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

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.

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

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,

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

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

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

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

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

There is a desire universally expressed by Core

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

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

Opening statement by Counsel to the Inquiry

MS LANGDALE: Thank you, Chair.

Introduction

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

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

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

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

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

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

2022, and then sent them over email to Elias at 11.52 pm. I will return to their contents later.

At 3.03 am, VC turned off his mobile phone as he walked towards the area of Ilkeston Road. He did not turn his phone back on again until he left the Ilkeston Road area. He had a history of violence and mental health problems. Although it was a summer night, he was dressed in a black top, trousers and a beanie hat pulled down so as to cover the top half of his face. He was carrying a rucksack of weapons: a Boker dagger, a Gerber survival knife, a large pointed knife and a metal scaffolding pole.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

psychiatric report obtained by the prosecution.

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

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

By the terms of reference this Inquiry cannot consider the judicial decision-making in this case and cannot determine matters of criminal or civil liability. The terms of reference also expressly exclude consideration of reform of the law relating to homicide, which is currently the subject of a Law Commission

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

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

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

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

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

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

The Ritchie Report 1994.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

further inquiries.

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

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

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

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

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

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

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

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

The report noted:

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

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

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

The report recommended that by October 2024 the CPS

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

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

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

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

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

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

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

Dr Joanne Perry.

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

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

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

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

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

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

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

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

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

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

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

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

associated with non-concordance.

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

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

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

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

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

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

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

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

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

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

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

As the report recognises, the CQC did not speak to

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

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

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

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

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

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

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

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

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

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

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

Theemis review.

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

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

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

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

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

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

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

The key findings included: VC lacked insight; he did

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

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

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

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

The report found the approach to risk assessment did

not fully consider all potential hazards in different treatment settings. By failing to consider community risks, the approach to risk assessment was not dynamic.

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

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

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

By the time of the fourth admission there was a pattern of concordance in hospital and non-concordance in the community. The in-patient team was trying to treat VC in the least restrictive way. The decision to discharge from hospital was ultimately the responsibility of the in-patient Responsible Clinician,

not the community team. Whilst the community team fed into discussion about VC's care, shared decision-making was missing.

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

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

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

The report recommended discussion and debate at a national level amongst NHS England and others, as to how the needs of people similar to VC were being met and how they were to be supported to thrive safely in the community. It was recommended that NHS England consider

how mental health and social care understand, assess and manage risk and the mechanisms in place to communicate risk across multiple agencies.

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

Common themes and building on the reports.

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

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

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

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

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

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

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

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

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

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

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

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

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

In September 2017, VC began studying towards an

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

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

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

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

mental health issues prior to his presentation in May 2020.

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

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

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

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

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

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

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

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

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

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

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

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

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

there was a pattern of assaults and escalating threats.

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

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

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

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

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

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

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

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

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

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

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

On the morning of 24 May, at 9.54 am, VC was seen in

custody by a Community Psychiatric Nurse from that team, Dominic Lloyd. Mr Lloyd noted that VC had kicked the door in to another flat causing damage. VC was noted to be presenting with mental health issues, hearing voices, appeared vacant, and had not slept for five days. Mr Lloyd does not recall feeling uncomfortable in VC's presence. Mr Lloyd was unclear as to his mental health needs and VC did not engage fully with the assessment. Mr Lloyd was under the impression VC was suffering a psychotic episode given his short answers and delayed responses, and that he appeared to be responding to stimuli. He considered VC lacked capacity about his mental health. In view of his assessment and VC's behaviour Mr Lloyd referred VC for a mental health assessment.

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

university work and exams. The assessing team noted that VC presented with limited insight. They agreed that the least restrictive option needed to be offered instead of in-patient admission. VC agreed to home treatment and a prescription of Olanzapine and Zopiclone. The plan was for the Crisis Team to visit VC that evening and to undertake twice weekly visits to assess him and his risk, and to consider a referral to the Early Intervention in Psychosis team.

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

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

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

of psychosis and a lack of information on risk history, but:

"the team of professionals considered the research evidence that shows over representation of young black males in detention. [He recalled that] Anna Palmer was able to persuade us that [the Crisis Team] could provide a safe and reasonable alternative ... with the option to admit if the community treatment plan failed."

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

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

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

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

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

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

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

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

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

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

MS LANGDALE: It is, Chair, thank you.

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

(11.18 am)

(Short Break)

(11.40 am)

THE CHAIR: Yes, Ms Langdale.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

It is clear that a fuller picture of the nature and

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

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

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

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

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

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

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

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

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

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

There was a meeting with the Crisis Team on 15 June

attended by Samantha Woodings of that team. Dr Seedat advised a three-day follow-up on discharge with continuing follow-up until the proposed move to Birmingham when there should be a referral to an EIP team in Birmingham; alternatively, a referral to a Nottingham EIP team. It was noted that Dr Seedat had no concerns as VC, who was described as largely keeping a low profile, had been very settled on the ward and had no issues with alcohol or illicit substances. It was noted that there was a risk of aggression.

VC was discharged by Dr Seedat on 17 June. The diagnosis was first episode psychosis, the plan to take medication for at least six to nine months and seek medical advice if he wished to stop. He was given 14 days of medication with further supplies to be provided by the GP. A letter was sent to VC's GP practice putting them on notice that VC had been admitted after being arrested by the police after gaining unlawful entry into a neighbour's flat. The neighbour jumped out of the flat's first floor window from fear and had to be taken to the emergency department "for minor injuries". VC was hearing voices and responding to unseen stimuli. He was admitted under section 2 for assessment, as it was his first presentation to mental health services. He was deemed

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

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

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

Daisy Coleman from the Crisis Team carried out a home visit on 23 June. She noted that VC appeared distracted at times and was staring for long periods. He said his mental state had improved since being admitted. He was able to manage the voices he was

hearing. He said he was taking his medication. His intention was to stay in Nottingham until at least the end of July.

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

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

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

The joint visit to VC by the Crisis and Early Intervention in Psychosis teams was on 30 June, attended by Claudia Birtles and Daisy Coleman. From this point on the EIP team took over his care. VC was provided with written information on Early Intervention in

Psychosis and recovery. He was described as well kept during the visit. Ms Birtles noted that he appeared distracted and some of his responses were delayed. He denied auditory hallucinations, contending that they hardly happened anymore. He denied any concerns regarding his mood. He said he was happy to continue taking medication but wasn't clear about how he would get a further supply.

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

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

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

There was no face-to-face meeting the following week

but Claudia Birtles spoke to VC by telephone on 9 July and he said everything was good. However, on 11 July, VC's mother contacted the Trust as she believed VC's mental state might be deteriorating. In recent discussions he was not making much sense. She thought he was not taking his medication as prescribed. Andrew Jackson, the nurse who spoke to VC's mother, felt unable to discuss VC's care without VC's consent. It will be recalled VC had previously given consent whilst an in-patient for his care to be discussed.

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

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

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

from PC Michael Plant who arrived on the scene at approximately 10.16 pm to find three residents having detained VC on the floor. The Street Triage Team attended and spoke with VC. A Street Triage Team includes both a police officer and a Community Psychiatric Nurse. You will hear from PC Jamie Severn who was the officer in that team.

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

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

Dr Seedat, along with Dr Manzar and Approved Mental Health Professional Geoff Culpin, carried out a mental health assessment of VC on the afternoon of

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

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

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

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

On 16 July, there was a ward review which described VC as settled on the ward. He had given, as his reason

for stopping medication in the community, the fact that he had read that it could slow the mind. He accepted that this may have made him "a little more paranoid". He was described as nonplussed when confronted with the effects of his recent behaviour on his neighbour on 13 July, and the previous incidents, and demonstrated no signs of remorse or insight into how his actions had affected others.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 December 2021.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

denied any thoughts of harm to himself or others.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VC before.

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

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

12 months.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

On 16 August, VC turned up at Highbury Hospital

wanting to speak to Dr Seedat. Instead he spoke to Ms Amanda Smilie. He told her he wanted to discuss with Dr Seedat whether there was an alternative explanation for the voices he heard. He asked whether staff on the ward heard voices and whether they communicated with artificial intelligence.

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

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

He said he had not been taking medication for days,

was not psychotic and never had been, and had no intention of seeing the EIP any longer. They were working in collaboration with the judicial system and had created technology to cause his voice experiences and monitor him.

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

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

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

On 3 September 2021 there was a further serious incident. VC assaulted a police officer, PC Barnaby Pritchard. A warrant had been obtained to detain VC

under section 135 of the Mental Health Act. Police attended to assist the medical professionals, Dr Lomas and Dr Manzar who were already at the address. VC was refusing to go with them. You will hear that PC Rachel Wakefield knocked on the door several times and VC opened the door. He refused to go. Dr Lomas explained to VC that he was required to go.

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

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

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

During the execution of the warrant, unused medication dating back to February 2021 was found at VC's flat.

VC was taken to the Queen's Medical Centre for treatment as a result of the taser deployment and then to the Cassidy Suite, a place of safety at Highbury Hospital. There a mental health assessment was undertaken that evening by Dr Lomas, Dr Manzar, and Approved Mental Health Professional Amy Staples. VC told the assessing team, politely it is noted, that "no assessment is going to happen" and they were "not going to admit him to any hospital or give him any medication".

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

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

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

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

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

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

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

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

and in light of their predominantly female staff.

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

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

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

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

Tribunal and appealed the following day.

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

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

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

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

Ms Birtles attended remotely VC's ward round on

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

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

The Tribunal meanwhile concluded:

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

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

provider rather than an out of area one.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

On 25 January there was an attempted home visit to

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

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

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

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

(12.56 pm)

(The lunch break)

(2.00 pm)

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

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

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

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

the assessors felt that further assessment was required given the lack of clear psychopathology currently, and the recommendation was detention under section 2.

Chair, given that the assessment team had in mind VC commencing depot medication, should that not have pointed them towards a section 3 admission which would have allowed for discharge with a Community Treatment Order and depot being a condition of the order? The Inquiry will explore this question and whether, quite aside from the issue of depot, a section 2 rather than section 3 admission was appropriate in circumstances where VC's diagnosis and treatment needs appeared relatively well-established and it was a little over three months since his last admission.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

was unhappy to have to collect medication weekly.

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

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

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

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

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

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

He was not confrontational and VC left when asked.

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

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

Chair, it will be a matter for you to determine

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Addresses for VC.

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

On 1 August 2018, an Ilkeston Road address was

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

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

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

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

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

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

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

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

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

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

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

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

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

Discharging VC to the GP, the discharge letter written by Sharon Heath, stated:

"Following a discussion in our [MDT] ... meeting on 22 September ... the decision has been made to discharge VC from our services due to non-engagement. No contact has been made with VC for a period of time ...."

That not being specified, Chair:

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

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

I turn now to following discharge between

23 September 2022 until 13 June.

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

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

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

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

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

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

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

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

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

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

On 5 May 2023 there was a further serious incident.

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

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

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

system.

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

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

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

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

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

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

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

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

David Sandall, the Temporary Chief Constable of

Leicestershire Police, will give evidence to the Inquiry in relation to the policies and procedures governing the officers' conduct and lessons learned by the force.

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

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

Chair, as I have set out, we will be hearing evidence and reviewing decisions made by the police, health professionals and the University in the period leading up to the attacks on 13 June. You will wish to consider what information was available to those working with VC, what information should have been available to

them and what should have happened if that information had been shared.

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

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

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

Following the chronological approach we have taken, and therefore completing the consideration of VC's treatment prior to 13 June, we turn now to the law on Mental Health Framework before moving to the attacks and the response of the police. The Mental Health Act 1983 contains provisions on the assessment, treatment and rights of those with a diagnosis or suspicion of a mental disorder, and its focus is the assessment and

treatment of detained patients. Its purpose is to ensure that those with severe mental illness receive necessary care and treatment, even in the absence of consent.

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

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

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

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

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

Fourth, purpose and effectiveness: decisions about

care and treatment should be appropriate to the patient, with clear therapeutic aims.

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

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

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

Where a patient lacks capacity to give or refuse consent to admission or treatment they are extremely unlikely to be admitted informally. A decision needs to be made as to whether detention ought to be pursuant to

the provisions of the Mental Health Act 1983 or whether instead reliance should be on the Mental Capacity Act and deprivation of liberty safeguards.

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

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

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

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

The Code of Practice states that section 2 should only be used if the full extent of the nature and degree of a patient's condition is unclear; there is need to carry out an initial in-patient assessment to formulate

a treatment plan, or to reach a judgment about whether the patient will accept treatment on a voluntary basis following admission; and if there is need to carry out a new in-patient assessment to re-formulate a treatment plan or reach a judgment as to whether a patient will accept treatment on a voluntary basis.

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

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

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

As we have set out, of VC's four admissions the

final two were both commenced as section 2 detentions. The third admission converted, during detention, to a section 3. The fourth admission was under section 2 throughout.

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

The Independent Review recommended that section 2 should only be used where it is truly necessary to assess someone, not because it is perceived as the least restrictive option. It recommended change to the Code of Practice to make clear that section 3 should be used where there has been a section 2 detention in the last 12 months. Where there has been a section 3 admission in the last 12 months, a material change should be demonstrated before an application under section 2 can be used.

If such an approach had been taken to VC, his fourth admission would certainly have been pursuant to section 3 given it was only three months following his third admission.

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

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

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

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

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

The Mental Health Act 2025.

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

Sir Simon Wessely has provided a witness statement

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

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

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

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

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

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

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

The Act does not explain what is meant by "serious

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

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

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

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

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

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

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

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

VC had initially consented to his community care

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

He went on to tell Ms Birtles that:

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

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

The starting point is that information provided by patients to clinicians is provided in confidence. Clinicians owe a common law duty to maintain that confidence. A breach of confidence is a breach of a duty of care and potentially of the patient's Article 8 rights and data protection legislation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Amongst the published questions to be addressed by

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

The context of this question is:

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

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

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

As to whether in general terms there is evidence of

an avoidance of the use of restrictive practices due to publicity in respect of mental health reforms, Dr Lade Smith, President of the Royal College of Psychiatrists, explains in her statement that recent statistics show that black people are four more times more likely than white people to be detained under the Mental Health Act, and eight times more likely to be placed under a CTO. The Royal College of Psychiatrists is not aware of any evidence about concerns about the disproportionate use of restrictive measures in respect of black patients impacts the approach taken by practitioners. There is no evidence that psychiatrists are not admitting patients because they are black. The rates of admission are the same as at the time of the publication of the independent review, and recent evidence shows that detentions are going up.

As to whether specifically in VC's case there is any evidence that restrictive practices were not used because he was black, this question has, in accordance with the published questions, been put to a significant number of the professionals who were dealing with him. The Inquiry may wish to consider further in oral evidence whether race was a factor in restrictive practices not being used as a result of publicity about mental health reforms in the period 2020 to 2022. The

evidence thus far received by the Inquiry does not suggest it was. It is to be observed that he was detained on four occasions, and five of his seven mental health assessments recommended detention.

Assessing risk (experts and professional opinion).

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

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

Dr Fazel will address the Inquiry on the various risk assessment tools that exist in this area. In his view, the use of such tools should be strongly encouraged. He considers that standardisation of tools would improve risk communication between services. He will say that training for clinicians working in general adult psychiatry in the risk assessment of violence is

currently limited and should be improved via, in his view, the Royal College of Psychiatrists.

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

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

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

In terms of how risk assessment should be done, he will highlight three main areas. First, taking

a comprehensive personal and clinical history that includes information about previous violence towards people, history of substance misuse, and triggers for any psychotic relapses. Such a history should aim for corroboration from informants and other sources where possible.

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

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

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

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

the Royal College of Psychiatrists in their 2016 guidance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

restrictive, principles of support.

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

(3.17 pm)

(Short Break)

(3.30 pm)

THE CHAIR: Yes, Ms Langdale.

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

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

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

You will hear from the Senior Investigating Officer,

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

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

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

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

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

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

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

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

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

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

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

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

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

attacks were preventable.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

By 4.09 am officers had asked for a CAT1 response

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

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

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

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

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

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

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

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

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

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

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

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

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

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

to the wider public as more information emerged.

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

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

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

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

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

The search for an attacker did not actually stop at that point. Other searches continued by officers and soon after by drone. These other searches were again principally focused towards the city centre.

A significant search occurred around Derby Road to the south following a report of a female shouting "Get off me", but it was ultimately not linked to VC. This search appears to have been coordinated by another officer and may bear comparison in its organisation with the response to the matters you are investigating, Chair.

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

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

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

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

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

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

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

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

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

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

The van attacks.

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

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

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

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

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

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

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

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

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

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

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

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

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

further threats.

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

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

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

Operation Hendrix.

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

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

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

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

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

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

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

Ensuring that effective engagement, communication

and support is provided to the affected families;

Providing reassurance to affected individuals and communities through an effective and proportionate support, engagement, media and communications plan;

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

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

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

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

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

with the media.

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

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

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

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

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

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

stage.

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

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

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

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

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

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

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

The record of Ms Bramley's assessment noted that VC was fit to be detained, did not require an appropriate adult but was not yet fit to be interviewed or fit to be charged, pending a period of rest following arrival. You will hear from Ms Bramley that VC refused to engage with the assessment. She says it was common practice for an initial rest period to be in place if a detainee presented with unusual behaviour, in order to allow time to assess the cause of that behaviour. It was for that reason, she says, VC was recorded as not yet fit to interview. Ms Bramley's assessment was completed by 8.12 am.

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

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

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

so that any psychiatric report could take into account any contemporaneous assessment?

At around 4 pm, Ms Draper, one of the Forensic Healthcare Professionals, attended VC for assessment. You will hear from Ms Draper an account similar to Ms Bramley's: that VC provided minimum engagement and she was unable to assess him properly. At this stage Ms Draper sought advice from the Liaison and Diversion Team as to whether a mental health assessment ought to be carried out.

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

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

taken even in the absence of consent. The justification given in respect of both was the need for forensic evidence to establish VC's involvement in the attacks which had taken place. Hand swabs, body mapping, nail scrapings and photographs were taken at 11.10 am on 13 June. DNA swabs and fingerprints were taken two hours later. No hair samples were taken.

Authorisation for the taking of an intimate sample, in the form of blood, was given later by Inspector Boylin at 3.50 pm. The blood sample was not for toxicology purposes but rather DNA profiling. Under section 62(1)(a) of the Police and Criminal Evidence Act 1984, an intimate sample could only be taken with VC's written consent. VC was asked later that evening, at about 9 pm, whether he would consent to a blood sample being taken. He refused and none was taken.

Detective Superintendent Sanders has given written evidence that a urine sample was authorised and VC's consent was sought for such a sample. This is currently an issue in dispute and should be clarified in oral evidence. Whilst the evidence recovery plan dated 13 June 2023 did mention the need for a urine sample, there is no evidence in the custody record that such a sample was ever authorised or requested.

Chair, you may wish to consider whether VC's

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

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

This is an issue that was raised directly with the police by Dr Kumar later in December. Dr Kumar asked in an email "can hair sampling be done of the defendant now to determine any drug use?" This issue became a prominent concern of both the O'Malley-Kumar and Webber families in December and into January 2024. This was not accepted by Detective Superintendent Sanders at the time. However, in his statement to the Inquiry, Detective Superintendent Sanders states that "it might have been better, with hindsight, simply to have taken head hair samples by force, to provide greater reassurance around the question whether controlled drugs were in VC's system or not."

In order to assist in respect of this issue, the Inquiry has sought expert evidence from

Professor Kim Woolf MBE, a senior academic and Director of King's Forensics at King's College London. Professor Woolf will give evidence as to the reliability of hair sampling and what it may or may not have been able to identify.

Across 14, 15 and 16 June, VC was interviewed by the police. He answered "no comment" to all questions of an evidential nature. During an interview on the night of 15 June 2023 VC was asked a number of questions about his mental health. This included questions about his previous admissions, voices in his head and why he felt he was the subject of government surveillance. He was formally charged with three counts of murder and three counts of attempted murder on 16 June. The following day he left Nottingham Custody Suite and made his first appearance at Nottingham Magistrates' Court.

4. CPS handling of the prosecution.

Chair, I turn now to the CPS handling of the prosecution.

Detective Superintendent Sanders contacted the Crown Prosecution Service via the Senior District Crown Prosecutor, Samantha Shallow, on the day of the attacks. Once it was established that the attack was not terror-related, it was decided that the case would be dealt with by the East Midlands Complex Casework Unit.

This unit typically deals with homicides involving multiple victims and cases attracting major media interest.

The key individuals that you will hear from within the CPS in addition to Ms Shallow will be the reviewing lawyer, a specialist prosecutor in the Complex Casework Unit, Mr Alan Murphy, and his line manager and the Deputy Head of the unit, Michelle Mannion. You will also hear from leading counsel for the prosecution, Karim Khalil KC.

This Inquiry is tasked by considering the handling by the CPS of the case between 13 June and the commencement of the sentencing hearing on 23 January. Whilst the issues that arise are varied, they will focus in particular on the charging decision and ultimate acceptance of pleas, as well as the communication with, and treatment of, the bereaved families and survivors throughout this period.

Charging decision and acceptance of pleas.

The day after the attack, on 14 June, Mr Murphy and Ms Shallow attended a briefing with police at Bradford Police Station at which the available evidence was presented and discussed. According to Mr Murphy, it was clear from the morning briefing that "mental health was undoubtedly going to be a feature of this case" and

there was reference to VC having been detained under the Mental Health Act, amongst other things.

As a result, Mr Murphy made the decision to retain the services of Dr Nigel Blackwood, a professor of forensic psychiatry at King's College London that same afternoon. You will hear oral evidence from Dr Blackwood about his instruction and the assessments that he made.

On the afternoon of 16 June Mr Murphy authorised that VC be charged with three offences of murder and three offences of attempted murder. In making the decision to charge he applied the threshold test under the Code for Crown Prosecutors. The threshold test allows for an immediate charging decision where evidence is outstanding in appropriate cases. Five conditions must be met before the test can be applied, namely:

There is insufficient evidence currently available to apply the evidential stage of the Full Code Test;

There are reasonable grounds for believing that further evidence will become available within a reasonable period;

The seriousness or the circumstances of the case justifies the making of an immediate charging decision;

There are continuing substantial grounds to object to bail in accordance with the Bail Act 1976;

In all the circumstances of the case it is proper to do so.

Moving forwards in time, once Mr Murphy received all of the evidence from the police he applied the Full Code Test on 2 October 2023. The Full Code Test under the Code for Crown Prosecutors has two-stages: (i) the evidential stage; followed by (ii), the public interest stage.

In relation to the evidential stage, prosecutors must be satisfied that there is sufficient evidence to provide a realistic prospect of conviction against each suspect on each charge. They must consider what the defence case may be and how it is likely to affect the prospects of conviction. A case which has not passed the evidential stage must not proceed no matter how serious or sensitive it may be.

In relation to the public interest stage, a prosecution will usually take place unless the prosecutor is satisfied that there are public interest factors tending against prosecution which outweigh those tending in favour. When considering the public interest stage the Code for Crown Prosecutors sets out a number of questions which the prosecutor should consider, including how serious the offence is, the level of culpability of the suspect and the impact on the

community.

The result was the same as the application of the Threshold Test. Mr Murphy was satisfied that the correct charges against VC at that stage were three offences of murder and three offences of attempted murder. How is it then that VC ultimately pleaded guilty to manslaughter on the basis of diminished responsibility?

On 2 October 2023 the CPS received the first defence psychiatric report from Dr McSweeney. The report stated that whilst VC was fit to plead and stand trial and that he was not insane, the partial defence of diminished responsibility was available to him.

In relation to the partial defence of diminished responsibility, CPS guidance explains the following:

"As the onus is on the defendant to establish diminished responsibility on the balance of probabilities, they are likely to need to obtain expert evidence in support. The prosecution will then review the case. In some cases it may not be necessary to obtain evidence from a further expert, because the defence expert evidence (on paper, or when challenged in cross-examination) is unlikely to substantiate the defence. More usually the prosecution will need to obtain evidence from a further expert."

The guidance continues thus:

"As part of the ongoing duty of review, the prosecution will further review the case. In doing so, it should be borne in mind that the jury is not bound to accept medical evidence and that the evidence, especially when tested through cross-examination, may not meet the elements of diminished responsibility."

Dr Blackwood had already been retained by Mr Murphy to provide that further expert report on behalf of the prosecution. You will hear that he had been provided with documentation about the case as early as July 2023, before being sent Dr McSweeney's report.

Mr Murphy sent final written instructions to Dr Blackwood on 5 October 2023. The instructions noted the prosecution's concerns relating to VC's text message to his brother which appeared to show an awareness of the attacks, and his apparent ability to exercise self-control at the time he attempted to break into Seely Hirst House.

By this stage VC had not consented to the prosecution accessing his full medical records but these were subsequently provided to Dr Blackwood on 14 November 2023. You will hear that Mr Murphy continued to provide Dr Blackwood with further evidence as it became available.

Chair, you may wish to consider the content of Dr Blackwood's instructions and the material provided to him. In particular, you may wish to consider whether further issues should have been raised with Dr Blackwood at this stage.

In preparing his report, Dr Blackwood interviewed VC at Ashworth Hospital for five hours. VC told him that he had experimented with cannabis on one occasion when he was a student at Nottingham University. Dr Blackwood was aware that toxicology was not available from the time VC was in police custody and urinary drug screening was not conducted on remand into prison. Dr Blackwood considered such information would have been helpful but the clinical picture was of a major mental illness with an onset and course unrelated to substance misuse.

Was Dr Blackwood provided with all of the information about VC and any possible links to illegal drugs?

On 21 October 2023, Mr Murphy received Dr Blackwood's report which also concluded that the partial defence of diminished responsibility was available to VC.

You will hear that on 23 November 2023 the first two psychiatric reports were discussed in conference with leading and junior counsel before Mr Murphy conducted

a full review of the case.

At that point the prosecution's view was that these two reports provided evidence to support the partial defence of diminished responsibility and that, subject to anything contrary in a third report, if pleas were offered on that basis they would be accepted.

On 24 November 2023, a second defence report was also available from Dr Shaffiulha, who similarly concluded the partial defence was available to VC.

On the same day there was a meeting between the prosecution team and the O'Malley-Kumar and Webber families. Also in attendance was Julian Hendy from the Hundred Families organisation at the request of the bereaved families. You will hear that both bereaved families were opposed to the CPS accepting pleas to manslaughter on the grounds of diminished responsibility.

Following the meeting, Dr Kumar contacted Detective Superintendent Leigh Sanders to highlight concerns in relation to the psychiatric reports, particularly in relation to VC's presentation on 13 June. The Inquiry will consider these concerns and whether delay in carrying out psychiatric assessments may have impacted the accuracy of the assessments.

Following these concerns, the CPS decided to

instruct a fourth expert, Dr Latham, and a letter of instruction was sent to him on 27 November 2023. Dr Latham will similarly be giving evidence to this Inquiry.

The instructions referred to concerns raised by Dr Kumar, and the new expert was asked to consider the three available psychiatric reports and evidence in the case, particularly regarding VC's presentation on 12 and 13 June, and to provide an expert opinion as to whether the conclusions reached by the psychiatrist on the issue of diminished responsibility had been properly reached.

He was also asked if he was able, in the absence of an interview with VC, to provide an expert opinion on whether at the time of the offences VC's mental health was such that he had available to him the partial defence. Following those instructions, you will hear that Mr Murphy also sent Dr Latham an email from Dr Kumar raising a number of discrete points so they could also be addressed in his report.

Chair, you may wish to consider the content of Dr Latham's instructions and the manner in which concerns from the bereaved families were put to him. Should he have seen VC and conducted a further independent assessment? By that stage VC had already been assessed in person by three expert psychiatrists.

Should the prosecution experts have met with or interviewed the survivors of the attacks, the bereaved families or the family of VC to inform their reports? This was something that was raised by the O'Malley-Kumar and Webber families.

Are there improvements that might be made to improve the rigour of these kinds of reports, even if they are not presently adopted, including speaking with third parties in order to better test the account given by a defendant?

After Dr Latham's report was received by the CPS, prosecution counsel was asked to provide advice concerning the acceptance of pleas and did so on Saturday 16 December 2023.

You will hear counsel advised the evidential test in the Code for Crown Prosecutors was no longer met in respect of the counts of murder. In those circumstances the pleas to manslaughter should be accepted.

The next day, Mr Murphy conducted a further review of the case. The Code for Crown Prosecutors sets out the responsibilities of the CPS in considering whether to accept guilty pleas to a less serious offence. The following aspects of the Code are of particular relevance:

Paragraph 4.1 of the Code states that prosecutors

must only start or continue a prosecution when the case has passed both stages of the Full Code Test;

As previously discussed, in relation to the charging decision, paragraph 4.6 states that a case which has not passed the evidential stage must not proceed no matter how serious or sensitive it may be;

Paragraph 4.7 states that the finding that there is a realistic prospect of conviction is based on the prosecutor's objective assessment of the evidence, including the impact of any defence and any other information that the suspect has put forward or on which they might rely. It means that an objective, impartial and reasonable jury or bench of magistrates or a judge hearing a case alone, properly directed and acting in accordance with the law, is more likely than not to convict the defendant of the charge alleged. This is a different test from the one that the criminal courts themselves must apply. A court may only convict if it is sure that a defendant is guilty;

By contrast, where the court passes the evidential stage, paragraph 9.5 of the Code states that "in considering whether the pleas offered are acceptable, prosecutors should ensure that the interests and, where possible, the views of the victim or, in appropriate cases, the views of the victim's family, are taken into

account when deciding whether it is in the public interest to accept the plea. However, the decision rests with the prosecutor."

The decision in this case was therefore an evidential one rather than a public interest one and, as a result, was a decision which rested entirely with the prosecution as a question of law to be determined with reference to the evidence.

Chair, you will be taken to the applicable CPS guidance on prosecutor homicide and on accepting pleas, in reviewing these decisions and, in particular, how the psychiatric evidence is to be used and assessed. You may wish to consider whether the process adopted by the prosecution complied with those policies and best practice; furthermore, whether there is or can be any role that victims and families of the bereaved may usefully play in such a process now or in the future.

We have touched upon some concerns raised by the families in respect of the expert evidence. I will now address the prosecution's communication with and treatment of the families and survivors more broadly during the course of the prosecution.

As a matter of policy, the Code of Practice for victims of crime, known as the Victims' Code, sets out the services and a minimum standard for these services

that must be provided to victims of crime by organisations including the CPS. The Victims' Code contains 12 rights which apply in different circumstances.

The rights engaged in this case included the right to be able to understand and be understood; the right to have services and support tailored to your needs, such as special measures at court; the right to be provided with information about the investigation and prosecution; the right to make a victim personal statement; the right to be given information about the trial, trial process and role as a witness; the right to be given information about the outcome of the case and any appeals; and the right to be able to make a complaint.

In addition to the rights provided in the Victims' Code, the CPS offers an enhanced service to bereaved family set out in the bereaved families scheme. A key aspect of this service is that the CPS will offer to meet bereaved families at key stages of the criminal justice system process to explain the anticipated progress of the case, what is expected to happen at each court hearing and the possible sentences available for the offences charged.

In addition, bereaved families are entitled to have

a Family Liaison Officer, known as an FLO, assigned where appropriate. The FLO will also act as the point of contact for communicating prosecution decisions to the family.

Under the scheme the CPS is required to write to families within ten days of a charging decision, setting out the reasons for the decision, to explain why a suspect has or has not been charged and the specific nature of the charges. In addition, in cases where a charge is substantially altered, for example in circumstances where the prosecution accepts pleas to a lesser offence, the CPS will write to the bereaved family within one day explaining the decision and offering a meeting.

You will hear that each of the bereaved family groups, as well as the survivors, were allocated an FLO, or in some cases two, who acted as the conduit between them and the prosecution. You will hear oral evidence from the Family Liaison Advisor, Detective Chief Inspector Claire Gould, who appointed those officers and who coordinated their deployments.

You will also hear from one of the FLOs, DC Raj Johal. You will also hear about the CPS' engagement through correspondence and face-to-face meetings.

An important consideration may in due course be

whether the role of an FLO, which is governed by the College of Policing's Authorised Professional Practice for Family Liaison and is primarily a police investigator, is suited to act as a conduit between the CPS and the families or survivors. Might, for example, an additional dedicated CPS officer be more suited to that role in the most serious or legally complex cases? Is a police investigator best placed to give advice on, for example, the issue of diminished responsibility?

The issues arising.

Initial contact was made with the bereaved families in the form of a letter dated 16 June from the Chief Crown Prosecutor, Suzanne Llewellyn. The letters offered meetings at the first appearance at Nottingham Magistrates' Court on Saturday, 17 June 2023, the preliminary hearing at Nottingham Crown Court on 20 June 2023, or at any point thereafter.

Although the bereaved family scheme does not specifically apply to the survivors of the attacks on 13 June, you will hear that the scheme was explained to the survivors who confirmed that they did not wish to meet the prosecutor at that stage and if they changed their minds they would inform the FLO.

While none of the bereaved family members or survivors attended the first appearance, the family of

Ian Coates attended the preliminary hearing on 20 June 2023 and spoke to Mr Murphy and junior prosecution counsel.

On 4 July 2023 the CPS was notified that the O'Malley-Kumar family would like to meet the prosecutor/prosecution counsel. No meeting took place over the summer in 2023 and on 2 October 2023 the FLOs informed the CPS that the O'Malley-Kumar and Webber families did not intend to attend the pre-trial and preparation hearing and did not feel able to hear any level of detail relating to the attack on 13 June at that point.

On the same day the defence representatives for VC served their first psychiatric report. This was a key moment in the case as it made clear for the first time what the likely issues concerning diminished responsibility were going to be.

On the same day the report was sent to the police with the request from Mr Murphy to let the FLOs know so they could inform the bereaved families. You will hear that the CPS did not suggest a form of words to be passed to the bereaved families or survivors in relation to the communication of this significant issue.

Chair, you may wish to consider whether it may have been helpful for the FLOs to have specific wording to

support that discussion and whether communication could have been improved in this respect.

On 13 November 2023 the CPS was informed that the Webber family had requested a remote meeting to discuss the issue of diminished responsibility and it later became clear the O'Malley-Kumar family wanted to join the meeting.

Shortly before the meeting on 22 November, the police explained to the CPS that at this stage the Coates family did not wish to meet with the CPS specifically. However, it should be noted that the family of Ian Coates was not invited to the meeting on 24 November 2023.

By the time of that meeting the prosecution was in receipt of the expert report from Dr Blackwood which similarly concluded that the partial defence of diminished responsibility was available.

The meeting on 24 November 2023 was attended by leading counsel. You will hear from Mr Khalil KC the matters that were discussed, including that the CPS intended to accept pleas to manslaughter on grounds of diminished responsibility and the possible sentencing options.

On the same day the family of Ian Coates and the survivors were informed of the intention to accept

pleas.

Following the meeting, as we have already set out, concerns were raised by the Webber and O'Malley-Kumar families, and Dr Kumar in particular, about the psychiatric evidence, including in relation to the focus on VC's mental state a considerable time after the attacks took place.

The plea and trial preparation hearing ultimately took place on 28 November 2023. At that hearing VC entered guilty pleas to three counts of manslaughter on the grounds of diminished responsibility and three counts of attempted murder. A meeting took place between the prosecution team, including Mr Khalil KC, the O'Malley-Kumar family and the family of Mr Coates.

You will hear that, following the final decision to accept pleas to manslaughter on the grounds of diminished responsibility, on 17 December a letter was sent to the bereaved families by the Chief Crown Prosecutor, Janine McKinney, which was delivered by the FLOs on 19 December.

The next day the O'Malley-Kumar family requested a further meeting with Mr Khalil KC in the new year. A similar request was received from the Webber family. A meeting took place on 15 January 2024. You will hear from the families that the families were concerned about

the tone of the meeting with leading prosecution counsel.

From 23 to 25 January the sentencing hearing took place at Nottingham Crown Court. Professor Blackwood, Professor McSweeney and Dr Ross Mirvis gave oral evidence and were cross-examined. Dr Mirvis, who continued to treat VC, will give oral evidence to this Inquiry.

During the course of the sentencing hearing the prosecution met with the family of Ian Coates and, following the conclusion of the hearing, the family of Wayne Birkett. Following the hearing the Chief Crown Prosecutor wrote to the bereaved families to offer another meeting.

As referred to earlier, the HMCPSI report recommended that the CPS undertake a review of all guidance relating to victims engagement to ensure that all staff are aware when the use of the terms "consult" or "consultation" is appropriate. You will hear that a review of CPS published guidance was completed in October 2024 and identified eight instances in which those terms were used when referring to engagement with victims or bereaved families around the legal decision-making in a case.

The Inquiry will build on this recommendation and

consider whether any further steps could or should be taken to improve communication with and treatment of victims and bereaved families.

THE CHAIR: I'm just looking at the remainder, Ms Langdale. If we sat until 5 o'clock would you be able to finish, do you think?

MS LANGDALE: I think so, yes.

5. Unauthorised access.

Moving now please, Chair, to unauthorised access.

We set out at the beginning of this opening how the brutal attacks of VC took lives and changed others forever. However, it is not only the attacks by VC that have caused harm to the families of the deceased and to the survivors. The actions of some officers and officials inappropriately accessing sensitive footage and information relating to the attacks after the events has caused real additional harm. Chair, you may think why anyone would unnecessarily access such distressing information beggars belief.

You will hear about officers and staff from Nottinghamshire Police, His Majesty's Courts and Tribunals Service, His Majesty's Prison and Probation Service and Nottingham City Council accessing material or disclosing information that they should not have been.

Nottinghamshire Police.

Within Nottinghamshire Police a number of individuals accessed case material without a proper purpose. Details of the attacks were also referred to in inappropriate telephone messaging with fellow officers and unrelated third parties. You will hear evidence from Superintendent Kathryn Craner, the head of the Professional Standards Directorate for Nottinghamshire Police, who will set out the detail of their investigations.

Superintendent Craner will give evidence which describes Nottinghamshire Police's acceptable use policy and generic security operating policy in relation to the holding and viewing of sensitive material. This includes a rule that officers and staff are only authorised to access, browse, use or disclose police information in the course of their official duties and for policing business purposes only. This was breached by several officers.

An initial audit scoping identified PC Matthew Gell, an officer who had had previous interactions with VC in 2022, as someone who had inappropriately accessed the NICHE computer records after the attacks on 15 June 2023. It was subsequently established that he sent a message to an associate who did not work in

policing indicating that the attacks by VC had been declared as a terrorist attack.

PC Gell was also party to a WhatsApp group in which a message was sent by another officer describing the attacks in graphic terms.

A subsequent investigation found that the original message was sent by an officer to pre-warn colleagues within the group using inappropriate language and PC Gell had wrongly forwarded it to his wife and an officer in another force. PC Gell was later the subject of a gross misconduct hearing and found to have committed gross misconduct. He received a two year final warning. You will hear from PC Gell in respect of this incident. You will also hear written evidence from a witness, Faye Tomlinson, who raises concerns about the transparency of the disciplinary proceedings.

Following further investigations the police standards department established that VC's record on the NICHE computer system had been accessed 381 times by 179 members of Nottinghamshire Police between 13 June 2023 and 16 June 2023. Of course a proportion of those will have been legitimate, but 22 individuals were identified as causing the most concern. Following further inquiries the access of 10 of the 22 individuals was found to be for a policing further. Out of the

remaining 12, various actions were taken by Nottinghamshire Police which included giving employees advice on accessing records, conducting intervention, putting notes on their vetting files, issuing negative performance records, or initiating misconduct processes.

In respect of the most serious of these cases one police staff member received a criminal caution for an offence contrary to the Computer Misuse Act 1990 following admissions that she had accessed numerous cases, including information about VC, without a policing purpose. She was also found to have committed gross misconduct and her employment was terminated.

A special constable had watched body-worn video of the aftermath of the attacks, including treatment of victims at the scene. He had also conducted other research on the policing system. The constable resigned, was the subject of an accelerated misconduct hearing and placed on a barred list in respect of future employment.

Chair, you will hear that the special constable admitted watching the body-worn video footage and that is how it came to be known to the police. Apparently there was no specific audit carried out by Nottinghamshire Police to establish whether anyone had

viewed body-worn footage or CCTV footage without a policing purpose. It appears that the audit in fact may have been aimed at identifying officers who may have leaked certain information about VC to the media, focused on VC's records rather than being carried out as a matter of concern for the families of the deceased or the survivors.

Was enough done to establish and discipline officers and employees who had accessed video footage? As I have already indicated, the Inquiry will also investigate whether sufficient and timely information of wrongdoing was provided to the family and the survivors.

Moving on to His Majesty's Courts and Tribunal Services and His Majesty's Prison and Probation Service, you will hear oral evidence from Amy Holmes, the interim Director General for the Chief Operating Group of the Ministry of Justice. Ms Holmes will explain how case material is held on the Crown Court case digital system and is accessible to certain staff members from HMCTS and HMPPS.

You will hear how the digital case system allows multiple parties to upload and access digital case information. Ms Holmes will explain the policies and procedures that govern the use of the system, including having users' access scrutinised by access coordinators

within HMCTS and online guidance provided to users.

CCTV and other video footage cannot be held on the digital case system and instead is shared via secure digital evidence management solutions which is managed by the police or the CPS with links to that system uploaded onto the digital case system.

You will hear how staff from both HMPPS and HMCTS are understood to have accessed evidence inappropriately and without authorisation. Ms Holmes will explain how each agency was notified of this and how investigations were carried out thereafter.

Starting with the Probation Service on 25 January 2024, the Crown Court Senior Probation Officer was contacted by the delivery manager at Nottingham Crown Court regarding inappropriate access by one member of staff. The investigation that followed identified 11 individuals who were questioned, with one being quickly discounted from the investigation. Of the remaining ten staff members, three staff members did not have clear grounds to access the material. They were all relatively new staff members and were dealt with by having individual conversations. A specific counter-corruption briefing was delivered to all probation staff at Nottingham Crown Court. This has not to date led to any charges being brought by the police.

In light of the discovery regarding probation staff, the delivery manager at Nottingham Crown Court caused an investigation to be carried out by HMCTS counter-fraud team into inappropriate access by court staff. This identified three members of court staff being identified as having inappropriately accessed the court file: a crown court clerk and an usher from Nottingham Crown Court and an administrative officer in a wholly different crown court in Lewes. These cases were submitted to the South East Regional Organised Crime Unit and the police respectively.

Disciplinary action was instigated against two employees who are now no longer working for HMCTS and the third resigned shortly after the inappropriate access was identified.

How is it that court staff members, including from a court that has no link to the attacks whatsoever, managed to access the material? You will hear about invitation-only functionality, Chair and how it should have been applied earlier in this case. Most importantly, what can be done to build in more automatic or wider limitations in the future? Again, this Inquiry will also investigate whether sufficient and timely information was provided to the families and survivors.

Nottingham City Council.

There was also unauthorised access from within Nottingham City Council. You will hear from Colin Wilderspin, the Strategic Director of Communities for Nottingham City Council. He will set out the policies relevant to the use of those systems, such as the data protection policy and IT acceptable use policy, and training on the General Data Protection Regulations and information security.

He will explain that the Council has an anti-social behaviour team who work closely with the police and who have access to the police's own NICHE system. Three officers from that team accessed information in this case. The Council understands that this was done in two cases with a genuine intention and also a professional curiosity to seek to identify risks arising to the public and also personally. In a third case the access is said to have been inadvertent and immediately closed down. In all three cases the information related to VC rather than the victims. This was subject to a police investigation and the officers were spoken to by the anticorruption team and a warning placed on their HR files.

Nottingham University Hospital's NHS Trust.

The Trust is an acute NHS Trust which provides services, including an A&E, to Nottingham and the

surrounding area. It features in this Inquiry not because it treated VC but because it provided treatment to the victims of his attacks.

You, Chair, will hear that in October 2024 the Trust became aware of potential unauthorised access by its staff of the medical records of Barney and Grace and subsequently unauthorised access of the records of surviving victims of VC's attacks. You will hear evidence from Dr Manjeet Shehmar, Medical Director at Nottingham University Hospital's NHS Trust, about the process the Trust has adopted to investigate the issue of unauthorised access. The Inquiry understands the investigation to be ongoing. At least 47 staff have been referred to a formal investigative process by the Trust to scrutinise their access of records after a first level review failed to determine that their access was legitimate.

In her written evidence Dr Shehmar maintains that the Trust has acted appropriately since becoming aware of the potential unauthorised access of medical records, in the steps it has taken to investigate the unauthorised access and in its communications with the bereaved families and surviving victims.

You will hear from the bereaved families and surviving victims that that has not been their

experience. In their written evidence Dr Sanjoy Kumar and Dr Sinead O'Malley-Kumar have raised their concerns about the adequacy of the investigation conducted by the Trust. They also describe the lack of candour and transparency of the Trust, sentiments echoed by Emma and James Webber; Lee, Darren and James Coates; and Sharon Miller in their respective evidence.

Chair, the public may be surprised to hear that information originating from the police can be accessed by those with no legitimate need to see it. It can, we will see, be accessed by a curious court clerk in a different town, or a council officer who has access to a police computer. This Inquiry will investigate what has gone wrong and, importantly, what might be done to ensure inappropriate accessing of police information cannot happen in the future.

You may also wish to consider the adequacy of the investigations that Nottingham University Hospital's NHS Trust has undertaken into unauthorised access of medical records.

You may also wish to consider whether there has been any failings in candour and transparency in the Trust's communication with the bereaved families and the surviving victims in respect of this.

6. Governance and wider canvas.

Finally, Chair, I move to governance and wider canvas. The clinicians, nurses and other Health Care Professionals who interacted with VC did not operate in a vacuum. The policies and procedures they followed, the training they received, the resources available to them and crucially the culture in which they worked were at least in part organisational and influenced by leadership.

The Inquiry will be examining whether the leadership and management of the Nottinghamshire Healthcare NHS Foundation Trust contributed to failings in how VC was treated and managed prior to 13 June. The Trust provides in-patient and community mental health care, high security forensic services and general community healthcare across Nottinghamshire and parts of neighbouring counties. As an NHS Foundation Trust it has a certain degree of financial and operational independence from NHS England and Central Government.

Like all Foundation Trusts, Nottinghamshire Healthcare is led by a board of directors comprising executive directors, including a chief executive, and non-executive directors, including a Chair. The board of directors exercises its functions through board meetings, delegation of certain powers to executive directors and a set of sub-committees. These

sub-committees include a quality committee whose function is to set, monitor and scrutinise patient safety standards across the Trust, including clinical risk and patient safety. The board of directors is accountable to a council of governors.

Chair, you will hear oral evidence from a number of current and former executive and non-executive directors of the Trust. This includes John Brewin, the Chief Executive Officer of the Trust from January 2019 to August 2022. You may note, Chair, that period covers all but the final month of VC's treatment at the Trust, VC being discharged into the care of his GP in September 2022.

In his statement to the Inquiry Mr Brewin describes his impression on joining the Trust that the executive and the board were not functioning optimally and that management and governance structures were impeding effective communication between staff and senior management. You will hear from Mr Brewin about the efforts which were made to improve governance of the Trust during his tenure and the challenges which remained. You will hear from Mr Brewin that issues such as the increasing acuity of admissions and staffing levels were a regular topic of discussion between executives.

Similar statements are made in the written evidence of other former and current senior management at the Trust, all of whom will be giving oral evidence.

Paul Devlin, Chair of the Trust from January 2020 to December, says he had realised there were issues with the culture of the board shortly before he joined.

Dr Susan Elcock, Executive Medical Director at the Trust since May 2021, and Deputy Chief Executive Officer since October 2023, describes a lack of cohesive model for governance across the Trust until divisional restructuring in 2022.

Ann-Marie Newham, Executive Director of Nursing at the Trust from January 2020 to August 2022 and subsequently interim and then Deputy Chief Executive Officer describes noticing issues with the reporting lines to her and the size of the quality team on joining.

The current Chief Executive Officer of the Trust, Iftikihar Majid, addresses a number of operational governance changes he made after joining the Trust in December 2022.

Diane Hull, the current Chief Nurse of the Trust, says it was apparent to her soon after starting her post in July 2023 that the nursing directorate needed to restructure to enable her to drive the quality, safety

experience agenda to support the Trust in making the improvements required.

Each of these individuals describes changes to governance at the Trust which were implemented during their tenure: reorganisation of the divisions in the Trust, the adding and deletion of leadership posts and the creation of new governance groups along with the consolidation of others.

The NHS is no stranger to organisational upheaval. You, Chair, may wish to consider the extent to which these changes met the challenges faced by the Trust and delivered any improvement to the mental health services provided by it.

You will also hear from Mr Brewin, Mr Devlin and Ms Newham as to the profound impact that the COVID-19 pandemic had on the Trust in terms of the ability of the Trust to deliver quality and governance improvements, but also in its day-to-day operations.

Mr Brewin describes in his written evidence that staffing was an increasing and ongoing issue at the Trust ever since he started his role, particularly in in-patient areas, and this was exacerbated by the pandemic.

A similar picture is described in relation to the use of out of area placements, an enduring issue for

the Trust. It was a national outlier which worsened during the pandemic.

Issues with governance were borne out in successive CQC inspections of the Trust. In May 2019 the CQC published the report of its inspection of the Trust. That inspection was carried out between January to March 2019. The overall rating for the Trust was "Requires improvement". This was a downgrade from its previous rating of "Good". The Trust's provision of acute adult wards and psychiatric intensive care units was rated as "Inadequate". In its inspection of those wards the CQC found there was inconsistency and lapses in governance; risk and safety were not always well managed; some patient records inspected were found to contain no risk assessment; others were found to contain inadequate risk assessments; issues were also identified with staffing levels and bed availability.

Further focused inspections of the Trust were carried out in 2020, 2021 and 2022. This included a reinspection of acute adult wards and psychiatric intensive care units from 19 to 29 July 2020. One of the wards inspected was Rowan 1 ward where VC was detained at the time. The service overall was rated as "Requires improvement", though the "Safe" and "Well-led" domains of the inspections both attracted an

"Inadequate" rating.

The Trust rating remains "Requires improvement" following a CQC inspection in March and April 2022. Issues with inadequate staffing levels were identified. The Trust was directed to embed governance structures across all divisions.

The CQC rapid review of mental health services at the Trust in March 2024, directed by the Secretary of State for Health and Social Care following VC's conviction, did not demonstrate improvement. The CQC identified staffing and leadership as enduring areas of concern. Actions by leadership to address safety concerns was found to be reactive rather than proactive. Staff approach to risk assessment and risk management was considered inadequate. Issues with staffing levels were again noted.

Finally, last month came the latest CQC inspection: a "Well-led" assessment of the Trust. The rating was again "Requires improvement", just as it was in January 2019.

You, Chair, may wish to consider whether the findings of the CQC since 2019 demonstrate a persistent failure of governance at the Trust and, if so, why has this occurred?

Of particular interest to the Inquiry is how patient

safety incidents, particularly those involving violence from patients, were identified, investigated and responded to at the Trust. How did and does the Trust learn from serious incidents and deaths?

The lists of groups within the Trust which previously had or currently have at least some responsibility in this area is a long one. They include the Quality Committee, the Serious Incident Review Group, the Patient Safety and Learning From Deaths Group, the Risk Group, the Quality Oversight Group, the Homicides, Attempted Homicides and Complex Incidents Group, Rapid Improvement Groups, Care Groups and the Police Liaison Operational Group.

Problems with the Trust's safety processes were in fact identified prior to the attacks committed by VC. In early 2023, the Trust's executive leadership team became concerned about a growing volume of serious incidents and prevention of future death reports. As a result, the Trust commissioned an independent evaluation of trust safety processes which was not completed until early 2024.

The evaluation concluded that there was a lack of trust-wide quality improvement projects addressing a number of repetitive problems within the Trust, those repetitive problems including crisis planning and

regular review, staffing recruitment, retention, capacity and demand, falsification of observation records, triage of referral, clinical risk assessment and regular review, communication and record keeping. The Trust has accepted these findings.

You, Chair, may find it striking how similar this list of so-called repetitive problems is to the set of issues raised by the care provided to VC by the Trust. You may ask why these problems at the Trust have been repetitive.

The Trust subsequently commissioned a thematic review of homicides and attempted homicides to review the reports which had been completed for serious incidents involving homicide or attempted homicide by the Trust's patients from 2019 to 2023. This included the case of VC.

The review panel considered there was a number of things which emerged from the incidents: poor engagement by patients, a lack of follow up, risk assessment which failed to consider risks to the wider public, delays and waits in patients being seen and a lack of multi-agency working and information sharing.

In respect of the incident reporting process itself, the review found a lack of engagement with families. Final reports were not completed in a timely manner.

Two reports were found to be of such poor quality that the review panel felt they should be reconsidered in their entirety. Again, the Trust accepted the findings of the review.

When asking questions about the Trust's failure to learn from the past on earlier or strikingly similar cases, we should make it clear, Chair, that the Inquiry team will not be descending into the detail of other cases. We will ask about those cases insofar as is necessary at a very high level to enable you to understand what impact earlier cases did or did not have on governance and improvement.

You, Chair, may wish to consider whether failures in the Trust governance processes for serious incidents and failures by the Trust to learn from previous incidents contributed to any issues in the care provided to VC.

Evidence regarding the wider canvas.

Chair, the Inquiry has obtained evidence that goes beyond the circumstances of VC's care in Nottingham and considers the picture nationally and historically in respect of similar cases and their impact. What do other cases indicate about lessons that should be learned?

As I have already said, the Inquiry will hear evidence from Julian Hendy. He is a documentary film

maker and investigative journalist. He is the founder and Chief Executive of the Hundred Families charity. He founded the charity after his father was murdered in Bristol in 2007 by a psychotic man with a documented history of serious mental illness, drug abuse and violence. He has worked tirelessly since then investigating the issue of mental health related homicides, compiling information, data and reports and supporting families that have experienced tragedies in circumstances similar to his own, including the Nottingham families.

Mr Hendy will provide a valuable and much needed insight into the concerns he and the families he works with have in this area. These include transparency of NHS investigations, an absence of clinical focus on public protection, failures by psychiatric services to pick up cases of masked compliance, a lack of assertive care when patients do not recognise their illness and/or decline to take medication, a misunderstanding of confidentiality and data sharing requirements by clinicians and Trusts, and a need for wider use of CTOs.

Mr Hendy has supported many families through court and Mental Health Tribunal proceedings. As regards the former, he will express the concern of families at the use of hospital orders. He will give evidence that

families consistently see a greater role for hybrid orders.

As to Mental Health Tribunals, he will tell the Inquiry of the work he has done to try and achieve greater transparency in respect of their decision-making and greater regard for family concerns.

Underlining all of Mr Hendy's evidence to the Inquiry is the view that family voices often get lost in the various clinical and justice processes and that is to the detriment of public safety and proper treatment.

The questionnaire.

The Nottingham Inquiry questionnaire was published on 22 May 2025. The Inquiry invited those who had been impacted by mental health homicides, whether through friends or family, to assist the Inquiry with their information, insights and experiences. There were 64 completed responses relating to 40 separate attacks between 2003 and 2024. Independent reports in relation to these attacks have been obtained and analysed where they are available.

Further to the questionnaire, the Inquiry legal team have obtained and scrutinised publicly available independent investigation reports into mental health homicides in England and Wales since the Clunis report in 1994.

As a result of this, the Inquiry's work on the questionnaire and its analysis of publicly available investigation reports, the Inquiry will have the benefit of the analysis of hundreds of publicly available independent investigation reports from recent decades. These reports have been analysed in order to extract recurring patterns, themes and failures in mental health related homicides. This analysis will be presented to the Inquiry in the latter stages of the hearing to provide you, Chair, with a broader canvas of cases from which to make any recommendations.

The Inquiry analysis shows that across all regions weak discharge planning is one of the most common factors in mental health related homicides.
A significant number of cases show either no discharge plan or an inadequate discharge plan. Other failings that the Inquiry legal team have identified as common in other reports are failures in governance, audit, supervisions and risk assessment, weaknesses in risk assessment and failures to engage families. Diagnostic uncertainty and non-concordance with medication are also common findings.

The analysis appears to show that the same recommendations are made time and again, suggesting a worrying trend of failing to learn from the horror and

personal tragedies that each of these cases represents.

Finally, Chair, the terms of reference require you to provide recommendations to ensure lessons are learned and to prevent similar attacks in the future. We have outlined throughout this opening issues that may lead to recommendations and undoubtedly more about these areas, and others, will emerge in the course of the Inquiry. It is, therefore, most appropriate to leave the question of recommendations to the end of the evidence.

THE CHAIR: Thank you, Ms Langdale.

We will finish there for today and I am grateful to everybody for staying a bit late, but it is important that we heard counsel's opening in one go.

We will start tomorrow, again at 10 o'clock, with the opening statements by the Core Participants. I think Mr Moloney, you are first. Thank you.

(5.03 pm)

(The hearing adjourned until 10.00 am on Tuesday, 24 February 2026)

I N D E X