(1.59 pm)

THE CHAIR: Yes, Mr Beer.

Statement on behalf of Nottingham Healthcare Trust

by MR BEER KC

MR BEER: I speak on behalf of the Trust. The events of 13 June 2023 had, and will continue to have a profound and enduring impact on many people, but above all on the families and friends of Ian Coates, Grace O'Malley-Kumar and Barney Webber who tragically lost their lives and upon Wayne Birkett, Marcin Gawronski and Sharon Miller who sustained life-threatening injuries.

The Trust remains deeply moved by the grief and anguish of those most seriously affected. It recognises that in the years preceding these tragic events there were opportunities that could have been identified, seized and acted upon differently and for this the Trust is profoundly sorry.

Looking back now, the Trust also recognises that its engagement with the families of those involved could and should have been better. Whilst its most important apology is rightly directed to VC's victims and their families, the Trust also acknowledges the profound impact of these events on VC's own family, on the wider communities that the Trust serves and upon the staff who cared for and treated VC. Many of those staff will give

evidence to this Inquiry. Many continue to carry the emotional weight of these events.

The Trust hopes that this Inquiry concludes with clear, enduring, national recommendations, the implementation of which will truly minimise the risk of events like these ever happening again.

The Trust approaches the Inquiry with openness, transparency and a sincere desire to support the process. It sees this as an opportunity to contribute to improvements not only locally but across mental health services nationally.

The Trust has disclosed about 11,000 documents to the Inquiry. Approximately 160 of its staff, current, former and agency staff, have provided written evidence to the Inquiry. The Trust has not sought anonymity, or Restriction Orders for any member of its staff. The Trust did not seek to argue that these proceedings or any part of them should not be live streamed. It has supported a transparent and publicly accessible process.

Since June 2023, three significant health focused investigations have examined VC's conduct, his care and treatment. The Trust level 2 comprehensive serious incident investigation was the first of them, externally chaired with the support of psychological approaches, concluding on 15 March 2024 with ten recommendations.

Secondly, the CQC's section 48 investigation concluding in three parts, the third part of which was released in August 2024, focusing specifically on VC and making nine recommendations.

The NHS commissioned independent homicide investigation, conducted by Theemis, and concluding in January 2025 with 12 recommendations.

The Trust has been committed to learning from each investigation and to responding to the regulatory actions. It has commissioned additionally internal reviews, including a serious incident review and reviews of the EIP team, crisis services, local mental health teams and a thematic review of homicides to inform its broader improvement programme.

Importantly, some of this work pre-dated the events of June 2023. The Trust had already identified weaknesses in its patient safety and incident learning infrastructure. An independent evaluation by Helen Collins between September and November 2023 set out 132 recommendations, all of which the quality committee confirmed as implemented in March 2025.

Across all external and internal reviews we would suggest that nine key themes have consistently emerged: risk assessment and management; discharge planning; medicines management, including depot medication and

restrictive options; the application of the Mental Health Act; patient engagement and follow up; family and multi-agency communication; care planning; clinical decision-making and documentation; and, lastly, balancing patients' rights with risk management.

The Inquiry's evidence base is considerably more extensive than any of the prior investigations. More individuals have provided written testimony and will give oral testimony and a wider set of records has been obtained and reviewed. It has become clear that the Trust's own chronology was incomplete as a result of gaps in record keeping and the limited information available to the Trust at the time about multi-agency activity and information sharing. Evidence from other Core Participants has highlighted significant gaps in what the Trust knew while treating VC, particularly concerning the volume and nature of police-related incidents.

Multiple agencies often recorded different versions of the same incidents, revealing inconsistent perspectives on risk and underlining the need for robust, shared multi-agency systems.

During the period up to August 2021, when VC appeared relatively stable, the Trust was unaware of several concerning incidents, for example the Trust did

not know of VC's behaviour outside MI5's headquarters on 31 May 2021 occurring just two days after his mother had contacted services about concerns regarding his mental health.

The Trust was also unaware of VC's assaults on his flatmates on 5 July 2021, although the attending police officer reportedly advised the victim to inform VC's mental health nurses, this information was not passed on.

Likewise, stalking incidents in April 2022, May 2022 and July 2022 during a period of disengagement, and shortly before discharge, were not shared with the Trust and therefore played no part in clinical decision-making. Had they been known they might have triggered further enquiries or different actions.

A warrant for VC's arrest was issued on 22 September 2022, at the same time as his discharge from services. The Trust did not know of the warrant.

More proactive communication from the police might have prompted further review of VC's mental state.

Additionally, the Trust was unaware of the alleged assault by VC on colleagues at his workplace on 5 May 2023. This may have represented another missed opportunity to assess his mental health.

The Trust recognises, of course, that the Inquiry

will focus particularly on the rationale for VC's discharge from services in September 2022. Oral evidence will, we suggest, provide a fuller and clearer picture than the documentary picture alone.

Now three years have passed since these tragic events. During that time the Trust under national regulatory oversight has undergone some significant change. The improvement journey began before June 2023 and has since accelerated. No Trust service is now rated as inadequate by the CQC, which is a fundamental shift from the earlier assessments. The latest well-led report recognises some clear progress.

The Trust accepts, however, that more work is required but believes the recent CQC findings reflect a pivotal movement as it moves from stabilisation to wider transformation.

In particular on staffing, agency use has reduced by 70 per cent and overtime use has reduced by 62 per cent. Demand, however, has increased with local mental health team caseloads rising from 8,619 in July 2022 to more than 10,000 as I speak today.

Two major changes implemented by the Trust which it believes have significantly reduced the likelihood of similar events. These deserve particular emphasis.

Firstly, patients are no longer discharged solely

for disengagement; a new patient engagement plan and assertive outreach pathway support those most likely to disengage. Any attempted disengagement based on discharge now triggers a system alert on the SafeNow dashboard requiring a mandatory senior review.

Secondly, the Trust has strengthened liaison with the police and other agencies, including participation in the Potentially Dangerous Person pathway, PDP pathway, a police-led multi-agency approach for individuals who present potential risk but fall outside of the MAPPA or the Prevent criteria.

This Inquiry's role extends beyond analysing past events. It must also consider what changes are required to prevent tragedies occurring in the future, both locally and nationally.

The Trust would respectfully urge national consideration of three areas at this stage. Firstly, the creation of a national repository where mental health homicide investigation reports are published by default with appropriate oversight. This would enable consistent learning across the UK and ensure transparency for families.

Second, a common categorisation framework for recording risk incidents across police, healthcare and other agencies and clearer frameworks for sharing

information about individuals who present risk but fall below MAPPA or Prevent thresholds.

Clearer national guidance is also needed on when health related information may be shared to protect public safety.

Third, clearer national guidance on the duty of candour in cases involving criminal proceedings, multiple victims and ongoing therapeutic relationships. Current guidance does not adequately address the complexity of homicide cases in mental health settings.

The Trust knows that no amount of organisational improvement can undo what has happened. However, it hopes that the Inquiry's thorough examination of events, its findings and its recommendations can ensure that positive change emerges.

The Trust does not consider such events entirely preventable, but believes the changes it has implemented go to the very heart of the risks that contributed to VC's case. The Trust commits fully through me to implementing the Inquiry's recommendations and continuing the work that it has already begun.

It thanks the Inquiry for its work and stands ready to assist it in any way possible.

THE CHAIR: Thank you, Mr Beer. Yes, Mr McNamara.

Statement on behalf of Nottingham City Council
by MR MCNAMARA

MR MCNAMARA: Chair, this is the opening on behalf of Nottingham City Council.

I begin by saying that Nottingham City Council and all who represent it offer their sincere and heartfelt condolences to the families of Ian, Grace and Barney and sincere and heartfelt sympathy to Wayne, Marcin and Sharon.

The city of Nottingham was shocked and appalled by what took place on 13 June 2023, as demonstrated by the public response in the days that followed. The atrocities committed by VC were, and remain, unthinkable.

The local authority, its witnesses and its officers are committed to providing every assistance to this Inquiry in answering the questions it has posed in its Terms of Reference, to respond frankly, candidly and openly to further questions, to listen and to learn.

NCC sincerely apologises for the isolated data protection breaches that occurred following VC's homicidal and violent activities. It is committed to learning and improving.

This brief opening statement contains merely a thumbnail chronology. It summarises the role of

Nottingham City Council's Approved Mental Health Practitioners, or AMHPs as they are frequently abbreviated to, and deals very briefly with the issue of data breaches following the events of 13 June and contains some early reflections.

The very brief chronology of Nottingham City Council's contact with VC.

There were seven occasions upon which NCC convened Mental Health Act assessments of VC between 24 May and 28 January 2022. Each occasion will of course be the subject of extensive evidence from the AMHPs and all of those in attendance on each occasion.

The first occasion upon which one of Nottingham City Council's employees, namely Ben Williams, met with VC was on 24 May 2020. He undertook an assessment with two other clinicians and on that occasion VC was not detained.

The following day, as we have heard as a consequence of another act of violence, very shortly after the initial one that resulted in his detention, a further Mental Health Act assessment was undertaken by Eleanor Cullen. On that occasion VC was detained.

Two months or so later, on 14 July of 2020, a further Mental Health Act assessment was required and on that occasion the local authority's Geoff Culpin and

two clinicians concluded it was appropriate for him to be detained.

On 3 September 2021 was the event we have heard about already involving substantial violence on the part of VC, when PC Pritchard was assaulted, and incapacitant spray and two taser rounds were required to subdue him as well as handcuffs and leg straps.

Next on 24 September 2021, a Mental Health Act assessment was undertaken by Alison Jacques. Again he was detained.

On 19 January 2022 a section 135 warrant was executed. He was not, however, detained on that occasion.

On 28 January 2022, so nine days or so later, a further section 135 warrant was issued but not executed on that occasion since he went essentially quietly. Fiona Parker and two clinicians concluded he be detained.

So what is the role of the Approved Mental Health Practitioner? As was noted by your counsel yesterday, Chair, the Inquiry will hear from nine witnesses from Nottingham City Council, eight of whom were employed as AMHPs during the period of May 2020 to January 2022. Accordingly, it is submitted that it is vital that the role of the AMHP, a creature of statute and informed by

related codes of practice, is understood.

The role of the AMHP is limited to interactions with individuals facing a mental health crisis, or those discharged from psychiatric treatment under a Community Treatment Order.

Once alerted to the need to assess such an individual, usually by a report from family, police or a mental health clinician, for example, it is the obligation of the AMHP to liaise with clinicians who can pronounce on whether the individual is suffering from a mental illness, make contact with and consult with the family of the individual, enquire as to the availability of a hospital place in the event that the individual needs to be detained, if necessary seek a warrant to remove the individual to a place of safety so they can be assessed, convene a Mental Health Act assessment with two physicians. Once that Mental Health Act assessment has been convened, consider how the individual can be helped by the least restrictive means.

If the individual needs to be detained for either assessment or treatment and if they are not already in a mental health setting, arrange conveyance of the individual to an appropriate psychiatric facility and, if after treatment, pursuant to section 3 of the Mental Health Act, an individual is discharged from psychiatric

in-patient care, subject to a Community Treatment Order or a CTO, to consider how the individual's social needs be met.

In short, an AMHP's role was and is closely prescribed. Each must act within the legal framework, independently, and balance the competing rights of the individual, including those rights under Articles 5 and 8 of the European Convention against the right of the public to be safe from random violence.

Once the process is complete, the individual becomes either a detained patient or is cared for by community mental health and, absent a Community Treatment Order upon discharge, the AMHP service is required only to step in again when called upon to do so by a fresh referral.

You are going to hear from one of the AMHPs, Geoff Culpin. He has attached to his statement a Department of Health and Social Care document from October 2019 entitled "National Workforce Plan for Approved Mental Health Professionals". Amongst other things it provides as follows:

The AMHP has a responsibility to organise and undertake an assessment under the Mental Health Act 1983 and, if the legal definitions are met, to authorise detention under the Act. AMHPs have specific

responsibilities to uphold the human rights of people assessed under the Act, consider the social perspective and following the guiding principles of the Mental Health Act, which includes applying the least restrictive principle.

The AMHP is also responsible for organising the complex inter-agency arrangements required to undertake the assessment and communicating with everyone involved, including the person's nearest relative.

Chair, the role has also been the subject of recent judicial thinking in the case of Khambra & Ors v Harrow London Borough Council. Mrs Justice Foster said, amongst other things, that the AMHP is performing a facilitative role for the local authority that has public facing duties in respect of appropriate admissions for assessment or treatment under the Act. This facilitative role follows from the language of sections 2 and 3 Mental Health Act in which admission is dependent upon the written recommendations and the prescribed form of two registered medical practitioners.

The case also reminds one that the role of AMHP is derived from statute, namely sections 11, 13 and 114 of the Mental Health Act, and also that the competence, training and practice of AMHPs is the subject of the Mental Health Act -- "(Approved Mental Health

Professionals) ... Regulations 2008".

This Inquiry will hear evidence from all of the AMHPs employed by Nottingham City Council that they were appropriately qualified to carry out their duties.

The role of AMHP in setting up the assessment is set out in paragraph 14.41 of the Code of Practice to the Mental Health Act of 1983:

"Unless different arrangements have been agreed locally between the relevant authorities, AMHPs who assess patients for possible detention under the Act have overall responsibility for co-ordinating the process of assessment."

The balanced position, as I describe it, that they occupy is described at paragraph 14.52 as follows:

"Although AMHPs act on behalf of a local authority, they cannot be told by the local authority or anyone else whether or not to make an application. They must exercise their own judgment, based on social and medical evidence, when deciding whether to apply for a patient to be detained under the Act. The role of AMHPs is to provide an independent decision about whether or not there are alternatives to detention under the Act bringing a social perspective to bear on their decision, and taking account of the least restrictive option and maximising independence guiding principle."

As in section 1 of the Mental Capacity Act, any decisions are made in the person's best interests and in a way that is less restrictive of their rights and freedom of action.

Absent a Community Treatment Order, once the immediate need to deal with an individual's mental health crisis is met, by either essentially hospitalisation or treatment in the community, the AMHP's statutory role comes to an end.

The AMHPs service would only reengage if following in-patient treatment, that is detention for treatment under section 3 as opposed to assessment under section 2 of the Mental Health Act, an individual is discharged under the provision of section 117.2, as amended, under what is known as the Community Treatment Order. At no stage, prior to 13 June 2023, was a CTO effected at the point of VC's discharge from psychiatric care and as a result Nottingham City Council was not involved in the provision of any after-care for the purposes of section 117.

Although chapter 33 of the Mental Health Act Code of Practice deals with the provision of care, as is made clear by one of the local authority's witnesses, namely Christopher Atherton, there was no statutory guidance around discharge at the time of NCC's involvement or

indeed prior to the fateful events of 13 June 2023. That was subsequently rectified on 26 January 2024 by the DHSC's discharge for mental health in-patient settings. That is also exhibited to Mr Atherton's statement.

One of the AMHPs also attaches to his statement the 12 local policies that were in place at the time. That's Ben Williams.

Nottingham City Council's AMHPs are busy. Geoff Culpin's second statement explains that the local authority has approximately 40 AMHPs who were responsible for carrying out on average 1,213 Mental Health Act assessments per year in the four years to 2024, with a further 999 by the time of the preparation of his statement in December of last year. The average annual number of cases requiring warrants during the same period was 93 and by December of last year, 79.

Treatment of those experienced in acute mental crises is a balancing exercise for the local authority's AMHPs. As set out above, their role is to coordinate and facilitate Mental Health Act assessments, a process that is based upon care being founded upon the least restrictive option.

It is the local authority's position that on each of the occasions that it was called in to deal with VC's

mental health crises, it did so promptly, responsibly, in accordance with its statutory obligations and in conformity to national and local policy provisions. Nonetheless, they are here to assist you.

Briefly on the data protection issue. There is, frankly, little the local authority can say other than to repeat the sincere and fulsome apology set out in the statement of Colin Wilderspin from 19 November 2025. It is submitted that it will become clear from the evidence that there is no culture of data breaches here and that the staff who accessed the information did so out of a misplaced professional curiosity and concern given the nature of the tragic events.

Some early reflections. The local authority recognises the agony caused by VC that day and it repeats its sincere condolences and sympathies. Of course, the witnesses have all reflected upon their involvement with VC. The atrocities that he went on to commit are outside of their experience in any other case in which they have been involved. Of course, the local authority reiterates its desire to engage in further reflection and learn from this Inquiry.

Although it is the local authority's broad view that at each step along the chronology its AMHPs experienced good inter-agency working, in an ideal world the care,

treatment, detention and discharge of those in crisis would be centred on a single integrated agency, or formalised inter-agency team drawn from, for example, policing, health, housing and social care, importantly with the resources and unified database to match.

The local authority also respectfully suggests that there is work to be done here by national government. Currently absent the formal structure of a Community Treatment Order, there is no requirement that other agencies such as a local authority are informed when a patient is discharged from psychiatric care after being detained. It is difficult to know as an aside what to suggest in terms of interactions with the likes of universities, so long as they enjoy charitable status and are not subject to a statutory duty in respect to students' welfare.

Despite the events of 13 June 2023 having prompted this Inquiry and the imperative for reflection, the local authority is cautious of suggesting a redrawing of fundamental principles based upon the actions of VC, not least since Parliament has largely reiterated the continuing principle of least restriction in the proposed revisions created by the Mental Health Act 2025 and that any Code of Practice must include that principle amongst others.

The revisions created by section 5 of the 2025 Act raises the bar for detention under sections 2 and 3 by including the concept of serious harm, whereas the current provisions do not require such a qualification below detention -- before detention can be authorised. That is it is obvious that if the Act is introduced as currently drafted, it will be harder to detain someone like VC.

The anti-social behaviour officers who accessed data related to VC should not have done so. They regret it. They have been investigated by the police and they have been internally disciplined with formal written warnings. The local authority responded in the autumn of 2023 with a new audit process.

I conclude by saying this, Chair. The city of Nottingham will not forget 13 June 2023 and the impact on the victims of VC and their families and the local authority reiterates that it is committed to complete engagement with this Inquiry. Its witnesses and representatives are here to assist and learn from the process and recommendations. Thank you.

THE CHAIR: Thank you, Mr McNamara. Ms Bicarregui.

Statement on behalf of NHS England by MS BICARREGUI

MS BICARREGUI: Thank you. Good afternoon, Chair. I appear on behalf of NHS England.

NHS England is grateful for this opportunity to address you and to reaffirm its commitment to help you and your team. NHS England's participation in the Inquiry will be aimed at furthering understanding, learning lessons and achieving improvements to the best of its abilities.

Chair, the scrutiny brought by this Inquiry is welcomed.

NHS England, and those of us working as part of the legal team, extend our deepest sympathies to the family and friends of Grace O'Malley-Kumar, Barney Webber and Ian Coates, and to Wayne Birkett, Marcin Gawronski, Sharon Miller and their families.

NHS England has read with great care the statements that have been provided by those personally affected by the events of 13 June 2023 and has also listened carefully to the opening statements made this morning.

The need, so clearly expressed, for answers, for transparency and for accountability has been understood. NHS England is committed to helping the Inquiry to answer the questions raised about these events, about their causes and about what has happened since to understand and to learn.

NHS England wishes to make an unreserved apology to the families and friends of Grace, Barney and Ian and to

the survivors Wayne, Marcin and Sharon and their family and friends.

The NHS and the system as a whole failed you with devastating consequences.

We have also heard what has been said by those affected and acknowledge that an apology alone is insufficient. The families need not only acceptance of responsibility but concrete changes to be made to help prevent future tragedies and NHS England is fully committed to working with the Inquiry in that spirit.

Chair, NHS England's written material goes into some detail about the role of NHS England in the overall NHS ecosystem. I'm not going to repeat that detail now, although it is of course important to understand the roles and responsibilities of various bodies in order to focus scrutiny and to target recommendations.

So briefly, Chair, NHS England is not the NHS in England, rather it provides strategic leadership for and coordinates the provision of healthcare services in England, with healthcare generally commissioned and then delivered by multiple partners, including as commissioners, integrated care boards and as providers of services, hospital and community trusts or independent contractors such as general practitioners.

NHS England also provides oversight of local

commissioners and providers of healthcare services, but in performing this oversight role it works in partnership with other bodies, including regulators, such as the CQC, which examines issues such as the quality of clinical services and on whose work NHS England draws.

So, Chair, against that background I would like to touch briefly on some of the key issues which arise from the written evidence and which focus on NHS England's role.

First, NHS England's oversight of NHS Trusts and, in this case, the Nottinghamshire Healthcare NHS Foundation Trust.

Second, NHS England's work identifying the systemic causes lying behind the events of 13 June 2023, including commissioning of the independent Theemis review.

Lastly, although we know there will be much more to examine, some of the emerging themes.

So as to oversight, Chair, the central way that NHS England seeks assurance about how hospital trusts are performing is through its oversight framework. At the time of the attacks in June 2023 the Trust was in segment 3, which meant that it had significant support needs against one or more of the five national oversight

themes, and it was in actual or suspected breach of its NHS provider licence.

However, the key drivers for the Trust entering segment 3 were the CQC ratings for the Rampton Hospital, a high secure service, and the Seacole ward at the Wells Road Centre, a low secure in-patient service. Neither of these services provided care to VC.

At this point in time the Trust's CQC rating overall was "Requires improvement" and "Requires improvement for well-led".

So the Trust had come under scrutiny both from the CQC and from NHS England in its oversight role, although the focus was not at this point on its community mental health services.

Following further submissions to NHS England's Midlands regional support group in February 2024, the Trust was moved to segment 4 of the oversight framework. The concerns expressed about the Trust covered a range of issues about the care, quality, safety and performance of a number of services. The ongoing investigations into the care and treatment of VC formed only one strand of the issues.

The move to segment 4 required a Recovery Support Programme to be put in place, leading to a high level of intensive support.

Chair, this is described in detail in the NHS England corporate witness statement and NHS England acknowledges that the Trust has been actively engaged with the Recovery Support Programme process.

Chair, oversight systems have to be designed so that they are manageable, whilst driving up standards of care and they must be capable of being implemented and operated across the country as a whole, but NHS England recognises the importance of learning and reflection on the system.

As counsel to the Inquiry set out yesterday and my learned friend from the Trust has just mentioned, since the tragic events of 13 June 2023 there have been a number of investigations seeking to understand what went wrong, carried out or commissioned by the Trust, the CQC and NHS England, whose role was to commission through its regional team the independent Theemis Report.

A number of recommendations have been made to the Trust and to NHS England. NHS England is determined to transform how the NHS treats people with a severe mental illness who often require long-term support.

Chair, we want to acknowledge that the Theemis Report has attracted criticism. Our corporate witness statement explains the purpose of that report and of

independent investigations of mental health homicides more generally. They are intended to identify the systemic causes of these tragedies. Some of the criticisms voiced of the Theemis Report, for example that staff involved are not named, are reflections of that policy approach. The NHS England corporate statement explains how separate decisions would be taken on whether the facts found in the investigation are considered to merit referrals to professional regulators.

We anticipate that this Inquiry will consider thoughtfully as part of its task of making recommendations how the various public interests involved have been balanced in developing this approach, and what more could be done to ensure effective learning and then effective implementation of such reports. This issue raises the question of the publication of the independent mental health homicide reports, such as the Theemis Report.

NHS England has disclosed the detailed legal advice it received in 2020 and 2023 which discussed the legal issues involved, including the protection afforded to confidential or personal information which may well include information about the treatment of mental health patients.

As we explained in our statement, a working group was set up in April 2024 to consider these issues further and to develop policy. The present position is that following further consideration and engagement, including with stakeholders such as the Department for Health and Social Care, a new internal policy has been developed which has recently been approved and disclosed to the Inquiry.

Chair, the default position is now that all future homicide investigations should be published in full. However, to summarise briefly some of the policy, there is no "one size fits all" approach to publishing information related to patient safety -- sorry, to patient safety incident investigations. The information which can be published will need to be considered on a case-by-case basis. This means that authors must consider, when drafting, the legitimacy of any disclosures of personal healthcare information, considering how to include sufficient information and analysis from the investigation process for the reader to understand those events and as a result take action to improve patient safety.

So there has been considerable further thought given to the reconciliation of interests and the application of law in this area, but as we remark in our corporate

witness statement, where tensions remain legislation or further action may be required to resolve them, or to set clearer guidelines for public bodies such as NHS England, or successive bodies in the future.

Finally, Chair, and briefly, it may be useful if we highlight some emerging themes from the investigations, or broader reflections available to date about the ways in which mental health services may be improved and the risks posed by mental health patients, both to others and themselves, may be reduced.

We note that Counsel to the Inquiry touched on many of these themes yesterday.

First, Chair, that the need for an effective and sustained community services and intervention, including teams that can consider and implement appropriate reactions to non-engagement and disengagement by patients is clear.

Developments of potential relevance to this point are the work on piloting 24/7 neighbourhood mental health centres which is set out in the witness statement of Professor Tim Kendall and NHS England's personalised care framework and modern service framework for severe mental illness which presents opportunities to set expectations.

A further theme is the need for a better shared

understanding of risk, not only across in-patient and outpatient teams but across health, housing and education. This has the potential to provide more ways of identifying patterns of behaviour or deterioration.

A repeated theme, and not one restricted to this Inquiry, is the need for the effective involvement of patients' families and carers in mental health care. As Dr Sokolov, NHS England, sets out in her statement, that work is not straightforward but it is important. This Inquiry will no doubt use its resources to link to the other Public Inquiries which are currently considering mental health in English health services, including the Lampard Inquiry which has heard evidence from families on this theme.

We also highlight, Chair, the evidence from Dr Adrian James regarding the importance of continued work on how investigative recommendations are most effectively formulated and tested, including for their applicability across the whole system, and then disseminated in the manner most likely to lead to change.

It is also impossible to ignore the issue of the impact that stretched resources have on the quality of care and risk management within the system as a whole. This includes in the case of VC the impact of the

COVID 19 pandemic. NHS England has sought to significantly increase resources to mental health services, including by increasing investment in mental health services through the NHS long-term plan and support for measures such as the mental health investment standard.

Now work must be done to consider both how the system can be enabled to provide appropriate care in normal times and at times when the system is under acute stress, such as during any future pandemic. We look to the Inquiry for any guidance or recommendations on achieving that balance as we develop future guidance and strategy for mental health services.

Chair, as I said at the outset, NHS England welcomes the scrutiny that this Inquiry brings and is ready to help you and your team with whatever is needed.

THE CHAIR: Thank you. Ms Scolding.

Statement on behalf of the Department of Health and Social Care by MS SCOLDING KC

MS SCOLDING: Chair, I appear on behalf of the Department of Health and Social Care. I start these submissions by expressing the department's heartfelt sympathies and condolences to the families of Grace O'Malley-Kumar, Barney Webber and Ian Coates. The families have met with the Secretary of State for Health and Social Care

and with Baroness Merron, the Minister of State for Mental Health, and sought answers from them about the failings which led to the events of June 2023.

They have heard first-hand of their appalling and enduring loss and pain. The department thanks them for their determination and dedication to make improvements to the system of mental health care in this country and admires their fortitude in doing so.

We also express our deepest sympathies to Sharon Miller, Wayne Birkett and Marcin Gawronski who live with the life-altering injuries sustained as a result of VC's actions. Our sympathies also extend to their families whose lives have been irrevocably changed.

The Secretary of State recently met with Sharon and Wayne to discuss their experiences and the impact the actions of VC have had on them. The department thanks them for the courage they show and their commitment to improving health provision.

Baroness Merron and the Secretary of State have also met with members of VC's family, including his mother Celeste and brother Elias, and listened to the concerns they had around the pressures faced by the mental health system. We appreciate that they too have been impacted by the failings of NHS mental health services.

The department also recognises the impact that these attacks had on the people of Nottingham and the impact that they continue to have upon the University community, the town and public services.

The department's written submissions set out in some detail the legislative framework and background to the provision of mental health care in this country, as well as its ultimate responsibility as a department to Parliament for any failures within it. The oral statement does not seek to repeat this, but to set out and acknowledge what the Secretary of State and ministers consider to be significant themes for the Inquiry to consider.

The department accepts that there were failures in the provision of healthcare to VC. He was not provided with active and assertive mental health services, despite presenting as acutely unwell with psychosis and not taking his medication. The views of his family were not taken seriously. The risk assessments undertaken in this case failed to identify the clear and present risks to VC and to others of him not taking his medication.

In response to the attacks, the department commissioned the CQC, as you have heard, to undertake a special review of Nottinghamshire Healthcare Foundation Trust. The CQC made its final

recommendations in August 2024 and the department has been monitoring implementation of those since that date.

We note that the Trust's most recent well-led CQC report identifies that it still requires improvement. This is despite there having been 39 inspections carried out by the CQC between May 2024 and August 2025. The Secretary of State and ministers do not consider that this is acceptable progress.

To address this the department has requested regular updates on implementing recommendations from prior CQC reports and are planning to meet the new leadership team, including a newly appointed Chair. We understand that recruitment is in place for a new chief executive and for other executive posts and the department will be scrutinising the action plan which the Trust submitted to the CQC on 12 February this year.

The department is ultimately accountable for the failings of the NHS and its organisations. It recognises that whilst there has been significant investment in mental health services over the past ten years, demand has risen and outpaced the services available. There has been an approximate 40 per cent increase in the number of people accessing community mental health services for adults and older adults during that period of time.

This significant and ongoing rise in demand means that there is a substantial treatment gap. The department acknowledges that too many people are not getting the support they require, or are waiting too long for that support. Waiting increases the need for crisis care and often requires longer standing and more intensive interventions. Early intervention is the key to avoid a crisis and the department knows that does not always happen. There are also difficulties with the provision of social care to those discharged from mental health services.

The department recognises furthermore that there are problems with continuity of care in mental health services and that there is not always sufficient capacity in the system for staff to provide the quality of care that they would wish.

The department sets out in its written opening the steps that have been taken to improve the system and touches on some of them today, but acknowledges that there is a need for radical change and redesign of how services are delivered.

The problems outlined above are long-term and require intensive and large-scale solutions. The department is committed to solving these problems, but it will take time.

The department views this Inquiry as a vital part of the ongoing work being carried out in this area and undertakes to carefully consider the evidence already presented and to be heard over the coming months. The Inquiry and other Core Participants will no doubt be asking the department probing and challenging questions about its responsibility for the failing they identify. We wish to reflect with candour and be open and honest as to the failings as we perceive them and as to any other failings that other Core Participants identify within our department.

You heard yesterday, Chair, that the government has recently passed the Mental Health Act 2025 which makes a significant number of amendments to the Mental Health Act 1983. You heard from Ms Langdale that there has been concern from some quarters and, more broadly, from those whose loved ones have lost their lives from those who are severely mentally unwell, that the Mental Health Act 2025 may make it more difficult to detain those who are a danger to themselves or to others. In particular, there has been criticism that amendments to the Act encourage too high a threshold for compulsory treatment than is required to reflect public protection.

Following the devastating events of June 2023, and before the Mental Health Bill was introduced into

Parliament in autumn 2024, the Department undertook a specific review of the Bill's draft provisions to ensure that they would not hinder the ability of clinicians to take decisions that would keep the public safe. The Department is of the view that the 2025 Act does not dilute or alter the fundamental powers of detention and compulsory treatment, where required.

These reforms are designed to provide more personalised care, attuned to the needs of the individual who is mentally unwell, to give them choice and control which we say is then more likely to lead to greater compliance and concordance, and to give family members a chance to be able to express their concerns and to be involved and engaged in the care of their loved ones.

Patient safety and public safety are the paramount considerations of the Act. The more that someone's mental health needs are met, the more likely they are to take medication and recover quickly.

Sir Simon Wessely, from whom you will hear, found in the course of his independent review of the Mental Health Act that greater clarity was required regarding criteria for detention, as set out. The 2025 Act therefore amends the criteria, both in section 2 and section 3 of the Act, so that persons can be detained on

the basis that serious harm may be caused to the health or safety of the patient, or of another person, unless the patient receives medical treatment, and that it is necessary, given the nature, degree and likelihood of the harm, for the patient to receive such treatment, and that appropriate medical treatment is available for it.

The Act will also provide for greater scrutiny of clinical decision-making in respect of discharge of those who have been detained, requiring a multi-disciplinary assessment before such discharge can take place, with people who know the patient.

In the changes further enacted by the 2025 Act, focus has also been placed on the creation of statutory and enforceable care and treatment plans. This ensures that patients, clinicians and everyone caring for or involved in a patient's care knows what treatment and support is required.

The care and treatment plans will have a specific focus on planning for safe and effective discharge, including a personalised safety management plan which will expressly set out an assessment of the person's risk to self and others and how this will be managed in the community prior to their discharge.

The Department further recognises that the involvement of family and friends in the care of those

with serious mental illness can make successful outcomes much more likely. The 2025 Act seeks to strengthen the role that friends and family can take and help them to be an early warning signal when they see health deteriorating.

Clinicians will have to consult with those interested in the patient's welfare prior to making decisions.

You have also heard from Ms Langdale about the Community Treatment Order, or CTO as it is more commonly known. A CTO is where someone is discharged from hospital to receive treatment in the community, but they must follow certain conditions, usually compulsory attendance at medical appointments and administration of medication, as a condition of their discharge. They serve an incredibly useful and vital purpose and it is exceptionally important that those who benefit from them continue to be able to use them.

However, they should not be used, as they have often been in the past and, as the independent review into mental health found, simply to gain access to services which should already be available.

The 2025 Act reforms community treatment orders to reflect the revised criteria I set out above. This will, it is hoped, ensure increased oversight and

scrutiny of such orders and prevent their unnecessary or inappropriate use.

However, they continue to be an important safeguard and it is vital that those who benefit from them can still be discharged, subject to the possibility of being recalled to hospital for further medical treatment if necessary, if the conditions are not met.

Alongside changes to the legislation, the Department is also undertaking a number of reforms to seek to improve community and in-patient mental health support. The Department has worked on this over recent years but recognises that there is still much to do. Demand for support rises and people are waiting too long to get the right on support for them in the community.

I shall speak briefly about some of those changes now which are set out in more detail in our written submissions.

First, the creation of a neighbourhood mental health centre. People with severe mental illness will be able to access on a 24/7 basis around the clock support including crisis beds and access to a range of multi-disciplinary clinical services on-site, which will include different mental health teams who may have previously been located in a disparate range of settings. People with severe mental illness can walk in

without an appointment to gain immediate access to specialist clinicians, medication or therapy. These centres can also help with the wider issues which those with severe mental illness often face and which delays their recovery: debt, lack of employment, lack of secure or any housing and a need for social support.

Second, the provision of outreach care and treatment by way of what is often known, and what has been described to you already, as Assertive Outreach. This is where specialist care managers and social workers work closely and over a long period of time with those who have severe and enduring mental ill health and have either refused treatment or failed to engage with it. There is evidence that this approach can have a positive impact on patients and is particularly of use for those suffering from psychosis.

NHS England published guidance in July 2024, updated in February 2025, which all Integrated Care Boards were to follow to support the development of improvements in these services. The Department has also committed, within its ten-year health plan, to improve Assertive Outreach care and treatment to ensure that there is 100 per cent national coverage in the next decade.

To support this roll-out, the Department acknowledges that further work may be required to

understand the evidence base and to provide guidance to local bodies to support an effective Assertive Outreach model.

Third, there has been a rolling out of alternative crisis services and the provision of specialist emergency response vehicles, and the provision of separate mental health emergency departments in the majority of hospitals.

Fourth, alongside this there will be publication of a personalised care framework guidance which will set out the core principles that those receiving mental health services should receive, and a modern service framework for severe mental illness which will set out the relevant interventions needed to improve mental health services and identify where innovation is required to drive progress.

Fifth, in 2025 the Prime Minister announced that NHS England and the Department for Health and Social Care would merge to become one organisation. This aims to reduce duplication between the two bodies. The Department believes that the new structure will better foster an environment of clear, open leadership. The merger will require legislation to effect it, but the Department is already some way towards the transition to one organisation with a single joint executive having

been in place since November 2025.

In conclusion, the Department ends these submissions as we began, focusing both on the bereaved and the survivors of the attack on 13 June 2023. We thank again the families of Grace O'Malley-Kumar, Barney Webber and Ian Coates, as well as those of the surviving victims, Sharon Miller and Wayne Birkett, for speaking to the Department of Health and Social Care, urging the Department of Health to do more, and for being so clear sighted and committed to the provision of better care and services.

We know that the events of June 2023 should not have happened. We apologise unreservedly for the part that the mental health system played in those failings.

Finally, we wish to restate our commitment to listen and act upon the findings of this Inquiry and the experience of those who give evidence to it. Thank you.

THE CHAIR: Thank you. Yes, Ms Zeb.

Statement on behalf of the Ministry of Justice by MS ZEB KC

MS ZEB: Chair, I appear before this Inquiry on behalf of the Ministry of Justice, who I shall refer to as the MoJ.

As the last advocate to come before you this afternoon, I wish to say on behalf of the MoJ that it offers its profound condolences and deepest sympathies

to the families of Barney, Grace and Ian who were tragically killed by VC, and to Wayne, Sharon and Marcin who were severely injured and harmed by him on 13 June 2023.

The MoJ is here to assist you, Chair, on a discrete but important issue concerning access to confidential and sensitive data by employees of HMCTS, that is His Majesty's Courts and Tribunal Service, and HMPPS, being His Majesty's Prison and Probation Service, through an electronic system used in the Crown Court known as the Crown Court Digital Case System, or DCS for short.

That access occurred by a small number of individuals after the arrest of VC for these horrendous crimes.

The MoJ appreciates and recognises the understandable strength of feeling held by those impacted by these data access issues and at the outset offers sincere apologies for the incidents of unauthorised data access.

The MoJ welcomes the opportunity to provide this short opening statement at the conclusion of today's oral statements and does so as the parent government department representing both HMCTS and HMPPS. The Department has disclosed relevant material to support the Inquiry's investigations and has also provided

a witness statement by Ms Amy Holmes, the interim Director General for the chief operating group of the MoJ.

It is accepted that data access occurred in circumstances that have given rise to legitimate concern and that this requires careful scrutiny. The Department recognises the seriousness of the issues under consideration and the importance of the Inquiry's task in establishing a clear and accurate account of events pertaining to this issue.

There is and will remain an ongoing commitment to assist the Inquiry in its important work, and the Department will continue to cooperate fully and as it has done so far with the Inquiry's disclosure process.

The MoJ is committed to listening and learning at this Inquiry and with a clear commitment to minimising the likelihood of unauthorised access being repeated by its agencies, and it looks forward to the Inquiry's recommendations in due course.

This brief opening statement aims to assist the Inquiry by explaining briefly the role of the MoJ HMCTS and HMPPS and their structures, with more detail obviously to be explored in the evidence in due course. It also aims to summarily address the important issues relating to the unauthorised access.

If I may turn then to the role of MoJ HMCTS and HMPPS. By way of some background, HMCTS is responsible for providing a system of support, including infrastructure and resources for the administration of business in the courts of England and Wales, providing the support necessary to enable the judiciary and the Magistracy to exercise their judicial functions independently.

HMPPS is comprised of His Majesty's Prison Service, the Probation Service, the Youth Custody Service and a headquarters which is focused on supporting frontline operations, including running prisons and Probation Services.

The MoJ's Data Protection Team, DPT, supports the entire MoJ cohort, including the executive agencies I referred to, driving the Department's data protection strategy and providing training and support in this regard.

With reference to point 3 within the Inquiry's terms of reference, the Department accepts that three HMCTS members of court staff and 11 HMPPS probation staff were involved in the unauthorised access of case files after VC's arrest. Subsequently, the Department and both executive agencies have had a direct and significant role in investigations, reviews, fact-finding exercises,

inter-agency communication, approach to policies and procedures, including disciplinary procedures, police referrals and policy change following these events.

Where appropriate, there has been communication with those impacted by the incidents of unauthorised access.

Chair, as you and your team know, police investigations remain ongoing in relation to these matters and the MoJ reassures this Inquiry and those at the heart of it that they are cooperating as required with those ongoing processes.

Considerable learning has taken place so far in respect of these matters and this continues to be built upon.

In addition to the facts and chronologies surrounding unauthorised access by HMCTS and HMPPS staff which is set out in the statement of Amy Holmes, it is recognised that there are a number of wider key issues to be considered, including but not necessarily limited to four points which I shall come to now.

First, the difference between the approach taken by HMCTS and HMPPS in respect of the unauthorised access of material by their respective staff members, including consideration of the application, efficacy and interoperability of relevant MoJ, HMCTS and HMPPS policies, guidance and procedures as they existed at the

time. An independent review was commissioned to look into these issues which I shall briefly return to in a moment.

Second, the available guidance and mandatory training of HMCTS and HMPPS staff regarding appropriate use of the DCS system.

Third, the Department's considerations around whether to inform those impacted by the unauthorised access of that occurrence, even though the threshold from a data protection perspective had not been reached, and then subsequently the manner in which those impacted were communicated with and the extent of that communication.

Fourth, the decision not to restrict access at the point at which VC's case was uploaded to DCS and regarding procedures adopted to protect access to case information.

Whilst robust controls to protect access to case information are needed and were indeed in place, it is necessary to undertake a risk-based balancing exercise to protect access to case information, but also support efficient business processes by allowing access within this part of the criminal justice system. Both of these factors are of course of significant public interest.

In relation to the unauthorised access of court

records by HMCTS and HMPPS staff, parliamentary under-secretary of state Alex Davies-Jones MP communicated with the bereaved families on 23 December 2024 and again on 7 and 15 April 2025 and the HMCTS Chief Executive Officer Nick Goodwin wrote to the solicitor for the bereaved families in May 2025.

To date a number of steps have been taken since these incidents were discovered and improvements continue to be made. There is an ongoing commitment to identifying any shortcomings in systems, processes or organisational responses and the Department and its executive agencies will listen carefully to the Inquiry's recommendations.

The evidence the MoJ has provided to the Inquiry sets out those considerable changes made thus far and to the extent that there may be any further updates in this regard, then Amy Holmes will assist the Inquiry accordingly when she comes to give her oral evidence at the public hearings in April.

In particular and to note, an independent review was commissioned on 20 January 2025 by the Permanent Secretary into the efficacy and interoperability of relevant policies titled "An independent review into the efficacy and interoperability of MoJ, HMPPS and HMCTS policies in high profile criminal and contentious

cases." This concluded, amongst other things, that the guidance for staff in relation to disciplinary action was not aligned within the agencies. This led to inconsistent approaches between agencies when dealing with issues of a similar nature to that which you, Chair, will consider.

Work is currently underway to implement the recommendations of this review, including harmonising conduct policies with one overarching policy intended to ensure consistency in approach across the MoJ.

12 of the 14 recommendations in this report have been implemented and the remaining two are due to be implemented in April 2026.

In addition, the MoJ can confirm that work is well underway to adopt a single code of conduct and disciplinary policy for the whole of the Department.

Therefore, in conclusion, Chair, the Department is confident that many of the problems identified to date regarding concerns around inappropriate data access have either been addressed and corrected or are in the process of being so where further opportunities to reduce the likelihood of similar incidents of unauthorised access occurring in the future, then the MoJ will continue to take those opportunities to make improvements.

Thank you and good afternoon, Chair.

THE CHAIR: Thank you. We are going to take a short break in a moment and then we are going to watch some films which have been put together by the families -- the bereaved families and also by the survivors.

We are going to do those in it alphabetical order and they will be played altogether, one after another. I think it is important, now that we have heard the opening statements, for us to remember why we are here and this is an opportunity to do so.

Anyone who doesn't want to watch the film in the room is obviously entitled not to do so and, as I say, we will finish after that. There will be no further submissions and we will all be able to reflect on what we have seen before we start the evidence tomorrow.

So we will take a short break now until 25 past 3 (sic). Thank you.

(3.11 pm)

(Short Break)

(3.40 pm)

THE CHAIR: Yes, I think if everybody is ready we will start. Thank you.

Videos played

THE CHAIR: Before we rise for today I want to thank you all for making those films and even more for sharing them

with the Inquiry. Thank you.

(4.15 pm)

(The Inquiry adjourned until 10.00 am on Wednesday, 25 February 2026)

I N D E X