. He had switched off his phone at 47 minutes  
17 past midnight. There is no cell site data, no financial  
18 transactions undertaken, or other information that has  
19 been obtained to identify his whereabouts.

20 He was carrying a large, very prominent Slazenger  
21 bag before he disappeared, which he had taken to London  
22 the night before and when he re-emerged he no longer had  
23 that bag and had changed his footwear. He had been  
24 wearing black trainers with a white sole. He reemerges  
25 on CCTV footage in black trainers with a black sole. VC

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1 attacks were preventable.

2 The first 999 call was received at 4.03 am. The  
3 caller reported "There are 2 people down there in the  
4 road ... one person lying down there in the road ... in  
5 front of Raleigh Park a girl and a guy."

6 Asked for a description of the person the caller  
7 said "Hoody and pants". The caller told the police: "He  
8 went down ... the way you go down to the city centre".

9 A second caller, at 4.04 am, gave more information.  
10 He reported a stabbing and gave the location Ilkeston  
11 Road near Mario's Pizzas. He stated that the attacker  
12 had just gone up Ilkeston Road towards town. When asked  
13 "Where is the victim?" he answered: "One's lying in the  
14 middle of the road, he's dead ... I think he's dead."

15 He gave a description of the attacker -- a black man  
16 with a black bag, all dressed in black. Over three  
17 minutes into the call the caller was asked "Just one  
18 victim as far as you are aware?" The caller replied  
19 that there were two victims, there was a girl on the  
20 other side of the road. The call handler asked "Where  
21 did she go?" The caller said: "She sat in a driveway of  
22 one of the eco houses but I think she has wandered off  
23 down the road. She was bleeding from the stomach".

24 You will hear an account of the events of 13 June  
25 from Superintendent Simon Allardice. His evidence is

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1 that in fact VC had not gone towards the city centre  
2 after these attacks and he was heading in a different  
3 direction.

4 Each call that came into the police on 13 June and  
5 the information callers provided is of real importance.  
6 What steps were taken to reach the two victims as these  
7 calls came in? What steps were taken to locate the  
8 attacker? Were there wider risks to assess? Was  
9 a threat assessment undertaken to develop the police  
10 response and, if so, when?

11 A threat assessment refers to the analysis of  
12 potential or actual harm to people, the probability of  
13 it occurring and the consequences or impact should it in  
14 fact occur.

15 Judgments made and decisions taken in this period  
16 are of enormous significance to the bereaved families  
17 and survivors. Was everything done that could be done  
18 within the first responses to prevent the deaths of  
19 Barney, Grace and Ian? Given the time to apprehend VC,  
20 were the later attacks preventable? The Inquiry will  
21 examine what judgments were made in the circumstances  
22 faced.

23 The College of Policing Approved Professional  
24 Practice makes clear that threat and risk assessment is  
25 necessary to develop a working strategy for the response

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1 At approximately 4.05 am, a call was made from  
2 the police control room to the East Midlands  
3 Ambulance Service requesting assistance. Also at  
4 4.05 am, a further 999 call was made from a taxi driver  
5 but that call has not been recorded.

6 Chair, you will hear of several other instances  
7 where the audio of 999 calls were not properly recorded  
8 and that is something that you may wish to understand  
9 further.

10 The police had graded the incident as "Grade 1",  
11 which is an "immediate" emergency incident. The target  
12 attendance time for such incidences is within 15 minutes  
13 for urban areas. There is evidence that officers had  
14 arrived by 4.08 am and engaged in first aid to Barney.  
15 That is a response time of approximately five minutes.

16 What about Grace? Notwithstanding the 999 calls  
17 referred to, it appears that it was not until 4.08 am  
18 that officers were updated by dispatch that a female had  
19 also been stabbed. An officer already at the scene was  
20 also alerted by a member of the public to Grace's  
21 whereabouts.

22 By 4.07 Force Incident Sergeant, Sergeant Gavin  
23 Berry, had considered what are called "golden hour"  
24 principles. These principles are set out in the College  
25 of Policing's Authorised Professional Practice on

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1 to any attacks. As an incident progresses, regular  
2 review of available information and intelligence is  
3 necessary. As Sir Andrew Marsh, College of Policing,  
4 will make clear in evidence, a threat assessment should  
5 be based on a number of matters, including information  
6 known at the time, historic information and to whom and  
7 under what circumstances the threat may occur.

8 The police arrived on the scene of the first attacks  
9 whilst the second caller I have referred to was still on  
10 the telephone.

11 You will hear from Superintendent Allardice that at  
12 4.04 am, recordings from a radio system known as  
13 "Airwave" show Operational Support officers being  
14 informed of the evidence and multiple officers being  
15 dispatched, including firearms officers and dog  
16 handlers.

17 You will hear from the Force Incident Manager, Chief  
18 Inspector David Mather. The force incident manager, or  
19 FIM, is a police officer, usually in the rank of Chief  
20 Inspector, responsible for the operation of the Force  
21 Control Room, and who coordinates the response and  
22 effective management of certain incidents.

23 The actions and decisions taken by Chief Inspector  
24 Mather will feature heavily in the assessment of the  
25 immediate response to the attack and its adequacy.

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1 Investigation Process. This golden hour is the period  
2 immediately following the report of an offence or  
3 incident when positive action should be taken.  
4 Effective action during the golden hour is intended to,  
5 and will, increase the opportunity to identify suspects,  
6 protect victims and witnesses and help to secure  
7 positive criminal justice outcomes.

8 The College of Policing guidance states that  
9 everyone involved in investigating crime or incident  
10 must help to preserve life, secure material, minimise  
11 the amount of material that could be lost to the  
12 investigation and maximise the chance of securing  
13 material that would be admissible in court. Preserving  
14 life surely includes, Chair, ensuring dangerous suspects  
15 are apprehended as soon as possible.

16 The incident log sets out the immediate steps that  
17 were communicated by Sergeant Gavin Berry,  
18 namely: officers to attend and activate body-worn video;  
19 obtain account from the victim; secure accounts from  
20 witnesses; early CCTV enquiries to be conducted; search  
21 to be conducted for any weapon; locate and secure  
22 a scene if necessary; early observations for potential  
23 offenders; considering cross-contamination.

24 By 4.07 am PC Dean Reynolds, from whom we will hear  
25 evidence, had offered to head towards the incident

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1 location from the city to see if they could see anyone  
2 matching the suspect's description. Surprisingly, you  
3 will hear that the only information passed to the  
4 officer was that it was "someone wearing a hoody".

5 Another officer, PC Marshall, asked if there was any  
6 known direction of travel and told that there was not as  
7 yet, despite the information given in the 999 calls.

8 At the same time, Operation Firearms Commander, PC  
9 Speeden asked whether armed authority was being  
10 considered to search for the attacker. That will be of  
11 particular importance to the family of Ian Coates and  
12 the survivors of the later attacks. Chief Inspector  
13 Mather informed PC Speeden that the priority was the  
14 victims as they had reports of a second victim.

15 Authorised Firearms Officers, known as AFOs, have  
16 greater first response training and equipment, which is  
17 why they had been sent to the victims of the first  
18 attacks. When the Ambulance Service arrived, however,  
19 was it necessary for these officers to remain at the  
20 scene?

21 PC Speeden has told the Inquiry that he and other  
22 firearms officers were frustrated that no authority to  
23 deploy firearms officers had been granted in response to  
24 the first attacks. This special authorisation is given  
25 where the authorising officer has reason to suppose that

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1 from the Ambulance Service. That is the fastest  
2 possible attendance. A firearms sergeant and firearms  
3 officer arrived at 4.10 am, by which time Grace had been  
4 found and the firearms sergeant, PS Hallam, started to  
5 provide first aid and engaged in CPR until the ambulance  
6 arrived.

7 By 4.10 am the response policing inspector,  
8 Inspector Shaw, had been informed of the incident and  
9 the first ambulance crew had arrived.

10 At 4.11 am the Operational Firearms Commander PC  
11 Speeden raised concerns about the whereabouts of VC. He  
12 said over the radio system:

13 "I know our priority is the victims at the moment,  
14 my only concern is the offender, we have unknown  
15 whereabouts for him. It's unknown if there will be  
16 future victims or that the offender might return to the  
17 scene."

18 You will hear from PC Speeden and his recollection  
19 of this issue.

20 You will hear from Superintendent Simon Allardice  
21 that there is no evidence that a review took place as to  
22 the risk posed to future victims at this stage,  
23 something that Chief Inspector Mather will plainly have  
24 to address. By this stage, or soon after, why wasn't  
25 there central coordination from the control room of who

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1 officers may have to protect themselves or others from  
2 a person who is so dangerous that the deployment of  
3 armed officers is considered appropriate.

4 We pause to note that officers arriving to the  
5 horror of the scene cannot have failed to recognise the  
6 potential danger of the attacker and that they had  
7 a lethal weapon. Footage of the brutal and sustained  
8 attacks was also quickly made available. We will ask  
9 why firearms officers were not deployed in the  
10 circumstances. In PC Speeden's view, if this had  
11 happened firearms officers would have "commenced an  
12 armed areas search for the subject". The search would  
13 have been run on the firearms channel, not the channel  
14 we have previously referred to and, in his view, areas  
15 would have been designated for officers to search  
16 without duplication.

17 Superintendent Allardice's evidence will be that  
18 there was no information known or available to Chief  
19 Inspector Mather at that time which would have strongly  
20 indicated the random nature of the attack or that it  
21 would become a marauding attack. The Inquiry will test  
22 the sufficiency of that explanation and whether in any  
23 event suitable emphasis was placed on identifying and  
24 finding the attacker.

25 By 4.09 am officers had asked for a CAT1 response

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1 was searching and where? Were those responsible  
2 directing a search in a structured manner? If not why  
3 not?

4 At 4.12 am two officers, PC Clarke and PC  
5 Brady-Johnson, passed a further description of the  
6 suspect over the radio. This was that he was a black  
7 male, about 6-foot 2, wearing all dark clothing with  
8 something grey on his back. He was described as holding  
9 a knife and running away. This had been taken from  
10 phone footage that had been obtained from the first 999  
11 caller.

12 You will hear from PC Dean Reynolds who was at the  
13 scene and, after assisting with the police cordon,  
14 appears to have used his initiative to conduct a search,  
15 including of alleyways and passageways that he thought  
16 that VC might have used to get away.

17 At 4.13 am two dog handlers arrived, PC Whysall and  
18 PC Marshall. PC Whysall referred to the suspect heading  
19 up Ilkeston Road and said they would start a search.  
20 Superintendent Allardice will give evidence in respect  
21 of the locations that these officers and other officers  
22 carried out their searches. This was now approximately  
23 eight minutes from the first 999 call and approximately  
24 five minutes after the police first attended at the  
25 scene.

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1 CCTV later recovered captures VC on Player Street  
2 heading towards Brook Court and Alferton Road at  
3 4.13 am. That is away from the city centre, closer to  
4 where VC had been earlier in the evening. Officers were  
5 viewing CCTV contemporaneously in a control room which  
6 is managed by Nottingham City Council but VC was not  
7 located at the time.

8 Superintendent Allardice will set out other searches  
9 that were taking place when officers arrived at the  
10 scene in the minutes that follow. He has exhibited  
11 detailed telematics data from police vehicles that  
12 attended the scene. The Inquiry will examine the maps  
13 which show VC's location and the police searches that  
14 were taking place. We will ask: were these searches  
15 focused too much on the area south and east of Ilkeston  
16 Road and towards the city centre?

17 Chair, it is unlikely to be controversial to say  
18 that many officers arrived at the scene of the first  
19 attacks in good time. We will ask whether officers were  
20 properly coordinated in respect of the search for VC and  
21 thereafter.

22 Superintendent Allardice will tell you that there  
23 should have been greater oversight by a coordinating  
24 supervisor. He also reflects that there should have  
25 been some further consideration of the threat VC posed

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1 his words: "We've got some cops looking for the suspect,  
2 haven't we, if not many?" Chief Inspector Mather  
3 responded, "He is going to be long gone now" and asked  
4 him to concentrate on the victims at the scene.

5 The search for an attacker did not actually stop at  
6 that point. Other searches continued by officers and  
7 soon after by drone. These other searches were again  
8 principally focused towards the city centre.  
9 A significant search occurred around Derby Road to the  
10 south following a report of a female shouting "Get off  
11 me", but it was ultimately not linked to VC. This  
12 search appears to have been coordinated by another  
13 officer and may bear comparison in its organisation with  
14 the response to the matters you are investigating,  
15 Chair.

16 Grace was taken away in an ambulance at 4.36 am to  
17 the Queen's Medical Centre. Barney was transported  
18 there at 4.45 am. Grace was declared life extinct  
19 around 4.48 am and Barney at 5.20 am.

20 The Inquiry will obtain evidence from a medical  
21 expert in pre-hospital emergency care through which we  
22 will explore whether there was a prospect that Barney,  
23 Grace or Ian could have survived the attacks upon them.

24 By 5.01 am Chief Inspector Mather contacted the  
25 on call Chief Officer now Temporary Deputy Chief

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1 to the wider public as more information emerged.

2 As new descriptions and location information was  
3 passed to the police by witnesses, were the police  
4 provided with sufficient information on talk channels to  
5 carry out effective searches? You will hear, for  
6 example, PC Speeden asking again for further information  
7 on progress in identifying the suspect at 4.24 am, but  
8 not being updated on a sighting slightly north of  
9 Ilkeston Road. In the absence of that information, he  
10 directed other officers towards the city centre to the  
11 east.

12 Detective Inspector Pam Dowson, the on call murder  
13 investigation Senior Investigation Officer, had been  
14 breached by 4.18 am and was en-route to the scene by  
15 4.25 am. That signals the beginning of the formal  
16 investigation with formal scene examination, forensic  
17 enquiries and evidence recovery taking place.

18 By 4.30 am, CCTV, which was later recovered,  
19 captured VC emerging from an alleyway between Maple  
20 Street and the Forest Park and Ride tram stop. He had  
21 been continuing north, somewhat away from the city  
22 centre.

23 Chair, there is an important radio discussion at  
24 4.32 am between Chief Inspector David Mather and  
25 Inspector Peter Shaw. Inspector Shaw observed that, in

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1 Constable Rob Griffin. You will hear from Deputy Chief  
2 Constable Rob Griffin about his involvement in the  
3 response to the attacks.

4 By this time, we know from footage recovered after  
5 the incident, VC was outside Seely Hirst House on  
6 Mapperley Road attempting to open a window. Seely Hirst  
7 House is a hostel with 52 rooms and provides social  
8 worker support to residents. You will hear from someone  
9 who works at this address called Ivan who spoke to VC  
10 when he was outside the property. VC asked what the  
11 building was and whether it was a hospital. Ivan  
12 explained it was a hostel and asked him to leave.  
13 Despite their close proximity during this exchange,  
14 there was no violence shown towards Ivan by VC, the only  
15 known instance of this in any encounters after VC was  
16 seen leaving the tram shortly after midnight in the  
17 early hours of 13 June.

18 VC left briefly, but then returned and tried to  
19 enter into a window into a resident's room. The  
20 resident managed to push VC away and close the window.

21 VC then left but is captured on CCTV returning  
22 shortly afterwards, at between 5.11 and 5.12 am, and  
23 using something heavy contained in a plastic bag to try  
24 and break into the property. Again he was unsuccessful.  
25 Following examination of VC's rucksack we now know this

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1 to have been a metal pole that was contained within an  
2 orange plastic bag.

3 Ivan was not seen on the CCTV when VC returned and  
4 we will hear he was unaware of this at the time. VC's  
5 first visit to Seely Hirst House was not reported to  
6 the police. His second visit was reported by a resident  
7 called Declan on Ivan's behalf, but only after police  
8 attended scene of the attack on Ian Coates which  
9 occurred a short distance away. They arrived at  
10 5.39 am.

11 At approximately 5.14 am VC carried out his attack  
12 on Ian Coates on Magdala Road, just around the corner  
13 from Seely Hirst House, before driving Ian Coates' van  
14 away from the scene. Footage shows VC driving the van  
15 towards the city centre.

16 The van attacks.

17 At 5.23 am a 999 call was received from a member of  
18 the public who saw the van hit a pedestrian. This call  
19 has not been recorded but the location was said to be  
20 Milton Street. The driver was described as a black male  
21 and he was said to be driving towards Parliament Street.  
22 Milton Street and Parliament Street are right in the  
23 heart of the city centre. The victim of this attack was  
24 Wayne Birkett. The police called the Ambulance Service  
25 at 5.25 am.

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1 Operation Gosemore, where he was referred to as  
2 "Officer J". The IOPC found that the speed on  
3 the police vehicle was well below the speed restrictions  
4 of the road, and that the actions of VC resulting in the  
5 serious injuries could not reasonably have been foreseen  
6 by PC Reynolds. This will be addressed in oral evidence  
7 by the Director General of the IOPC, Rachel Watson, and  
8 in the statement of the Director of Investigations  
9 Nicola Marfleet.

10 The ambulance service arrived to treat Wayne Birkett  
11 at 5.28 am, within approximately five minutes from the  
12 first 999 call. Sharon Miller and Marcin Gawronski were  
13 initially treated by a member of the Nottingham public  
14 and police officers, including PC Reynolds, until an  
15 ambulance arrived.

16 By 5.30 am Operation Plato had been activated. You  
17 will hear that Operation Plato is a national identifier  
18 for a multi-agency response to an ongoing marauding  
19 terrorist attack. Force incident manager, Chief  
20 Inspector Mather, announced this over the radio, giving  
21 the registration of the vehicle.

22 Chair, you may wish to consider whether the  
23 announcement and timing of Operation Plato were  
24 appropriate, and you will also hear about the timing and  
25 use by the police of "METHANE" reports, which are tools

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1 By 5.26 am a second caller had called 999. The  
2 caller explained that the vehicle may have intentionally  
3 swerved towards the victim. He also described a white  
4 van going quickly to Parliament Street. The control  
5 room requested available officers but no response was  
6 received. This occurred for a second time. However,  
7 the Force Incident Sergeant, Sergeant Gavin Berry,  
8 deployed PCs Yallop and Bower to Milton Street,  
9 providing the description of a black male heading  
10 towards Parliament Street. Other officers also joined  
11 the search, including firearms officers. You will hear,  
12 Chair, from both PCs Yallop and Bower.

13 By 5.28, five minutes after the first 999 call  
14 relating to the van attack, PC Dean Reynolds confirmed  
15 that he was behind the van. Chair, you will hear from  
16 PC Reynolds. The vehicle was described as driving along  
17 Parliament Street. You will hear distressing audio of  
18 the radio message from PC Reynolds who describes the  
19 vehicle as running people over, with "two people down".

20 He requested the ambulance service straight away.  
21 Those two people were Sharon Miller and Marcin  
22 Gawronski.

23 Chair, it may be worth noting at this point that the  
24 actions of PC Reynolds in following the van was later  
25 the subject of an IOPC investigation,

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1 for alerting other emergency services of key information  
2 about developing major incidents. Could key information  
3 have been shared more quickly and effectively  
4 earlier on?

5 A few minutes later, at around 5.33 am, the police  
6 confronted VC who was sitting in the van on  
7 Bentinck Street. The declaration of Operation Plato  
8 minutes before did not apply. VC can be seen on  
9 body-worn video footage holding a knife and he is  
10 tasered by officers and detained. He was carrying the  
11 rucksack which can be seen on CCTV being carried by him  
12 prior to the attacks on Ilkeston Road. VC was not  
13 enforced into a stop. He appears to have been  
14 blocked in.

15 Chair, you have now heard about the response to the  
16 attacks on the victims. However, you will note that  
17 I have not referred to the treatment of Ian Coates at  
18 the scene. That is because it was not until  
19 approximately 05.35 am that a call was received that  
20 a male was lying in the road in Magdala Road, well after  
21 20 minutes after he was attacked.

22 At 05.39 am officers arrived at the scene. Chief  
23 Inspector David Mather radioed that he wanted this to be  
24 dealt with by the ambulance service rather than  
25 additional armed officers attending because there may be

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1 further threats.  
 2 The ambulance service were called and the officers  
 3 who were already at the scene commenced CPR. The  
 4 ambulance service arrived by 5.44 am, approximately  
 5 seven minutes from the 999 call. By 5.50 am an air  
 6 ambulance crew had arrived.

7 The police soon established the link between Ian  
 8 Coates and the van, and the working assumption, which  
 9 ultimately proved to be correct, was that VC had taken  
 10 the van, killed Ian Coates and carried out the later  
 11 attacks with the van.

12 It was at 6.06 am that a witness who had seen the  
 13 attack on Ian Coates made a 999 call and confirmed this  
 14 to be the case.

15 Operation Hendrix.

16 At 5.53 am Temporary Deputy Chief Constable Griffin  
 17 was updated on the attacks and assumed the role of  
 18 Gold Commander, the senior officer with overall  
 19 strategic command. The overall operational name  
 20 allocated to the investigations was called  
 21 Operation Hendrix. He appointed  
 22 Detective Superintendent Leigh Sanders as the Senior  
 23 Investigating Officer soon after.

24 Temporary Deputy Chief Constable Griffin will  
 25 explain that he declared the incident as "Critical",

1 and support is provided to the affected families;  
 2 Providing reassurance to affected individuals and  
 3 communities through an effective and proportionate  
 4 support, engagement, media and communications plan;

5 Ensuring a professional and effective investigative  
 6 response to the murders and incidents, to identify the  
 7 suspect(s) and effect their arrest and prosecution and  
 8 secure justice for the victims and their families;

9 Working in partnership with the Local Resilience  
 10 Forum, other strategic partners, both locally and  
 11 nationally, and the Counter Terrorism Network, to  
 12 maintain the Trust and confidence in the communities of  
 13 the response and actions of Nottinghamshire Police;

14 To ensure that Nottinghamshire Police discharge  
 15 their responsibilities fully in relation to  
 16 policies/guidance, and governing notifications to  
 17 scrutineers, such as the IOPC;

18 To provide welfare support to affected officers and  
 19 staff from all agencies.

20 This Inquiry will assess whether these were the  
 21 right objectives and, if so, whether they were  
 22 adequately addressed. There is one area in particular  
 23 that is likely to be a focus of the Inquiry's  
 24 investigation and it concerns the issue of  
 25 communication, both with the families and victims and

1 meaning that the effectiveness of the police response  
 2 was likely to have a significant impact on the  
 3 confidence of victims, families and/or the community.

4 To address this he established a Gold Group,  
 5 a command structure which provides strategic oversight  
 6 and direction during the management of an incident. The  
 7 first meeting of the Gold Group took place at 11.45 am  
 8 on 13 June.

9 In addition to the Gold Group, two further  
 10 multi-agency response groups were established to work  
 11 over the days in the immediate aftermath of the attacks:  
 12 the Strategic Coordination Group and the Tactical  
 13 Coordination Group. Police representatives chaired  
 14 those meetings which comprised police, fire and rescue,  
 15 ambulance services, local authorities and others.

16 It was at the Gold Group that issues such as  
 17 referral to the IOPC, the time of the response to the  
 18 attacks, the police's previous police contact with VC  
 19 and responses to the media were discussed. The  
 20 Gold Group had a series of strategic objectives. These  
 21 included:

22 Minimising the risk of harm to people living in or  
 23 visiting the area of the reported attacks, the wider  
 24 area and to keep people safe;

25 Ensuring that effective engagement, communication

1 with the media.

2 Chair, we set out earlier the issue of the  
 3 outstanding warrant for VC which had not led to any  
 4 significant action over the eight months that preceded  
 5 the attacks on 13 June. Once the outstanding warrant  
 6 was established by the police on 13 June, was sufficient  
 7 and timely information about this provided to the  
 8 families and survivors? What about VC's other prior  
 9 incidents and the police's previous conduct with VC?  
 10 Was sufficient information of those incidents given to  
 11 the families and survivors? If not, why not?

12 What about to the public as a whole? On 16 June  
 13 Chief Constable Kate Meynell made a statement to the  
 14 media which announced that VC had been charged and the  
 15 charges arose "as a result of [the police's] thorough  
 16 investigation into these horrific incidents that  
 17 occurred in our city."

18 Another example in respect of media engagement is  
 19 a statement issued by Nottinghamshire Police on  
 20 25 January 2024. The statement quoted Temporary Deputy  
 21 Chief Constable Griffin who described the outstanding  
 22 warrant for VC's arrest as follows: "We should have done  
 23 more to arrest him." However, he stated that in his  
 24 opinion "it is highly unlikely that he [VC] would have  
 25 received a custodial sentence for the alleged assault."

1 You will hear from Temporary Deputy Chief Constable  
2 Griffin, and will no doubt consider his explanation that  
3 this statement was and remains an accurate reflection of  
4 his professional judgment. The Inquiry will look into  
5 further interviews and statements, including in respect  
6 of an interview with ITV on the same day.

7 When considering the police response and statements  
8 in the aftermath of VC's arrest, the Inquiry will  
9 consider the following: what about the time it took to  
10 arrest VC on 13 June? Were the later attacks  
11 preventable? Was a debrief within the police conducted  
12 in relation to the time taken to address VC? What  
13 senior officers were aware of PC Speeden's concerns, for  
14 example? Were the police transparent in communications?

15 In addition to this, the Inquiry will assess the  
16 sufficiency of information that was provided in respect  
17 of the police's Professional Standards Directorate  
18 investigations. We will address in due course the fact  
19 that, in addition to other issues of inappropriate  
20 accessing of police materials, senior officers became  
21 aware as early as 20 September 2023 that a Special  
22 Constable had viewed distressing footage of the attack.  
23 The families were not informed until February 2024. We  
24 will look at reasons for this delay and ask whether more  
25 could have been done to share information at an earlier

1 on 15 January 2022; the others were Ryan and Sam.

2 VC was booked into custody by Custody Sergeant  
3 Farren. During the booking in process, VC was asked by  
4 Sergeant Farren whether he suffered from any mental  
5 health issues, whether he took or was supposed to take  
6 any medication and whether he had consumed any alcohol  
7 recently. VC did not respond to any of the questions.

8 Once booked into custody, VC was taken to a cell.  
9 At 8.01 am, Holly Bramley, a Forensic Healthcare  
10 Professional, performed a medical assessment of VC. You  
11 will hear oral evidence from two Forensic Healthcare  
12 Professionals who saw VC in custody: Ms Bramley and her  
13 senior lead, Rosie Draper.

14 The record of Ms Bramley's assessment noted that VC  
15 was fit to be detained, did not require an appropriate  
16 adult but was not yet fit to be interviewed or fit to be  
17 charged, pending a period of rest following arrival.

18 You will hear from Ms Bramley that VC refused to engage  
19 with the assessment. She says it was common practice  
20 for an initial rest period to be in place if a detainee  
21 presented with unusual behaviour, in order to allow time  
22 to assess the cause of that behaviour. It was for that  
23 reason, she says, VC was recorded as not yet fit to  
24 interview. Ms Bramley's assessment was completed by  
25 8.12 am.

1 stage.

2 Temporary Deputy Chief Constable Griffin will give  
3 evidence that the police's approach "lacked coordination  
4 and clarity" which resulted in the families not being  
5 given information they should have received.

6 Returning to the detention of VC, he was arrested by  
7 PC Matthew Bower, a firearms officer, at 5.35 am on  
8 13 June. He was transported to Nottingham Custody Suite  
9 by police van and arrived there at 6.10 am. On being  
10 removed from the police van, VC kicked a female officer  
11 who was assisting other officers. You will hear from  
12 Chief Inspector Lisa Murray in relation to VC's time at  
13 the Nottingham Custody Suite once he was detained.

14 On arrival VC was searched. Several items of  
15 property were removed from his clothing. They included  
16 a 32 gigabyte memory card, a SIM card, an iPhone, and  
17 a handwritten note with an email address which had been  
18 torn in two.

19 VC's arrest also led to a formal search of his  
20 rucksack. The contents included a mobile phone which  
21 contained two SIM cards, a further loose SIM card and  
22 three USB memory sticks. Within a zip pocket of the  
23 rucksack was a piece of paper with the names of three of  
24 VC's former flatmates written on it. One of the names  
25 was Chris, the flatmate whom VC had placed in a headlock

1 That was the first of a number of attendances to VC  
2 by healthcare practitioners on 13 June. At 12.44 pm, VC  
3 was referred to the Liaison and Diversion Team at  
4 Nottingham Custody Suite. Liaison and Diversion is  
5 a service provided by Nottinghamshire Healthcare NHS  
6 Foundation Trust based on a national model, which  
7 provides mental health assessment and support for those  
8 in the criminal justice system. Natalie Iles, a Liaison  
9 and Diversion Practitioner, offered VC a triage  
10 assessment but he refused consent. The note of the  
11 assessment recorded that VC did not verbally respond to  
12 questions. However, his prior history of mental illness  
13 was noted, including previous admissions to hospital and  
14 a, working diagnosis of paranoid schizophrenia. The  
15 outcome was recorded as no further action from the  
16 Liaison and Diversion Team.

17 Custody Sergeant Oppon-Kusi and healthcare  
18 practitioners working at the Custody Suite were now  
19 aware of VC's history of mental illness.

20 How does that sit, Chair, with the evidence of  
21 Detective Superintendent Leigh Sanders that it was "only  
22 later when notified of a Psychiatric report by the CPS  
23 [that] the issue of diminished responsibility [became]  
24 fully apparent?" Should greater steps to assess VC's  
25 mental health while he was in custody have been taken,

1 so that any psychiatric report could take into account  
2 any contemporaneous assessment?  
3 At around 4 pm, Ms Draper, one of the Forensic  
4 Healthcare Professionals, attended VC for assessment.  
5 You will hear from Ms Draper an account similar to  
6 Ms Bramley's: that VC provided minimum engagement and  
7 she was unable to assess him properly. At this stage  
8 Ms Draper sought advice from the Liaison and Diversion  
9 Team as to whether a mental health assessment ought to  
10 be carried out.

11 You will hear from Louisa Hagan, a Service Manager  
12 for the Liaison and Diversion Team. She advised  
13 Ms Draper that referral for a Mental Health Act  
14 assessment should not be made due to the serious and  
15 indictable nature of the offences for which VC had been  
16 arrested. Was this a missed opportunity for a fuller  
17 psychiatric assessment of VC, regardless of his  
18 suitability for the Liaison and Diversion programme?  
19 What changes to policies and practice might address any  
20 concerns in this respect?

21 Whilst in custody VC was asked whether he would  
22 consent to having non-intimate body mapping photographs  
23 and swabs of his hands taken. VC refused consent.  
24 Authority was subsequently given for body mapping and  
25 hand swabs. As non-intimate samples, they could be

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1 behaviour in custody and the nature of his offences  
2 meant that toxicology tests should have been carried out  
3 if the relevant consent, where required, could have been  
4 obtained. A hair sample is a non-intimate sample and  
5 could lawfully have been taken without VC's consent.

6 Chief Inspector Lisa Murray will give evidence that  
7 there was no drug testing considerations relevant on  
8 13 June 2023 when VC was arrested, such as to obviate  
9 the clear need for toxicology. Whether drug testing was  
10 indicated is a matter the Inquiry will examine.

11 This is an issue that was raised directly with  
12 the police by Dr Kumar later in December. Dr Kumar  
13 asked in an email "can hair sampling be done of the  
14 defendant now to determine any drug use?" This issue  
15 became a prominent concern of both the O'Malley-Kumar  
16 and Webber families in December and into January 2024.  
17 This was not accepted by Detective Superintendent  
18 Sanders at the time. However, in his statement to the  
19 Inquiry, Detective Superintendent Sanders states that  
20 "it might have been better, with hindsight, simply to  
21 have taken head hair samples by force, to provide  
22 greater reassurance around the question whether  
23 controlled drugs were in VC's system or not."

24 In order to assist in respect of this issue, the  
25 Inquiry has sought expert evidence from

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1 taken even in the absence of consent. The justification  
2 given in respect of both was the need for forensic  
3 evidence to establish VC's involvement in the attacks  
4 which had taken place. Hand swabs, body mapping, nail  
5 scrapings and photographs were taken at 11.10 am on  
6 13 June. DNA swabs and fingerprints were taken  
7 two hours later. No hair samples were taken.

8 Authorisation for the taking of an intimate sample,  
9 in the form of blood, was given later by  
10 Inspector Boylin at 3.50 pm. The blood sample was not  
11 for toxicology purposes but rather DNA profiling. Under  
12 section 62(1)(a) of the Police and Criminal Evidence Act  
13 1984, an intimate sample could only be taken with VC's  
14 written consent. VC was asked later that evening, at  
15 about 9 pm, whether he would consent to a blood sample  
16 being taken. He refused and none was taken.

17 Detective Superintendent Sanders has given written  
18 evidence that a urine sample was authorised and VC's  
19 consent was sought for such a sample. This is currently  
20 an issue in dispute and should be clarified in oral  
21 evidence. Whilst the evidence recovery plan dated  
22 13 June 2023 did mention the need for a urine sample,  
23 there is no evidence in the custody record that such  
24 a sample was ever authorised or requested.

25 Chair, you may wish to consider whether VC's

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1 Professor Kim Woolf MBE, a senior academic and Director  
2 of King's Forensics at King's College London.  
3 Professor Woolf will give evidence as to the reliability  
4 of hair sampling and what it may or may not have been  
5 able to identify.

6 Across 14, 15 and 16 June, VC was interviewed by  
7 the police. He answered "no comment" to all questions  
8 of an evidential nature. During an interview on the  
9 night of 15 June 2023 VC was asked a number of questions  
10 about his mental health. This included questions about  
11 his previous admissions, voices in his head and why he  
12 felt he was the subject of government surveillance. He  
13 was formally charged with three counts of murder and  
14 three counts of attempted murder on 16 June. The  
15 following day he left Nottingham Custody Suite and made  
16 his first appearance at Nottingham Magistrates' Court.

#### 17 4. CPS handling of the prosecution.

18 Chair, I turn now to the CPS handling of the  
19 prosecution.

20 Detective Superintendent Sanders contacted the Crown  
21 Prosecution Service via the Senior District Crown  
22 Prosecutor, Samantha Shallow, on the day of the attacks.  
23 Once it was established that the attack was not  
24 terror-related, it was decided that the case would be  
25 dealt with by the East Midlands Complex Casework Unit.

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1 This unit typically deals with homicides involving  
2 multiple victims and cases attracting major media  
3 interest.

4 The key individuals that you will hear from within  
5 the CPS in addition to Ms Shallow will be the reviewing  
6 lawyer, a specialist prosecutor in the Complex Casework  
7 Unit, Mr Alan Murphy, and his line manager and the  
8 Deputy Head of the unit, Michelle Mannion. You will  
9 also hear from leading counsel for the prosecution,  
10 Karim Khalil KC.

11 This Inquiry is tasked by considering the handling  
12 by the CPS of the case between 13 June and the  
13 commencement of the sentencing hearing on 23 January.  
14 Whilst the issues that arise are varied, they will focus  
15 in particular on the charging decision and ultimate  
16 acceptance of pleas, as well as the communication with,  
17 and treatment of, the bereaved families and survivors  
18 throughout this period.

19 Charging decision and acceptance of pleas.

20 The day after the attack, on 14 June, Mr Murphy and  
21 Ms Shallow attended a briefing with police at Bradford  
22 Police Station at which the available evidence was  
23 presented and discussed. According to Mr Murphy, it was  
24 clear from the morning briefing that "mental health was  
25 undoubtedly going to be a feature of this case" and

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1 In all the circumstances of the case it is proper to  
2 do so.

3 Moving forwards in time, once Mr Murphy received all  
4 of the evidence from the police he applied the Full Code  
5 Test on 2 October 2023. The Full Code Test under the  
6 Code for Crown Prosecutors has two-stages: (i) the  
7 evidential stage; followed by (ii), the public interest  
8 stage.

9 In relation to the evidential stage, prosecutors  
10 must be satisfied that there is sufficient evidence to  
11 provide a realistic prospect of conviction against each  
12 suspect on each charge. They must consider what the  
13 defence case may be and how it is likely to affect the  
14 prospects of conviction. A case which has not passed  
15 the evidential stage must not proceed no matter how  
16 serious or sensitive it may be.

17 In relation to the public interest stage,  
18 a prosecution will usually take place unless the  
19 prosecutor is satisfied that there are public interest  
20 factors tending against prosecution which outweigh those  
21 tending in favour. When considering the public interest  
22 stage the Code for Crown Prosecutors sets out a number  
23 of questions which the prosecutor should consider,  
24 including how serious the offence is, the level of  
25 culpability of the suspect and the impact on the

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1 there was reference to VC having been detained under the  
2 Mental Health Act, amongst other things.

3 As a result, Mr Murphy made the decision to retain  
4 the services of Dr Nigel Blackwood, a professor of  
5 forensic psychiatry at King's College London that same  
6 afternoon. You will hear oral evidence from  
7 Dr Blackwood about his instruction and the assessments  
8 that he made.

9 On the afternoon of 16 June Mr Murphy authorised  
10 that VC be charged with three offences of murder and  
11 three offences of attempted murder. In making the  
12 decision to charge he applied the threshold test under  
13 the Code for Crown Prosecutors. The threshold test  
14 allows for an immediate charging decision where evidence  
15 is outstanding in appropriate cases. Five conditions  
16 must be met before the test can be applied, namely:

17 There is insufficient evidence currently available  
18 to apply the evidential stage of the Full Code Test;

19 There are reasonable grounds for believing that  
20 further evidence will become available within  
21 a reasonable period;

22 The seriousness or the circumstances of the case  
23 justifies the making of an immediate charging decision;

24 There are continuing substantial grounds to object  
25 to bail in accordance with the Bail Act 1976;

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1 community.

2 The result was the same as the application of the  
3 Threshold Test. Mr Murphy was satisfied that the  
4 correct charges against VC at that stage were three  
5 offences of murder and three offences of attempted  
6 murder. How is it then that VC ultimately pleaded  
7 guilty to manslaughter on the basis of diminished  
8 responsibility?

9 On 2 October 2023 the CPS received the first defence  
10 psychiatric report from Dr McSweeney. The report stated  
11 that whilst VC was fit to plead and stand trial and that  
12 he was not insane, the partial defence of diminished  
13 responsibility was available to him.

14 In relation to the partial defence of diminished  
15 responsibility, CPS guidance explains the following:

16 "As the onus is on the defendant to establish  
17 diminished responsibility on the balance of  
18 probabilities, they are likely to need to obtain expert  
19 evidence in support. The prosecution will then review  
20 the case. In some cases it may not be necessary to  
21 obtain evidence from a further expert, because the  
22 defence expert evidence (on paper, or when challenged in  
23 cross-examination) is unlikely to substantiate the  
24 defence. More usually the prosecution will need to  
25 obtain evidence from a further expert."

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1 The guidance continues thus:  
 2 "As part of the ongoing duty of review, the  
 3 prosecution will further review the case. In doing so,  
 4 it should be borne in mind that the jury is not bound to  
 5 accept medical evidence and that the evidence,  
 6 especially when tested through cross-examination, may  
 7 not meet the elements of diminished responsibility."  
 8 Dr Blackwood had already been retained by Mr Murphy  
 9 to provide that further expert report on behalf of the  
 10 prosecution. You will hear that he had been provided  
 11 with documentation about the case as early as July 2023,  
 12 before being sent Dr McSweeney's report.  
 13 Mr Murphy sent final written instructions to  
 14 Dr Blackwood on 5 October 2023. The instructions noted  
 15 the prosecution's concerns relating to VC's text message  
 16 to his brother which appeared to show an awareness of  
 17 the attacks, and his apparent ability to exercise  
 18 self-control at the time he attempted to break into  
 19 Seely Hirst House.  
 20 By this stage VC had not consented to the  
 21 prosecution accessing his full medical records but these  
 22 were subsequently provided to Dr Blackwood on  
 23 14 November 2023. You will hear that Mr Murphy  
 24 continued to provide Dr Blackwood with further evidence  
 25 as it became available.

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1 a full review of the case.  
 2 At that point the prosecution's view was that these  
 3 two reports provided evidence to support the partial  
 4 defence of diminished responsibility and that, subject  
 5 to anything contrary in a third report, if pleas were  
 6 offered on that basis they would be accepted.  
 7 On 24 November 2023, a second defence report was  
 8 also available from Dr Shaffulha, who similarly  
 9 concluded the partial defence was available to VC.  
 10 On the same day there was a meeting between the  
 11 prosecution team and the O'Malley-Kumar and Webber  
 12 families. Also in attendance was Julian Hendy from the  
 13 Hundred Families organisation at the request of the  
 14 bereaved families. You will hear that both bereaved  
 15 families were opposed to the CPS accepting pleas to  
 16 manslaughter on the grounds of diminished  
 17 responsibility.  
 18 Following the meeting, Dr Kumar contacted  
 19 Detective Superintendent Leigh Sanders to highlight  
 20 concerns in relation to the psychiatric reports,  
 21 particularly in relation to VC's presentation on  
 22 13 June. The Inquiry will consider these concerns and  
 23 whether delay in carrying out psychiatric assessments  
 24 may have impacted the accuracy of the assessments.  
 25 Following these concerns, the CPS decided to

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1 Chair, you may wish to consider the content of  
 2 Dr Blackwood's instructions and the material provided to  
 3 him. In particular, you may wish to consider whether  
 4 further issues should have been raised with Dr Blackwood  
 5 at this stage.  
 6 In preparing his report, Dr Blackwood interviewed VC  
 7 at Ashworth Hospital for five hours. VC told him that  
 8 he had experimented with cannabis on one occasion when  
 9 he was a student at Nottingham University. Dr Blackwood  
 10 was aware that toxicology was not available from the  
 11 time VC was in police custody and urinary drug screening  
 12 was not conducted on remand into prison. Dr Blackwood  
 13 considered such information would have been helpful but  
 14 the clinical picture was of a major mental illness with  
 15 an onset and course unrelated to substance misuse.  
 16 Was Dr Blackwood provided with all of the  
 17 information about VC and any possible links to illegal  
 18 drugs?  
 19 On 21 October 2023, Mr Murphy received  
 20 Dr Blackwood's report which also concluded that the  
 21 partial defence of diminished responsibility was  
 22 available to VC.  
 23 You will hear that on 23 November 2023 the first two  
 24 psychiatric reports were discussed in conference with  
 25 leading and junior counsel before Mr Murphy conducted

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1 instruct a fourth expert, Dr Latham, and a letter of  
 2 instruction was sent to him on 27 November 2023.  
 3 Dr Latham will similarly be giving evidence to this  
 4 Inquiry.  
 5 The instructions referred to concerns raised by  
 6 Dr Kumar, and the new expert was asked to consider the  
 7 three available psychiatric reports and evidence in the  
 8 case, particularly regarding VC's presentation on 12 and  
 9 13 June, and to provide an expert opinion as to whether  
 10 the conclusions reached by the psychiatrist on the issue  
 11 of diminished responsibility had been properly reached.  
 12 He was also asked if he was able, in the absence of  
 13 an interview with VC, to provide an expert opinion on  
 14 whether at the time of the offences VC's mental health  
 15 was such that he had available to him the partial  
 16 defence. Following those instructions, you will hear  
 17 that Mr Murphy also sent Dr Latham an email from  
 18 Dr Kumar raising a number of discrete points so they  
 19 could also be addressed in his report.  
 20 Chair, you may wish to consider the content of  
 21 Dr Latham's instructions and the manner in which  
 22 concerns from the bereaved families were put to him.  
 23 Should he have seen VC and conducted a further  
 24 independent assessment? By that stage VC had already  
 25 been assessed in person by three expert psychiatrists.

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1 Should the prosecution experts have met with or  
2 interviewed the survivors of the attacks, the bereaved  
3 families or the family of VC to inform their reports?  
4 This was something that was raised by the O'Malley-Kumar  
5 and Webber families.

6 Are there improvements that might be made to improve  
7 the rigour of these kinds of reports, even if they are  
8 not presently adopted, including speaking with third  
9 parties in order to better test the account given by  
10 a defendant?

11 After Dr Latham's report was received by the CPS,  
12 prosecution counsel was asked to provide advice  
13 concerning the acceptance of pleas and did so on  
14 Saturday 16 December 2023.

15 You will hear counsel advised the evidential test in  
16 the Code for Crown Prosecutors was no longer met in  
17 respect of the counts of murder. In those circumstances  
18 the pleas to manslaughter should be accepted.

19 The next day, Mr Murphy conducted a further review  
20 of the case. The Code for Crown Prosecutors sets out  
21 the responsibilities of the CPS in considering whether  
22 to accept guilty pleas to a less serious offence. The  
23 following aspects of the Code are of particular  
24 relevance:

25 Paragraph 4.1 of the Code states that prosecutors  
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1 account when deciding whether it is in the public  
2 interest to accept the plea. However, the decision  
3 rests with the prosecutor."

4 The decision in this case was therefore  
5 an evidential one rather than a public interest one and,  
6 as a result, was a decision which rested entirely with  
7 the prosecution as a question of law to be determined  
8 with reference to the evidence.

9 Chair, you will be taken to the applicable CPS  
10 guidance on prosecutor homicide and on accepting pleas,  
11 in reviewing these decisions and, in particular, how the  
12 psychiatric evidence is to be used and assessed. You  
13 may wish to consider whether the process adopted by the  
14 prosecution complied with those policies and best  
15 practice; furthermore, whether there is or can be any  
16 role that victims and families of the bereaved may  
17 usefully play in such a process now or in the future.

18 We have touched upon some concerns raised by the  
19 families in respect of the expert evidence. I will now  
20 address the prosecution's communication with and  
21 treatment of the families and survivors more broadly  
22 during the course of the prosecution.

23 As a matter of policy, the Code of Practice for  
24 victims of crime, known as the Victims' Code, sets out  
25 the services and a minimum standard for these services  
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1 must only start or continue a prosecution when the case  
2 has passed both stages of the Full Code Test;

3 As previously discussed, in relation to the charging  
4 decision, paragraph 4.6 states that a case which has not  
5 passed the evidential stage must not proceed no matter  
6 how serious or sensitive it may be;

7 Paragraph 4.7 states that the finding that there is  
8 a realistic prospect of conviction is based on the  
9 prosecutor's objective assessment of the evidence,  
10 including the impact of any defence and any other  
11 information that the suspect has put forward or on which  
12 they might rely. It means that an objective, impartial  
13 and reasonable jury or bench of magistrates or a judge  
14 hearing a case alone, properly directed and acting in  
15 accordance with the law, is more likely than not to  
16 convict the defendant of the charge alleged. This is  
17 a different test from the one that the criminal courts  
18 themselves must apply. A court may only convict if it  
19 is sure that a defendant is guilty;

20 By contrast, where the court passes the evidential  
21 stage, paragraph 9.5 of the Code states that "in  
22 considering whether the pleas offered are acceptable,  
23 prosecutors should ensure that the interests and, where  
24 possible, the views of the victim or, in appropriate  
25 cases, the views of the victim's family, are taken into  
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1 that must be provided to victims of crime by  
2 organisations including the CPS. The Victims' Code  
3 contains 12 rights which apply in different  
4 circumstances.

5 The rights engaged in this case included the right  
6 to be able to understand and be understood; the right to  
7 have services and support tailored to your needs, such  
8 as special measures at court; the right to be provided  
9 with information about the investigation and  
10 prosecution; the right to make a victim personal  
11 statement; the right to be given information about the  
12 trial, trial process and role as a witness; the right to  
13 be given information about the outcome of the case and  
14 any appeals; and the right to be able to make  
15 a complaint.

16 In addition to the rights provided in the Victims'  
17 Code, the CPS offers an enhanced service to bereaved  
18 family set out in the bereaved families scheme. A key  
19 aspect of this service is that the CPS will offer to  
20 meet bereaved families at key stages of the criminal  
21 justice system process to explain the anticipated  
22 progress of the case, what is expected to happen at each  
23 court hearing and the possible sentences available for  
24 the offences charged.

25 In addition, bereaved families are entitled to have  
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1 a Family Liaison Officer, known as an FLO, assigned  
2 where appropriate. The FLO will also act as the point  
3 of contact for communicating prosecution decisions to  
4 the family.

5 Under the scheme the CPS is required to write to  
6 families within ten days of a charging decision, setting  
7 out the reasons for the decision, to explain why  
8 a suspect has or has not been charged and the specific  
9 nature of the charges. In addition, in cases where  
10 a charge is substantially altered, for example in  
11 circumstances where the prosecution accepts pleas to  
12 a lesser offence, the CPS will write to the bereaved  
13 family within one day explaining the decision and  
14 offering a meeting.

15 You will hear that each of the bereaved family  
16 groups, as well as the survivors, were allocated an FLO,  
17 or in some cases two, who acted as the conduit between  
18 them and the prosecution. You will hear oral evidence  
19 from the Family Liaison Advisor, Detective Chief  
20 Inspector Claire Gould, who appointed those officers and  
21 who coordinated their deployments.

22 You will also hear from one of the FLOs, DC Raj  
23 Johal. You will also hear about the CPS' engagement  
24 through correspondence and face-to-face meetings.

25 An important consideration may in due course be  
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1 Ian Coates attended the preliminary hearing on 20 June  
2 2023 and spoke to Mr Murphy and junior prosecution  
3 counsel.

4 On 4 July 2023 the CPS was notified that the  
5 O'Malley-Kumar family would like to meet the  
6 prosecutor/prosecution counsel. No meeting took place  
7 over the summer in 2023 and on 2 October 2023 the FLOs  
8 informed the CPS that the O'Malley-Kumar and Webber  
9 families did not intend to attend the pre-trial and  
10 preparation hearing and did not feel able to hear any  
11 level of detail relating to the attack on 13 June at  
12 that point.

13 On the same day the defence representatives for VC  
14 served their first psychiatric report. This was a key  
15 moment in the case as it made clear for the first time  
16 what the likely issues concerning diminished  
17 responsibility were going to be.

18 On the same day the report was sent to the police  
19 with the request from Mr Murphy to let the FLOs know so  
20 they could inform the bereaved families. You will hear  
21 that the CPS did not suggest a form of words to be  
22 passed to the bereaved families or survivors in relation  
23 to the communication of this significant issue.

24 Chair, you may wish to consider whether it may have  
25 been helpful for the FLOs to have specific wording to  
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1 whether the role of an FLO, which is governed by the  
2 College of Policing's Authorised Professional Practice  
3 for Family Liaison and is primarily a police  
4 investigator, is suited to act as a conduit between the  
5 CPS and the families or survivors. Might, for example,  
6 an additional dedicated CPS officer be more suited to  
7 that role in the most serious or legally complex cases?  
8 Is a police investigator best placed to give advice on,  
9 for example, the issue of diminished responsibility?

10 The issues arising.

11 Initial contact was made with the bereaved families  
12 in the form of a letter dated 16 June from the Chief  
13 Crown Prosecutor, Suzanne Llewellyn. The letters  
14 offered meetings at the first appearance at Nottingham  
15 Magistrates' Court on Saturday, 17 June 2023, the  
16 preliminary hearing at Nottingham Crown Court on 20 June  
17 2023, or at any point thereafter.

18 Although the bereaved family scheme does not  
19 specifically apply to the survivors of the attacks on  
20 13 June, you will hear that the scheme was explained to  
21 the survivors who confirmed that they did not wish to  
22 meet the prosecutor at that stage and if they changed  
23 their minds they would inform the FLO.

24 While none of the bereaved family members or  
25 survivors attended the first appearance, the family of  
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1 support that discussion and whether communication could  
2 have been improved in this respect.

3 On 13 November 2023 the CPS was informed that the  
4 Webber family had requested a remote meeting to discuss  
5 the issue of diminished responsibility and it later  
6 became clear the O'Malley-Kumar family wanted to join  
7 the meeting.

8 Shortly before the meeting on 22 November,  
9 the police explained to the CPS that at this stage the  
10 Coates family did not wish to meet with the CPS  
11 specifically. However, it should be noted that the  
12 family of Ian Coates was not invited to the meeting on  
13 24 November 2023.

14 By the time of that meeting the prosecution was in  
15 receipt of the expert report from Dr Blackwood which  
16 similarly concluded that the partial defence of  
17 diminished responsibility was available.

18 The meeting on 24 November 2023 was attended by  
19 leading counsel. You will hear from Mr Khalil KC the  
20 matters that were discussed, including that the CPS  
21 intended to accept pleas to manslaughter on grounds of  
22 diminished responsibility and the possible sentencing  
23 options.

24 On the same day the family of Ian Coates and the  
25 survivors were informed of the intention to accept  
220

1 pleas.  
2 Following the meeting, as we have already set out,  
3 concerns were raised by the Webber and O'Malley-Kumar  
4 families, and Dr Kumar in particular, about the  
5 psychiatric evidence, including in relation to the focus  
6 on VC's mental state a considerable time after the  
7 attacks took place.

8 The plea and trial preparation hearing ultimately  
9 took place on 28 November 2023. At that hearing VC  
10 entered guilty pleas to three counts of manslaughter on  
11 the grounds of diminished responsibility and three  
12 counts of attempted murder. A meeting took place  
13 between the prosecution team, including Mr Khalil KC,  
14 the O'Malley-Kumar family and the family of Mr Coates.

15 You will hear that, following the final decision to  
16 accept pleas to manslaughter on the grounds of  
17 diminished responsibility, on 17 December a letter was  
18 sent to the bereaved families by the Chief Crown  
19 Prosecutor, Janine McKinney, which was delivered by the  
20 FLOs on 19 December.

21 The next day the O'Malley-Kumar family requested  
22 a further meeting with Mr Khalil KC in the new year.  
23 A similar request was received from the Webber family.  
24 A meeting took place on 15 January 2024. You will hear  
25 from the families that the families were concerned about

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1 consider whether any further steps could or should be  
2 taken to improve communication with and treatment of  
3 victims and bereaved families.

4 **THE CHAIR:** I'm just looking at the remainder, Ms Langdale.  
5 If we sat until 5 o'clock would you be able to finish,  
6 do you think?

7 **MS LANGDALE:** I think so, yes.

8 5. Unauthorised access.

9 Moving now please, Chair, to unauthorised access.

10 We set out at the beginning of this opening how the  
11 brutal attacks of VC took lives and changed others  
12 forever. However, it is not only the attacks by VC that  
13 have caused harm to the families of the deceased and to  
14 the survivors. The actions of some officers and  
15 officials inappropriately accessing sensitive footage  
16 and information relating to the attacks after the events  
17 has caused real additional harm. Chair, you may think  
18 why anyone would unnecessarily access such distressing  
19 information beggars belief.

20 You will hear about officers and staff from  
21 Nottinghamshire Police, His Majesty's Courts and  
22 Tribunals Service, His Majesty's Prison and Probation  
23 Service and Nottingham City Council accessing material  
24 or disclosing information that they should not have  
25 been.

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1 the tone of the meeting with leading prosecution  
2 counsel.

3 From 23 to 25 January the sentencing hearing took  
4 place at Nottingham Crown Court. Professor Blackwood,  
5 Professor McSweeney and Dr Ross Mirvis gave oral  
6 evidence and were cross-examined. Dr Mirvis, who  
7 continued to treat VC, will give oral evidence to this  
8 Inquiry.

9 During the course of the sentencing hearing the  
10 prosecution met with the family of Ian Coates and,  
11 following the conclusion of the hearing, the family of  
12 Wayne Birkett. Following the hearing the Chief Crown  
13 Prosecutor wrote to the bereaved families to offer  
14 another meeting.

15 As referred to earlier, the HMCPSI report  
16 recommended that the CPS undertake a review of all  
17 guidance relating to victims engagement to ensure that  
18 all staff are aware when the use of the terms "consult"  
19 or "consultation" is appropriate. You will hear that  
20 a review of CPS published guidance was completed  
21 in October 2024 and identified eight instances in which  
22 those terms were used when referring to engagement with  
23 victims or bereaved families around the legal  
24 decision-making in a case.

25 The Inquiry will build on this recommendation and  
222

1 Nottinghamshire Police.

2 Within Nottinghamshire Police a number of  
3 individuals accessed case material without a proper  
4 purpose. Details of the attacks were also referred to  
5 in inappropriate telephone messaging with fellow  
6 officers and unrelated third parties. You will hear  
7 evidence from Superintendent Kathryn Craner, the head of  
8 the Professional Standards Directorate for  
9 Nottinghamshire Police, who will set out the detail of  
10 their investigations.

11 Superintendent Craner will give evidence which  
12 describes Nottinghamshire Police's acceptable use policy  
13 and generic security operating policy in relation to the  
14 holding and viewing of sensitive material. This  
15 includes a rule that officers and staff are only  
16 authorised to access, browse, use or disclose police  
17 information in the course of their official duties and  
18 for policing business purposes only. This was breached  
19 by several officers.

20 An initial audit scoping identified PC Matthew Gell,  
21 an officer who had had previous interactions with VC in  
22 2022, as someone who had inappropriately accessed the  
23 NICHE computer records after the attacks on  
24 15 June 2023. It was subsequently established that he  
25 sent a message to an associate who did not work in

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1 policing indicating that the attacks by VC had been  
2 declared as a terrorist attack.

3 PC Gell was also party to a WhatsApp group in which  
4 a message was sent by another officer describing the  
5 attacks in graphic terms.

6 A subsequent investigation found that the original  
7 message was sent by an officer to pre-warn colleagues  
8 within the group using inappropriate language and  
9 PC Gell had wrongly forwarded it to his wife and  
10 an officer in another force. PC Gell was later the  
11 subject of a gross misconduct hearing and found to have  
12 committed gross misconduct. He received a two year  
13 final warning. You will hear from PC Gell in respect of  
14 this incident. You will also hear written evidence from  
15 a witness, Faye Tomlinson, who raises concerns about the  
16 transparency of the disciplinary proceedings.

17 Following further investigations the police  
18 standards department established that VC's record on the  
19 NICHE computer system had been accessed 381 times by 179  
20 members of Nottinghamshire Police between 13 June 2023  
21 and 16 June 2023. Of course a proportion of those will  
22 have been legitimate, but 22 individuals were identified  
23 as causing the most concern. Following further  
24 inquiries the access of 10 of the 22 individuals was  
25 found to be for a policing further. Out of the

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1 viewed body-worn footage or CCTV footage without  
2 a policing purpose. It appears that the audit in fact  
3 may have been aimed at identifying officers who may have  
4 leaked certain information about VC to the media,  
5 focused on VC's records rather than being carried out as  
6 a matter of concern for the families of the deceased or  
7 the survivors.

8 Was enough done to establish and discipline officers  
9 and employees who had accessed video footage? As I have  
10 already indicated, the Inquiry will also investigate  
11 whether sufficient and timely information of wrongdoing  
12 was provided to the family and the survivors.

13 Moving on to His Majesty's Courts and Tribunal  
14 Services and His Majesty's Prison and Probation Service,  
15 you will hear oral evidence from Amy Holmes, the interim  
16 Director General for the Chief Operating Group of the  
17 Ministry of Justice. Ms Holmes will explain how case  
18 material is held on the Crown Court case digital system  
19 and is accessible to certain staff members from HMCTS  
20 and HMPPS.

21 You will hear how the digital case system allows  
22 multiple parties to upload and access digital case  
23 information. Ms Holmes will explain the policies and  
24 procedures that govern the use of the system, including  
25 having users' access scrutinised by access coordinators

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1 remaining 12, various actions were taken by  
2 Nottinghamshire Police which included giving employees  
3 advice on accessing records, conducting intervention,  
4 putting notes on their vetting files, issuing negative  
5 performance records, or initiating misconduct processes.

6 In respect of the most serious of these cases one  
7 police staff member received a criminal caution for an  
8 offence contrary to the Computer Misuse Act 1990  
9 following admissions that she had accessed numerous  
10 cases, including information about VC, without  
11 a policing purpose. She was also found to have  
12 committed gross misconduct and her employment was  
13 terminated.

14 A special constable had watched body-worn video of  
15 the aftermath of the attacks, including treatment of  
16 victims at the scene. He had also conducted other  
17 research on the policing system. The constable  
18 resigned, was the subject of an accelerated misconduct  
19 hearing and placed on a barred list in respect of future  
20 employment.

21 Chair, you will hear that the special constable  
22 admitted watching the body-worn video footage and that  
23 is how it came to be known to the police. Apparently  
24 there was no specific audit carried out by  
25 Nottinghamshire Police to establish whether anyone had

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1 within HMCTS and online guidance provided to users.

2 CCTV and other video footage cannot be held on the  
3 digital case system and instead is shared via secure  
4 digital evidence management solutions which is managed  
5 by the police or the CPS with links to that system  
6 uploaded onto the digital case system.

7 You will hear how staff from both HMPPS and HMCTS  
8 are understood to have accessed evidence inappropriately  
9 and without authorisation. Ms Holmes will explain how  
10 each agency was notified of this and how investigations  
11 were carried out thereafter.

12 Starting with the Probation Service on 25 January  
13 2024, the Crown Court Senior Probation Officer was  
14 contacted by the delivery manager at Nottingham Crown  
15 Court regarding inappropriate access by one member of  
16 staff. The investigation that followed identified 11  
17 individuals who were questioned, with one being quickly  
18 discounted from the investigation. Of the remaining ten  
19 staff members, three staff members did not have clear  
20 grounds to access the material. They were all  
21 relatively new staff members and were dealt with by  
22 having individual conversations. A specific  
23 counter-corruption briefing was delivered to all  
24 probation staff at Nottingham Crown Court. This has not  
25 to date led to any charges being brought by the police.

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1 In light of the discovery regarding probation staff,  
2 the delivery manager at Nottingham Crown Court caused an  
3 investigation to be carried out by HMCTS counter-fraud  
4 team into inappropriate access by court staff. This  
5 identified three members of court staff being identified  
6 as having inappropriately accessed the court file: a  
7 crown court clerk and an usher from Nottingham Crown  
8 Court and an administrative officer in a wholly  
9 different crown court in Lewes. These cases were  
10 submitted to the South East Regional Organised Crime  
11 Unit and the police respectively.

12 Disciplinary action was instigated against two  
13 employees who are now no longer working for HMCTS and  
14 the third resigned shortly after the inappropriate  
15 access was identified.

16 How is it that court staff members, including from  
17 a court that has no link to the attacks whatsoever,  
18 managed to access the material? You will hear about  
19 invitation-only functionality, Chair and how it should  
20 have been applied earlier in this case. Most  
21 importantly, what can be done to build in more automatic  
22 or wider limitations in the future? Again, this Inquiry  
23 will also investigate whether sufficient and timely  
24 information was provided to the families and survivors.

25 Nottingham City Council.

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1 surrounding area. It features in this Inquiry not  
2 because it treated VC but because it provided treatment  
3 to the victims of his attacks.

4 You, Chair, will hear that in October 2024 the Trust  
5 became aware of potential unauthorised access by its  
6 staff of the medical records of Barney and Grace and  
7 subsequently unauthorised access of the records of  
8 surviving victims of VC's attacks. You will hear  
9 evidence from Dr Manjeet Shehmar, Medical Director at  
10 Nottingham University Hospital's NHS Trust, about the  
11 process the Trust has adopted to investigate the issue  
12 of unauthorised access. The Inquiry understands the  
13 investigation to be ongoing. At least 47 staff have  
14 been referred to a formal investigative process by the  
15 Trust to scrutinise their access of records after  
16 a first level review failed to determine that their  
17 access was legitimate.

18 In her written evidence Dr Shehmar maintains that  
19 the Trust has acted appropriately since becoming aware  
20 of the potential unauthorised access of medical records,  
21 in the steps it has taken to investigate the  
22 unauthorised access and in its communications with the  
23 bereaved families and surviving victims.

24 You will hear from the bereaved families and  
25 surviving victims that that has not been their

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1 There was also unauthorised access from within  
2 Nottingham City Council. You will hear from Colin  
3 Wilderspin, the Strategic Director of Communities for  
4 Nottingham City Council. He will set out the policies  
5 relevant to the use of those systems, such as the data  
6 protection policy and IT acceptable use policy, and  
7 training on the General Data Protection Regulations and  
8 information security.

9 He will explain that the Council has an anti-social  
10 behaviour team who work closely with the police and who  
11 have access to the police's own NICHE system. Three  
12 officers from that team accessed information in this  
13 case. The Council understands that this was done in two  
14 cases with a genuine intention and also a professional  
15 curiosity to seek to identify risks arising to the  
16 public and also personally. In a third case the access  
17 is said to have been inadvertent and immediately closed  
18 down. In all three cases the information related to VC  
19 rather than the victims. This was subject to a police  
20 investigation and the officers were spoken to by the  
21 anticorruption team and a warning placed on their HR  
22 files.

23 Nottingham University Hospital's NHS Trust.

24 The Trust is an acute NHS Trust which provides  
25 services, including an A&E, to Nottingham and the

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1 experience. In their written evidence Dr Sanjoy Kumar  
2 and Dr Sinead O'Malley-Kumar have raised their concerns  
3 about the adequacy of the investigation conducted by  
4 the Trust. They also describe the lack of candour and  
5 transparency of the Trust, sentiments echoed by Emma and  
6 James Webber; Lee, Darren and James Coates; and Sharon  
7 Miller in their respective evidence.

8 Chair, the public may be surprised to hear that  
9 information originating from the police can be accessed  
10 by those with no legitimate need to see it. It can, we  
11 will see, be accessed by a curious court clerk in  
12 a different town, or a council officer who has access to  
13 a police computer. This Inquiry will investigate what  
14 has gone wrong and, importantly, what might be done to  
15 ensure inappropriate accessing of police information  
16 cannot happen in the future.

17 You may also wish to consider the adequacy of the  
18 investigations that Nottingham University Hospital's NHS  
19 Trust has undertaken into unauthorised access of medical  
20 records.

21 You may also wish to consider whether there has been  
22 any failings in candour and transparency in the Trust's  
23 communication with the bereaved families and the  
24 surviving victims in respect of this.

25 6. Governance and wider canvas.

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1 Finally, Chair, I move to governance and wider  
 2 canvas. The clinicians, nurses and other Health Care  
 3 Professionals who interacted with VC did not operate in  
 4 a vacuum. The policies and procedures they followed,  
 5 the training they received, the resources available to  
 6 them and crucially the culture in which they worked were  
 7 at least in part organisational and influenced by  
 8 leadership.

9 The Inquiry will be examining whether the leadership  
 10 and management of the Nottinghamshire Healthcare NHS  
 11 Foundation Trust contributed to failings in how VC was  
 12 treated and managed prior to 13 June. The Trust  
 13 provides in-patient and community mental health care,  
 14 high security forensic services and general community  
 15 healthcare across Nottinghamshire and parts of  
 16 neighbouring counties. As an NHS Foundation Trust it  
 17 has a certain degree of financial and operational  
 18 independence from NHS England and Central Government.

19 Like all Foundation Trusts, Nottinghamshire  
 20 Healthcare is led by a board of directors comprising  
 21 executive directors, including a chief executive, and  
 22 non-executive directors, including a Chair. The board  
 23 of directors exercises its functions through board  
 24 meetings, delegation of certain powers to executive  
 25 directors and a set of sub-committees. These

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1 Similar statements are made in the written evidence  
 2 of other former and current senior management at the  
 3 Trust, all of whom will be giving oral evidence.

4 Paul Devlin, Chair of the Trust from January 2020 to  
 5 December, says he had realised there were issues with  
 6 the culture of the board shortly before he joined.

7 Dr Susan Elcock, Executive Medical Director at the  
 8 Trust since May 2021, and Deputy Chief Executive Officer  
 9 since October 2023, describes a lack of cohesive model  
 10 for governance across the Trust until divisional  
 11 restructuring in 2022.

12 Ann-Marie Newham, Executive Director of Nursing at  
 13 the Trust from January 2020 to August 2022 and  
 14 subsequently interim and then Deputy Chief Executive  
 15 Officer describes noticing issues with the reporting  
 16 lines to her and the size of the quality team on  
 17 joining.

18 The current Chief Executive Officer of the Trust,  
 19 Iftikhar Majid, addresses a number of operational  
 20 governance changes he made after joining the Trust  
 21 in December 2022.

22 Diane Hull, the current Chief Nurse of the Trust,  
 23 says it was apparent to her soon after starting her post  
 24 in July 2023 that the nursing directorate needed to  
 25 restructure to enable her to drive the quality, safety

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1 sub-committees include a quality committee whose  
 2 function is to set, monitor and scrutinise patient  
 3 safety standards across the Trust, including clinical  
 4 risk and patient safety. The board of directors is  
 5 accountable to a council of governors.

6 Chair, you will hear oral evidence from a number of  
 7 current and former executive and non-executive directors  
 8 of the Trust. This includes John Brewin, the  
 9 Chief Executive Officer of the Trust from January 2019  
 10 to August 2022. You may note, Chair, that period covers  
 11 all but the final month of VC's treatment at the Trust,  
 12 VC being discharged into the care of his GP in  
 13 September 2022.

14 In his statement to the Inquiry Mr Brewin describes  
 15 his impression on joining the Trust that the executive  
 16 and the board were not functioning optimally and that  
 17 management and governance structures were impeding  
 18 effective communication between staff and senior  
 19 management. You will hear from Mr Brewin about the  
 20 efforts which were made to improve governance of the  
 21 Trust during his tenure and the challenges which  
 22 remained. You will hear from Mr Brewin that issues such  
 23 as the increasing acuity of admissions and staffing  
 24 levels were a regular topic of discussion between  
 25 executives.

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1 experience agenda to support the Trust in making the  
 2 improvements required.

3 Each of these individuals describes changes to  
 4 governance at the Trust which were implemented during  
 5 their tenure: reorganisation of the divisions in  
 6 the Trust, the adding and deletion of leadership posts  
 7 and the creation of new governance groups along with the  
 8 consolidation of others.

9 The NHS is no stranger to organisational upheaval.  
 10 You, Chair, may wish to consider the extent to which  
 11 these changes met the challenges faced by the Trust and  
 12 delivered any improvement to the mental health services  
 13 provided by it.

14 You will also hear from Mr Brewin, Mr Devlin and  
 15 Ms Newham as to the profound impact that the COVID-19  
 16 pandemic had on the Trust in terms of the ability of the  
 17 Trust to deliver quality and governance improvements,  
 18 but also in its day-to-day operations.

19 Mr Brewin describes in his written evidence that  
 20 staffing was an increasing and ongoing issue at  
 21 the Trust ever since he started his role, particularly  
 22 in in-patient areas, and this was exacerbated by the  
 23 pandemic.

24 A similar picture is described in relation to the  
 25 use of out of area placements, an enduring issue for

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1 the Trust. It was a national outlier which worsened  
 2 during the pandemic.  
 3 Issues with governance were borne out in successive  
 4 CQC inspections of the Trust. In May 2019 the CQC  
 5 published the report of its inspection of the Trust.  
 6 That inspection was carried out between January to  
 7 March 2019. The overall rating for the Trust was  
 8 "Requires improvement". This was a downgrade from its  
 9 previous rating of "Good". The Trust's provision of  
 10 acute adult wards and psychiatric intensive care units  
 11 was rated as "Inadequate". In its inspection of those  
 12 wards the CQC found there was inconsistency and lapses  
 13 in governance; risk and safety were not always well  
 14 managed; some patient records inspected were found to  
 15 contain no risk assessment; others were found to contain  
 16 inadequate risk assessments; issues were also identified  
 17 with staffing levels and bed availability.  
 18 Further focused inspections of the Trust were  
 19 carried out in 2020, 2021 and 2022. This included  
 20 a reinspection of acute adult wards and psychiatric  
 21 intensive care units from 19 to 29 July 2020. One of  
 22 the wards inspected was Rowan 1 ward where VC was  
 23 detained at the time. The service overall was rated as  
 24 "Requires improvement", though the "Safe" and "Well-led"  
 25 domains of the inspections both attracted an

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1 safety incidents, particularly those involving violence  
 2 from patients, were identified, investigated and  
 3 responded to at the Trust. How did and does the Trust  
 4 learn from serious incidents and deaths?

5 The lists of groups within the Trust which  
 6 previously had or currently have at least some  
 7 responsibility in this area is a long one. They include  
 8 the Quality Committee, the Serious Incident Review  
 9 Group, the Patient Safety and Learning From Deaths  
 10 Group, the Risk Group, the Quality Oversight Group, the  
 11 Homicides, Attempted Homicides and Complex Incidents  
 12 Group, Rapid Improvement Groups, Care Groups and  
 13 the Police Liaison Operational Group.

14 Problems with the Trust's safety processes were in  
 15 fact identified prior to the attacks committed by VC.  
 16 In early 2023, the Trust's executive leadership team  
 17 became concerned about a growing volume of serious  
 18 incidents and prevention of future death reports. As  
 19 a result, the Trust commissioned an independent  
 20 evaluation of trust safety processes which was not  
 21 completed until early 2024.

22 The evaluation concluded that there was a lack of  
 23 trust-wide quality improvement projects addressing  
 24 a number of repetitive problems within the Trust, those  
 25 repetitive problems including crisis planning and

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1 "Inadequate" rating.

2 The Trust rating remains "Requires improvement"  
 3 following a CQC inspection in March and April 2022.  
 4 Issues with inadequate staffing levels were identified.  
 5 The Trust was directed to embed governance structures  
 6 across all divisions.

7 The CQC rapid review of mental health services at  
 8 the Trust in March 2024, directed by the Secretary of  
 9 State for Health and Social Care following VC's  
 10 conviction, did not demonstrate improvement. The CQC  
 11 identified staffing and leadership as enduring areas of  
 12 concern. Actions by leadership to address safety  
 13 concerns was found to be reactive rather than proactive.  
 14 Staff approach to risk assessment and risk management  
 15 was considered inadequate. Issues with staffing levels  
 16 were again noted.

17 Finally, last month came the latest CQC inspection:  
 18 a "Well-led" assessment of the Trust. The rating was  
 19 again "Requires improvement", just as it was in  
 20 January 2019.

21 You, Chair, may wish to consider whether the  
 22 findings of the CQC since 2019 demonstrate a persistent  
 23 failure of governance at the Trust and, if so, why has  
 24 this occurred?

25 Of particular interest to the Inquiry is how patient

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1 regular review, staffing recruitment, retention,  
 2 capacity and demand, falsification of observation  
 3 records, triage of referral, clinical risk assessment  
 4 and regular review, communication and record keeping.  
 5 The Trust has accepted these findings.

6 You, Chair, may find it striking how similar this  
 7 list of so-called repetitive problems is to the set of  
 8 issues raised by the care provided to VC by the Trust.  
 9 You may ask why these problems at the Trust have been  
 10 repetitive.

11 The Trust subsequently commissioned a thematic  
 12 review of homicides and attempted homicides to review  
 13 the reports which had been completed for serious  
 14 incidents involving homicide or attempted homicide by  
 15 the Trust's patients from 2019 to 2023. This included  
 16 the case of VC.

17 The review panel considered there was a number of  
 18 things which emerged from the incidents: poor engagement  
 19 by patients, a lack of follow up, risk assessment which  
 20 failed to consider risks to the wider public, delays and  
 21 waits in patients being seen and a lack of multi-agency  
 22 working and information sharing.

23 In respect of the incident reporting process itself,  
 24 the review found a lack of engagement with families.  
 25 Final reports were not completed in a timely manner.

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1 Two reports were found to be of such poor quality that  
2 the review panel felt they should be reconsidered in  
3 their entirety. Again, the Trust accepted the findings  
4 of the review.

5 When asking questions about the Trust's failure to  
6 learn from the past on earlier or strikingly similar  
7 cases, we should make it clear, Chair, that the Inquiry  
8 team will not be descending into the detail of other  
9 cases. We will ask about those cases insofar as is  
10 necessary at a very high level to enable you to  
11 understand what impact earlier cases did or did not have  
12 on governance and improvement.

13 You, Chair, may wish to consider whether failures in  
14 the Trust governance processes for serious incidents and  
15 failures by the Trust to learn from previous incidents  
16 contributed to any issues in the care provided to VC.

17 Evidence regarding the wider canvas.

18 Chair, the Inquiry has obtained evidence that goes  
19 beyond the circumstances of VC's care in Nottingham and  
20 considers the picture nationally and historically in  
21 respect of similar cases and their impact. What do  
22 other cases indicate about lessons that should be  
23 learned?

24 As I have already said, the Inquiry will hear  
25 evidence from Julian Hendy. He is a documentary film  
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1 families consistently see a greater role for hybrid  
2 orders.

3 As to Mental Health Tribunals, he will tell the  
4 Inquiry of the work he has done to try and achieve  
5 greater transparency in respect of their decision-making  
6 and greater regard for family concerns.

7 Underlining all of Mr Hendy's evidence to the  
8 Inquiry is the view that family voices often get lost in  
9 the various clinical and justice processes and that is  
10 to the detriment of public safety and proper treatment.

11 The questionnaire.

12 The Nottingham Inquiry questionnaire was published  
13 on 22 May 2025. The Inquiry invited those who had been  
14 impacted by mental health homicides, whether through  
15 friends or family, to assist the Inquiry with their  
16 information, insights and experiences. There were 64  
17 completed responses relating to 40 separate attacks  
18 between 2003 and 2024. Independent reports in relation  
19 to these attacks have been obtained and analysed where  
20 they are available.

21 Further to the questionnaire, the Inquiry legal team  
22 have obtained and scrutinised publicly available  
23 independent investigation reports into mental health  
24 homicides in England and Wales since the Clunis report  
25 in 1994.

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1 maker and investigative journalist. He is the founder  
2 and Chief Executive of the Hundred Families charity. He  
3 founded the charity after his father was murdered in  
4 Bristol in 2007 by a psychotic man with a documented  
5 history of serious mental illness, drug abuse and  
6 violence. He has worked tirelessly since then  
7 investigating the issue of mental health related  
8 homicides, compiling information, data and reports and  
9 supporting families that have experienced tragedies in  
10 circumstances similar to his own, including the  
11 Nottingham families.

12 Mr Hendy will provide a valuable and much needed  
13 insight into the concerns he and the families he works  
14 with have in this area. These include transparency of  
15 NHS investigations, an absence of clinical focus on  
16 public protection, failures by psychiatric services to  
17 pick up cases of masked compliance, a lack of assertive  
18 care when patients do not recognise their illness and/or  
19 decline to take medication, a misunderstanding of  
20 confidentiality and data sharing requirements by  
21 clinicians and Trusts, and a need for wider use of CTOs.

22 Mr Hendy has supported many families through court  
23 and Mental Health Tribunal proceedings. As regards the  
24 former, he will express the concern of families at the  
25 use of hospital orders. He will give evidence that  
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1 As a result of this, the Inquiry's work on the  
2 questionnaire and its analysis of publicly available  
3 investigation reports, the Inquiry will have the benefit  
4 of the analysis of hundreds of publicly available  
5 independent investigation reports from recent decades.  
6 These reports have been analysed in order to extract  
7 recurring patterns, themes and failures in mental health  
8 related homicides. This analysis will be presented to  
9 the Inquiry in the latter stages of the hearing to  
10 provide you, Chair, with a broader canvas of cases from  
11 which to make any recommendations.

12 The Inquiry analysis shows that across all regions  
13 weak discharge planning is one of the most common  
14 factors in mental health related homicides.  
15 A significant number of cases show either no discharge  
16 plan or an inadequate discharge plan. Other failings  
17 that the Inquiry legal team have identified as common in  
18 other reports are failures in governance, audit,  
19 supervisions and risk assessment, weaknesses in risk  
20 assessment and failures to engage families. Diagnostic  
21 uncertainty and non-concordance with medication are also  
22 common findings.

23 The analysis appears to show that the same  
24 recommendations are made time and again, suggesting  
25 a worrying trend of failing to learn from the horror and  
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1 personal tragedies that each of these cases represents.  
 2 Finally, Chair, the terms of reference require you  
 3 to provide recommendations to ensure lessons are learned  
 4 and to prevent similar attacks in the future. We have  
 5 outlined throughout this opening issues that may lead to  
 6 recommendations and undoubtedly more about these areas,  
 7 and others, will emerge in the course of the Inquiry.  
 8 It is, therefore, most appropriate to leave the question  
 9 of recommendations to the end of the evidence.

10 **THE CHAIR:** Thank you, Ms Langdale.

11 We will finish there for today and I am grateful to  
 12 everybody for staying a bit late, but it is important  
 13 that we heard counsel's opening in one go.

14 We will start tomorrow, again at 10 o'clock, with  
 15 the opening statements by the Core Participants.

16 I think Mr Moloney, you are first. Thank you.

17 **(5.03 pm)**

18 (The hearing adjourned until 10.00 am on Tuesday,  
 19 24 February 2026)

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129/23  <b>4 February 2022 [1]</b>  117/20  <b>4 January 2021 [1]</b>  86/22  <b>4 July [2]</b> 129/8  219/4  <b>4 June [1]</b> 64/1</p>	<p><b>4 November [2]</b>  82/19 105/3  <b>4 October 2021 [1]</b>  77/16  <b>4 pm [1]</b> 201/3  <b>4.03 [1]</b> 176/2  <b>4.03 am [1]</b> 10/10  <b>4.04 [1]</b> 178/12  <b>4.04 am [2]</b> 50/16  176/9  <b>4.05 am [2]</b> 179/1  179/4  <b>4.07 [1]</b> 179/22  <b>4.07 am [1]</b> 180/24  <b>4.08 am [2]</b> 179/14  179/17  <b>4.09 am [1]</b> 182/25  <b>4.1 [1]</b> 213/25  <b>4.10 [1]</b> 183/3  <b>4.10 am [1]</b> 183/7  <b>4.11 am [1]</b> 183/10  <b>4.12 am [1]</b> 184/4  <b>4.13 am [2]</b> 184/17  185/3  <b>4.18 am [1]</b> 186/14  <b>4.24 am [1]</b> 186/7  <b>4.25 [1]</b> 186/15  <b>4.30 [1]</b> 186/18  <b>4.32 [1]</b> 186/24  <b>4.36 [1]</b> 187/16  <b>4.45 am [1]</b> 187/18  <b>4.47 am [1]</b> 10/17  <b>4.48 [1]</b> 158/8  <b>4.48 am [1]</b> 187/19  <b>4.52 am [1]</b> 10/18  <b>4.6 [1]</b> 214/4  <b>4.7 [1]</b> 214/7  <b>40 [1]</b> 243/17  <b>41 [2]</b> 15/11 18/9  <b>42 minutes [1]</b> 175/4  <b>47 [1]</b> 231/13  <b>47 minutes [1]</b>  174/16  <b>48 [4]</b> 30/10 30/11  91/11 132/5  <hr/> <b>5</b>  <b>5 am [2]</b> 11/17 92/25  <b>5 January 2022 [1]</b>  132/12  <b>5 July [1]</b> 91/19  <b>5 June [1]</b> 64/11  <b>5 March 2021 [1]</b>  132/14  <b>5 May [1]</b> 139/5  <b>5 May 2023 [3]</b> 21/21  138/25 172/21  <b>5 November [3]</b> 83/2  105/7 105/8  <b>5 o'clock [1]</b> 223/5  <b>5 October 2023 [1]</b>  209/14  <b>5 September [1]</b>  132/14  <b>5-milligram [1]</b> 64/21  <b>5.01 am [2]</b> 10/24</p>
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203/1 230/10</p> <p><b>behind [4]</b> 12/21 13/9 173/5 190/15</p> <p><b>being [80]</b> 6/3 8/24 14/15 18/11 18/12 25/21 26/2 27/16 31/16 34/20 39/23 45/22 47/7 51/22 55/16 57/12 58/12 63/6 63/12 63/20 66/18 67/24 71/13 75/9 77/9 77/14 80/19 81/13 84/9 87/14 88/24 89/22 90/18 90/19 92/17 99/11 99/15 99/24 100/4 100/10 100/14 101/24 102/6 107/24 111/24 115/8 116/13 116/21 116/23 119/22 125/15 129/7 135/7 137/2 139/8 141/13 142/17</p>	<p>143/4 151/16 154/4 158/1 159/24 162/24 169/24 171/7 178/13 178/14 181/9 186/8 192/11 198/4 198/9 202/16 209/12 227/5 228/17 228/25 229/5 234/12 240/21</p> <p><b>beings [1]</b> 18/13</p> <p><b>belatedly [1]</b> 138/2</p> <p><b>belief [2]</b> 138/14 223/19</p> <p><b>beliefs [1]</b> 63/19</p> <p><b>believe [3]</b> 93/21 99/9 101/7</p> <p><b>believed [12]</b> 59/18 60/5 63/6 63/7 63/11 63/14 70/3 70/17 84/22 88/11 101/4 118/20</p> <p><b>believes [1]</b> 125/10</p> <p><b>believing [2]</b> 72/3 206/19</p> <p><b>below [2]</b> 6/24 191/3</p> <p><b>Ben [1]</b> 51/18</p> <p><b>bench [1]</b> 214/13</p> <p><b>benchmarking [3]</b> 32/17 32/23 33/20</p> <p><b>beneficial [2]</b> 120/6 136/6</p> <p><b>benefit [3]</b> 131/7 156/25 244/3</p> <p><b>benefits [4]</b> 41/2 75/3 157/7 166/6</p> <p><b>Bentinck [1]</b> 192/7</p> <p><b>Bentinck Street [1]</b> 192/7</p> <p><b>bereaved [40]</b> 8/4 15/4 15/7 15/15 16/11 16/20 22/20 23/7 24/2 24/14 25/5 25/15 25/22 25/25 26/6 177/16 205/17 211/14 211/14 212/22 213/2 215/16 216/17 216/18 216/20 216/25 217/12 217/15 218/11 218/18 218/24 219/20 219/22 221/18 222/13 222/23 223/3 231/23 231/24 232/23</p> <p><b>Berry [3]</b> 179/23 180/17 190/7</p> <p><b>best [11]</b> 2/11 6/23 65/19 100/9 142/9 168/3 168/8 169/4 170/23 215/14 218/8</p> <p><b>better [9]</b> 25/12 74/18 87/14 103/10 117/5 120/11 160/23 203/20 213/9</p> <p><b>between [45]</b> 20/13 20/13 20/15 27/11 31/25 32/18 34/10 42/7 43/16 44/14 44/15 45/7 76/22</p>
(69) authorities... - between				

<b>B</b>	176/16 184/6 189/20 190/9	<b>Bramley's [3]</b> 199/14 199/24 201/6	84/1 87/7 87/19 92/14	108/25 109/6 127/11 139/3 139/15 179/23 188/9 189/7 189/24 190/1 193/2 193/20 240/7
<b>between...</b> [32] 78/14 80/5 91/15 102/11 123/5 128/15 135/25 149/5 155/11 157/17 160/2 160/23 163/14 163/16 163/23 165/16 167/3 169/2 186/19 186/24 188/22 193/7 205/12 211/10 217/17 218/4 221/13 225/20 234/18 234/24 237/6 243/18	<b>Blackwood [14]</b> 12/2 206/4 206/7 209/8 209/14 209/22 209/24 210/4 210/6 210/9 210/12 210/16 220/15 222/4	<b>bravely [1]</b> 9/21 <b>breach [3]</b> 155/19 155/19 159/13 <b>breached [2]</b> 186/14 224/18 <b>breaching [2]</b> 156/8 156/24 <b>breadth [1]</b> 153/3 <b>break [7]</b> 56/2 56/7 114/1 172/3 172/7 188/24 209/18 <b>breakdown [1]</b> 58/3 <b>breaks [1]</b> 2/18 <b>Brewin [6]</b> 234/8 234/14 234/19 234/22 236/14 236/19 <b>brief [1]</b> 128/18 <b>briefing [4]</b> 22/11 205/21 205/24 228/23 <b>briefly [2]</b> 21/11 188/18 <b>brilliant [1]</b> 65/12 <b>bring [2]</b> 96/17 126/6 <b>bringing [2]</b> 7/6 78/5 <b>Bristol [1]</b> 242/4 <b>broader [2]</b> 128/7 244/10 <b>broadly [3]</b> 47/17 110/19 215/21 <b>broke [1]</b> 78/10 <b>broken [4]</b> 55/19 70/24 95/9 125/3 <b>Brook [15]</b> 48/23 48/24 49/2 49/19 53/21 53/25 60/20 70/24 71/21 76/13 76/21 132/2 132/2 143/7 185/2 <b>brother [14]</b> 8/22 10/18 10/19 17/21 57/19 58/1 63/3 74/12 88/14 119/1 173/9 173/10 174/6 209/16 <b>brought [4]</b> 50/16 102/24 125/19 228/25 <b>browse [1]</b> 224/16 <b>brutal [4]</b> 9/18 17/1 182/7 223/11 <b>brutally [1]</b> 7/18 <b>Buffalo [1]</b> 119/8 <b>build [7]</b> 16/24 21/8 40/12 123/11 175/21 222/25 229/21 <b>building [4]</b> 40/7 48/25 49/14 188/11 <b>buildings [1]</b> 13/8 <b>burden [1]</b> 14/21 <b>Burford [2]</b> 133/9 172/22 <b>Burford Road [2]</b> 133/9 172/22 <b>Burri [12]</b> 46/10 80/8 81/1 81/12 81/16 81/17 83/11 83/20	<b>Burri's [1]</b> 85/2 <b>bus [1]</b> 12/18 <b>Busby [2]</b> 90/8 90/12 <b>Busby-McVey [1]</b> 90/8 <b>business [1]</b> 224/18 <b>busy [4]</b> 93/16 104/13 104/16 130/12 <b>but [123]</b> 2/20 3/7 6/12 6/24 8/24 10/3 12/2 18/4 18/10 20/18 21/24 23/24 24/23 26/17 29/23 33/8 34/17 37/19 39/18 44/23 47/23 48/24 49/7 50/3 53/2 53/17 54/4 57/24 59/10 60/8 63/2 64/3 64/7 65/8 69/7 70/1 70/12 73/21 74/9 75/20 77/15 79/23 81/24 82/3 82/14 84/19 85/24 86/18 87/8 87/24 88/2 88/8 90/11 91/5 93/15 94/9 95/17 96/10 99/6 99/8 100/19 101/6 102/21 103/3 105/4 105/13 105/14 106/7 109/24 110/4 111/17 112/9 114/17 114/19 114/25 116/16 117/7 117/16 117/19 118/18 119/24 120/17 121/8 122/25 123/25 124/12 126/12 126/19 129/1 129/9 131/11 136/16 138/12 141/2 147/10 154/5 156/14 156/23 164/8 166/23 169/20 173/15 175/3 176/22 179/5 185/6 186/7 187/11 188/18 188/21 189/7 189/19 190/5 199/16 200/10 202/11 209/21 210/13 225/22 231/2 234/11 236/18 245/12	<b>caller [12]</b> 127/7 176/3 176/6 176/7 176/9 176/17 176/18 176/21 178/9 184/11 190/1 190/2 <b>callers [1]</b> 177/5 <b>calling [1]</b> 91/24 <b>calls [11]</b> 10/14 102/9 107/3 113/1 126/8 134/3 135/9 177/7 179/7 179/16 181/7 <b>calm [6]</b> 74/5 79/11 85/22 89/17 96/8 103/4 <b>calmed [1]</b> 109/10 <b>calmly [2]</b> 10/8 48/11 <b>Calocene [4]</b> 4/15 7/17 10/18 57/13 <b>cam [1]</b> 13/10 <b>came [16]</b> 9/17 10/15 11/13 12/3 38/10 48/14 85/2 138/12 144/6 159/20 160/5 164/5 177/4 177/7 226/23 238/17 <b>camera [3]</b> 89/13 96/18 139/22 <b>cameras [1]</b> 175/8 <b>Campbell [1]</b> 58/8 <b>Campbell-Ritchie [1]</b> 58/8 <b>campus [4]</b> 43/8 91/12 110/7 125/18 <b>can [45]</b> 3/9 4/1 5/20 5/23 7/4 16/5 17/3 77/25 84/11 98/14 100/22 106/22 121/15 130/20 131/4 131/7 138/20 142/9 147/10 148/24 149/8 150/7 150/13 156/5 156/23 157/2 157/17 158/17 160/9 164/9 164/12 166/23 168/6 168/22 169/7 169/9 175/2 192/8 192/11 203/13 206/16 215/15 229/21 232/9 232/10 <b>candour [3]</b> 5/16 232/4 232/22 <b>cannabis [1]</b> 210/8 <b>cannot [12]</b> 14/23 15/13 15/20 15/22 103/2 145/19 145/21 166/22 175/3 182/5 228/2 232/16 <b>canvas [6]</b> 5/4 20/22 232/25 233/2 241/17 244/10 <b>cap [1]</b> 19/11
<b>between April 2020</b> [1] 32/18	<b>Blackwood's [2]</b> 210/2 210/20	<b>breaks [1]</b> 2/18	74/9 75/20 77/15 79/23 81/24 82/3 82/14 84/19 85/24 86/18 87/8 87/24 88/2 88/8 90/11 91/5 93/15 94/9 95/17 96/10 99/6 99/8 100/19 101/6 102/21 103/3 105/4 105/13 105/14 106/7 109/24 110/4 111/17 112/9 114/17 114/19 114/25 116/16 117/7 117/16 117/19 118/18 119/24 120/17 121/8 122/25 123/25 124/12 126/12 126/19 129/1 129/9 131/11 136/16 138/12 141/2 147/10 154/5 156/14 156/23 164/8 166/23 169/20 173/15 175/3 176/22 179/5 185/6 186/7 187/11 188/18 188/21 189/7 189/19 190/5 199/16 200/10 202/11 209/21 210/13 225/22 231/2 234/11 236/18 245/12	<b>caller [12]</b> 127/7 176/3 176/6 176/7 176/9 176/17 176/18 176/21 178/9 184/11 190/1 190/2 <b>callers [1]</b> 177/5 <b>calling [1]</b> 91/24 <b>calls [11]</b> 10/14 102/9 107/3 113/1 126/8 134/3 135/9 177/7 179/7 179/16 181/7 <b>calm [6]</b> 74/5 79/11 85/22 89/17 96/8 103/4 <b>calmed [1]</b> 109/10 <b>calmly [2]</b> 10/8 48/11 <b>Calocene [4]</b> 4/15 7/17 10/18 57/13 <b>cam [1]</b> 13/10 <b>came [16]</b> 9/17 10/15 11/13 12/3 38/10 48/14 85/2 138/12 144/6 159/20 160/5 164/5 177/4 177/7 226/23 238/17 <b>camera [3]</b> 89/13 96/18 139/22 <b>cameras [1]</b> 175/8 <b>Campbell [1]</b> 58/8 <b>Campbell-Ritchie [1]</b> 58/8 <b>campus [4]</b> 43/8 91/12 110/7 125/18 <b>can [45]</b> 3/9 4/1 5/20 5/23 7/4 16/5 17/3 77/25 84/11 98/14 100/22 106/22 121/15 130/20 131/4 131/7 138/20 142/9 147/10 148/24 149/8 150/7 150/13 156/5 156/23 157/2 157/17 158/17 160/9 164/9 164/12 166/23 168/6 168/22 169/7 169/9 175/2 192/8 192/11 203/13 206/16 215/15 229/21 232/9 232/10 <b>candour [3]</b> 5/16 232/4 232/22 <b>cannabis [1]</b> 210/8 <b>cannot [12]</b> 14/23 15/13 15/20 15/22 103/2 145/19 145/21 166/22 175/3 182/5 228/2 232/16 <b>canvas [6]</b> 5/4 20/22 232/25 233/2 241/17 244/10 <b>cap [1]</b> 19/11
<b>between May [1]</b> 76/22	<b>block [1]</b> 125/24 <b>blocked [1]</b> 192/14 <b>blocked in [1]</b> 192/14 <b>blocking [1]</b> 109/3 <b>blood [5]</b> 11/16 79/15 202/9 202/10 202/15	<b>breakdown [1]</b> 58/3	74/9 75/20 77/15 79/23 81/24 82/3 82/14 84/19 85/24 86/18 87/8 87/24 88/2 88/8 90/11 91/5 93/15 94/9 95/17 96/10 99/6 99/8 100/19 101/6 102/21 103/3 105/4 105/13 105/14 106/7 109/24 110/4 111/17 112/9 114/17 114/19 114/25 116/16 117/7 117/16 117/19 118/18 119/24 120/17 121/8 122/25 123/25 124/12 126/12 126/19 129/1 129/9 131/11 136/16 138/12 141/2 147/10 154/5 156/14 156/23 164/8 166/23 169/20 173/15 175/3 176/22 179/5 185/6 186/7 187/11 188/18 188/21 189/7 189/19 190/5 199/16 200/10 202/11 209/21 210/13 225/22 231/2 234/11 236/18 245/12	<b>caller [12]</b> 127/7 176/3 176/6 176/7 176/9 176/17 176/18 176/21 178/9 184/11 190/1 190/2 <b>callers [1]</b> 177/5 <b>calling [1]</b> 91/24 <b>calls [11]</b> 10/14 102/9 107/3 113/1 126/8 134/3 135/9 177/7 179/7 179/16 181/7 <b>calm [6]</b> 74/5 79/11 85/22 89/17 96/8 103/4 <b>calmed [1]</b> 109/10 <b>calmly [2]</b> 10/8 48/11 <b>Calocene [4]</b> 4/15 7/17 10/18 57/13 <b>cam [1]</b> 13/10 <b>came [16]</b> 9/17 10/15 11/13 12/3 38/10 48/14 85/2 138/12 144/6 159/20 160/5 164/5 177/4 177/7 226/23 238/17 <b>camera [3]</b> 89/13 96/18 139/22 <b>cameras [1]</b> 175/8 <b>Campbell [1]</b> 58/8 <b>Campbell-Ritchie [1]</b> 58/8 <b>campus [4]</b> 43/8 91/12 110/7 125/18 <b>can [45]</b> 3/9 4/1 5/20 5/23 7/4 16/5 17/3 77/25 84/11 98/14 100/22 106/22 121/15 130/20 131/4 131/7 138/20 142/9 147/10 148/24 149/8 150/7 150/13 156/5 156/23 157/2 157/17 158/17 160/9 164/9 164/12 166/23 168/6 168/22 169/7 169/9 175/2 192/8 192/11 203/13 206/16 215/15 229/21 232/9 232/10 <b>candour [3]</b> 5/16 232/4 232/22 <b>cannabis [1]</b> 210/8 <b>cannot [12]</b> 14/23 15/13 15/20 15/22 103/2 145/19 145/21 166/22 175/3 182/5 228/2 232/16 <b>canvas [6]</b> 5/4 20/22 232/25 233/2 241/17 244/10 <b>cap [1]</b> 19/11
<b>between May 2020</b> [1] 169/2	<b>block [1]</b> 125/24 <b>blocked [1]</b> 192/14 <b>blocked in [1]</b> 192/14 <b>blocking [1]</b> 109/3 <b>blood [5]</b> 11/16 79/15 202/9 202/10 202/15	<b>breakdown [1]</b> 58/3	74/9 75/20 77/15 79/23 81/24 82/3 82/14 84/19 85/24 86/18 87/8 87/24 88/2 88/8 90/11 91/5 93/15 94/9 95/17 96/10 99/6 99/8 100/19 101/6 102/21 103/3 105/4 105/13 105/14 106/7 109/24 110/4 111/17 112/9 114/17 114/19 114/25 116/16 117/7 117/16 117/19 118/18 119/24 120/17 121/8 122/25 123/25 124/12 126/12 126/19 129/1 129/9 131/11 136/16 138/12 141/2 147/10 154/5 156/14 156/23 164/8 166/23 169/20 173/15 175/3 176/22 179/5 185/6 186/7 187/11 188/18 188/21 189/7 189/19 190/5 199/16 200/10 202/11 209/21 210/13 225/22 231/2 234/11 236/18 245/12	<b>caller [12]</b> 127/7 176/3 176/6 176/7 176/9 176/17 176/18 176/21 178/9 184/11 190/1 190/2 <b>callers [1]</b> 177/5 <b>calling [1]</b> 91/24 <b>calls [11]</b> 10/14 102/9 107/3 113/1 126/8 134/3 135/9 177/7 179/7 179/16 181/7 <b>calm [6]</b> 74/5 79/11 85/22 89/17 96/8 103/4 <b>calmed [1]</b> 109/10 <b>calmly [2]</b> 10/8 48/11 <b>Calocene [4]</b> 4/15 7/17 10/18 57/13 <b>cam [1]</b> 13/10 <b>came [16]</b> 9/17 10/15 11/13 12/3 38/10 48/14 85/2 138/12 144/6 159/20 160/5 164/5 177/4 177/7 226/23 238/17 <b>camera [3]</b> 89/13 96/18 139/22 <b>cameras [1]</b> 175/8 <b>Campbell [1]</b> 58/8 <b>Campbell-Ritchie [1]</b> 58/8 <b>campus [4]</b> 43/8 91/12 110/7 125/18 <b>can [45]</b> 3/9 4/1 5/20 5/23 7/4 16/5 17/3 77/25 84/11 98/14 100/22 106/22 121/15 130/20 131/4 131/7 138/20 142/9 147/10 148/24 149/8 150/7 150/13 156/5 156/23 157/2 157/17 158/17 160/9 164/9 164/12 166/23 168/6 168/22 169/7 169/9 175/2 192/8 192/11 203/13 206/16 215/15 229/21 232/9 232/10 <b>candour [3]</b> 5/16 232/4 232/22 <b>cannabis [1]</b> 210/8 <b>cannot [12]</b> 14/23 15/13 15/20 15/22 103/2 145/19 145/21 166/22 175/3 182/5 228/2 232/16 <b>canvas [6]</b> 5/4 20/22 232/25 233/2 241/17 244/10 <b>cap [1]</b> 19/11
<b>between November</b> <b>2020 [1]</b> 44/15	<b>board [9]</b> 18/2 36/18 39/10 233/20 233/22 233/23 234/4 234/16 235/6	<b>breakdown [1]</b> 58/3	74/9 75/20 77/15 79/23 81/24 82/3 82/14 84/19 85/24 86/18 87/8 87/24 88/2 88/8 90/11 91/5 93/15 94/9 95/17 96/10 99/6 99/8 100/19 101/6 102/21 103/3 105/4 105/13 105/14 106/7 109/24 110/4 111/17 112/9 114/17 114/19 114/25 116/16 117/7 117/16 117/19 118/18 119/24 120/17 121/8 122/25 123/25 124/12 126/12 126/19 129/1 129/9 131/11 136/16 138/12 141/2 147/10 154/5 156/14 156/23 164/8 166/23 169/20 173/15 175/3 176/22 179/5 185/6 186/7 187/11 188/18 188/21 189/7 189/19 190/5 199/16 200/10 202/11 209/21 210/13 225/22 231/2 234/11 236/18 245/12	<b>caller [12]</b> 127/7 176/3 176/6 176/7 176/9 176/17 176/18 176/21 178/9 184/11 190/1 190/2 <b>callers [1]</b> 177/5 <b>calling [1]</b> 91/24 <b>calls [11]</b> 10/14 102/9 107/3 113/1 126/8 134/3 135/9 177/7 179/7 179/16 181/7 <b>calm [6]</b> 74/5 79/11 85/22 89/17 96/8 103/4 <b>calmed [1]</b> 109/10 <b>calmly [2]</b> 10/8 48/11 <b>Calocene [4]</b> 4/15 7/17 10/18 57/13 <b>cam [1]</b> 13/10 <b>came [16]</b> 9/17 10/15 11/13 12/3 38/10 48/14 85/2 138/12 144/6 159/20 160/5 164/5 177/4 177/7 226/23 238/17 <b>camera [3]</b> 89/13 96/18 139/22 <b>cameras [1]</b> 175/8 <b>Campbell [1]</b> 58/8 <b>Campbell-Ritchie [1]</b> 58/8 <b>campus [4]</b> 43/8 91/12 110/7 125/18 <b>can [45]</b> 3/9 4/1 5/20 5/23 7/4 16/5 17/3 77/25 84/11 98/14 100/22 106/22 121/15 130/20 131/4 131/7 138/20 142/9 147/10 148/24 149/8 150/7 150/13 156/5 156/23 157/2 157/17 158/17 160/9 164/9 164/12 166/23 168/6 168/22 169/7 169/9 175/2 192/8 192/11 203/13 206/16 215/15 229/21 232/9 232/10 <b>candour [3]</b> 5/16 232/4 232/22 <b>cannabis [1]</b> 210/8 <b>cannot [12]</b> 14/23 15/13 15/20 15/22 103/2 145/19 145/21 166/22 175/3 182/5 228/2 232/16 <b>canvas [6]</b> 5/4 20/22 232/25 233/2 241/17 244/10 <b>cap [1]</b> 19/11
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