

IN THE MATTER OF THE INQUIRIES ACT 2005
AND IN THE MATTER OF THE INQUIRY RULES 2006

THE NOTTINGHAM INQUIRY

OPENING STATEMENT OF
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST

A. APOLOGY AND RECOGNITION OF IMPACT

1. The events of 13 June 2023 in Nottingham have had, and will continue to have, a profound and everlasting impact upon many people but especially the families and friends of Ian Coates, Grace O'Malley-Kumar, and Barnaby Webber – all of whom lost their lives on that awful day – and for Wayne Birkett, Marcin Gawronski and Sharon Millar and who suffered life changing injuries at that time.
2. The Trust continues to be profoundly moved by the grief and anguish that those who have been most seriously affected by the events of June 2023 express so naturally and understandably.
3. Nottinghamshire Healthcare NHS Foundation Trust (“the Trust”) recognises that in the years before these tragic events there were opportunities that could have been seized and might have been acted on differently. For this, the Trust is profoundly sorry and extends its deepest and heartfelt sympathies to all those involved. With hindsight the Trust also recognises that its engagement with the families of those involved could, and should, have been better.
4. Almost three years have passed since the events of June 2023 but for those most closely involved it will still feel like yesterday. Time has moved on but for those most dramatically impacted by these horrific attacks it will feel as if time never moves on.
5. And it is not just the families of Valdo Calocane’s (“VC”) victims who have been so intensely affected. His own family also have been profoundly impacted.

6. Of course, the Trust's most important apology is rightly extended to VC's victims and their families, but the Trust also regrets the fact that the community it serves may have diminished confidence in the Trust's ability to provide to some local people with the high-quality care and treatment that they need, and it recognises the impact of these events on the Trust staff who cared for and treated VC. Many of these staff will be giving evidence to this Inquiry and the Trust recognises the impact these events have had on them too.
7. This Inquiry will examine in depth the role of numerous organisations and their staff, with a view to establishing the facts and identifying lessons for the future. However, for the victims and their families it will be a painful reminder of those terrible events, and we feel deeply for them.
8. The Trust hopes that the Inquiry concludes with enduring national recommendations that truly minimise the risk of events like this ever happening again.

B. INTRODUCTION TO THE TRUST

9. The Trust is an NHS provider delivering integrated services across mental health, intellectual and developmental disability, community services (including hospice) and physical health. The Trust provides services to the population of Nottingham and Nottinghamshire (combined population approximately 1.1 million) across a variety of settings, including community locations, acute wards, community hospitals, children's centres, health centres, GP practices, plus people's own homes. The Trust is also a provider of regional and national forensic mental health services. The Trust has approximately 2.5 million patient contacts per year.
10. The Trust operates within a wider national landscape, with policy and priorities often set at this level and then implemented at provider level accordingly. It was the publication in 1999 of the National Service Framework for Mental Health that established quality standards for mental health services and led to the introduction of Early Intervention, Assertive Outreach and Crisis Intervention teams. As William Vineall explains in his witness statement evidence on behalf of the DHSC [paragraph 10, page 3, WITN0155001], "the Secretary of State is responsible for setting the strategic direction and the priorities for NHS bodies", with commissioners (currently NHS England and Integrated Care Boards) responsible for determining what services are provided to patients through the contracts they enter into with providers like the Trust.¹

¹ See also paragraph 14 of William Vineall's statement [WITN0155001].

11. More recently, in the period from 2012 when the commissioner/provider split was introduced, policy and priorities have been communicated from DHSC to NHS England through the annual mandate to NHS England. William Vineall states that the mandates in place during the period 2012-2025 “show that the Secretary of State considered that mental health provision requirement improvement” [paragraph 42, page 14, WITN0155001]. An important development during this period was the publication in 2016 of the Five Year Forward View for Mental Health², which included specific commitments around those experiencing psychosis.
12. Dale Bywater describes,³ in his witness statement evidence on behalf of NHS England, the national variation that exists in terms of Assertive Outreach and the work that has more recently been undertaken by NHS England and ICBs to “strengthen intensive and assertive outreach”. The Trust describes later in its Corporate Witness Statement [table at paragraph 514, WITN0133001] and in this Opening Statement its work in relation to assertive outreach and how it uses data to support this.
13. In the post-Covid period, the Trust’s view is that there has been an understandable focus on children and young people’s mental health, adult community mental health and psychological therapies, and suicide. There has also, rightly, been a focus on early intervention and preventative initiatives. However, it may be that this Inquiry presents a renewed opportunity to consider those with severe and enduring mental health conditions. Current proposals for transformation within the NHS, including through the 10-Year Plan, present both an opportunity and a risk in the Trust’s view, in terms of ensuring that the needs of those with severe mental health conditions are not negatively affected by the development, and consequential resourcing, of initiatives like neighbourhood health [WITN0133001, paragraph 534].

Services

14. The Trust provides a wide range of services for children, young people, adults of working age and older adults supporting their physical and mental health needs as well as providing services for those with an intellectual and developmental disability. These include community-based nursing and therapy teams to meet specific needs, as well as universal services such as health visiting and school nursing for children and families.
15. The Trust also provides specialist services nationally, including the National High Secure Deaf service, the National High Secure Women’s service, the National High

² See paragraph 13, WITN0133001.

³ See paragraphs 317-329, WITN0310001

Secure Personality Disorder Service and The Nottingham Centre for Transgender Health.

16. The Trust is one of three designated high-security mental health providers (as approved by the Secretary of State for such purposes [NHSE0000020]).
17. Since October 2023, the Trust has operated through three Care Groups: Mental Health, Community Health, and Forensic Care [see paragraphs 81-84 of the First Witness Statement of Diane Hull, WITN0133001]. These Care Groups help ensure that operational delivery is aligned with specialist clinical pathways and local geography, ensuring clear accountability for both quality and performance. Each care group is led by a tripartite leadership team involving a Care Group Director, Care Group Nurse Director and Associate Medical Director.
18. The Care Group most relevant to the matters that the Inquiry is exploring is the Mental Health Care Group. This Group serves the population of the City of Nottingham, Nottinghamshire County and Bassetlaw, comprising four Care Units (Mental Health Inpatient and Crisis, Older Persons, Children's and Young People, and Adult Mental Health Community), each led by a triumvirate leadership team.
19. Inpatient services operate from main bases including Highbury Hospital, Sherwood Oaks, Hopewood and Blossom Wood, with liaison services embedded in acute hospitals and GP practices. These services provide short-term intensive care for severe mental distress that cannot be safely managed in the community.
20. The Trust operates 11 Local Mental Health Teams serving adults aged 18 to 65 with moderate to severe mental health problems. These teams provide daily triage, assessment, treatment and follow-up, working collaboratively with primary care, social care and third sector providers to deliver comprehensive, holistic support.

Staffing

21. The Trust employs over 11,000 staff, including healthcare assistants, nurses, doctors, and management.
22. Staffing in the NHS is determined within a framework shaped by commissioning and funding arrangements: Trust services are commissioned by organisations including Integrated Care Boards, NHS England at national and regional levels, and Local Authorities (with Trust income in 2024/25 being 44% from NHS England, 44% from Nottingham and Nottinghamshire ICB, 2% from local authorities and 10% from other sources), and these commissioning and funding arrangements shape workforce

budgets, which in turn determine the staffing levels which can be applied to the Trust's services.

23. The Trust retains discretion to determine the specific composition and deployment of staffing within each team's funded establishment through a formal establishment review process.
24. The Associate Directors of Nursing, along with professional colleagues, undertake a detailed review of their clinical areas to understand the staffing profiles based on the right staff, with the right skills, in the right place. This work informs the setting of staffing profiles. The establishment review process is overseen by the Care Group Nurse Director and signed off by the Chief Nurse, with Board oversight provided through the Quality Committee.
25. There is no equivalent of safer staffing for psychiatrists [paragraph 322 of the First Witness Statement of Dr Susan Elcock, WITN0356001]. As teams and clinical services have been set up there is an allocated number of medical posts or sessions, often based on the original service clinical staffing model [paragraph 315, WITN0356001]. Medical capacity is regularly reviewed and posts are moved if needs change [paragraph 324, WITN0356001].

Mental health care

26. Mental health care is provided across a wide range of conditions with varying severity and presentation, from mild/temporary distress to severe, persistent illnesses such as schizophrenia and dementia. Within local mental health teams, the Trust's community treatment offer is structured around five main pathways, including recovery from anxiety and depression, support for complex personality needs, enduring psychosis, early intervention in psychosis (EIP), and a recovery pathway for people with enduring psychosis and complex problems. On average, the Trust provides services to approximately 3,500 adult mental health patients who have a psychotic-related illness, of which around 125-175 are receiving inpatient care at any one time.
27. The Trust acknowledges the complexity and variability of its mental health patient population and care. Patients and the available support represent a complex and varied landscape such that it is impossible to describe a 'typical' approach" to management. The Inquiry will hear from witnesses from the Trust, other core participants, and experts, in relation to the complexity of mental health treatment, including the difficult balance between autonomy and public protection [see paragraph 10 of the First Witness Statement of Professor Sir Simon Wessely, WITN0322001, and page 5 of the Final Report of the Independent Review of the Mental Health Act 1983, WITN0155008]. It

will be important for the Inquiry to have in mind these challenges throughout the evidence it hears, and the impact that it has on patients, staff, and national mental health strategies, in order to establish the context and produce recommendations which can be applied to that complex landscape.

28. The Inquiry has also obtained expert evidence from Alex Ruck Keene KC [WITN0288001], which the Trust has considered with interest. His evidence highlights the complexity and evolving nature of mental health law, including as a result of case law, and the challenges of applying this in a clinical context, including the importance of clear and consistent translation of law into codes of practice and guidance.

Commitment to the Inquiry

29. The Trust approaches this Inquiry with openness, transparency, and a genuine desire to support the process. The Trust's hope is that this Inquiry will serve as a vehicle to improve care both locally and across the mental health sector nationally. The Trust has been, and remains, committed to ensuring that all information needed will emerge through the Inquiry's work.
30. Approximately 160 staff members have given evidence to the Inquiry, including current staff, former staff, and agency staff who had involvement in VC's care, and the Trust has provided support where requested by those individuals. The Trust has not sought restriction orders or anonymity for any member of staff, and it supported a transparent and publicly accessible approach to the Inquiry's hearings. The Trust reiterates its confidence expressed at the time of the Inquiry's Preliminary Hearing that its staff will openly and candidly provide their evidence to the Inquiry.
31. The Trust recognises the impact that involvement in both the events that are the subject matter of this Inquiry, and in the Inquiry process itself, can have on staff. It has therefore offered independent psychological support to those involved, recognising not only its duty as an employer, but also that its staff have valuable accounts to provide to the inquiry, and that they should be supported to undertake this task and provide their best evidence to assist the Inquiry's evidence gathering.
32. The Trust has provided approximately 11,000 documents to the Inquiry.

C. LEARNING FROM INVESTIGATIONS AND REGULATORY ACTIONS

33. Since the tragic events of June 2023, the Trust has been committed to learning from the various investigations and regulatory actions that have followed, including those initiated by the Trust (in addition to the SI report into the treatment of VC, the Trust commissioned reviews into the EIP Team [NHFT0000461], Crisis Services

[NHFT0000462], Local Mental Health Teams [NHFT0000545], and a Thematic Review of Homicides [NHFT0000518]) and those externally commissioned.

34. This has built on the improvement works which commenced prior to June 2023. For example, in early 2023, the Trust's Executive Leadership Team identified a concerning increase in Serious Incidents, inquests, and Prevention of Future Death reports, raising concerns about patient safety, public confidence, and regulatory compliance. An independent evaluation by Helen Collins, conducted between September and November 2023, made 132 recommendations in January 2024 [NHFT0000422], all of which were confirmed as implemented by the Quality Committee in March 2025 [NHFT0000763].
35. Each review to date has been carried out for a specific purpose, within a particular framework, and each has had limitations. The Trust expects that the factual findings and themes arising from previous investigations may change due to the increased volume of evidence before this Inquiry, which is able to go further than previous investigations by looking at VC's mental health care in the wider context of all agencies (as discussed at D below).

SI report / Internal Investigation

36. The first NHS review of the care and treatment provided to VC was the Trust's Serious Incident investigation. This was conducted as a Level 2 Comprehensive Internal Investigation [as per the Serious Incident Framework, NHSE0000058], but with the support of an independent chair (from an external company, Psychological Approaches).⁴
37. Although the Serious Incident investigation was commenced promptly in the immediate aftermath of the events [see paragraphs 475-76 of the First Witness Statement of Diane Hull, WITN0133001 and NHFT0000583], on 20 July 2023, Nottinghamshire Police requested that the investigation be paused given the live criminal investigation that was ongoing [NHFT0008391]. As a result, the tabletop review of VC's clinical record was delayed until October 2023 and staff interviews were conducted in November 2023 [NHFT0008391], once the Police had confirmed that this step could proceed. It proceeded fairly promptly from that time, although as the Trust has recognised the intended involvement of the Families of those who were killed or injured by VC did not take place. The Trust reiterates its apology for this and the detrimental impact this had on their understanding and trust in the investigation [NHFT0000494, NHFT0000495,

⁴ See also paragraphs 535-537 of Dale Bywater's witness statement evidence on behalf of NHS England [WITN0310001].

NHFT0000496, NHFT0000497, NHFT0000498, NHFT0000499, NHFT0000500, NHFT0000501, NHFT0000502]].

38. The investigation panel examined the care provided by the Trust to VC from the first contact it had with him in May 2020 until his discharge back to his GP in September 2022. It accessed VC's medical records held by the Trust, Trust Policies and Procedures, national guidance and policy, and interviewed a small number of Trust staff who the investigation panel considered were relevant to their investigation.
39. The report was finalised by Psychological Approaches on 15 March 2024 [NHFT0000452]. The report considered that VC's risk of violence to others was moderate overall rather than high, exclusively driven by a deterioration in psychotic symptoms, and that no reasonable risk formulation in September 2022 would have anticipated a fatal attack perpetrated on strangers with a weapon. The report noted several areas of good practice, including in terms of contact with family, collaboration between teams and thoughtful care provided by the EIP team. However, the panel identified some learning points, detailed throughout the report. The Trust fully accepted the findings made by the Panel.

CQC Section 48 Review

40. After VC's conviction in January 2024, the Secretary of State commissioned a CQC rapid review under section 48 of the Health and Social Care Act 2008 [WITN0133001, paragraphs 490-495]. It was published in three parts—parts 1 and 2 in March 2024 [CQCM0016517], and part 3 relating specifically to VC's care in August 2024 [CQCM0016518].
41. Whilst the CQC reviewed VC's care records, it did not interview or speak with any member of Trust staff involved in VC's care. The review does not look more widely than the Trust's care of VC, for example, it does not comment on VC's interactions with the police, other than where this converged with the care provided by the Trust⁵.
42. The CQC found no single point of failure but identified errors, omissions and misjudgements, including inconsistent approaches to risk assessment, lack of holistic care planning, gaps in follow-up and engagement (including family information not consistently acted on), lack of evidence of consultation with VC's family, GP, university and police at discharge, and concerns about medication management, depot/CTO consideration, and discharge decision-making. The CQC made nine recommendations

⁵ See "Scope of our report" CQCM0016518 pages 8-9

to the Trust (and seven to NHS England). The Trust accepted all those recommendations directed to it and developed an action plan to implement them.

Theemis Report

43. NHS England commissioned Theemis Consulting Ltd (“Theemis”) to investigate VC’s care by NHS services between May 2020 and June 2023 [paragraphs 535-555 of Dale Bywater’s witness statement evidence on behalf of NHS England [WITN0310001]. This was an Independent Homicide Investigation, as per the Appendix 1 of the Serious Incident Framework [NHSE0000058].
44. Theemis conducted interviews with some members of Trust staff. The Trust also understands that they interviewed representatives of two independent acute mental healthcare providers, primary care staff, the Integrated Care Board, VC’s family and VC himself. The investigation also consulted the author of the Trust’s internal investigation report and mental healthcare experts to provide wider context. The Trust understands that the University of Nottingham declined to be interviewed but provided written evidence and that Nottinghamshire Police were unable to engage due to an ongoing Independent Office for Police Conduct investigation. Theemis’ document review included publicly available papers, national policies, legislation, mental health reports, professional guidance and academic papers, alongside local Trust policies, governance structures, serious incident investigations, Board papers and internal reviews covering 2020-2023. They reviewed VC’s clinical notes, from Trust services, two independent providers and primary care⁶.
45. The investigation was finalised in January 2025 [NHFT0000530] and issued 12 recommendations, 10 of which were directed to the Trust. The Trust has accepted all recommendations with an implementation action plan and is actively implementing these.

Themes arising from the Investigations conducted to date

46. The Trust would suggest that from the totality of the three reviews, the following themes have emerged as areas of focus:
- I. **Risk Assessment and Management:** concerns were identified about inconsistent approaches to risk assessment, with risk assessments potentially minimising or missing key details. Further, the reviews highlighted the apparent difference in understanding as to how risk

⁶ See “Evidence Collection” NHFT0000530 pages 46 – 48.

assessments should be used to respond to changing circumstances and thereby inform risk management.

- II. **Discharge Planning and Processes:** issues were identified around discharge planning, with questions raised about the adequacy of longer-term understanding and planning around VC's pattern of behaviour, risks and needs, which had a consequential impact on how well he was managed in the community. Specific concerns were also identified around the decision to discharge VC back to his GP in September 2022 and the Trust recognises this will also likely be a key area of focus for the Inquiry. Improvements were identified in terms of the Trust's processes and protocols for discharge, including how to manage non-engagement.
- III. **Depot and Use of Restrictive Options:** each review considered the way in which VC's medication was managed and whether options, including the use of depot medication, had been sufficiently considered. Questions were raised around whether VC's preferences around medication were appropriately balanced with other information, as well as whether non-concordance was understood as a risk feature of his illness.
- IV. **Mental Health Act Application:** over the course of VC's four admissions to inpatient mental health care, differing clinical approaches were taken as to the basis for his detention and, specifically, whether to use Section 2 or Section 3 of the MHA. This was explored in each review, along with the consequential impact this had on options for care in the community.
- V. **Patient Engagement and Follow-up:** teams did not take sufficient steps to follow up and re-engage people, for example there were large gaps between visits and no face-to-face review of VC in September 2022 to determine his mental state prior to discharge. Discharge in the absence of a face-to-face meeting with a patient created potential for greater risk.
- VI. **Family and Multi-agency Communication:** VC's family were not told about his discharge or advised how to access services should they have concerns in the future, and the Trust did not write to VC directly to inform him of his discharge. VC's GP, Nottingham University and the police were also not consulted when VC was discharged back to his GP. There were not effective processes for ensuring the sharing of knowledge between the Trust, primary care and the Police to inform estimation of risk and insight on effectiveness of care and treatment. There was also a concern about whether the voice of VC's family was considered in relation to dynamic risk evaluation.

- VII. Care Planning:** compliance with national guidance, and whether teams took a holistic approach by considering how future non-concordance with medication, disengagement from services and how deteriorating mental health might be responded to.
- VIII. Clinical Decision-Making and Documentation:** teams did not fully record or reflect their professional thinking and rationale for decision-making, as there was as a lack of shared decision-making across teams.
- IX. Balancing Patient Rights and Risk Management:** Whether too much emphasis was placed on positive risk management and complying with VC's priorities for his education, and sufficient weight was given to the risks associated with non-concordance.

47. The Theemis report, perhaps due to its wider remit and evidence base, was able to go further than the previous investigations to focus on the following additional themes:

- I. Service Configuration and Resources:** The majority of dedicated assertive outreach teams were disbanded over 10 years ago, and whilst VC's clinical records demonstrated an element of an assertive approach, this was constrained by the service model and workload within the team. EIP staff were working with caseloads beyond recommended levels, and the complexity and acuity of service users was not reflected in workload allocation, with a lack of Trust oversight to identify signs of staff's inability to effectively deliver the intended model of care. The Trust had to send VC to beds out of area due to lack of local capacity, and these admissions came at an important point when a pattern of inpatient engagement versus community non-engagement was forming, representing a missed opportunity to explore a Community Treatment Order.
- II. Organisational Governance and Oversight:** Ahead of the COVID-19 pandemic there was evidence that Trust governance structures and processes needed strengthening to ensure 'ward to board' visibility of key information, with the impact of COVID-19 potentially compounding existing issues around organisational structure and change. Existing processes and organisational approaches to managing incident data specific to harm to others did not support effective oversight and learning, with an absence of a robust approach to risk management and assurance to the Board on evaluation and effectiveness of intended controls. Frontline risks created by workforce issues and increased use of subcontracted providers did not

appear to be visible at Board level, instead being primarily managed by community NHS staff.

- III. External Oversight and System-Wide Issues:** Assurance and oversight arrangements at the ICB in 2023 had limitations, were not formalised or robust enough to fully identify signals of issues with safety and risk, and governance arrangements were not mature enough to triangulate intelligence with partner organisations. At all levels of the regional healthcare system there was knowledge about the challenges faced by the Trust, yet despite this knowledge, the risk remained for Trust frontline staff to manage.

48. The Trust has set out in its corporate witness statement [WITN0133001] its key reflections arising from these reviews in relation to the care provided to VC and it has had the opportunity to reflect further in light of the documentary evidence gathered by the Inquiry, as detailed below.
49. The Trust's "Integrated Improvement Programme" in 2024/2025 focussed on immediate actions required, whereas the "Refreshed IIP" of 2025/2026 moved to focus on meeting regulatory requirements around the Section 48 review and implementation of the Theemis recommendations [NHFT0002439 p22]. The Trust is actively working to address the actions contained in the Refreshed IIP and progress is being monitored, including through assurance to external stakeholders.

D. FURTHER UNDERSTANDING OF VC TREATMENT AND INTERACTIONS

50. The gathering of evidence through the Inquiry process has been more comprehensive than any other investigation that has taken place to date. Across all core participants, far more people have been involved in providing evidence, and far more records have been reviewed, which will provide this Inquiry with a fuller picture of the treatment of, and interactions with, VC.
51. One of the first tasks that the Trust undertook to support the Inquiry was the production of a chronology relating to the care and treatment provided by the Trust to VC [WITN0133001 Annex D]. This was done purely on the basis of the information contained in VC's Rio record and, in terms of the post-incident interactions, information contained on SystemOne.
52. It has subsequently become increasingly clear to the Trust that the information documented in the chronology does not tell the full story. The key reasons for this are:

incomplete record keeping and information not previously available to the Trust in relation to multi-agency working and information sharing.

53. The wider remit and evidence gathering undertaken by the Inquiry has therefore had an impact on the Trust's understanding of events, which has developed throughout this process. Before addressing specific aspects of VC's care and treatment, the Trust wishes to make clear that it does not want to influence the evidence that its staff will give to the Inquiry. Staff should continue to be able to tell their version of events in a manner uninfluenced by any organisational view the Trust has to best assist the Inquiry in discharging its tasks under the Terms of Reference, including in terms of establishing a definitive and comprehensive chronology of events. For this reason, the following areas are intended as key areas that the Trust anticipates the Inquiry will wish to explore and are set out in relatively high level. The Trust recognises that this may mean a more developed understanding about certain aspects of VC's care will emerge as the Inquiry hears oral evidence.

Documentation and Record-Keeping

54. As discussed above, a significant issue that has emerged through the previous investigations into these events is that, at times, it is difficult to understand from the documentary record what happened and why, because the documents do not provide sufficient information. The Level 2 investigation, for example, identified that record-keeping did not adequately capture professional thinking and rationale in complex decisions [NHFT0000452 pages 18, 22, 34]. The Trust is therefore left with the need for detailed factual examination of witnesses to understand decision-making processes, as will be done through the Inquiry's hearings.
55. This has shone a light on the critical importance of documenting not only decisions themselves, but also the rationale behind them—the clinical reasoning and working-out that leads to a particular course of action.
56. In particular, the lack of documentation of multi-disciplinary team decision-making has been identified as a problem when seeking to examine events retrospectively. For example, there are no minutes of the MDT meeting (the corresponding entry within the RiO record notes the fact of an MDT discussion having taken place, along with a high-level summary of the rationale for discharge - NHFT0000168, page 271) on 22 September 2022 when it was decided to discharge VC to his GP (see paragraph 54 of the First Witness Statement of Dr Tuhina Lloyd [WITN0357001]). This means that it is not readily apparent from the contemporaneous documents: who was present; what was discussed; and the rationale for any decisions taken. The Trust understands that

this is because the relevant team did not keep minutes of such meetings [see paragraph 247 of the First Witness Statement of Diane Hull, WITN0133001]. It is now Trust policy that minutes are kept of all MDT meetings, including a log of actions [see paragraph 248 of the First Witness Statement of Diane Hull, WITN0133001].

57. The personal accounts of staff involved in VC's care will therefore be highly relevant to the Inquiry's work. It also appears that the Rio records may not reflect the contents and depth of the discussion that had taken place, although this will likely be a matter for the Inquiry to explore through oral witness examination.
58. The Inquiry will also want to understand who was present in these meetings; noting the differing recollections witnesses have provided; compare, for example, paragraph 347 of Dr Tuhina Lloyd's First Witness Statement [WITN0357001], with the evidence given by Abigail Parsonage [WITN0317001, paragraphs 209-12], Frances Doughty [WITN0385001, paragraph 81-83], Emma Robinson [WITN0315001, paragraph 106], Adele Pinder [WITN0396001, paragraph 175], Paul Williams [WITN0122002, paragraph 7-8] and Gary Carter [WITN0368001, paragraphs 294-295, 304]. In addition, paragraph 362 of the First Witness Statement of Dr Tuhina Lloyd [WITN0357001] states that she cannot remember why Sharon Heath, the EIP team leader, wrote the discharge papers rather than VC's Care Co-Ordinator Gary Carter. Sharon Heath states, in paragraph 43 of her First Witness Statement [WITN0292001], that Gary Carter was on leave [paragraphs 291 and 295 of the First Witness Statement of Gary Carter, WITN0368001] and, while she cannot remember with certainty, she suggests this may be why she took on this task.

Multi-Agency Working and Information Sharing

59. A core aspect of the Inquiry's work will be establishing a complete chronology of the treatment of, and interactions with VC across all agencies. A review of the evidence provided by other Core Participants has highlighted gaps in the Trust's knowledge at the time of treating VC, particularly in terms of the scale of the incidents that VC was involved in that were attended by the police. This awareness is emerging as the Trust reviews Core Participant evidence and will likely continue as the evidence progresses and is heard by the Inquiry.
60. The Trust would suggest that one striking feature that has emerged through the evidence gathering process is that there are multiple versions of the same incidents recorded by different agencies. This reinforces the critical importance of effective cross-organisational and multi-agency working. A common understanding of risk incidents,

including: what they are, how they should be classified, and what they mean, is essential to support accurate assessment and a proper longitudinal view of risk. This relies on strong multi-agency information sharing.

61. The Trust's review of the written evidence disclosed to-date by other Core Participants shows that there are incidents which were not shared with the Trust and appear to have been seen and dealt with in isolation. On the information currently available to the Trust, and in hindsight, it is hard to know whether these instances in isolation should or could have been shared with health services, but the Trust suggests that they would have added value to the information the Trust had regarding VC at relevant times, particularly as they coincide with times where concerns were emerging or where VC was disengaging and therefore would have been key to support more understanding about his mental state.
62. This is particularly apparent on the following occasions. First, the period to August 2021, which was a period in which VC appeared to be relatively stable and living in the community. Reflecting on this emerging additional context, and seeking to avoid hindsight bias, it is likely that at the very least this information would have enhanced the clinical team's understanding of VC's mental state and risk profile, enabling more informed decision-making and potentially prompting additional safeguarding measures or closer monitoring during critical periods.
63. For example, the evidence shows that there was an incident involving VC outside MI5 headquarters in London on 31 May 2021 (see evidence of PC William Nash [WITN0003001 paragraphs 6-26], PC Graham Foster [WITN0004001 paragraphs 6-24], Superintendent Busby-McVey [WITN0012001 paragraphs 5-11]). On 29 May 2021, VC's mother had contacted the Trust, concerned about his mental health and a nurse called him and was assured that he was not deteriorating [NHFT0000168 p153]. A face-to-face visit took place on 2 June 2021, without the knowledge of the MI5 incident [NHFT0000168 p154]. Although staff had responded to VC's concerns, without the knowledge of the MI5 incident, there was at that time nothing tangible for the team to address with him: he reported that he was mentally well and compliant with medication, and there were no signs of deterioration.
64. The assault by VC on his flatmate on 5 July 2021 (see evidence of Sebastian [WITN0151001 paragraphs 27-35], PS Zoey Price [WITN0016001 paragraphs 15-19], PC Amy Pannell [WITN0015001 paragraphs 8-22]) was not shared by the Police with the Trust, despite the fact that it is reported that the police officer advised the victim to consider making VC's mental health nurses aware of the incident when they next called.

It is also during this period when, according to the evidence of VC's family, VC drove to the family home in Wales but refused to enter the house because the people in his head would put his family in danger, and in addition to the voices, he said that people were able to access his vision like a camera, read his mind and give him visions and dreams. He told his family that this was called 'remote neural monitoring'. The Trust was unfortunately not made aware of this detail [WITN0085101 para 57].

65. It is of note that these events were during VC's longest period in the community, and the detail of these incidents would have been key to develop a wider understanding of VC given that he gave very minimal information to Trust staff during this time. The Trust recognises that it is difficult to understand how this would have impacted on his treatment. However, it would suggest that if these incidents had been known to those treating VC, it would have given more context to the formulation and understanding about his mental health over the longer term.
66. Second, the Trust has also learned further details through the Inquiry about VC's admission to the private provider Cygnet in September 2021 (see evidence of Charlotte Metcalfe [WITN0290001 paragraph 12], Andrew Clark [WITN0295001 paragraph 7], and Nieve Raw [WITN0231001 paragraph 12]). It is reported that he expressed delusional thoughts and ideas around psychotropic/electronic harassment, believing it to be the authorities' way of punishing him for breaking lockdown rules the previous year. Again, the Trust was not made aware of this which, as above, this may have added to Trust clinicians' knowledge and give a wider ability to develop informed clinical formulations. Similarly, one of VC's community consultants has set out in her evidence that her team did not have opportunity to contribute to VC's discharge plan on discharge from the Priory in October 2021 (Dr Tuhina Lloyd [WITN0357001 para 270 - 271])
67. Third, the Trust is also now aware of reported stalking incidents involving VC's former flat mate in April, May and July 2022, which was the period when VC was disengaging, and in the lead up to his discharge from Trust services (Sebastian [WITN0151001 Paragraphs 53-55, 57-58], PS Langham [WITN0029001 Paragraph 8-18, 28 – 30], and PC Sarah Barnes [WITN0043001 Para 9-14, 21-26]). As they were not known to the Trust, they were not taken into account. These events were in the same time period that VC had accessed a previous flat and was escorted off the site in April 2022 (see evidence of Eleanor Turner [WITN0054001 para 121 – 122]) which was relayed to VC's Care Co-ordinator. Whilst the clinical team were aware of one (non-violent and non-confrontational incident), the lack of visibility of this as part of a series of incidents meant that they did not have access to intelligence about his presentation in the community

which would have enabled a more detailed understanding about him. These additional incidents might have triggered further Trust action or led to more enquiries being made.

68. Fourth, the Trust has since been made aware of a warrant for VC's arrest that was issued on 22 September 2022 due to VC's failure to appear at Nottingham Magistrates' Court, following a charge for assaulting an emergency worker on 3 September 2021. After this, VC was not arrested and no proactive steps (other than circulating VC as wanted on the PNC and placing the warrant in the relevant tasking folder) were taken to locate VC (see evidence of TDCC Griffin [WITN0074001 paragraphs 217, 630, 941]). This was at the time that VC was discharged from the Trust's services (on 23 September 2022) and the Trust wonders whether better joint working and more proactive communication from the police regarding this warrant would have enabled more curiosity about VC's mental state at that time. There was therefore much more information regarding VC's actions, which could have informed his mental state in the period running up to VC's discharge, which the clinical team was not made aware of and may have resulted in a different course of action being taken [see the First Witness Statement of Dr Lloyd [WITN0357001, at paragraph 390).
69. Fifth, the Trust was not aware of the incident at VC's workplace Avarto on 5 May 2023 when he allegedly punched a man and pushed a woman over (see evidence of Volodimir **GRO-B** [WITN0057001] and statements of PC Connor Amos-Perkins [WITN0010001 paragraphs 7-19], PC May-Taylor [WITN0009001 paragraphs 9-23] Temporary Chief Constable David Sandall [WITN0001001 paragraphs 17-19], and T/PS Mark Read [WITN0011001 paragraph 18]). Another witness recalls telling the police that it seemed VC was mentally unstable (see Louisa Beed [WITN0373001]. This was potentially a further missed opportunity to assess VC's mental state or collaborate with wider system partners.

Discharge decisions

70. It is clear to the Trust that the Inquiry will want to explore in detail with the clinicians and nurses who were involved in caring for VC in the community, following his final discharge from inpatient services in February 2022, and will want to understand the rationale and decision-making around his discharge from the Trust's services in September 2022. It is equally clear to the Trust that there are significant questions to be answered.
71. The Trust's internal Level 2 investigation [NHFT0000452] identified learning including discharge planning and risk management issues: the need to review and update written

care plans and risk assessments at discharge; the importance of relapse, crisis and contingency planning; and the need to share a risk formulation and future crisis plan with the GP. The investigation also identified failures to appropriately involve and notify VC's family at discharge.

72. There are questions over how actively those responsible for VC's care tried to engage with him in the months before his final discharge, and whether his disengagement was seen as a red flag—as part of him becoming unwell—or whether they interpreted it as indicating he must be stable. The Trust recognises that whilst the evidence will enable the Inquiry and families to understand why certain decisions were taken, this will not change the outcome or remove the need for critical examination.

Risk Assessment of incidents

73. The CQC has previously identified the inconsistent approaches taken to risk assessment by clinicians, and highlighted concerns that VC's documented risk profile did not adequately reflect the incidents that occurred. The Trust accepts that the lack of factual descriptive evidence in records seems to have resulted in the minimisation of significant risk events.
74. There also does not appear to have been a longitudinal view of VC's risk throughout the period he was under the Trust's care, and there may not have been a clear enough understanding of each incident to enable clinicians to see his presentation in the round.
75. The Trust acknowledges but does not propose to address in detail in this opening statement the consequential clinical decisions around community treatment orders and depot medication, recognising that expert evidence will address these matters and that there are differing views among experts and clinicians, which it will be important to hear in evidence.
76. Another barrier to effective information sharing has been clinicians' interpretation of their duties around confidentiality and the privacy of medical records.

Post-Incident Engagement with Families

77. Regrettably, the Trust has found itself navigating a difficult conflict between wanting to do the right thing and supporting people in a compassionate way, whilst also operating within the boundaries and framework around criminal proceedings and data protection. The Trust believes that in similar circumstances, it would push back more robustly now than it did in 2023.
78. The Trust acknowledges that, in hindsight, its involvement and engagement with families has not felt satisfactory. In this case, the Trust has been engaging with victims'

families to whom it has no duty of care as their loved ones were not patients of the Trust, and the guidance from NHS England does not adequately address how to navigate this situation.

79. With regard to VC's own family, the Trust accepts that it could and should have done more, whilst recognising that it is understandable that family contact was at times inconsistent given the difficult circumstances all were facing.
80. Key learnings for the Trust include: the extent to which the Trust allowed itself to be directed by the police in terms of what contact could be had with victims and their families; and the broader questions around the duty of candour, i.e. what should be said, what documents should be shared, and with whom, in circumstances where there is no clear national guidance to assist organisations in navigating these complex situations.

E. HOW THINGS ARE DIFFERENT TODAY

General Changes

81. Nearly three years have now passed since these events. The Trust appreciates that to those directly impacted by the events of June 2023, it will still feel like yesterday and will continue to do so for a very long time. In that time, however, there has been a great deal of change nationally, in the NHS, and at the Trust.
82. One illustration of the difference between then and now is that when VC was receiving care from the Trust, between 2020 and 2022, it was at the height of the COVID-19 pandemic. The Inquiry will hear from various witnesses about the specific impact that the pandemic had on the Trust, and the care they delivered. That is just one way in which the Trust is a very different place to what it was in 2023.
83. Since June 2023, the Trust has operated under Regulatory Enforcement Undertakings and National Oversight Framework ("NOF") Level 4 oversight, as well as significant CQC regulatory activity and requisite actions. (The background to the Trust entering NOF 4 and the Regulatory Enforcement Undertakings required is set-out on pages 148-152 of Dale Bywater's witness statement evidence on behalf of NHS England [WITN0310001]).
84. In response to this regulatory environment, the Trust made a strategic decision to prioritise quality and safety stabilisation. Navigating this environment; working to make the improvements needed; while seeking to continue to deliver mental and community health services to our population has been challenging. The Trust accepts it has not

always got the balance right between driving turnaround and enabling long-term, sustainable cultural transformation.

85. The CQC's recent Well Led report provided assurance as to the progress that the Trust has made in establishing strengthened and improved quality and safety systems and processes, while clearly identifying areas where the Trust has not moved quickly enough to make improvements: culture, staff experience, and equality and diversity.
86. The report acknowledges progress the Trust has made in these foundational areas, including improvements in patient safety infrastructure, governance frameworks, and clinical leadership. It recognised strengthened clinical leadership and accountability frameworks, as well as the substantial investment and positive impact that the Trust has seen through its work to improve patient safety. This includes through the expansion and bringing back in-house a dedicated patient safety team, under the leadership of the Chief Nurse; the development of SafeNow (which we return to in the next section of this Opening Statement); and strengthened family liaison and mortality review processes.
87. One of the areas the Trust has acknowledged that it was not delivering as well as it could or should have was in the way that it engages with carers and families, including families of victims of incidents of mental health homicide and attempted homicide. A dedicated Family Liaison team was established in April 2022 and work continues to strengthen and improve the way that this team supports carer and family involvement, including through Patient Safety Incident Response Framework-aligned reviews, including involvement in terms of reference, raising questions and concerns, receiving updates, receiving draft reports, and providing 'pen portraits'.
88. No services today remain rated inadequate by the CQC, which represents a fundamental shift from where the Trust was. The Trust sees the Well Led report as capturing the Trust at a pivotal point as it transitions from stabilisation to broader transformation.

Staffing Context

89. As described earlier in this Opening Statement, the Inquiry has gathered evidence from a wide range of current and former Trust staff, including agency workers. During the period VC was receiving care, approximately one-third of the staff who had contact with him were not established members of staff but were agency or temporary workers. The Trust understands that the Inquiry may wish to explore what impact this may have had. In the period from January 2019 to January 2026, the Trust has worked to reduce the

use of agency and bank workers and to improve its staff retention rates. The data on this shows real progress has been made:

- I. Agency usage has reduced from 79.55wte to 23.90wte (70% decrease).
- II. Bank usage has reduced from 218.81wte to 199.26 (7% decrease).
- III. Overtime usage has reduced from 15.43wte to 5.90wte (62% decrease).

90. However, the Trust recognises that how it feels to staff when working in a team is not driven solely by staffing establishments but also by factors such as levels of sickness absence and the intensity and complexity of the clinical activity being undertaken. Acuity has increased significantly in community teams, with total Local Mental Health Team caseload rising from 8,619 in July 2022 to 10,107 at present. As at March 2025, the average time to first assessment for patients seen by Local Mental Health Teams is 9.6 weeks, and 1,730 patients were waiting for Local Mental Health Team assessment—the highest monthly level for over 24 months. This demonstrates that whilst improvements have been made in some areas, demand pressures remain significant.

91. The feeling of being under pressure is fuelled by acuity and complexity, and also by issues of confidence and experience. The Trust, like many mental health providers, now has a higher proportion of newly qualified nurses in roles that historically would have been filled by more experienced practitioners.

92. To address this, the Trust has invested in training programmes designed to ensure that staff working with patients with serious mental illness have both the confidence and the clinical skills to provide high-quality care, with a particular focus on working effectively with families. The Trust introduced updated Clinical Risk and Safety training beginning in November 2024 for inpatient services, with roll-out across community, crisis, liaison, older persons, forensics and specialist services continuing through 2025 with completion targets into March 2026.

F. SPECIFIC PREVENTATIVE IMPROVEMENTS

93. The Trust recognises that learning from incidents needs to be followed by actions that make an impact and has sought to focus its improvement work on changes that are genuinely preventative and reduce the risk of similar events occurring in the future.

94. Two of the changes described below fall under the overall work that the Trust has carried out to develop the SafeNow dashboard in response to the recommendations made by the CQC following its section 48 review [see September 2024 report on SafeNow, NHFT0001252, paragraphs 521-526 of the First Witness Statement of Diane

Hull, WITN0133001, paragraphs 30, 342-344, 468 of the Second Witness Statement of Diane Hull, WITN0133041, paragraph 81 of the First Witness Statement of Susan Elcock, WITN0356001, and the November 2025 update on SafeNow, NHFT0015911, NHFT0017616]. This dashboard allows the Trust to review key safety indicators weekly and triangulate metrics across its electronic systems (Rio, AMaT, Ulysses). It tracks around 50 metrics across adult and older people's mental health inpatient, community and crisis services and is used in a structured weekly review cycle, with actions escalated to the Executive Leadership Team and monthly reporting to NHS England. The positive impact that the use of SafeNow has had on data driven decision making and harm reduction is noted at paragraph 507(d) of Dale Bywater's witness statement evidence on behalf of NHS England [WITN0310001].

95. Two aspects that are particularly relevant here are the way in which SafeNow supports a strengthened approach to (a) disengagement and patient engagement and (b) risk assessment.

Disengagement and Patient Engagement

96. Each community pathway (e.g. EIP, Local Mental Health Teams, Assertive Outreach) has access to a patient engagement report, showing how many patients on their caseload have recorded multiple "Did Not Attends" ("DNAs"). Crucially, nobody is now discharged from the Trust's services simply because they have disengaged. The Trust has implemented a new patient engagement plan and assertive outreach pathway for patients known to be more complex and at risk of disengagement [see paragraph 530 of the First Witness Statement of Diane Hull, WITN0133001, paragraphs 262-263 of the Second Witness Statement of Diane Hull, WITN0133041, paragraph 405 of the First Witness Statement of Iftikhar Majid, WITN0263001]. These both reduce the risk that someone disengages and enables the Trust to take more assertive steps to try to re-engage individuals before their condition deteriorates. For patients on the Assertive Outreach pathway, two "Did Not Attends / DNAs" being recorded on teams engagement dashboard means that the team picks them up in a weekly meeting and they compile a bespoke exception report which can gather vital information such as when they were last contacted, whether they have taken their medication, and contact with family.
97. Sitting above the engagement report for each pathway, the SafeNow dashboard is an overarching system allows the Trust to have oversight of all community patients [see table at paragraph 514 and paragraph 362 of the First Witness Statement of Diane Hull, WITN0133001]. It includes a "discharge due to disengagement" metric as a failsafe across all services [see example report presented at the Trust Executive Leadership

Team at NHFT0017695]. If a team tries to discharge a patient due to disengagement, it will flag in SafeNow, triggering a mandatory review by senior leadership, for example an Associate Director of Nursing or Associate Director of Operations, who will examine the case with the clinical team to determine whether the discharge is appropriate and all of the necessary engagement steps have been taken. If a discharge attempt is flagged, the senior team would typically redirect the clinical team to continue engagement efforts rather than proceed with discharge, unless there were other factors which meant that discharge was appropriate (acknowledging that the Trust deals with a very broad spectrum of mental health conditions and severity).

Liaison with Other Agencies

98. The Trust has undertaken significant work to improve liaison with the police and other agencies. The Potentially Dangerous Person pathway is a supportive and proactive multiagency Police led pathway, that considers the strengths and vulnerabilities of individuals alongside safeguarding, to put positive strategies in place to reduce the risk of harm [see paragraph 388 of the Second Witness Statement of Diane Hull, WITN0133041, paragraphs 557-559 of the First Witness Statement of Iftikhar Majid, WITN0263001]. A Potentially Dangerous Person (PDP) is someone who:

- I. Shows behaviour suggesting they have the potential to cause serious harm;
- II. Does not meet MAPPA or PREVENT criteria;
- III. Cannot be managed safely through normal agency processes alone (e.g., Mental Health services, safeguarding, police).

99. PDP is used only when:

- I. There is credible evidence of possible serious physical or psychological harm; and
- II. Existing safeguarding routes are not enough.

Risk Assessment and Discharge Standards

100. Since SafeNow's implementation in May 2024, risk assessments updated within the last four weeks for ward patients improved to 98% [see paragraph 525 of the First Witness Statement of Diane Hull, WITN0133001], and escalation of physical health issues to a senior clinician improved from 60% in May 2024 to 94% at present.

101. The Trust monitors eight discharge standards through SafeNow [see table at paragraph 514 of the First Witness Statement of Diane Hull, WITN0133001]: updated-

at-discharge risk assessment; updated-at-discharge care planning; patient view; carer view; MDT support; follow-up plans including responsible persons; DNA features; and discharge summary to all relevant parties. This provides much stronger oversight and multi-disciplinary discussion of risk, supported by improved training for staff and robust systems of oversight.

102. The Trust acknowledges that creating structures and processes is an important first step, but cultural change and embedding these improvements into everyday practice takes time and sustained effort.

G. RECOMMENDATIONS FOR THE INQUIRY

103. The Trust understands that this Inquiry is charged not only with examining the events themselves, understanding the chronology and identifying omissions, but also with considering what changes might need to happen to prevent similar tragedies in the future, both in Nottinghamshire and across the UK.

104. This Inquiry comes at an important time for the NHS. The Government's 10-year plan for the NHS represents both an opportunity and a risk for mental health services, and this Inquiry has an important role to play in shaping how NHS services develop through the recommendations it makes.

105. The Trust respectfully urges that the Department of Health and Social Care is not permitted to lose its focus on serious and enduring mental illness. There is a risk that a focus on mental wellbeing, whilst important, results in less attention and fewer resources being directed to people with enduring mental illness who require ongoing specialist care. The diminishment in national focus on mental health homicides is evident from examining when current policy and guidance was produced, as much of it is historic, dating from the early 2000s or before.

106. The Trust has set out in its Corporate Witness Statement [WITN0133001] various potential recommendations that the Inquiry should consider. Throughout the Inquiry process, the Chair will likely hear various recommendations from witnesses. At this stage, the Trust suggests the following as three areas of focus for the Inquiry in terms of recommendation which require the Inquiry's input, as opposed to local / organisational improvements:

Publication of Mental Health Homicide Reports

107. As referenced earlier in this statement, the Trust recognises that the incidents of June 2023 have an effect on the wider community: those patients undergoing treatment for mental health conditions who fear the trajectory that an illness such as paranoid

schizophrenia could take; those who live with people with serious mental illnesses; and the general public who fear repeats of such incidents.

108. The Trust would suggest that part of the fear and concern around mental health homicides stems from a lack of information and understanding. There is a significant deficit in the information and data held nationally about mental health homicides.

109. In 2023 alone, there were 65 mental health homicides in England and Wales about which very little is publicly known. Every year since has seen further homicides, and the importance of ensuring proper support for all families affected by such tragedies and ensuring systematic learning from these cases is critical.

110. A national repository where mental health homicide investigation reports are published with appropriate national oversight would enable trusts and other agencies to learn from similar cases in a formal and structured way, rather than relying on informal networks of sharing.

111. NHS England-commissioned mental health homicide investigation reports should be published as the default position and should be held on a searchable national repository.⁷ In cases where there is no public inquiry, there is currently uncertainty about what constitutes the most definitive report; in theory it should be the NHS England-commissioned independent investigation, but these are not routinely published and there is no central place where they can be accessed.

112. Such a repository would enable trusts and other agencies to learn from similar cases in a formal and structured way, rather than relying on informal networks of sharing. It would also provide transparency for families affected by mental health homicides and ensure that lessons learned in one part of the country are available to inform practice nationally.

Multi-Agency Working Framework

113. Improvements to multi-agency working will require an Inquiry to drive change, as different agencies are governed by different legal frameworks and have different statutory responsibilities. The Inquiry will need to be clear about what would constitute a game-changer in practice.

114. There should be a common classification system used across police, healthcare and other agencies for how risk incidents are recorded, to enable a shared understanding and proper multi-agency risk assessment.

⁷ See also paragraph 553 and 554 of Dale Bywater's witness statement evidence on behalf of NHS England [WITN0310001].

115. There should also be clearer frameworks for the sharing of information about individuals who present risks, but who do not meet the threshold for Multi-Agency Public Protection Arrangements (MAPPA). While this could be locally developed, and the PDP Pathway is an example of the Trust working to do so, national consistency would be desirable in ensuring a common framework that is understood by those working in both the health and public protection agencies, irrespective of where in the country they are operating.

116. The Trust would suggest that there is a need for multi-agency terminology for understanding and classifying risk incidents, and for a clearer multi-agency understanding about when medical information should be shared that goes beyond an individual patient's rights to confidentiality, particularly where there are public safety concerns.

National Guidance on Duty of Candour in Complex Cases

117. There is a need for clear national guidance on how NHS organisations should discharge their duty of candour when serious incidents involve criminal proceedings, multiple victims and families, and ongoing therapeutic relationships with patients. The current guidance does not adequately address the complex situations that arise in mental health homicide cases, leaving organisations to navigate difficult ethical and legal territory without clear direction.

118. The Trust recommends national guidance that all relevant agencies must work to when responding to a mental health homicide, setting out clearly who can do what and when.

H. CLOSING

119. The Trust has approached this Inquiry with openness and a genuine commitment to learning. The Trust recognises the profound impact these events have had on the victims and their families, on VC's family, on the communities the Trust serves, and on its own staff.

120. The Trust knows that no amount of organisational improvement can change what happened. However, the Trust hopes that through this Inquiry's thorough examination of events, clear findings about what went wrong and why, and recommendations that drive meaningful change both locally and nationally, some good may come from this tragedy. The Trust has already implemented changes that it considers will have a meaningful impact in terms of enabling prompt identification of those patients at risk of disengagement, to facilitate intensive support and proactive risk management. While the Trust is cautious of the term prevention, it does consider these changes are

preventative in nature, in that they reduce risks that contributed to the events in VC's case.

121. The Trust commits to implementing the Inquiry's recommendations and to continuing the work it has begun to ensure that the care it provides to people with serious and enduring mental illness is of the highest standard, that families are properly involved and supported, that risks are properly assessed and managed, and that when things do go wrong, there is genuine learning and accountability.

122. The Trust thanks the Inquiry for its work and stands ready to assist in whatever way is needed to help the Inquiry reach its conclusions.