THE NOTTINGHAM INQUIRY

BEFORE HH TAYLOR

IN THE MATTER OF:

THE NOTTINGHAM INQUIRY

OPENING STATEMENT

ON BEHALF OF THE SURVIVORS WAYNE BIRKETT AND SHARON MILLER AND THEIR RESPECTIVE PARTNERS TRACEY HODGSON AND MARTIN REED

Introduction

1. These are the submissions made on behalf of the Survivor Core Participants, namely victims Wayne Birkett and Sharon Miller who VC attempted to murder on 13.6.23 and their respective partners Tracey Hodgson and Martin Reed.

2. At the outset, to the families of Grace, Barney and Ian, we offer our deepest sympathy to each one of you. We thank you for your tireless and selfless campaign seeking the establishment of this Inquiry and in the pursuit of truth, accountability and to achieve justice for Grace, Barney and Ian. We acknowledge this additional burden alongside your indescribable and profound grief.

3. Many members of the public, when they hear about the Nottingham attacks of 13.6.23, do not appreciate that as well as the fatal stabbings, VC used a van as a weapon in an attempt to kill Nottingham residents making their way to work on the morning of 13.6.23 too. Having carried out the most brutal and barbaric attacks on Grace and Barney at 4am, which later resulted in their deaths at hospital, and then at 5.15am having brutally killed Ian, VC then then stole Ian's van.

4. Just after 5.23am, VC drove the stolen van at speed, intentionally and deliberately into Wayne, swerving and striking him from behind as he crossed the road. Wayne had been making his way to work on foot, having commuted into Nottingham earlier by bus.

5. 7 minutes later at 5.30am, and having driven past Nottingham Police Station, VC drove at speed delibereately into Sharon Miller and Marcin Gawronski[1] with a police officer now driving in pursuit behind VC in the van with blue lights and sirens activated.

6. Wayne and Sharon have suffered appalling and life changing injuries caused by VC.

The Chair, ILT and the Secretariat

7. Chair, you and your team have worked tirelessly since this Inquiry was announced in your preparations for a hearing of this magnitude. We are grateful to you and your team for your considerable efforts and for the volume of disclosure that has been made to date.

8. We welcome your confirmation that this work will continue and those lines of inquiry, including where appropriate drawing on expert opinion, will be kept under review.

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

10. Wayne was a hard-working fork lift truck driver working for ABB Furse. He is a loving partner, father and grandfather. Wayne appreciates that he is lucky to be alive, however, has said repeatedly he wished his life had been taken rather than those of Grace, Barney and Ian. Tracey, his partner, feels that a large part of the man he was before the attack did in fact die that morning. VC's attempted murder of him has stolen a lifetime of memories as a result of the fractured skull and permanent brain injury caused by VC.

11. Sharon is a mother to her much-loved daughter and lives with her childhood sweetheart, Martin. Sharon was incredibly close to her own mother. She was making her way to work as a cleaner for DTZ on the morning of 13.6.23. This was a job she had done diligently for over

[1] Who is unrepresented and not participating in the Inquiry.

27 years. Her work life ended on 13.6.23. She has not been able to work since.

12. Tracey took a year off work to care and support Wayne, first through his coma, and then when conscious again helping him with his ongoing rehabilitation for his brain injury. Every step of the way trying to help remind him of the man he was and recall his memories. Martin has made so many sacrifices to nurse, care and support Sharon for her physical and psychological injuries with their wedding put on hold until the Inquiry is concluded. Sharon now rarely leaves her home.

Acknowledgements on behalf of the Survivors

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

14. For the many individuals, members of the public, who were nothing short of heroes in the aftermath of these atrocities, and who have not been recognised for their compassion, courage and simple humanity, we thank you.

15. Sharon in particular wants to thank a member of the public who came to her aid immediately after she was attacked, Melissa Austin [WITN0408001]. Ms Austin's statement details how the incident she witnessed has had a significant impact on her and how her role and assistance has never been recognised by the police. On behalf of the Survivors, we acknowledge and formally thank Ms Austin for all that she did, her kindness and care. Sharon hopes one day to be able to thank you in person.

16. Wayne wants to thank **Headway Nottingham**, the brain injury association charity, which has been invaluable in helping him adjust to his life with an acquired brain injury.

17. For reasons that will become clear during the evidence and touched upon during this opening, the following can be added to the list of victims of VC's violence and aggression failed by State agents:
    a. Feven and many other residents at Brook Court, Player Street relating to incidents on 24 May 2020 and numerous incidents by VC towards another resident at Player Court, Liam;
    b. PC Pritchard and the officers on duty with PC Pritchard, one of whom feared for their life, during the attack on them in September 2021 [NGPF0000023];

c. Christopher and other students present at the time of the assault and "hostage taking" in January 2022 and further attempts by VC to access accommodation in 2022;
d. Sebastian who suffered harassment and stalking from VC in incidents that occurred in July, August and December 2021 and April and July 2022.
e. The two colleagues attacked by VC whilst they worked at Arvato on 5th May 2023.

A call for Candour and a reminder of existing duties

18. We ask that the Inquiry reminds:
    a. the Police of the duty of candour as contained within the Code of Practice for Ethical Policing, which puts a responsibility on chief police officers to ensure openness and candour within their force;
    b. Health and social care professionals of their statutory duty under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the professional duty of candour integrated into professional guidance that has been subject of recommendations previously.[2]

19. We also remind all Inquiry Participants of what Sir Brian Langstaff, Chair of the IBI Report called in his Volume 1 report his "sixth theme" equally applicable to this Inquiry:

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

20. The Public Office Accountability Bill, also known as Hillsborough Law, currently before the Committee stage of the House of Commons, has the objective to ensure that public authorities, officials and those working for public authorities, at all times perform their functions with candour, transparency and frankness. It will later this year create a legal duty of candour with criminal sanction for non-compliance.

---

[2] Public Inquiry into Mid Staffordshire NHS Foundation Trust 2005-2009 chaired by Sir Robert Francis. See also comments of Sir Brian Langstaff Chair of the Infected Blood Inquiry in the Inquiry Report: "*It is a sad fact that very few inquiries into aspects of the health service or parts of it have ended without recognition that the* ***culture needed to change****. Over the past 50 to 60 years there have been several inquiries, of different types – but nearly all have had some such recommendation.* See also comments from Joint Committee on Human Rights on Candour from May 2024: "It is far from clear" if the duty of candour already imposed in the NHS [through the statutory and professional duty of candour duties] is being met. See also the DHSC Review of the Duty of candour review - GOV.UK which has made, "*clear that limited or noncompliance with the duty cannot be justified. Our aim is to deliver recommendations for better meeting the policy objectives of the duty and which can be implemented at pace*"

21. Clause 11 will also create a new offence of misleading the public, which will apply where a public authority or public official acts with the intention of misleading the public (or is reckless as to that possibility) and they know, or ought to know, that their act is seriously improper.

22. Under this duty, public bodies and officials will be required to assist inquiries, inquests and other investigations to achieve their objectives: with candour; promptly and **proactively** and without favour to their own position.

23. To ensure there is the fullest investigation and understanding of all matters detailed in the Terms of Reference we ask that you, Chair, make clear that you and your Inquiry expects candour, transparency and frankness from all witnesses and organisations at all time.

Candour Issues

24. Tracey wants the police to be open and honest. In her statement [WITN0274001para 94] she details that in her first meetings with DC Johal, the survivors shared allocated FLO, she was still extremely confused about how these awful events caused by VC had been allowed to happen. During an early meeting, she directly asked DC Johal whether VC was known to the police prior to June 2023, and was told he was not. Tracey now clearly understands that this was not correct, as it has since become apparent that the police had an existing history with VC.

25. It is of concern to discover in the disclosure that withholding of relevant information appears to be an issue considered at the highest level of Nottingham Police. It is clear that by the 15.6.23 ACC Griffin had been provided with a list of many previous police contacts with VC which that were on Nottingham Police's systems[3] [NGPF0007869] including the two occasions on 24.5.20 [Feven]; on 13.7.20 [Liam], details of VC's police contact after his attendance at Thames House, - the home of MI5 in London - on 31.5.21 when VC asked to be arrested, September 2021 [PC Pritchard], January 2022 [Christopher] and that at the time of the murders and attempted murders he was wanted on the PNC for a FTA warrant from September 2022 and the attack in May 2023 [the Arvato workers attack].

26. In January 2024 ACC Rob Griffin, in an email exchange, can be seen approving what was to be a Timeline to be provided to journalists of police contacts. It made no reference to the May 2020 incidents and adopted an approach regarding the January 2022 incident which suggests

[3] Save those that related to Sebastian are not included

a lack of transparency and frankness. He also approved the following statement: *"The defendant had committed no violent incidents in our city and county and none were reported to us since September 2021."*

27. He also approved on 16.1.24 [NGPF0006693] an only "***if asked***" press statement, at the time of sentencing, if questions were asked about the warrant not backed for bail issued by the court in September 2021 which Nottinghamshire Police had failed to execute. When read carefully, what is detailed in these emails betokens an approach completely at odds with the College of Policing's Charter for Families Bereaved through Public Tragedy[4] in many respects. This press statement reads:

"IF ASKED - WARRANT STATEMENT

Assistant Chief Constable Rob Griffin said: "This was an horrendous crime which caused unimaginable pain to the families of Grace, Barnaby and Ian, and the wider Nottingham community.

"I can confirm that Nottinghamshire Police previously engaged with the suspect while supporting our colleagues in the NHS.

"In September 2021, we were requested to support a Section 135 warrant to section the suspect under the Mental Health Act.

"We transported the suspect to Highbury Hospital and during this encounter he assaulted one of our police officers.

"We also had two further encounters with the suspect on January 19 and January 28 2022 to again support a Section 135 warrant to section the suspect under the Mental Health Act.

"Again, officers supported by transporting the suspect to Highbury Hospital on both occasions.

"In August 2022, he was reported for summons at court for the assault on our officer. He failed to appear and therefore a warrant was issued for his arrest in September 2022.

"We were unable to locate him due to his nomadic lifestyle. However, this was an assault on one of our officers and was highly unlikely to result in a custodial sentence.

"This case has now been discontinued.

"He carried out no further offences in our city and county since our last interaction with him on January 28, 2022."

28. We invite the Inquiry to scrutinise this account provided during the Inquiry with care as the Survivors believe this suggests a Force that was placing its own reputation above that of the public interest and misleads the public. We look forward to the Inquiry examining what, if anything, the Police did do to execute the warrant and locate VC after September 2022 as

[4] charter-for-families-bereaved-through-public-tragedy.pdf

suggested in the briefing and the foundation for reference to VC's "nomadic lifestyle" and the inability to locate him. As is known, VC continued to work in warehouses during this time.

Full and Fearless Investigation

29. Throughout this Inquiry process, those who we represent have had but one objective. That objective is to achieve a thorough, fearless and critical examination of all material which can answer the fundamental questions of how VC, despite the knowledge and information of so many individuals and organisations as to his risk, violence and aggression and untreated schizophrenia, failed to take actions to prevent the attacks before the 13.6.23 and on the morning itself.

30. It will be for this Inquiry to find out why that did not happen; for any organisation or person who fell short of their duties and responsibilities to tell the truth and share their knowledge and experience without fear or favour to ensure that every last drop of learning is squeezed out. Grace, Barney and Ian deserve nothing less.

31. On behalf of the Survivors, we are concerned that Nottinghamshire police has not been subjected to an independent and unbiased assessment of their response on 13.6.23. Crime Commissioner Caroline Henry commissioned the College of Policing to conduct an independent review into Nottinghamshire Police's policing response and regarding the events of 13.6.23 which was said, *"would constitute an exhaustive examination of police process, actions and policy"*. This was suspended due to the IOPC investigation.

32. Further still, the Theemis independent investigation and report details that: "*The investigation tried on a number of occasions to engage the Nottinghamshire Police. Nottinghamshire Police* ***were unable to engage with the review*** *as they remain under investigation by the Independent Office for Police Conduct (IOPC) in relation to the matters directly associated with the terms of reference of this review."*

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

34. The IOPC various investigations and Operations have been limited and considered in silo. The Operation Gosemore review of the police contact of PC Reynolds, the driver of the police car behind VC when he drove into Sharon, did not have available to it all of the appropriate

information and fails to address that firearms officers were unable to communicate with PC Dean Reynolds just prior to the attack on Sharon, as he was on a different talk group or that he had self-deployed rather than having been commanded to go there.

35. To date no qualified, independent and unbiased policing expert or body has yet assessed whether police actions from 04:04 onwards on 13.6.23 complied with relevant policies, procedures, or addressed the preventability of attack considerations in respect of the Survivors. Nor has it considered matters independently by reference to deployment of assets, use of police tactics including armed officers, specialist munitions, vehicle tactics available to AFOs, a coordinated search strategy.

36. Time must be taken during the Inquiry to examine with care the command and control of the police response on 13.6.23. Timelines and transcripts from the BWV and from the control room top desk footage are still awaited. One aspect of this top desk footage is still yet undisclosed [NGPF0008561]. No comprehensive chronology and transcripts from the talk groups has been provided by Nottinghamshire police identifying which officers are captured speaking. All of this is of central importance to the Survivors who maintain that the attacks on them could and should have been prevented if Nottingham Police had appropriately responded to the threat and risk clearly identifiable from the brutal attack on Grace and Barney and had the National Decision-Making policy been applied.

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

38. Were police intelligence systems interrogated? The Survivors want to know if police searched intelligence systems quickly for any IC3 black male with a marker for unprovoked violence and with links to addresses on Ilkeston Road - all of which VC had on his PNC record. Police systems showed VC had links to two addresses at 89 and 97 Ilkeston Road. VC had also provided 209 Ilkeston Road as a discharge address from hospital and his GP had recorded 109 Ilkeston Road. An image on the PNC could have been cross checked with the mobile phone footage, CCTV and door cam footage which members of the public had quickly provided for police review to police when they arrived on Ilkeston Road.

39. A search of police systems would also have revealed VC's connection to other nearby addresses of significance.

40. Where VC attacked Grace and Barney was in eye sight of Maddison Court **Raleigh Park** at the junction of the road. Here in January 2022, VC had assaulted a student called Christopher who he had shared accommodation with and held him and another student Ryan "hostage". VC was evicted from this accommodation but had then revisited it without permission and trespassed in February and April 2022. Ryan's statement describes one occasion VC was caught by security trying to enter the building dressed all in black and had a black backpack with him.

41. In VC's back pack on 13.6.23 was a slip of paper with the names of Christopher and two other students who had been in the flat at the time. Christopher was assaulted and taken hostage- Ryan and Sam [NGPF0007359]. This piece of paper suggest a worrying potential motivation and deep-seated resentment. The Survivors want to know if the CPS took this into account when considering the issue of intent as part of the murder investigation.

42. All of the Survivors believe the full context of the events of 11-13 June 2023, and what VC did, support that he did have capacity and the ability to form the intent to murder notwithstanding his mental health issues. They are aware that VC as early as 00.44am on 12.6.23 the day before the attacks, at a time when he was in London, was saying to his brother that this would be the last time he would talk to him ...and "if anything happens don't come and see me in hospital." [NGPF0004340_0009]. Over the course of the next day, VC went on to perform a number of sophisticated counter surveillance measures, including swapping his SIM at 02.50 on 13.6.23, deleting and re-installing the end to end encryption app Whatsapp as well as clearing his Whatsapp messages and turning off his phone at 03.03 and turning it back on again after he had attacked Grace and Barney at 04.47, immediately then trying to re-install. He called his brother at 04.53 to tell him to take the family out of the country and that "it's already done." [NGPF0004340_0021].

43. The Survivors have always been concerned about VC's trip to London over 11 to 12 June 2023 to stay with a person they now know was a person of interest. Tracey and Martin have always been concerned about VC's attendance at the BBQ in London on 11.6.23 and how the

ability to easily commute across London to this man's address fits with a man said to be so mentally unwell.

44. The Survivors have recently learned there was relevant intelligence for this man. He also had warning markers for Firearms, weapons, drugs, violence/anti police, sexual/domestic. [NGPF0001671].

45. What is clear from the Sequence of events [NGPF0004340] is that when VC travelled back from his trip having stayed at the person of interest's accommodation, arriving back into Nottingham just after midnight on 12.6.23, VC must more likely have had the bag containing the knives and scaffolding pole with him..

46. CCTV shows VC walking towards Radford Road via Wilkinson St at 00:23 with a small rucksack and larger Slazenger sports bag. By 1:17am CCTV shows him walking on Zulu Road towards Chard St and the bag is no longer visible nor has the larger bag ever been found. [WITN0074001_0188 para 806]

47. Who called VC at 01:56:48 hours on 13.6.23 from Bournemouth, and who called him less than 10 minutes before the attack at 03.51.25 from a number originating from Bodmin? [NGPF NGPF0003743 002].

48. The Survivors also are concerned to learn that the Person of Interest VC visited in London had a connection to an address on Mapperley Road further down than the road from Seely Hirst House on 62-68 Mapperley Road where VC sought to gain access shortly before killing Ian. [NGPF0001671_0010].

49. On 13.6.23 having attacked Barney and Grace, VC walked from Ilkeston Road to **Brook Court Player Street -** another address on police systems connected to VC– the route VC had in fact taken when he turned left onto Hopedale Drive- the direction of travel that had been shared with police shortly after 4am, at 04.19 [NGPF00004743] and where VC then continued on to Player Street where he was from 04.15-04.22 [NGPF0004340_0020]. The footage available at the scene also showed the direction VC had left. The survivors want to know why air support, the police helicopter and drone support were not called for immediately as part of a strategic and tactical plan to find, disrupt and arrest the attacker. Police arrived at what

any view was an extra-ordinary scene of a truly horrific attack at 04.08 with clear footage showing just how dangerous the attacker was. This horrific footage is the equivalent of investigative gold as it quite literally captured every aspect of the brutality VC inflicted on Barney and Grace. The Survivors fail to understand why it took until 05.01am before the FIM called the Strategic Commander ACC Griffin that morning. [WITN0074001_0024 para 82] Nearly all of the golden hour had by that time been lost.

50. Sharon wants to know why the police did not block the van in before it was used to strike her and why the police did not take up a position in front of or blocking in the Van rather than, as she witnessed, the blue lights and siren in her opinion encouraging VC's murderous attack towards her. Where were the firearms officers trained in driving tactics and with firearms and special munitions such as tyre breaching rounds and CS gas who could have been there to protect Wayne and to stop VC long before he hit Sharon.

The events of the day- Policy and Procedure

51. The College of Policing Approved Professional Practice makes clear:

"Assess threat and risk and develop a working strategy

The primary purpose of the threat assessment is to assess the threat posed by the subject(s) and the potential risk to others associated with that threat. This may include a threat posed to the subject(s) by others (for example, other individuals with criminal intent), or by the subject to themselves (for example, by self-harm). An accurate, multi-dimensional threat assessment will ultimately allow for an effective prioritised working strategy and the formulation of a proportionate response. Such a multi-dimensional assessment should include, where time allows, the level and nature of the threat along a timeline. This timeline should span from the first time when a commander considers the criteria for armed deployment, until the operation or investigation is concluded and there is no realistic anticipation of further armed deployment. Consideration should also be given to who is at risk and how that may change.

Consideration of the possible threat and risks along this timeline ensures that a commander is able to develop appropriate contingencies, identify potential investigative or evidential thresholds or tipping points, and take mitigating action when required.

Where information or intelligence leads to a change in the threat assessment, this may ultimately affect the working strategy and the primary tactical plan.

The aim is to protect the public by the most appropriate method, balancing the risk of harm to the public in

*both the short and longer term. (See **sustained public protection**).*

As an incident progresses, the regular review of available information and intelligence will ensure that the threat assessment remains relevant.

Multi-dimensional threat assessment may identify a tipping point(s) that requires a change to, or implementation of, a tactical plan. This should be briefed to those involved in the operation. A tipping point occurs when a threat and risk assessment indicate that the risk of harm is, or may be, so great that it is necessary to take decisive or mitigating action. This may occur prior to the investigative or evidential threshold being reached and may therefore affect the SIO/lead investigator strategy. Where practicable in the circumstances, this should be discussed with the SIO/lead investigator.

A tipping point may also emerge unexpectedly during an incident or operation. It may require immediate action to be taken, the implementation of a contingency or a deviation from the original plan.

Threat assessment – definition

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 occur. It is based on fact, information and intelligence and will vary over time. A threat assessment is used to develop a prioritised working strategy and ultimately forms the basis on which the proportionality of the police response will be judged.

A threat assessment:

- *should be based on information known at the time*
- *may be supported by historic information*
- *should take account of the nature of any threat anticipated and its proximity*
- *should identify to whom and under what circumstances the threat may occur*
- *should describe any consequences or impacts*
- *should take account of the impact of change*
- *may take the form of an analytical report or problem or subject profile*

Where possible, threat assessments should be time specific so that actions can be prioritised accordingly. It is important to evaluate how police action or inaction may impact on the threat assessment."

52. The Survivors have not seen any suitable or sufficient Police Threat and Risk assessments in line with the NDM after 04.04 on 13.6.23, regarding the fact that there was an armed and dangerous man who had carried out a "frenzied" attack, with the known significant injuries that shortly led to death and who had a knife in his back pack. The hours after the attack took

place are relevant in light of the content of page 14 of "Armed Policing Strategic Threat and Risk Assessment 2023" as to ARV Capability during this relevant time window. On any view, with the attacker at large armed with his knife, there was an immediate and overriding risk to public safety.

53. The statements disclosed from Officers Mather, Allardice and Griffin do not deal with the Threat and Risk assessments and strategic plans that are contained within the incident logs which are wholly inadequate. Nor do their statements address why these were not revisited and updated as more information became known. These record, at 04.05 on the Incident log, that the threat to the public and attending officers was **low**. At 04.10 the following is recorded:

> "RISK OF SERIOUS HARM OR DEATH
> RISK This is the possibility of something occurring and
> affects how the incident is graded?
> HIGH RISK - EMAS AND POLICE REQUIRED
> IMMEDIATELY"

54. The statements do not address the fact that on any view the criteria for armed deployment had been met as detailed in the College of Policing APP for Armed deployment shortly after 4am:

> ***"Criteria for the deployment of AFOs***
>
> *The deployment of AFOs should only be authorised in the following circumstances:*
>
> - *where the officer authorising the deployment has 'reason to suppose'* ***that officers may have to protect themselves or others from a person who:***
>   - ***is in possession of, or has immediate access to,*** *a firearm or other* ***potentially lethal*** *weapon, or*
>   - ***is otherwise so dangerous that the deployment of armed officers is considered to be appropriate,*** *or*
>   - ***as an operational contingency in a specific operation (based on the threat assessment), or***
>   - *for the destruction of animals which are dangerous or are suffering unnecessarily.*

> ***Reason to suppose***
>
> *Use of the words 'reason to suppose' sets the level of knowledge required (about the existence of a threat justifying the deployment of AFOs) at a far lower level than that which would actually justify the use of firearms.*

Chief officers must ensure that there is an officer immediately available in their force area to consider and authorise the deployment of AFOs where one or more of the criteria for deployment have been met.

The authorisation of the deployment of AFOs in this context relates to the decision that the criteria for such deployment has been met and not to the associated approval and authorisation regarding the tactics or tactical plans to be implemented if required.

The initial authority for the deployment of AFOs can be given by an accredited Strategic Firearms Commander (SFC) or a Tactical Firearms Commander (TFC), depending on the circumstances and nature of the incident or operation. Where practicable, any subsequently authorised armed deployment must be subject to appropriate tactical advice.

In spontaneous incidents, where the initial authority is given by a TFC, an SFC should be contacted as soon as practicable and informed that an incident requiring the deployment of armed officers is taking place. Where the SFC is in a position to take a command role, and make command decisions, they should ratify or rescind the initial authority.

Where it has not been practicable to inform the SFC while the armed deployment is ongoing, it will still be necessary to inform the SFC as soon as practicable thereafter. This will enable the SFC to review the incident and either confirm that there is no continuing requirement for the AFOs to be deployed in order to minimise risk to the public, or authorise their continued deployment and set tactical parameters where appropriate. It will also provide an opportunity for the SFC to identify any other relevant issues, such as related incidents, trends or community considerations.

In planned armed operations, the deployment of AFOs must be authorised by an SFC, having reviewed the associated tactical plan developed by the TFC, prior to the deployment. In developing the tactical plan, the TFC must consult a firearms tactical advisor.

It is the responsibility of the officer deploying AFOs to ensure that an appropriate ***command structure*** *is instigated as soon as is practicable. Authorising officers should be aware that AFOs may deploy with a range of firearms,* ***specialist munitions*** *and* ***less lethal options****. Chief officers should decide on the types of firearms, specialist munitions and less lethal options that are available to officers undertaking differing roles. This decision should be based on the force's Armed Policing* ***Strategic Firearms Threat and Risk Assessment*** *and in accordance with the Code of Practice on Armed Policing and Police use of Less Lethal Weapons 2020.*

Unless there is an immediate and overriding risk to public safety, the use of specialist munitions must be authorised in accordance with authority levels agreed by the chief officer of the force."

55. It was known that the attacker had left the scene shortly before police arrival with the knife and was evidently highly dangerous in light of what is captured on the BWV in respect of the brutality of the attack he had carried out on Grace and Barney. The available CCTV, dashcam and door cam footage shows this was a completely random and unprovoked attack. The extra ordinary nature of the attack is abundantly clear having viewed the BWV.

56. It is said that FIM Mather made the decision not to authorise the deployment of armed officers as they were needed for the provision of first aid [see para 35 WITN0034001_0010]. This does not properly reflect how the AFOs were utilised at the scene and the availability of the paramedics and doctors as shown on the BWV. It is significant that the statements fail to address for example that a significant proportion of OFC Speeden's time at the scene was taken up with entry into the property on Ilkeston Road and putting away the tools used to affect such entry. Similarly, Officer Mather does not address the fact that the criteria for armed deployment [as detailed above] had been met.

57. In respect of the emergency response on 13.6.23; to understand whether things went wrong and, if they did, to identify what those things were, why they went wrong and what can be done to prevent them happening again; or to assess whether it might be done better in the future, is of central importance.

58. The BWV that was inspected has demonstrated that it did not, in fact, take long for concerns to emerge about the way in which the emergency services responded to the attacks. Indeed, that very night some of those on the ground were to express frustration at how events developed.

59. AFO Speeden was an AFO who acted as OFC deployed to Ilkeston Road and was proximate to the arrest of VC on Bentick Road. It is clear from a conversation captured on his BWV, that we have been permitted to inspect, that he experienced considerable disappointment at not being authorised as part of a firearm's spontaneous operation after his initial attendance to Ilkeston Road. OFC Speeden is captured speaking to control shortly after 06.26.10 on his BWV which is yet to be disclosed where he conveyed his concern that no firearm authority had been granted in the context of an unknown offender walking away with the clear potential for future victims and police also being a target. In summary, he did not understand why there

was no firearms authority much earlier at Ilkeston Road.

60. It is of significant concern that none of the police statements address these issues raised by Officer Speeden with command shortly after 6am. Nor is this detailed within the Operation Hendrix debrief report. The absence of this aspect of the recording from Speeden's BWV in the statement of Officer Allardice is particularly stark and raises concerns as to the candour, transparency and frankness of Nottingham Police.

61. The Survivors emphasise their particular interest in transparency in the context of this Inquiry. The drip feed of information into the public domain has been re-traumatising for them and and has operated to frustrate the public interest. The concern is especially acute in Nottingham where issues have been identified with their core state agency service providers and institutions.

62. A key issue for the Survivors for the events of the 13.6.23, is the issue of ***preventability*** of the attacks upon them and the ***interoperability*** of the Blue light services and others. The actions and movements of VC, in particular following the killings of Grace and Barney, and what the Police and others did thereafter requires forensic examination. The attack by VC on Grace and Barney was captured on door cam footage and brought to the immediate attention of the police who attended within minutes of the attacks. This provided significant information, including the clothing and identity of VC, clear evidence of the most significant risk he posed to the public and that he was armed and dangerous. The response by the relevant State agencies and in particular the police in the 90 plus minutes that followed, is central to understanding this issue of preventability for the attacks that followed. On behalf of the Survivors, we submit that this aspect of the evidence from the 13.6.23 should be subject to detailed scrutiny.

63. We believe that the emergency response to the attacks gives rise to serious concerns about the police response and the co-operation and co-ordination between the different emergency service agencies.

64. The Inquiry will need to be a driver for major improvement in how Nottinghamshire Police respond to a critical incident later designated as a Major Incident and an MTA Plato incident and of the type with which we are concerned.

65. The Inquiry should address the following:

a. Whether the Control Room at Nottingham Police operated adequately or effectively on the night, and whether more should have been done to generate an improved understanding in the Control Rooms and to promote the challenging of information as it was received. As made clear in the Volume 2 Manchester Arena Inquiry report, Control Rooms, represent the first possible point of failure in any critical and major incident requiring significant cycles of exercising.

b. Whether the declaration of Operation Plato (the declaration of an incident involving a Marauding Terrorist Attack "MTA") was actively and accurately managed.

c. Whether the first hour of the emergency response was managed appropriately. The first hour of an emergency response will determine its overall success. As a recognition of this period's importance, some emergency responders refer to it as 'the golden hour'. The aim for the commanders in the golden hour should be to gather information and decide what needs to be done, putting in place structures that bring order to the inevitable chaos as quickly as possible. Where there is a threat, this should be swiftly contained and neutralised. There should be a concentrated focus on rescuing victims as quickly as possible. For those who are critically injured, minutes or seconds can count. Commanders needed to 'grip the situation' or 'grip the incident'. From what we have seen of the Top desk control footage this did not take place following the declaration of Plato, and from what we have seen and read, certainly not within the Golden Hour and the 90 minutes that followed the attack on Grace and Barney.

d. The effectiveness of training and exercising. Another phrase commonly used by emergency responders and as described in the Volume 2 Manchester Arena Inquiry report, is 'muscle memory'. This captures the idea that a particular way of behaving has become ingrained and is instinctive. To create 'muscle memory' requires effective training and exercising. Nottingham Police have not addressed why, when two firearms cars and their first aid kits had been utilised, these were not restocked, or calls made for support bearing in mind the decision to utilise AFOs for apparent first aid at a murder crime scene which then contaminated their further use to protect the public. We submit it was clear that calls to neighboring forces for AFO support should have been made before 5am.

e. Whether there were appropriate actions undertaken and compliance with:

- All relevant National and local policies and procedures, SOPs operative in Nottingham as at June 2023 as relevant to the Terms of Reference;

- If appropriate intelligence searches were conducted on 13 June 2023;

- Guidance, policies, procedures and standards for responding to a spontaneous incident including:

    1. The National Decision Model [NDM];
    2. Joint Decision Model [JDM];
    3. APP;
    4. National Critical Incident Guidance;
    5. NGPF **Managing Critical Incidents Procedure**;
    6. Police pursuits;
    7. NGPFs SOPs, response plans relating to MTFA and Operation Plato.
    8. JESIP and the Interoperability framework and if there was appropriate liaison with the ambulance service and the paramedic Incident commanders;
    9. The NGPF Operation Response Plan;
    10. Gold Strategy Plan;
    11. Activation of use of any NGPF Force Command Module Plan and Strategic Co-ordination Centre;
    12. Major Incident Plan;
    13. NGPF or any Nottinghamshire Generic Response Plan;
    14. NGPF SCG;
    15. Relevant policies and procedures that govern ARVs and tactics available to NGPF Firearm officers;
    16. Use of Talk groups and airwaves and on a multi-agency basis too.
    17. If appropriate ETANE and METHANE messages as required were given.

- Policies and procedures that provide overview of the size, Structure and Leadership of NGPF as at June 2023 including [as applicable]:

    1. MIT;
    2. CTU;
    3. CTSA team;
    4. Specialist Operations Branch [EMSOU];
    5. Firearms Unit;
    6. Firearms Support Teams [FST].

7. NGPF National Mutual Aid procedures to include any that related to talk groups and telephony.

- Command Structure and command and control as at June 2023 to include:

    1. Gold Silver and Bronze and for firearms operations SFC, TFC and OFC;
    2. expectation of NGPF command in a critical incident;
    3. expectation of NGPF command in a major incident;
    4. expectation of NGPF command in a Plato/MTFA and Multi-agency command and control as at June 2023;

- Multi-agency approach to command and control.

- If the Commanders, FIM and SIO [both for armed and unarmed officers] working/responding or on call/ involved/ deployed on 13.6.23 were appropriately trained.

- To undertake a review of all call records for Commanders, FIM and SIO on 13.6.23; noting that ACC Griffin's calls records, as the SFC, do not commence until after 5am and that he was not consulted at any point before this time despite the police being alerted to the attacks at 4:04am.

- Officers' familiarity with roles and responsibilities in a Critical Incident/ Major Incident / Plato incident/ and to include any Role cards, Action cards and in particular for use in an MTFA/Plato.

- Decision making during an incident to include, information recording by Commanders;

- Operation Plato to include:
    1. Any Review of Operation Plato Response Plans;
    2. Any Plato Seminars;
    3. Training;
    4. Any Plato Assurance Visit;
    5. Any Amendments to Plato plans after any Assurance Visit.

- Any knowledge before 13 June 2023 that calls were all not being recorded and retained and steps taken in response to this. Steps taken after 13 June 2023 in response to the failures to retain calls.

- If all potentially relevant items were seized and retained – see NGPF0007760

"THEY HAVE SEEN A BAG UNATTENDED. WHAT 3
WORDS LOCATION "CLAIMS.ALSO.WISHES"
13/06/2023 13:25:56 3807 - HAD A LOOK AT THE AREA. IT LOOKS LIKE 3000318
A BAG WITH SOME CLOTHES IN IT DUMPED NEXT
TO A BIN
13/06/2023 13:28:30 3807 - BAG IS ON BOTTLE LANE DOWN THE SIDE 3000318
OF TESCO AND OPP KINETIC GYM
13/06/2023 13:29:03 217: COULD BE A HOMELESS PERSONS BAG - WE 3003449
WILL DO SOME DIGGING AND COME BACK TO
YOU
13/06/2023 13:30:40 3807: HAPPY THIS BAG IS PURELY A BAG OF 3003449
CLOTHES"

66. We look forward to the Inquiry's interrogation of these matters during the hearing.

VC risk of murder, violence and aggression: Schizophrenia and VC's known decision not to take his anti-psychotic medication in the community

67. As early as 16.7.2020 it had been identified in VC's medical notes by his Responsible Clinician, Dr Seedat, at Highbury Hospital during his second detention under s3 MHA [14.7.20-31.7.20] that [NHFT0000168_0064-0065] VC may kill someone[5]. This was in circumstances where the same Responsible Clinician apparently did not know that the incident of violence and aggression by VC on 24.5.20 before this first period of detention under the Mental Health Act when he was RC also [25.5.20-17.6.20], had resulted in the victim Feven sustaining significant injuries, namely T12B fracture stabilised via operation, posterior fixation with metal work and screws to T12 vertebrae and also fractures to L1 and L2 and damage to the sacroiliac joint connecting the hip bone to the sacrum.

68. Dr Seedat has stated in his witness statement to the Inquiry that "there was no evidence or suggestion that VC had assaulted anyone." This was in fact completely wrong. On any view VC's actions had caused Feven to sustain Grievous Bodily Harm in May 2020.

69. It is clear from Dr Seedat's recordings on 16.7.20 from VC's Highbury hospital admission that VC should not have been discharged until the issue of his medication had been safely addressed:

> *"Valdo describes stopping medication two weeks after discharge from his last admission because he read that it could 'slow the mind'. He concedes that doing so may have 'made me a little more paranoid'. Seems non- plussed when confronted with the effects of his behaviour with the neighbour during this incident and also the previous admission. No signs of remorse or insight into how his actions have affected others. Just says 'there will not be a next time'.* ***Dr Seedat observed that there seems to be no insight or remorse and that the danger is that this will happen again and perhaps Valdo will end up killing someone.*** *Valdo simply responds by saying 'it will not happen again'. Police are not intending to press charges.*
>
> *Dr Seedat explored Valdo's insight into his mental state and possible serious mental illness. Very frank discussion. Valdo does not accept that he may have an enduring mental illness. Dr Seedat reflected that it seemed strange he had not chosen to read up on psychosis and possible causes. In his opinion it appears increasingly* ***likely that Valdo has schizophrenia.*** *Valdo does not fully accept this - he is hoping it will go away 'that I can use my will to power through it'. Discussed depot -* ***Valdo takes medication while on the ward but then stops once discharged.*** *Dr Seedat explained pros and cons of depot. Valdo will think about it - ward staff to provide information. Also, brief discussion about mechanisms of action of antipsychotics. Dr Seedat explained the consequences of being placed on a section 3 MHA e.g. visas/insurance/mortgages etc"*

70. Like the experience of the Ritchie Inquiry, material disclosed from the Inquiry identifies one failure or missed opportunity after another and of a preventable and predictable homicide

71. In the National Confidential Inquiry into Suicide and Safety in Mental Health, Appleby et al (2018) [WITN0075013] recorded that 258 of 600 patients between 2006 — 2016 who perpetrated a homicide "were either non adherent or had missed their final contact with services."

72. The Inquiry statement of Christopher Hart makes clear that:

> [6] *"non-compliance is easy to assess. The patient is not attending appointments or away from their accommodation at the agreed time of an appointment and does not respond to reasonable attempts to re-arrange. There is either a direct refusal to take medication, prescriptions are not being collected or other indications that it is not being taken. Agreed parts of a plan are not being followed (and this is perhaps one of the most powerful arguments for the use of care plans, that they can be audited and the patient's concordance/compliance assessed on this.*
>
> *97. Compliance should not be confused with concordance, but gauging the patient's engagement is an essential part of a risk assessment. The best risk management plan in the world will not work if the patient is not going to follow it. In these circumstances, the clinician is forced down the road of more restrictive practices, but this emphasises the need for the clinician to be clear about the patient's commitment to working with them."*

73. He identifies that, "the *significance of the presence of psychotic symptoms is fully discussed by Allnutt et al (2010, Clinical Risk Assessment & Management: A Practical Manual for Mental Health Clinicians) [WITN0075016], who note that the risk of violence increases in cases where the person's symptoms are not being treated, particularly if this is due to the patient refusing treatment. Violent offences are often linked to delusional beliefs.*"[7] Hart also provides research from Hodgins (2008, Violent behaviour among people with schizophrenia: a framework for investigations of causes, and effective treatment, and prevention) [WITN0075017], which details that: "*among violent offenders with schizophrenia there are three distinct types who are defined by the age of onset of antisocial and violent behaviour*

> *Type 1: `Early starters' display a pattern of antisocial behaviour that emerges in childhood or early adolescence, well before the onset of any illness. Their violence tends to remain stable across their lifespan;*
>
> *Type 2: Constitutes the largest group of violent offenders with schizophrenia. They show no antisocial behaviour prior to the onset of the illness then repeatedly engage in aggressive behaviour towards others;*
>
> *Type 3: A small number display a chronic course of schizophrenia with no aggressive behaviour for 1 - 2 decades after illness onset then engage in serious violence, often killing those who care for them.*"[8]

[6] WITN0075001_0030
[7] WITN0075001_0033-0034
[8] WITN0075001_0034

74. Set against this known risk background from available research, we ask the Inquiry to explore in evidence what we maintain is clear, that the criteria for a CTO with power of recall and requirement for depot medication was clearly indicated prior to discharge at the end of July 2020. As clearly and succinctly explained in a statement from Helen Foster:

> *"Everyone involved needs to be open and honest about what has happened. There needs to be a change at ward level and there needs to be some accountability. If people are let out in the community, then assurances need to be made to ensure they are safe. There needs to be open communication, a breakdown of communication means we will not learn from this, and the same things will happen again. A lot of tragic incidents have happened and nothing has changed, people need to be more vigilant and there needs to be more training. I do think there is good training available, it just needs to be put into practice*" [9].

75. Further still the Survivors believe the attack on Feven should have been prosecuted and it should have been left to the court to determine if VC was criminally responsible, fit to plead and stand trial. Even if VC had presented evidence of this nature the Court would have been able to consider a Hospital Order and a Restriction Order [s37/s41 MHA] as early as 2020 and long before the same was imposed by Mr Justice Turner on 14.5.24 following the finalisation of the Murders and Attempted murders trial.

76. The clear picture between 2020 and 2023 was of VC's escalating and increasing risks to the public from his violence and aggression, fixated thoughts and conspiracy theories, his diagnosis of schizophrenia for which VC was non-compliant with the required anti-psychotic medication to reduce psychotic symptoms, delusions and agitation.

77. Many knew VC was not engaging with the necessary services and process meant to be operated by the Police, Mental Health Services, hospitals and Local Authorities to protect the public.

78. The discharge of VC from metal health services should have never happened **as** made clear by NHS guidance that it is vital that DNAs (Did Not Attends) are never used as a reason for discharge for this vulnerable patient group, and in particular where the safeguarding concerns were blindingly obvious. This discharge should have been a **never event a**nd in particular for VC where there had been repeated discussions, when VC was subject to s3 Detention, of the need for a Community Treatment Order with the power of recall if VC did not take his

[9] WITN0393001_004 Para 17

medication and the obvious need for this to include a requirement of this to be delivered by depot injection. Medicines management, is a particular concern to the family and in particular when they heard at Trial reference to "treatment resistant" Schizophrenia. This was **not** the case for VC – he was a patient who was refusing to take his medication. He was treatment non-compliant and they strongly believe this is relevant to the intent that VC had. They are concerned that at no point was medication gripped and Clozapine and depot injections mandated for VC from July 2020 onwards.

79. On 22.9.22, VC failed to attend court to face the allegation of a "serious assault" [NGPF0002214_0014] on an emergency worker – namely PC Pritchard – an incident captured on BWV available to the inquiry which displays a level of violence and aggression from VC which is truly terrifying and caused one officer to regard in the incident log that they had feared for their life during the attack on them in September 2021 [NGPF0000023]. This offence provided another opportunity for the courts to impose a Hospital Order.

80. What steps did the Trust take to ensure all practicable efforts are made to engage patients and who have disengaged from the early intervention in psychosis service and what did they do with VC's case. This includes referring people who find it difficult to engage with services to a team that provides assertive and intensive support.

81. What steps did the Trust take to ensure there was a standard operating procedure in place for early intervention in psychosis and community teams to follow when a patient does not attend for appointments and follow-up actions are defined for care coordinators / lead professionals?

82. The starkest illustration of missed opportunities and failures, is the decision to discharge VC at the same time as the Court was issuing a warrant not backed for bail for his arrest. EIP and mental health teams in the community in September 2022 should have been monitoring as part of "early intervention in psychosis" in the face of knowledge of non-attendance at appointments and failure to collect or utilise his required anti-psychotic medication. This was not a time to step away. It was a time to escalate and take combined multi-agency action to protect the public.

83. The Survivors are determined that lessons are learned and that mental health services are improved for the people of Nottingham.

84. They have considerable concerns regarding the decision to discharge VC back to his GP in September 2022 but also in addition are concerned as to the discharge processes between

inpatient care and community care.

85. The Survivors are also concerned about inconsistent approaches to risk assessments and in particular of the need for risk assessments to be longitudinal in nature, looking at patterns over a number of episodes of care. Enough was known in September 2022 to put together all the pieces of the now clear risk jigsaw and take immediate action rather than a neglectful discharge and inadequate handover to the GP. A GP practice who at no point saw VC before the attacks, with a brief telephone conversation on 1.3.23 inviting VC to book a health check required for his anti-psychotic medication which was declined by VC. [CPSE0000613_0003].

86. Never events are defined as Serious incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national land local level and should have been implemented by all healthcare providers.

87. It is said that Never events may highlight potential weaknesses in how an organisation manages fundamental safety issues process and are essential for improving patient safety. NHFT had plain and clear warnings from other never events in 2023 by the stabbings of other patients who had been patients at Highbury Hospital such as Junior Dietlin, who and his serious incident in February 2023, also a patient said to be under the "care of EIP team at the time of his attacks" and incidents involving Easom Cooper in April 2023 https://share.google/X1c56I3QOu9IoszRg.

88. In a redacted format, these and other warning serious incidents are captured on [NHFT0000603] the Report compiled by Justine Rosser and Theresa Dorey Re: Internally Commissioned Thematic Homicide and Attempted Homicide Review; for NHFT Executive Leadership Meeting.[10] Significantly the case of KK, a patient also discharged from the EIP in March 2023, who on 29 June 2023 aged 32, boarded a Nottingham City Tram and attempted to stab an unknown passenger/member of the public. During the incident KK sustained a fatal stab wound(s). KK too before discharge like VC had been a patient on the same EIP pathway.

89. There are so many missed opportunities and failures revealed in the disclosure, where, had individuals and State agents followed appropriate processes and procedures, then each of the

[10] And as addressed in WITN0133041

six attacks by VC carried out to kill and attempt to murder we are clear could have been prevented.

90. Many who could and should have taken action, failed to take the clearly indicated and appropriate steps to adequately protect the public and in doing so would have protected and saved Grace, Barney, Ian, and prevented the injuries to Wayne, Sharon and Marcin long before the events of 13.6.23 but also on the 13.6.23 itself.

91. This inquiry will hear evidence as to failures in risk assessment and management of the risks presented by VC between 2020- 2023 by many individuals and organisations including:

    Nottinghamshire Police and many of their officers;

    Leicestershire Police;

    The Nottinghamshire Magistrates Court for failing to ensure the warrant not backed for bail for his arrest when he failed to attend court in September 2022 was ever executed- however, we suspect this too will be a failure attributable to the failure to take action by both Nottinghamshire and Leicestershire Police.

    The Metropolitan Police;

    Security Services - The Survivors look forward to understanding why nobody from Security services, CTP or the Metropolitan Police ever asked VC on 31.5.21 or at any point thereafter what he had done that resulted in him requesting repeatedly to be arrested;

    Nottinghamshire Healthcare Foundation Trust including by VC's responsible clinicians, and members of the Early Intervention in Psychosis team, the Crisis Team and CMHT and in its liaison with individuals at Nottingham University;

    Nottingham University;

    The Priory Arnold;

    Cygnet Darlington; and

    VC's General Practitioner.

92. The harm suffered for the Survivors has continued since the attack. Unlawful accessing of their personal and confidential data and data breaches. Many occasions of being forgotten and failed to be mentioned or considered in media reports or invitations to reviews or updates regarding outcomes of processes with which they have the keenest of interests. On many occasions they have felt forgotten and overlooked and in particular by those who should have been supporting them, including during the trial and on the day of sentence.

93. Aspects of disclosure has been very difficult for the Survivors to read with repeated insensitivities. References in documents to them as "walking wounded" who had a "second tier FLO". Victims who not only did not merit their own individual FLOs but who, in the opinion of DCI Claire Gould were victims solely of a RTC who were lucky to have a FLO, rather than was the case, as victims of crime who VC had tried to murder, each deserving of an appropriately trained FLO:

"*I could have made the decision* ***not to deploy FLOs to the RTC victims*** *but given this was potentially an Op Plato incident and clearly anticipated the national interest and scrutiny, I decided to do so, from the limited resources I had." [NGPF0009313*] As it was one FLO was shared between Wayne, Tracey and Marcin.

94. Wayne and Sharon want to know where their letters of condolence from the King said by FLO Johal to have been delivered on 3.7.23[11] are? The Survivors are adamant these were never delivered and for understandable reasons they would like their letters from His Royal Highness King Charles III. Martin had been told by FLO Johal that the Survivors would not be getting any letters from the King or any other member of the Royal family a comment at the time which he remembers as it was particularly tactless If there were in fact letters, the insensitivity in not providing such significant letters that would have given Wayne and Sharon great comfort falls at the opposite end of a trauma informed and victim sensitive approach which FLOs are meant to deliver.

Pen Portraits

95. We thank the Inquiry for the arrangements made to create the pen portraits that will be played in Court on 24 February 2026. These short videos capture the essence of the hard working, decent and kind people Wayne, Sharon, Tracey and Martin are. Each pen portrait, provides a glimpse into the life changing injuries that have been sustained and the devastating ripple effects that have resulted to each one of them as a result of VC's murderous actions of 13.6.23.

96. In short, the people they were **before** 13.6.23 and their completely altered lives from 5.30am that day.

[11] WITN360001_0016

97. Participation in the Inquiry for the Survivors will not be easy as a result of the physical, psychological and emotional impact VC attacks have had on them. Attendance at the hearings comes with personal sacrifices. They are a long way from their homes in Nottingham, but Wayne, Sharon, Tracey and Martin are determined to participate in this Inquiry as they want the truth to come out. They want accountability for failings. They demand that all witnesses act with candour, transparency and frankness. Lessons must be learned. As residents of Nottingham, they want to see meaningful change to ensure that Police, health care and mental health services make the necessary changes to ensure that a day like 13.6.23 never happens again. The Survivors want to see changes so that these public services for the people of Nottingham are fit for purpose and operate always to keep the public safe.

19 February 2026

Sophie Cartwright KC
Deans Court Chambers
Manchester

Leila Benyounes
Parklane Plowden Chambers
Leeds

Instructed by
Greg Almond of
ROTHERA | BRAY