

Monday, 30 March 2026

1
 2 (2.05 pm)
 3 **THE CHAIR:** Yes, Mr Straw.
 4 **Questioned by MR STRAW**
 5 **MR STRAW:** Thank you, Chair.
 6 Professor Blackwood, I represent Celeste and Elias
 7 Calocane.
 8 **A.** Thank you.
 9 **Q.** In your report at paragraph 106, you say:
 10 "... the assaults [on the 13th June] would not have
 11 occurred but for [VC's] ... psychotic symptoms. The
 12 offending was in my view entirely attributable to his
 13 mental illness."
 14 Do you stand by that conclusion?
 15 **A.** I do.
 16 **Q.** In addition to what VC told you, I'd like to ask you
 17 about triangulation, so what other information you had,
 18 what other evidence you had to support that conclusion.
 19 I'd like to go through seven different sources, if
 20 I may, to ask you if they supported that conclusion?
 21 So the first source, do you recall the messages or
 22 communications between VC and Elias in early 2020, which
 23 had been transcribed by Elias and then passed on to the
 24 medical team?
 25 **A.** Yes, I do.

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1 personality disorder or a significant substance misuse
 2 issue. This was always treated as a psychiatric
 3 illness. I think the term schizophrenia should have
 4 been used earlier than it was. But treatment was always
 5 attempted to be effected for that. Again, in my view,
 6 he should have been treated more conservatively with
 7 a depot antipsychotic earlier than he was.

8 But there's never any doubt of the diagnosis. He
 9 concealed, I think, as is clear from a lot of his
 10 writings, the depth of some of his experiences from the
 11 treating team, but he -- you know, there are good
 12 relationships there with, for example, his care
 13 coordinator who did realise when he needed to be in the
 14 hospital, and got him back into hospital.

15 So there was evidence of good care.

16 **Q.** And obviously having regard to him concealing, but were
 17 those numerous reports over a long period by a broad
 18 range of people, were they consistent with the account
 19 that VC was giving you later in 2023?

20 **A.** Yes.

21 **Q.** You referred there to the depth of the experiences.
 22 We've seen in the medical records from May 2020, VC
 23 describing hearing screaming, hearing his mother being
 24 raped, being in pain, and he acted in response to that.

25 Is it your opinion that he felt those hallucinations

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1 **Q.** For example, those -- VC in those messages has said he
 2 heard voices, voices coming from the next apartment,
 3 that he was being monitored by AI technology, and so on.

4 **A.** Yes.

5 **Q.** And did those have significance to your conclusion in
 6 respect of 13 June 2023?

7 **A.** Of course.

8 **Q.** I'm going to list the sources and then perhaps come at
 9 the end to ask if you want to give any further sort of
 10 explanation as to why they supported your conclusion.

11 But the second source is numerous entries in the
 12 medical records from psychiatrists, from psychiatric
 13 nurses, between May 2020 and August 2022, recounting not
 14 just what VC told them but also their observations of
 15 his behaviour, some of whom had assessed him for weeks
 16 or months. What significance did those entries have,
 17 for you?

18 **A.** Well, they were consistent with a man who -- this is
 19 inpatient admissions or community care?

20 **Q.** All of it.

21 **A.** All of it, yeah.

22 **Q.** All of it, all of the difference psychiatrists, the
 23 psychiatric nurses and so on.

24 **A.** I don't think there was any doubt about the underlying
 25 diagnosis. There was never any question of a comorbid

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1 were real?

2 **A.** Yes.

3 **Q.** And how powerful or traumatic were they for him?

4 **A.** Yes, I think just if any of us attempt to enter his
 5 shoes at that point, it's a horrific experience.

6 **Q.** The symptoms that were described by the psychiatrists
 7 and others during that lengthy period, did they include
 8 classic symptoms of schizophrenia?

9 **A.** Yes, they did. So classic auditory hallucinations,
 10 insertions of thought, withdrawals of thought, broadcast
 11 of his thoughts, loss of ownership of his thoughts and
 12 actions, all associated with disturbance in his emotions
 13 in terms of fear and anger.

14 **Q.** The third source of information is information from
 15 Elias, and I'd like to put it up on screen, please.
 16 Could we have WITN0087001, and page 23 of that.

17 So this is from Elias Calocane's witness statement
 18 for the Inquiry. At the bottom of the page, there at
 19 paragraph 85, he describes here the call between Elias
 20 and VC on 12 June at 7.09 pm. He says, for example,
 21 there:

22 "The content of our conversation was similar to
 23 previous conversations that I had had with him ...[VC]
 24 said 'This is not a mental illness. I am fine. I am
 25 not ill but there is 2-way communication and 24/7 voices

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1 in my head, they are intelligent people and they are
2 making threats'."

3 He talked about some files, and a bit further on:
4 "The majority of the call was him talking about his
5 delusional beliefs and trying to persuade me that some
6 research he had done would prove everything he believed.
7 He talked about his mind being controlled ... there
8 [was] ... [a] connection issue during the call ... [and]
9 [VC] was adamant that it was the technology he was
10 referring to interfering and that he was being
11 monitored. At some point he said 'just disassociate
12 yourself from me, if anything happens don't come and see
13 me in the hospital'."

14 Then I think it was referred to earlier, at the
15 bottom of the page, Elias then describes the
16 conversation between VC and Elias the next morning on
17 13 June at 4.52 am in which VC says, "take the family
18 out of the country".

19 Did that support your conclusion that his offending
20 was entirely attributable to his mental illness?

21 **A.** Yes, he has those psychiatric experiences for
22 four years, he is initially perplexed, why has he been
23 chosen for these various things? He's afraid, he's
24 angry. He interprets those things, given his background
25 in mechanical engineering, as evidence of

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1 **A.** Yes.
2 **Q.** So do you recall, on 13 and 14 June 2023, there were
3 several entries by police officers who did have concerns
4 about his mental health?
5 **A.** Yes, and they note frequently "We do not know his
6 current state of mind".
7 **Q.** Then, similarly, the third one, in prison on
8 17 June 2023, so four days after the arrest when he was
9 taken to Nottingham Prison, he was described on
10 reception as:

11 "Guarded, bizarre in his presentation and he
12 appeared mentally acutely unwell." (*As read*)
13 Do you recall that?
14 **A.** Yes, so his presentation is driven by his experiences of
15 reality distortion. He does not largely have problems
16 with the other clusters -- one of the other cluster of
17 symptoms in the disorganisation domain. So his
18 behaviour isn't profoundly disorganised. In the police
19 station he sits quietly in his cell. He engages with
20 the interview, as we discussed this morning. The
21 appropriate adult and his solicitor don't raise
22 immediate concerns about his mental state because he
23 doesn't have any of that disorganisation that perhaps
24 people first think about when they are thinking: is this
25 man mentally unwell?

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1 electromechanical devices interfering with him, remote
2 neural monitoring, he draws on the scientific literature
3 to try to explain what is happening to him. He finds
4 support for his beliefs from the internet in terms of
5 mind control and gang stalking.

6 Who could be doing this? It must be a government
7 agency, or an intelligence agency or a computer
8 programme. It's illegal. "Why is it being done to me?
9 Are they trying to -- is all this monitoring and
10 interference justified in some way by some future
11 offending that I'm going to do?"

12 So all of his offences, violent offences, including
13 the series of terrible events in June, are founded in
14 his psychosis.

15 **Q.** I was going to come on to the zip file. You've already
16 explained that. So the fifth area was observations of
17 him just after his arrest.

18 Now, just to pick three examples of those. In the
19 RiO notes on 13 June 2023, there's an entry from the
20 healthcare professionals noting:

21 "VC's responses were delayed based on history and
22 current presentation, HCPs believe VC is mentally
23 unwell." (*As read*)

24 So that was just after he was arrested.

25 I think, is it right, you'd seen the custody record?

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1 So his psychosis comes from symptoms of reality
2 distortion which he hides from others and has done for
3 years before that, and then there are suggestions of
4 that, his guardedness, his suspiciousness, the delayed
5 responses the lack of emotional resonance when he looks
6 at all the terrible events in police interviews, and
7 then further evidence emerges in prison. They pick it
8 up very early on, but then there are better descriptions
9 as he begins to engage with psychiatrists.

10 **Q.** Coming onto that, Dr McSweeney assessed him on 10
11 July 2023 and then Dr Ullal on 11 July 2023,
12 Dr McSweeney noting that:

13 "VC was actively psychotic and required urgent
14 transfer to a psychiatric unit." (*As read*)

15 Again, was that significant to your conclusion that,
16 at the time of the indexed offences, he was psychotic?

17 **A.** Yes.

18 **Q.** Then there is the prison notes on 21 July 2023 that he
19 made, for example, saying people -- he heard voices that
20 people who he knew and cared about vividly were
21 screaming for help. Again, that was something you took
22 into account?

23 **A.** Yes.

24 **Q.** Thank you. In summary, is it fair to say that in
25 addition to what VC told you, there was a large number

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1 of other sources, triangulation, that was consistent
 2 with the account that he gave to you, and supported your
 3 conclusion that his offending was entirely attributable
 4 to his illness?
 5 **A.** Yes, there was.
 6 **Q.** Now, it's been pointed out that VC was rational in some
 7 respects, for example he slowed down when he went over
 8 a speed bump, he made a "no comment" interview. You
 9 touched on this earlier, but that does that undermine
 10 the conclusion that his psychosis caused the offending?
 11 **A.** No, individuals with reality distortion symptoms,
 12 without disorganisation symptoms can appear rational in
 13 brief interactions with others. More automatic parts of
 14 the behaviour, like slowing for speed bumps, are
 15 maintained.
 16 **Q.** Similarly, what about the fact that he was observed to
 17 be calm at the time of the indexed offences; does that
 18 show he wasn't psychotic?
 19 **A.** No, I think he's emotionally blunted at this point.
 20 What he does is unconscionable and it does appear to be
 21 done calmly and brutally, because he lacks access to any
 22 sense of empathy or fellow feeling for those that he's
 23 assaulting. He is driven by his psychosis to act in the
 24 way that he does.
 25 **Q.** You explored briefly earlier that him stopping taking

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1 to stop taking medication?
 2 **A.** Yes, he interprets interference in his inner world as
 3 a Government agency, potentially, is it the MI5 that's
 4 involved and, by extension, then, could the police be
 5 involved? And then, when he's in hospital, by
 6 extension, perhaps even the mental health professionals
 7 are involved, and he tells Celia Birtles (*sic*) that.
 8 **Q.** Similar topic: what led him to be guarded? So what led
 9 him to conceal his symptoms, to mislead medical
 10 professionals as to his symptoms? Again, did the voices
 11 at times tell him not to reveal his symptoms?
 12 **A.** Yes, that's one possible explanation. The other is that
 13 he's avoiding inpatient care or aspects of outpatient
 14 care. He's avoiding antipsychotic treatments, secure in
 15 his own understanding of what is going on.
 16 **Q.** Is the paranoia also a potential explanation for him
 17 being guarded?
 18 **A.** (*The witness nodded*).
 19 **Q.** So his paranoia that there's a conspiracy against him
 20 including the medical professionals --
 21 **A.** (*The witness nodded*).
 22 **Q.** -- so therefore he wants to disguise his symptoms from
 23 them?
 24 **A.** Yes, persecuted beliefs are commonly associated with
 25 guardedness.

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1 medication wasn't a culpable admission; it was
 2 determined by features of his illness. I'd like to ask
 3 you whether -- what were the particular features of his
 4 illness that led him to stop? Firstly, is this right,
 5 he believed the hallucinations he was suffering were
 6 real --
 7 **A.** (*The witness nodded*).
 8 **Q.** -- and therefore thought he didn't need any medication?
 9 **A.** Yes, he perhaps briefly considered with doctors that
 10 there might be another explanation, but I think, even if
 11 that's true, he quickly reverted to his own
 12 understanding that he was a targeted individual who was
 13 being interfered with by remote neural monitoring, and
 14 he interpreted his symptoms in the context of his
 15 engineering knowledge.
 16 **Q.** Then, secondly, is it right that the voices actually
 17 told him to stop taking medication at times?
 18 **A.** That is his account, yes.
 19 **Q.** Then, thirdly, is it right that he suffered paranoid
 20 delusions about medical professionals and others, there
 21 was a conspiracy against him, I think you mention in
 22 your report he felt a team of henchmen had been sent to
 23 liquidate him, something like that. Is that a faction
 24 of paranoia about the medical professionals who are
 25 prescribing the medications to him that may have led him

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1 **Q.** Is being guarded uncommon in those with paranoid
 2 schizophrenia?
 3 **A.** No.
 4 **Q.** Substance misuse. I think you mention in your report
 5 there's no evidence of substance misuse, but then you go
 6 on to say:
 7 "... even if substance misuse had [taken place] in
 8 the weeks before or on the day in question, his illness
 9 was not/ [and] is not reducible to a drug-induced
 10 psychosis. The clinical picture is of a major mental
 11 illness, (paranoid schizophrenia), with an onset and
 12 course unrelated to substance misuse."
 13 **A.** (*The witness nodded*).
 14 **Q.** Is that right and can you explain how you came to that
 15 conclusion?
 16 **A.** Yes, I certainly agree that there is and will always be
 17 residual uncertainty about the extent of his substance
 18 use. I think I came across one drug test in all the
 19 hospital records which was negative. There's that
 20 mention that I referred to this morning of perhaps he
 21 was tested for drugs in the emergency department
 22 admission right at the beginning of his story in 2020,
 23 but the bloods were clear of substances. But then there
 24 is no testing in the police station, no testing at
 25 remand and into imprisonment, and then there is testing

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1 when he comes to Ashworth which is all negative many
 2 months later.
 3 So there is always going to be a degree of
 4 uncertainty. I bear in mind the fact that there aren't
 5 accounts from flatmates or others, or family members,
 6 that substance misuse was an issue. There was certainly
 7 no suggestion that he was intoxicated at the point of
 8 arrest. But we will never know whether that -- those
 9 are the things that point to substance misuse not being
 10 a major part of the story.
 11 **Q.** Did the fact that his symptoms continued for several
 12 months in high security hospital in segregation support
 13 your conclusion that substance misuse was unrelated
 14 to --
 15 **A.** Yes, so you bear in mind the possibility, individuals
 16 can have short-lived periods of psychosis related to
 17 drug misuse. The diagnosis used is a drug-induced
 18 psychosis. All the symptoms have to resolve within
 19 a month of use of that substance, and very clearly he
 20 had psychotic symptoms well beyond a month. So even if
 21 he had misused drugs close to the fatal assaults, the
 22 fact that those symptoms continued long after any
 23 substance left his system suggests that it's the major
 24 mental illness that is important here.
 25 **MR STRAW:** Chair, if I may, just two very short final

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1 Can I start, please, back in October of 2023. We
 2 know in fact you were retained by the CPS on 14 June,
 3 just a day after these attacks, and some materials were
 4 sent to you prior to your formal instruction.
 5 **A.** *(The witness nodded).*
 6 **Q.** Once the defence report of Dr McSweeney had raised the
 7 partial defence, in an email you noted a "helpful degree
 8 of instruction" from the letter Mr Murphy sent you. Can
 9 I ask you, please, why did you make that comment that it
 10 was a "helpful degree of instruction"?
 11 **A.** I thought Mr Murphy was very clear about what was
 12 required and subsequently about concerns expressed about
 13 my initial report and further thoughts to be had. It's
 14 not entirely unusual, when instructed by the CPS, to
 15 have very little in the way of formal instructions and
 16 there's an assumption that you know what you're doing.
 17 So Mr Murphy was very, very clear throughout, and
 18 always has been, in my work with him, about exactly what
 19 was required.
 20 **Q.** Thank you. You were sent a number of materials over the
 21 course of the months leading up to your report. From
 22 your perspective, was there any evidence that was
 23 obviously missing in the material that you were sent?
 24 **A.** No.
 25 **Q.** Was there anything precluding you from asking for

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1 topics.
 2 **THE CHAIR:** Well, we're over time anyway but if they're very
 3 short ...
 4 **MR STRAW:** I will hopefully just be no more than a minute,
 5 if I might.
 6 **THE CHAIR:** All right.
 7 **MR STRAW:** The first one is that certain new information had
 8 been put to you in questions earlier today. For
 9 example, CTI explained what the CCTV of the assault on
 10 PC Pritchard showed. Does that new information cause
 11 you to alter your conclusions that his offending was
 12 attributable to his mental illness?
 13 **A.** No, it does not.
 14 **Q.** Okay. And finally, it was suggested to you that you
 15 could have asked certain further questions of VC. Does
 16 that -- does the fact that you didn't ask those
 17 questions, does that undermine your conclusions or are
 18 you still confident in your conclusions?
 19 **A.** No, I remain secure in my conclusions.
 20 **MR STRAW:** Thank you.
 21 Chair, thank you very much and apologies to go over.
 22 **THE CHAIR:** Yes, Ms Carey.
 23 **Questioned by MS CAREY**
 24 **MS CAREY:** Dr Blackwood, I ask questions on behalf of the
 25 Crown Prosecution Service.

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1 further information or evidence if you needed it?
 2 **A.** No, there was not.
 3 **Q.** You've been referred to today to some other evidence the
 4 Inquiry has heard of, for example, the assault of
 5 PC Pritchard when the mental health warrant was being
 6 executed, or indeed the tribunal findings from the
 7 hearing when VC was seeking to be released from
 8 hospital.
 9 **A.** *(The witness nodded).*
 10 **Q.** You've just told Mr Straw that that information, and
 11 there's other documents as well, does not alter your
 12 conclusion.
 13 **A.** *(The witness nodded).*
 14 **Q.** In your view do any of those bits of information support
 15 your conclusion that the partial defence of diminished
 16 responsibility was available to VC?
 17 **A.** Well, they're all helpful pieces of information. The
 18 tribunal records, I think, are helpful. The new
 19 information about applying to have his surveillance
 20 taken away from him is very important information, but
 21 it's additional information that I think supports my
 22 ultimate conclusion and doesn't cause me to doubt my
 23 conclusions.
 24 **Q.** So it doesn't alter, it doesn't undermine.
 25 **A.** No.

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1 Q. But it does, in your view, support.
 2 A. It's helpful further information for the Inquiry to
 3 consider.
 4 Q. I think you are aware, because you addressed in your
 5 witness statement to the Inquiry, some of the concerns
 6 the families had about your conclusion that diminished
 7 responsibility was applicable.
 8 A. Yes.
 9 Q. I know they fall into broad headings, I won't go through
 10 them all with you, Doctor, but there was a concern that
 11 you had failed to consider VC's mental state at the time
 12 of the offences as opposed to the time of your interview
 13 when you saw him in November 2023. I think you
 14 addressed that in your paragraph 40 of your witness
 15 statement. But can you help us, please: was there any
 16 concern in your mind that you were somehow conflating
 17 how he presented on the 14 November with how he was
 18 presenting on 13 June 2023?
 19 A. Yes, I bear in mind the families' difficulties, perhaps
 20 in that they don't simply sit down with my report and go
 21 through it and evidence is being presented to them,
 22 potentially piecemeal, and they're thinking he's
 23 focusing far too much on what he was told in Ashworth
 24 and he's not thinking about how he was in the police
 25 station. And of course there needs to be careful

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1 presentation, if I can put it like that?
 2 A. No, there isn't. There's different clusters of symptoms
 3 within schizophrenia. He is -- his psychosis
 4 characterised by distorted reality. It's not
 5 particularly characterised by disorganisation. There is
 6 some disorganised thoughts later in his prison -- period
 7 of imprisonment, which may be consistent with his mental
 8 state somewhat deteriorating in prison. His writings
 9 don't make coherent sense in places.
 10 But in the police station, he is guarded, he's
 11 suspicious, his responses are delayed. There is no
 12 Mental Health Act assessment because he's going to be
 13 retained within the criminal justice system.
 14 The police note on multiple occasions that we don't
 15 know his current state of mind, and the police
 16 interviews show a man who is emotionally blunted and cut
 17 off, because of his psychosis, from the impact of what
 18 he has done.
 19 Q. Dr Kumar, when he gave evidence last week, spoke of some
 20 experiences he had when he was an FME, including, for
 21 example, seeing people who were severely unwell drinking
 22 out of custody suite toilets. Does the fact that VC was
 23 not doing things like that mean ergo that he was not
 24 psychotic?
 25 A. No, it does not. So those are exactly the sort of

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1 consideration of his mental state at the time of the
 2 offences and within the police station. I think that
 3 was present in my report, and taken into account, and
 4 none of the particular concerns of Dr Kumar about
 5 aspects of his behaviour that were maintained impacted
 6 on my consideration that he was still actively psychotic
 7 in the police station.
 8 Q. Can I ask you about that. In your paragraph 49, you
 9 make reference to VC's contact with his brother, Elias,
 10 on both the 12th and into the morning of the 13th. What
 11 weight did you attach to Elias's evidence when assessing
 12 VC's state at the time of the offences?
 13 A. It's incredibly important. It's there before the
 14 offences and it's there in the middle of the offences,
 15 and in both sets of information speak to his psychotic
 16 motivation.
 17 Q. In that regard I think you are aware, Doctor, that in
 18 custody VC did not display what are perhaps thought to
 19 be obvious signs of psychotic behaviour, and there may
 20 be a belief or a misperception, call it what you will,
 21 that people who are psychotic present in a particular
 22 way --
 23 A. *(The witness nodded)*.
 24 Q. -- that is obvious to the layperson. Do all psychotic
 25 people behave in the same way? Is there a stereotypical

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1 features that might be in somebody with more
 2 disorganised features, which [VC] is not like. It is
 3 not unusual, and I've seen individuals like this, in the
 4 police station and shortly thereafter, in prison, to
 5 have exactly what he shows: that guardedness, the
 6 suspiciousness, the degree of being slightly cut off,
 7 perhaps superficially appearing calm and considered, but
 8 gradually the psychotic underpinnings of what's going on
 9 are revealed.
 10 Q. The suggestion may be being made, Professor, that you
 11 have taken VC's account at face value when there is
 12 other evidence to suggest he's an unreliable, if not
 13 wholly lying historian. I think you are familiar with
 14 the concept of malingering. Can you explain, please,
 15 what that is?
 16 A. Yes, it's someone who either fabricates or exaggerates
 17 their clinical picture, here of psychotic symptoms, in
 18 a deliberate attempt to influence, here, criminal
 19 proceedings.
 20 Q. Did you have any conclusion about whether VC was
 21 malingering in this case, based on what he was telling
 22 you?
 23 A. No, he gave a compelling account of an under- and
 24 untreated psychosis, the symptoms are entirely
 25 consistent with our experience of illness for many years

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1 and that's fortified by years of psychiatric
2 investigations pre-dating, and then post-dating the
3 offence.
4 **Q.** Can I ask you about that, please. And if you would,
5 would you stand back for a moment, please, Professor.
6 We have evidence from at least May 2020, if not before,
7 VC was psychotic. We have evidence that once in prison,
8 his behaviour resulted in a transfer to Ashworth High
9 Security Hospital, and he may well have been psychotic
10 for many months during the autumn, at least, into the
11 winter of 2023.

12 **A.** Yes.

13 **Q.** The suggestion may be being made, however, that on the
14 12th and 13th he was not so unwell, not so psychotic,
15 that the partial defence of diminished is not available
16 to him. Do you consider whether that is a realistic
17 possibility, given everything that you have seen, read
18 and heard about VC?

19 **A.** I do not.

20 **Q.** In your view is it likely that in the 90 minutes or so
21 when he carried out these awful acts, he was not
22 psychotic, and yet was for the years running up to it
23 and was indeed in the months after the events.

24 **A.** Yes, that does not make sense to me, the alternative.

25 **Q.** The other suggestion maybe being made is that you came
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1 point that you made in your statement, and also earlier
2 in your evidence about a mental health assessment as
3 soon as somebody who appears to have serious mental
4 health problems in relation to a homicide goes into
5 custody.

6 **A.** Yes.

7 **THE CHAIR:** I think you said that it should be done by
8 a Consultant Forensic Psychiatrist. They should be
9 called in, and on call.

10 **A.** Well, that's what used to happen, 30 years ago.

11 **THE CHAIR:** Is that not a better system than, for example,
12 the Liaison and Diversion that we have now?

13 **A.** Well, I think Liaison and Diversion services do good
14 work and individuals with mental illness with lesser
15 offending --

16 **THE CHAIR:** I was going to say in these particular types of
17 cases.

18 **A.** Well, I think there is an argument too for these more
19 serious cases to have an assessment exactly as the
20 families have sought by a consultant or a senior higher
21 trainee, so that there is that recognised baseline from
22 the police station that may be a little bit more
23 developed or detailed than what was available here from
24 the healthcare professionals.

25 **THE CHAIR:** How would that be done because obviously someone
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1 into the case with a blinkered view that diminished
2 responsibility was always going to be your finding,
3 which is why, having spoken to him in Ashworth on the
4 14th, you emailed the CPS to say you thought the partial
5 defence applied. Did you pre-judge your findings in
6 VC's case?

7 **A.** No. I think it is fair to say that, looking at all the
8 materials before going to Ashworth, I considered it very
9 likely that this was a man with paranoid schizophrenia
10 who was psychotic at the time of the events, and would
11 have that partial defence available to him, but that
12 doesn't mean I pre-judge. I go in and carefully spend
13 time with him, think about it with him, think about it
14 with his treating clinicians, review all the materials,
15 before coming to my final conclusion.

16 The reason I write to the CPS on the way home from
17 Ashworth is that I was aware that time was of the
18 essence, families were waiting for opinions, meetings
19 were going to be held, and I wanted to alert Mr Murphy
20 and the CPS to my thoughts.

21 **MS CAREY:** Thank you very much. They are all my questions.

22 Thank you, Chair.

23 **Questioned by THE CHAIR**

24 **THE CHAIR:** Thank you.

25 Professor Blackwood, I wanted to ask you about the
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1 going into the police station wouldn't have all the
2 prosecution papers at that stage, because ideally it
3 would be done as soon as possible.

4 So how would you go about it? What would be the
5 way --

6 **A.** It would be an individual, in an on-call either forensic
7 or general adult rota, who is responsible for the police
8 stations as part of their work, who then goes in to
9 assess that individual, aware of their mental health
10 records at least, aware from the police of the nature of
11 the offending, and then hoping to use some of that
12 information to assess, even if it is only he appears
13 guarded and suspicious and refuses to engage with me.
14 That's entirely possible, but you could perhaps do a
15 little bit more digging or teasing out knowing his
16 background history and some of his previous concerns.
17 I bear in mind --

18 **THE CHAIR:** So if he didn't cooperate, didn't engage --

19 **A.** That's right.

20 **THE CHAIR:** -- you would still be able to have some
21 assessment at that stage?

22 **A.** Yes, you know, those, to be fair to the Liaison
23 Diversion services, intimations are there of his
24 guardedness, suspiciousness, et cetera, but I think an
25 extra layer of scrutiny by an experienced psychiatrist
24

1 would be helpful.

2 **THE CHAIR:** In doing that, you obviously have to rely to

3 some extent, as you've said in relation to these

4 matters, to the PNC, the record?

5 **A.** Yes.

6 **THE CHAIR:** That that should be accurate.

7 **A.** Yes.

8 **THE CHAIR:** It should also include information which would

9 assist you about the details of what had happened.

10 **A.** Yes.

11 **THE CHAIR:** Whether or not it led to a conviction.

12 **A.** Yes, I think that's --

13 **THE CHAIR:** Would you find that useful?

14 **A.** Yes, of course.

15 **THE CHAIR:** Because I think you said that some work that has

16 been done by Dr Fazel is now recognised that it's not

17 just previous convictions in risk assessment --

18 **A.** No, absolutely not.

19 **THE CHAIR:** -- but also a previous history of engagement in

20 criminal activity.

21 **A.** Yes, so to be -- I mean, I may not have been clear this

22 morning, but it used to be that in his risk assessment

23 instrument you had to have a conviction for violent

24 behaviour. He's amended that in the last two or

25 three years to say that if you look at a behaviour

25

1 somebody who is in hospital is looking at on their

2 phone?

3 **A.** Yes, you're hopeful that your nursing staff are keeping

4 an eye on that, and that they restrict access when

5 there's been clear breaches of that sort of nature that

6 relate to an individual's delusions.

7 **THE CHAIR:** How do they know?

8 **A.** It's actually dependent --

9 **THE CHAIR:** You're not actually looking at what's on the

10 phone.

11 **A.** So the forensic wards I worked on, it's -- you know,

12 it's restricted access. People didn't get their mobiles

13 until they were going out on leave, et cetera, and

14 carefully monitored access of computers, et cetera.

15 That's perhaps not the case in general adult settings.

16 **THE CHAIR:** Finally, generally speaking, not only in

17 relation to this case, but is it right that those with

18 schizophrenia are perhaps very often, if not always, or

19 generally, poor historians?

20 **A.** Not necessarily. So individuals with this sort of

21 picture, with predominantly reality distortion symptoms,

22 particularly in an intelligent man, I think are able to

23 give a good account, and he did give a good account,

24 whether there are inaccuracies or he's telling lies at

25 places. Nevertheless, he gives a good history of his

27

1 exactly as here, that has not resulted in a formal

2 conviction but is nevertheless violent behaviour, that

3 gets a tick for violent behaviour, which of course makes

4 entire sense.

5 **THE CHAIR:** Because I think, in fact, you've said in your

6 statement that because of the lack of criminal record,

7 that he may very well not have really been assessed as

8 having a higher risk.

9 **A.** Yes, I think almost before you get to risk management

10 you think about treatment of the illness, and the

11 illness wasn't properly treated. Then you get to risk

12 assessment, and even not using any tool, you know that

13 this man's psychosis drives his offending. He's not the

14 sort of person that sits quietly with delusions and

15 hallucinations and does nothing about it. He acts on

16 those delusions and hallucinations and that's available

17 from a very first breaking into the flat.

18 **THE CHAIR:** One of the things I was going to ask, he's

19 obviously been under section and inpatient treatment.

20 **A.** *(The witness nodded).*

21 **THE CHAIR:** He has also, as we now know, been looking at

22 some material online which is in relation to what

23 I think you've said is the delusion of being interfered

24 with by the secret services and MI5, MI6.

25 But would it be helpful for clinicians to know what

26

1 life.

2 Other individuals who are more disorganised or have

3 more negative symptoms of the disorder which impacts

4 people's attention or drive can be very poor historians,

5 but I don't think VC is a poor historian.

6 **THE CHAIR:** I think I put that wrongly, a poor historian,

7 I don't mean that he's not given an account, but as to

8 whether that's accurate or not given the background to

9 it.

10 **A.** Yes, clearly his psychosis is going to colour his

11 account. But I think he gives a reasonable account of

12 his development through to the onset of his psychosis

13 and then a good account of how he thought about those

14 psychotic experiences.

15 **THE CHAIR:** Yes, thank you. Those are all the questions

16 that I wanted to ask.

17 So we'll rise now for five minutes, in order for the

18 next witness, thank you.

19 **MS LANGDALE:** Thank you.

20 **(2.42 pm)**

21 **(A short break)**

22 **(2.46 pm)**

23 **MR BLAKE:** Thank you, Chair. Can I please call Dr Richard

24 Latham.

25

28

1 **DR RICHARD LATHAM (affirmed)**
 2 **Questioned by MR BLAKE**
 3 **MR BLAKE:** Thank you, Dr Latham. You should have in front
 4 of you a witness statement dated 13 November 2025, with
 5 a URN of WITN0126001; is that correct?
 6 **A.** Yes.
 7 **Q.** Is that statement true to the best of your knowledge and
 8 belief?
 9 **A.** Yes, it is.
 10 **Q.** Thank you. I should make very clear at the outset that
 11 you didn't see VC and therefore my questions today are
 12 going to be quite brief.
 13 You are a Consultant Forensic Psychiatrist; is that
 14 right?
 15 **A.** Yes, that's right.
 16 **Q.** You've summarised in your witness statement your
 17 expertise at paragraph 2.
 18 **A.** Yes.
 19 **Q.** You say in your statement that you were contacted by
 20 Alan Murphy of the CPS on 27 November 2023, and asked to
 21 consider the psychiatric reports that had already been
 22 prepared in the case; is that right?
 23 **A.** Yes, that's right.
 24 **Q.** If I could please bring on to screen your letter of
 25 instruction that's CPSE0000165. That's dated the very
 29

1 Then finally:
 2 "(If you are able to in the absence of your own
 3 interview ...) provide an expert opinion on whether, at
 4 the time of the offences, the defendant's mental health
 5 was such that he has available to him the partial
 6 defence of diminished responsibility."
 7 Then the paragraph below says:
 8 "It is not intended at this stage that you yourself
 9 interview the defendant. This is primarily to avoid the
 10 same potential concern being raised about any expert
 11 opinion you may be able to give".
 12 What did you understand by that?
 13 **A.** That was about the concern that the assessments had
 14 considered the defendant's mental state at the time of
 15 their assessments, rather than the relevant time for
 16 diminished responsibility which was at the time of the
 17 offences.
 18 **Q.** Then you have below that a schedule of material that has
 19 been provided to you. Now, that sets out all of the
 20 material that was provided to you. We've heard today
 21 about other materials. So audio of Sebastian's call to
 22 999, the assault on the police officer, the video of
 23 that, the video of the headlock, other documents
 24 relating to, for example, VC's psychiatric history
 25 pre-2020.

31

1 same date as you spoke to Mr Murphy; is that right?
 2 **A.** Yes, that's correct.
 3 **Q.** And if we turn over to the second page, I'll just read
 4 to you briefly from the instructions. It says there on
 5 the third paragraph -- if we could scroll up just one
 6 bit, thank you very much, it says:
 7 "All three psychiatrists agree that the partial
 8 defence of diminished responsibility is available to the
 9 defendant in respect of the three counts of murder due
 10 to the presence of paranoid schizophrenia at the time of
 11 the offences."
 12 Then it says:
 13 "You are specifically instructed to do the
 14 following".
 15 The first is:
 16 "Review the three psychiatric reports ..."
 17 Second:
 18 "Review the available evidence in the case ... or as
 19 much of it as in your expert opinion you feel is
 20 appropriate ..."
 21 The third is:
 22 "Provide an expert opinion on whether the
 23 conclusions reached by the psychiatrists on the issue of
 24 diminished responsibility have been properly reached by
 25 them".

30

1 **A.** Yes.
 2 **Q.** Might it have been helpful to you to have been provided
 3 with that additional material?
 4 **A.** I don't think it would have been helpful in terms of my
 5 ultimate opinions, but I think it's always helpful to
 6 have all of the potentially relevant information, and
 7 obviously you don't know, as an expert, what is out
 8 there that you haven't seen, but I think the general
 9 principle is: give me all the information you've got and
 10 let me read it, watch it, and then I can use that to
 11 come to my overall opinions.
 12 **Q.** You didn't interview VC. We've heard today, as well,
 13 about potential questions that might have been put to VC
 14 about, for example, the note containing the names --
 15 **A.** Yes.
 16 **Q.** -- of the other flatmates, about the weapons, about the
 17 Buffalo shooting videos and other violent material on
 18 his phone, also about the EMAS, the ambulance material
 19 from 2020.
 20 Again, would it have been helpful to have had VC's
 21 comments on those things?
 22 **A.** I think it would have -- I think it would have been
 23 useful in terms of completeness but I don't think it
 24 would have been helpful in terms of having any likely
 25 impact on the ultimate opinions.

32

1 Q. So when you say not helpful in terms of the ultimate
2 opinions, that's because, in the same way as
3 Dr Blackwood, your opinion remains the same but in fact
4 you haven't actually seen that material, have you?

5 A. No. I've seen some of it now because of it being
6 introduced in the Inquiry or seen it referred to. But
7 I think the reason I have said that I don't think it
8 will be helpful is because I don't think any of it has
9 been shown to contradict the overall opinion about both
10 his mental disorder, the nature of his mental disorder,
11 and likely impact of that on his actions.

12 Q. And I'd like to ask you about the basis for your
13 instruction. Can we please bring up on to screen
14 CPSE0003209.

15 Your instruction followed an email from Dr Kumar to
16 his Family Liaison Officer, and we can see that at the
17 bottom email. And he said as follows, and this is
18 27 November, he said:

19 "I have serious concerns about the use of
20 Dr Blackwood's report which is about the patient's state
21 of mind 5 months down the line. The report cannot
22 accurately reflect the day of the 13th June and only an
23 examination or observations on the day would be
24 admissible.

25 "No one is respectfully challenging the diagnosis,
33

1 I've been involved in it, people assessed at that time.
2 They're not assessed to consider things like the mental
3 state at the time of the offence and the relationship
4 with diminished responsibility; they are assessed for
5 the purposes of sectioning. Even though everyone knows
6 that hospital admission is unlikely, the assessment
7 still goes ahead because, in ordinary circumstances,
8 were it not such a serious offence, that's what would
9 happen.

10 So I think there are some differences in practice
11 here, and sometimes there are assessments in police
12 custody.

13 Q. Has there been a decline in that facility over the
14 years?

15 A. I heard Professor Blackwood's evidence. I'm not sure,
16 overall, whether there has been a decline or not. But
17 I certainly, in my training as a senior trainee, recall
18 assessing at least three people charged with very
19 serious offences in police custody in these
20 circumstances. I think the change has been because
21 the -- usually social workers, the Approved Mental
22 Health Professionals who are contacted to conduct these
23 assessments, I think there may have been a slight change
24 in the practice because they're the ultimate
25 decision-makers about whether that assessment goes

35

1 it is the 'state of mind' on the day that is of
2 significance as many ... health patients are absolutely
3 lucid and hence discharged and allowed to function in
4 the community."

5 So he's there expressing some concerns about
6 Dr Blackwood's report and in particular that it couldn't
7 accurately reflect VC's mental state as at the day.

8 Why is it that those suspected of very serious
9 offences, displaying signs of mental illness, aren't
10 formally assessed in police custody?

11 A. The first thing to say is that they can be, in some
12 circumstances. And in this case, VC was not assessed
13 other than by the people working for the Liaison and
14 Diversion team, and that was quite limited, because the
15 only access to an assessment at that time was a formal
16 Mental Health Act assessment which is the process by
17 which it's decided whether or not someone should be, in
18 lay terms, sectioned. And the decision at that time was
19 that because he could not be, because the hospital he
20 would need to go to would not be directly available from
21 police custody, that that assessment would not take
22 place.

23 The reason I say he could have been assessed is
24 that -- and this is another area that I'm involved in
25 professionally -- sometimes in that situation, because

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1 ahead. And frankly, some of that, I think, is about
2 resource. I think they are overwhelmed with work and
3 going to do an assessment on someone when there is no
4 prospect of them being admitted to hospital is simply
5 a piece of work that may not be prioritised in those
6 circumstances.

7 Q. And had you, for example, been called on the day to
8 attend the custody suite, what kind of things would you
9 have asked VC to establish his state of mind as at that
10 date?

11 A. I think the nature of the assessment depends a lot on
12 the person in custody, because the initial part of any
13 assessment is going to be about trying to engage someone
14 in conversation and see whether they're willing to talk
15 to you at all. Most of that assessment is probably not
16 going to be geared -- assuming I'm not there instructed
17 as an expert witness, most of that is going to be geared
18 towards trying to understand the nature of their mental
19 health problems at that time, and the way you go about
20 that will depend to a large extent on how someone is.
21 But the questions would be open questions to start with,
22 asking people how they are, what's going on, do they
23 understand why they are there. Then you may narrow that
24 down into more direct and closed questions about
25 specific symptoms that might be relevant, like hearing

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1 voices or the perception of being threatened or followed
 2 or those kind of things.
 3 **Q.** Putting resource considerations to one side, if VC had
 4 in fact been assessed on that day, would it have given
 5 a useful indication as to his mental state or the nature
 6 of his disorder as at that time?
 7 **A.** Yes, it would have clearly been relevant information.
 8 I think it can be difficult when there are assessments
 9 in police custody because sometimes the duration is
 10 shorter than you would normally expect from an
 11 assessment. Some people, often people where the primary
 12 symptoms are delusions, can be, as VC was described,
 13 guarded, and they don't openly volunteer the nature of
 14 what is in their mind. So again, you are sometimes
 15 having to weigh up that assessment with other
 16 information. But yes, a full psychiatric assessment in
 17 police custody would have been clearly relevant
 18 information.
 19 **Q.** If it can't happen in police custody, when, in your
 20 view, is the ideal time to have that assessment?
 21 **A.** Well, there are different stages at which assessments
 22 occur. If it's an expert witness assessment when the
 23 instructions are specifically about, for example,
 24 diminished responsibility or insanity or fitness to
 25 plead, which is the other issue, then as soon as

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1 method of triangulation, to use the same term, when you
 2 have information about someone's mental illness from
 3 several years leading up to their arrest.
 4 **Q.** Separate to mental health assessment, what about risk
 5 assessment? I mean, we've heard about, for example,
 6 HCR-20, I think we're going to hear more about that in
 7 due course.
 8 **A.** Yes.
 9 **Q.** Also even the Royal College of Psychiatrists Best
 10 Practice Guide and I think it's called Assessment and
 11 Management of Risks?
 12 **A.** Yes.
 13 **Q.** As a matter of basic risk management and perhaps also
 14 taking action to reduce immediate risks, should more be
 15 done at that police custody stage?
 16 **A.** Can I just check I've understood the question? This
 17 is -- because obviously once he was in police custody
 18 arrested on suspicion of these offences, there weren't
 19 going to be many chances taken in terms of risk, but
 20 obviously he had been -- well, the police had been
 21 involved before.
 22 **Q.** Both.
 23 **A.** So I think, yeah -- I mean, I think risk assessment --
 24 because obviously, looking at the risk retrospectively,
 25 we know how dangerous he was. But there is a question

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1 possible. But the reality is most people in this
 2 situation first assessment after they are charged and
 3 remanded is going to be from a professional within the
 4 prison mental health team.

5 Again, that's an assessment that might have
 6 a slightly different purpose, because the main question
 7 there might be: is this person mentally unwell now and,
 8 if they are, should we be starting some treatment? Or
 9 does this person need a referral to hospital so that
 10 they can receive treatment under the Mental Health Act,
 11 or they need to receive treatment under the Mental
 12 Health Act, because it needs to be given compulsorily.

13 **Q.** Do you agree with Dr Blackwood that detention can
 14 deteriorate somebody's mental health and therefore,
 15 I suppose in theory, the longer it takes for that
 16 assessment to take place, the less reliable it may
 17 become?

18 **A.** Yes, I think that's a risk and I think it's particularly
 19 a risk when there is no antecedent history of mental
 20 health problems and so the first time that someone is
 21 found to be mentally ill is two or three months down the
 22 line, and then, working backwards, becomes much more
 23 complicated because the question of: well, when did the
 24 mental illness start?

25 I think it is slightly different in terms of this

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1 about whether it is possible, or was possible, to have
 2 predicted quite how dangerous he could have been, prior
 3 to these offences. And the reality is that we can try
 4 and predict but if we try and predict that someone is
 5 going to do something this serious, we will inevitably
 6 gather up a whole lot of people who would never have
 7 gone on to do anything by labelling them as high risk or
 8 dangerous, because the science is just not good enough
 9 to reliably pick out who is at risk.

10 So one of the things I think with risk in mental
 11 health care there's different levels: there's risk
 12 assessment, which is trying to gather all the relevant
 13 information. There's risk formulation, which is a way
 14 of trying to sort of put together all those bits of
 15 information and understand what the risk is, and then we
 16 try to have a risk management plan, which might be ways
 17 to mitigate that risk, which might be helping people
 18 with social factors, it might be treating their mental
 19 illness, it might be helping them with drug addiction.

20 What isn't very helpful, I would say -- and you may,
 21 I understand, hear slightly different evidence about
 22 this -- is trying to engage in a reliable risk
 23 prediction because for the reasons I've said, it's just
 24 too difficult to reliably predict what an individual
 25 person will do.

40

1 Q. Thank you. I'm going to move on to the report itself.
2 That can be found at CPSE000017. This is your report
3 date 12 December 2023. Page 3, we have the summary of
4 your opinion, and you say:

5 "In summary, the conclusions reached about
6 diminished responsibility are, in my opinion, the proper
7 conclusions based on the information available to, and
8 described by, the experts who have assessed [VC] ..."

9 You say "information available" there; is it
10 ultimately really information made available?

11 A. Yes. I think, as an expert, there are two layers here.
12 You can only work with what you're given, but I do think
13 there is a burden on experts, based on their experience,
14 to know what information might be available. And so,
15 for example, the custody record. That's important
16 information often very soon after someone has been
17 arrested, and I occasionally have given evidence and not
18 been sent that custody record, but I know that exists;
19 or I've been sent a front sheet and not more detail.

20 So I think there will always -- I think there was
21 a burden on experts to ask for what they know should be
22 there, but sometimes there is information that you
23 simply don't know exists until someone provides you
24 with it.

25 Q. Because some of that material that we heard about this

41

1 Q. The EMAS documents.

2 A. Yeah. I think sometimes you do know, sometimes -- and
3 this didn't occur to me, but sometimes, for example,
4 you'll get general practice records, and there will be
5 letters in those general practice records from a mental
6 health trust, in other words, you know, a different
7 organisation.

8 And then I suppose you have an advantage as
9 a doctor, by recognising that that organisation will
10 also have their own set of records. And I've certainly
11 been involved in situations where people move around and
12 you'll find one letter which gives you a clue that there
13 is probably a whole set of records somewhere else.

14 So I think there is a sort of reciprocal
15 relationship between the expert and whoever has
16 instructed you in terms of highlighting to the legal
17 representatives that there should be a request for
18 records from somewhere else.

19 Q. Thank you. Then the very final topic is the penal
20 element. Can we please bring up on to screen
21 CPSE0008432. There was a possibility at one stage that
22 you may have to give a further opinion on disposal on
23 sentence; is that right?

24 A. Yes.

25 Q. I'd like to read that first, that top email from

43

1 morning is information you wouldn't necessarily know
2 about. Do you think that there is enough visibility and
3 actually enough time for experts to go through
4 sufficient information to carry out their task?

5 A. I think there is pressure to provide an opinion
6 sometimes before having all of the information. The --
7 just the sequence of events, the prosecution will be
8 gathering the evidence which will then be at some point
9 served, but the defence may have instructed an expert
10 before all of that evidence has been served, and so if
11 you are an expert for the defence, you may be provided
12 with everything that has been served, but there is more
13 information to be served. And then, if I am a defence
14 expert, then I will be going back to the defence and
15 saying, "Is there anything else?" Or "Have we got
16 anything else".

17 Or if, for example, in VC's case I wasn't provided
18 with the medical records, I would be saying: I simply
19 cannot give anything other than a very provisional
20 opinion without the medical records.

21 Q. Something like the medical records that went back before
22 2020, should the relevant experts have known about that
23 information, and how would they know about that
24 information?

25 A. The -- so this is with reference to the --

42

1 yourself to Alan Murphy of the CPS. You say:

2 "... the penal element is also tricky because
3 there's really variation in judge's attitudes to
4 psychiatric evidence on culpability. Nigel ..."

5 That is Professor Blackwood, is it?

6 A. Yes.

7 Q. "... gave his view on this but I try and avoid it too
8 much because it veers so clearly into moral judgement
9 rather than a medical one. I suspect I couldn't do any
10 kind of assessment until early-mid Feb[ruary]. I'm not
11 sure that interviewing him does make much difference ...
12 because it amounts to a medical recommendation for
13 detention, I think it would be hard to justify doing
14 that without interviewing him."

15 Can you assist us with what you mean there about
16 moral judgment and the fact that you avoid those kinds
17 of opinions?

18 A. I think probably it's helpful to say that with
19 diminished responsibility that's a very specific test
20 and the language is very much medically derived, I
21 think, now. It changed in 2010, but the language feels
22 very medical.

23 So that is, if you like, giving an opinion on
24 responsibility, where it feels like it is very medical.
25 But when it comes to culpability, the next question, if

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1 there is a finding of diminished responsibility, is: how
2 much responsibility is left? And there are very clearly
3 medical or medically relevant opinions that go towards
4 that decision, which might be about the degree to which
5 the mental disorder is formulated as being associated
6 with the actions. But the ultimate decision involves
7 incorporating different factors.

8 So that whilst it might be sort of unnecessarily
9 pedantic, I would usually avoid going to the ultimate
10 question of how much culpability someone has, but rather
11 say their mental illness, in my opinion, for example,
12 was the dominant factor in understanding their actions
13 or it was the most significant factor, but just stop
14 short of a final opinion on that, because responsibility
15 is not a medical -- or culpability is not a medically
16 determined concept.

17 **MR BLAKE:** Thank you very much, Dr Latham. Those are all
18 the questions I ask. There are questions from
19 Mr Moloney.

20 **THE CHAIR:** Yes, Mr Moloney.

21 **Questioned by MR MOLONEY**

22 **MR MOLONEY:** Not many.

23 Did you watch Dr Blackwood's evidence this morning?

24 **A.** Yes, I did.

25 **Q.** Thank you. Early in your evidence, Mr Blake read out to

45

1 **A.** No, we didn't.

2 **Q.** No. The only GP notes that there were were from
3 Nottingham, weren't they?

4 **A.** Yes.

5 **Q.** So that's a gap in terms of that.

6 **A.** Yes.

7 **Q.** I'm not -- no criticism, but did you ask for them,
8 Dr Latham?

9 **A.** I mean I think probably at the stage I was at, I had
10 assumed to some extent that everything had already been
11 asked for. There were some additional records I asked
12 for which were the prison ones, and the Ashworth
13 Hospital ones, but I didn't ask for further GP records.
14 I don't --

15 **Q.** Because you came in at the end, as a sort of peer
16 reviewer.

17 **A.** Yes, I think it did have some -- I think that was --
18 I mean obviously I had to consider what it was I was
19 doing because it was somewhat unusual, but it was a sort
20 of peer review type process, albeit as an expert.

21 **Q.** Yes. You didn't have school records.

22 **A.** No.

23 **Q.** Did you ask for them?

24 **A.** I didn't ask for them, no.

25 **Q.** And you didn't have work records.

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1 you a list of things that you didn't see?

2 **A.** Yes.

3 **Q.** And you said that none of the things would have helped
4 in terms of your ultimate opinions?

5 **A.** Yes, that's correct.

6 **Q.** Now, the EMAS document suggested he had a longer history
7 of mental illness?

8 **A.** Yes.

9 **Q.** The statements from the flatmates in South Wales
10 suggested he had a longer history of mental illness.

11 **A.** Yes.

12 **Q.** The CPS document, the police record from 14 June,
13 suggested that he was out of touch with his family for a
14 long time.

15 **A.** Yes.

16 **Q.** They didn't know where he was or what he was doing, and
17 in effect thought he was in Newcastle and not in
18 Birmingham and they didn't know what he was studying.

19 **A.** Yes.

20 **Q.** So there's a gap in knowledge about him.

21 **A.** Yes.

22 **Q.** And you said that there was a burden on the expert to
23 ask for what they know should be there.

24 **A.** Yes.

25 **Q.** Now, you didn't have the GP notes from Wales, did you?

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1 **A.** No.

2 **Q.** Did you ask for them?

3 **A.** No.

4 **Q.** So there was that gap and there were no records to fill
5 that gap, but you're still prepared to say, Dr Latham,
6 with evidence of poor mental health potentially in 2013,
7 2014, on the basis of the statement and another(?) that
8 no matter what was said in those things, they wouldn't
9 affect your ultimate opinion?

10 **A.** Yes, because I don't think that they changed the
11 situation in those three years before the offences, the
12 time around the offences, and the time after the
13 offences. They potentially are useful in terms of
14 longer-term treatment and understanding, because they
15 might give a picture of when his mental illness really
16 started, because mental illness doesn't tend to start
17 suddenly; it does tend to come on gradually and some of
18 the things that I heard and that were put to
19 Professor Blackwood do support that notion really, that
20 there was a sort of social decline before there was
21 a clear process of mental illness with delusions and
22 hallucinations.

23 **Q.** And those gaps could have perhaps showed the reasons for
24 that decline.

25 **A.** Yes, and they -- yes, so they may have provided more

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1 information about that natural history of his mental
 2 illness. And there were some things about those gaps,
 3 but there were some excerpts, for example, from medical
 4 records that filled those gaps, there were occasional
 5 conversations with his mother in hospital, and things
 6 like that, but it wasn't a comprehensive picture at that
 7 time.
 8 **Q.** And just finally, you're aware of course that the
 9 potential for co-morbidity or psychotic disorder with
 10 other conditions.
 11 **A.** Yes.
 12 **Q.** And the psychotic disorder may become dominant in the
 13 latter years prior to the killings.
 14 **A.** Yes.
 15 **Q.** But there could have been a co-morbid disorder of
 16 another type.
 17 **A.** Yes.
 18 **Q.** And that could have contributed to dysfunction.
 19 **A.** Yes, it could have done.
 20 **Q.** Just one other issue, if the Chair will allow me, just
 21 for two minutes. Thank you, Chair.
 22 You gave an opinion on VC's credibility.
 23 **A.** I don't think I did direct -- well, I don't think I did
 24 directly.
 25 **Q.** You said that it was unlikely that he's fabricated

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1 **A.** No, I didn't.
 2 **Q.** Would you have liked to have interviewed VC before
 3 producing your report?
 4 **A.** I -- I mean I think I -- the conversation and my views
 5 were that there were two different reports that I could
 6 do in about VC. One was, if you like, a full expert
 7 opinion in which case it was absolutely essential that I
 8 saw him. And when I had the conversation with Alan
 9 Murphy, I think we had a really clear mutual
 10 understanding of what I could and could not do by just
 11 looking at the material. And so it was a choice,
 12 really, because the -- I was prepared to do the report
 13 I did, but if I had done the other kind of report, then
 14 I would have needed longer and time to go and see him.
 15 **Q.** I see. So I mean ideally, as an experienced
 16 psychiatrist, you'd have liked to have done the full
 17 report and seen him?
 18 **A.** Yes, to give -- I mean if it was, if you like, a full
 19 expert opinion, then yes.
 20 **Q.** But you weren't actually providing your report until
 21 December of 2023, were you?
 22 **A.** No, I wasn't.
 23 **Q.** And was it thought that it's time-sensitive, this, we
 24 need to get on with it, we've got a hearing in January?
 25 **A.** Well, yes, and I think actually I hadn't realised until

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1 symptoms.
 2 **A.** Ah, I see, yes.
 3 **Q.** So you said the three experts who have interviewed him
 4 all found what he described to be consistent with his
 5 mental illness, it's unlikely that he's fabricated
 6 symptoms.
 7 **A.** Yes.
 8 **Q.** And to that extent, expressed credibility opinion.
 9 **A.** Yes, I mean I can see it would certainly be interpreted
 10 as going towards credibility but I mean it's
 11 a complicated area -- a bit like culpability,
 12 credibility is a complicated area for an expert to
 13 comment on. It's not in many ways --
 14 **Q.** Well, quite, because you went on to say, as well, and
 15 I'll take you to it if necessary:
 16 "He has given a consistent account to psychiatrists
 17 of being driven to act as he did in committing these
 18 offences by a combination of voices and the persecutory
 19 beliefs about the conspiracy as it related to him."
 20 **A.** Yes.
 21 **Q.** And that, of course, is relevant to his credibility.
 22 **A.** Yes. It is, in that if his -- if he is -- if his
 23 account is not considered credible, then it does -- it
 24 is information that undermines the overall opinion.
 25 **Q.** Absolutely. But you didn't see him, did you?

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1 I was provided with a secondary bundle that the initial
 2 email that I was sent, which I think came from someone
 3 else, I think I just said, "No, I don't have time," and
 4 I think that's when Alan Murphy called me and said,
 5 "Actually, we're not asking you to see him and do an
 6 assessment." I also wasn't available for the scheduled
 7 trial date. And he then called me and said, "We'd like
 8 you to do something different." And I thought about it
 9 and said, "In that case I think I can do this."
 10 **MR MOLONEY:** Thank you very much, Dr Latham.
 11 **THE CHAIR:** Thank you.
 12 Yes, Mr Straw?
 13 **Questioned by MR STRAW**
 14 **MR STRAW:** Thank you, Chair.
 15 Dr Latham, in your report you say that mental
 16 illness was a very compelling dominant explanation for
 17 these offences.
 18 **A.** Yes.
 19 **Q.** Do you stand by that conclusion?
 20 **A.** Yes.
 21 **Q.** And, just to be clear, do you stand by that conclusion
 22 notwithstanding the fact that further questions or
 23 enquiries could have been made of VC, as has been
 24 suggested earlier?
 25 **A.** Yes, I do.

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1 Q. And notwithstanding the new information that was drawn
2 to the attention of the court earlier on?

3 A. Yes.

4 Q. Triangulation. So leaving aside VC's accounts, I'd like
5 to just look very briefly at what other evidence there
6 was to support, and the accounts that he gave to
7 psychiatrists after he committed the offences.

8 A. Yes.

9 Q. The voluminous medical records, accounts from
10 psychiatrists, psychiatric nurses, going from May 2020
11 to August 2022, by the mental health tribunal about VC's
12 mental state, people who had had some time to assess
13 him, what significance did that have to your opinion?

14 A. I think the main significance is absolute corroboration
15 of the fact that he had a serious mental illness. But
16 it also provides information about the nature of the
17 symptoms that he has or had, the delusional beliefs, the
18 delusions of control where he felt like external forces
19 were controlling him, that the voices, even though to
20 him the voices were manufactured by something, he was
21 hearing voices.

22 But also the content, and there the content being
23 the sort of overall conspiracy against him, but also,
24 there was a history of his family being incorporated
25 into that, concerns about the safety of his family, and

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1 though, when you go to his medical records, he never
2 really gave people that level of detail, it shows the,
3 if you like, the dedication to his delusions. He had
4 sought to try to understand these frightening
5 experiences he was having, and that's where the
6 delusions had arisen from.

7 Q. Then, in custody, we've heard that some police officers
8 and prison officers did not pick up on any symptoms, but
9 some healthcare professionals, a couple of prison police
10 officers and so on, did, they raised concerns about his
11 mental illness. What significance did that all have to
12 your opinion?

13 A. Well, it's significant in that there isn't always
14 a behavioural -- an external behavioural manifestation
15 of mental illness. You can't tell that people are
16 mentally ill by looking at them or observing their
17 behaviour, but in his case there were observations, even
18 before he said anything about his behaviour, the way he
19 responded to questions, that caused people concern. And
20 so they are, if you like, another piece of the overall
21 picture that points towards the fact that he was
22 mentally ill at that time.

23 Q. Then, finally, the evidence from after the offences. So
24 the evidence from the various psychiatrists who assessed
25 him in custody in July, August and so on.

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1 so the whole thing provides some consistency.

2 And I suppose the thing that stands out, and perhaps
3 the reason for the strength of the opinions is this is
4 such a classic case of schizophrenia, the symptoms are
5 so classic and so consistent, and the progression of his
6 illness is so typical and, whilst violence of this
7 nature is not typical in people with schizophrenia, the
8 schizophrenia itself is so typical, and that's what
9 those records provided.

10 Q. The calls, then, that Elias Calocane gives evidence of,
11 between Elias and VC on 12th and 13th June, what
12 significance did those have to your conclusions that
13 mental illness was a compelling dominant explanation for
14 the offences?

15 A. They provide information about his abnormal mental state
16 at that time. They -- I accept that there is something
17 a bit tantalising about the things he said to Elias, and
18 it wasn't entirely clear what he meant, but they have
19 the tone and the content of someone who is psychotic,
20 and I think they provide really important information
21 about the fact that he was likely to have still been
22 psychotic at that time.

23 Q. The zip file, was that significant to your conclusion?

24 A. Yes. I mean that is significant in that it gives the
25 detail of the extent of his delusional beliefs. Even

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1 What was their significance? How did that fit into
2 the other information that we've been looking at?

3 A. Again, there was -- they found him to be mentally
4 unwell, and it was a combination of clear descriptions
5 of symptoms, but also behavioural manifestations of
6 mental illness, if you like. So the way he responded to
7 questions, other aspects of his behaviour, some of the
8 aggression in custody, in prison. So they again were
9 just more pieces of the overall picture.

10 MR STRAW: Okay. Thank you very much. No, more questions.

11 THE CHAIR: Thank you very much, Ms Carey.

12 Questioned by MS CAREY

13 Q. Dr Latham, I ask questions on behalf of the Crown
14 Prosecution Service. Just four topics, please, from me.
15 You were not asked to do a full report, were you, in
16 this case?

17 A. That's correct.

18 Q. Do I understand your evidence to be that, had you been
19 asked to do a full report, you would have felt it
20 necessary to interview VC?

21 A. Yes.

22 Q. Can you explain to us, please, why you would have felt
23 it necessary to interview him?

24 A. In many ways, for completeness, because a lot of the
25 relevant evidence here was going to be the evidence from

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1 around that time and his medical records, but I think
2 there is -- I think it is just necessary, if I was to
3 give an opinion about him specifically to conduct an
4 assessment of him, and I just don't think I would give
5 an opinion on someone in those circumstances without
6 meeting them.

7 And, for example, occasionally I've given an opinion
8 on someone who was just completely uncooperative within
9 interview, and it lasts 15 or 20 minutes, even on
10 several occasions. And I would still give an opinion,
11 but I think I would at least attempt to conduct an
12 assessment.

13 **Q.** Thank you. The second topic: do you have in front of
14 you, please, doctor your psychiatric report?

15 **A.** I don't have my report.

16 **Q.** Can I put it up on screen to help, please.

17 **A.** Yes, you can, yes.

18 **Q.** Can we have on screen CPSE0000017, page 25.

19 Doctor, take a moment, it's in the middle of your
20 report, I want to ask you about two passages in
21 paragraph 23, and starting, please, with 23.1. You are
22 asked to opine on some of the aspects of VC's behaviour
23 and mental state, particularly in custody, and whether
24 that accords with perhaps a layman's understanding of
25 how someone who is psychotic behaves and whether that

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1 that you saw from the custody record or his behaviour
2 upon arrest which undermines the suggestion that he was
3 not psychotic on 13 June?

4 **A.** No.

5 **Q.** Slightly different topic, please, and over to page 26,
6 and it's really about the word "capacity" and its use
7 or, dare I suggest, misuse --

8 **A.** Yes.

9 **Q.** -- in a criminal context. I see you smile wryly there.

10 **A.** Mm.

11 **Q.** Can you help us, please. Clearly there is the Mental
12 Capacity Act --

13 **A.** Yes.

14 **Q.** -- which is one issue, but in terms of the criminal
15 justice system, the test you are applying for diminished
16 responsibility, does the phrase "capacity" or "notions
17 of capacity" assist with determining whether someone has
18 the partial defence available to them?

19 **A.** No, it doesn't.

20 **Q.** Can you help expand that because some people may be
21 struggling with the use of the word "capacity" and
22 perhaps use it in different contexts.

23 **A.** Yes, so I think "capacity" in the criminal justice
24 system is sometimes used in a very general sense to mean
25 someone's ability to either participate or to have, if

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1 affects your ultimate conclusion in the case. And you
2 say at paragraph 23.1, you make reference there to the
3 way he behaved at times calmly.

4 **A.** Yes.

5 **Q.** And equally, abusively when he swore at the officer who
6 was arresting him. We know he assaulted the officer as
7 he got out of the police van.

8 **A.** Yes.

9 **Q.** You said:

10 "Calmness is not however necessarily representative
11 of a normal mental state ..."

12 You go on to say that:

13 "It is long documented that even when he was
14 seriously unwell in the past, a serious violent incident
15 could be followed by long periods of calm and
16 undisturbed behaviour - medical records from his
17 inpatient treatment reflect this. The important point
18 is that severely mentally ill people do not necessarily
19 look or behave in a way that allows determination of
20 whether they are in fact ill. His lack of communication
21 in custody does not mean he was mentally well and in
22 fact probably reflects the opposite position."

23 I think you may have heard me ask

24 Professor Blackwood about whether there's

25 a stereotypical presentation, but was there anything

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1 you like, been fully capable of committing an offence.
2 It also has a specific meaning in mental capacity law in
3 the Mental Capacity Act, which is a form of ability to
4 make decisions about your care and treatment, or, for
5 example your finances. I think where this comes from is
6 that there has been a longstanding issue, when people
7 are arrested for offences, of psychiatrists being asked,
8 particularly psychiatrists who have an existing
9 relationship with the patient: did they have capacity?

10 And the problem is that that question is largely
11 meaningless and the police have traditionally been asked
12 to ask that question of the psychiatrist, who in turn
13 the police have been asked by the CPS. And actually
14 there's now guidance for the CPS saying, "Please don't
15 ask questions about capacity."

16 So it's -- I think it's a sort of relic of something
17 that exists so that the police are able to decide with
18 the CPS about whether a prosecution is likely to be
19 successful. But it doesn't exist as a word or a test
20 anywhere within diminished responsibility.

21 **Q.** Thank you. And that test is defined in the Act.

22 **A.** Yes.

23 **Q.** Indeed, would it be safer from your perspective to talk
24 about whether the person has the relevant *mens rea* or
25 mental element --

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1 **A.** *(The witness nodded).*
 2 **Q.** -- in this case did he intend to kill or cause serious
 3 harm and, if that intention is made out, does then the
 4 partial defence apply?
 5 **A.** Yes, but again it gets complicated there, as well,
 6 because, I suppose, there are -- well, there were more
 7 than two but in this situation there were two routes to
 8 a finding of manslaughter. And one doesn't make any
 9 sense because it is, as you said, about whether someone
 10 intended to kill, and no one has ever disputed that VC
 11 intended to kill.

12 But the other route is this diminished
 13 responsibility route which is a separate set of
 14 criteria. And so you do get to a position where, on the
 15 face of it, it does not make any sense that VC's pleas
 16 to manslaughter were accepted, because he clearly
 17 intended to kill, but that's not relevant to the
 18 manslaughter by reason of diminished responsibility.

19 **Q.** Thank you very much.
 20 Final topic, please. Can you have up on screen
 21 page 28 of your report and it's paragraph 26.
 22 You say there:
 23 "The partial defence of diminished responsibility is
 24 the proper conclusion [of] ... each of the expert[s]
 25 ..."

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1 **THE CHAIR:** So you've said in some cases people can be
 2 assessed in custody, rather than by the Liaison and
 3 Diversion team, and that would be a Mental Health Act
 4 assessment, would it?

5 **A.** Yes.

6 **THE CHAIR:** And that's really about treatment and so on,
 7 even if it's not going to be the case that they're then
 8 admitted under the Mental Health Act --

9 **A.** Yes.

10 **THE CHAIR:** -- because of the seriousness of the offence.

11 **A.** Yes.

12 **THE CHAIR:** That's what you're saying. I think you said
 13 that sometimes, and I think you've said that you've done
 14 that yourself --

15 **A.** Yes.

16 **THE CHAIR:** -- have carried out an assessment, and you can
 17 do that whether or not someone cooperates?

18 **A.** You can do your best if someone isn't cooperating.

19 **THE CHAIR:** But it's at least a contemporaneous
 20 assessment --

21 **A.** Yes.

22 **THE CHAIR:** -- at the time they're brought into custody.

23 **A.** Yes, and I should say there are other reasons that
 24 someone might be assessed other than a Mental Health Act
 25 assessment. For example, if someone is in custody --

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1 A little lower down, you say:

2 "Any other conclusion with respect to diminished
 3 responsibility would be highly unusual in the
 4 circumstances."

5 Would you be able to expand a little on why you came
 6 to that conclusion, please, Doctor?

7 **A.** Yes, I think -- I mean I think expanding on that,
 8 I think it's about experience of, if you like, other
 9 diminished responsibility cases, and looking at the
 10 diversity of cases where diminished responsibility is
 11 an issue, and I don't mean to sort of trivialise the
 12 process but this is such a clear diminished
 13 responsibility case for so many reasons, that I think it
 14 is very difficult to see how the experts, with the
 15 information they had, excepting the questions and the
 16 points that have been made about what might have not
 17 been there, how they could have reached any other
 18 conclusion in this case.

19 **MS CAREY:** Thank you very much.

20 Thank you, Chair.

21 **Questioned by THE CHAIR**

22 **THE CHAIR:** Yes, I just wanted to go back over the point you
 23 were making, I think at the outset, about reports in
 24 custody.

25 **A.** Yes.

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1 I work in London, and we always, in the organisation
 2 I work in, always have a forensic psychiatrist who is on
 3 call. And I think there is a reasonable likelihood that
 4 if someone was in custody and there was suspicion of
 5 them having a serious mental illness, then one of us may
 6 well go out and see them in custody at that time, if it
 7 was known that they had a history of mental illness.

8 Some parts of the country will not always have
 9 a forensic psychiatrist on call because there is simply
 10 not enough of them to run a 24 hours a day, seven days
 11 a week on-call system. So that's a different route to
 12 the Mental Health Act assessment.

13 But yes, the question about cooperation, you can do
 14 your best, and I've certainly assessed someone, or
 15 attempted to assess someone, charged with a very serious
 16 offence who would not say a word to me, and the best
 17 I could do was an observation of their behaviour.

18 **THE CHAIR:** Yes, but you wouldn't then be the expert for the
 19 trial. You'd have done that on a separate basis.

20 **A.** Yes. I'd be reluctant, if I was asked to go and see
 21 someone for a specifically treatment reason, to then
 22 become the expert. It might be hard to avoid being
 23 called as a witness, but I would probably try and avoid
 24 giving expert opinion in a case like that. Partly
 25 because it would be unfair to the person who'd been

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1 arrested that the purpose for me seeing them was for
2 a treatment reason and then to turn into an expert,
3 there may be a question about whether I'd properly taken
4 consent for that process.

5 **THE CHAIR:** You've touched on the issue of capacity, and
6 perhaps you said a misunderstanding by the police as to
7 what's meant by capacity, if someone has capacity to
8 commit an offence, meaning what's their mental state at
9 the time.

10 **A.** Yeah, I mean I think it's probably unfair to say it's
11 a misunderstanding by the police. Because I've been
12 involved in this over several years, I think that there
13 was guidance that the police were asked to follow, and
14 often were asked to enquire as to someone's capacity,
15 and it was a request that was unclear, but, if you like,
16 the police were simply doing as they were asked to do in
17 those situations.

18 And sometimes psychiatrists would give an opinion on
19 it, and I think sometimes they weren't quite sure what
20 they were giving an opinion on, but there'd been several
21 attempts to try and resolve this issue and get some
22 consistency about what a psychiatrist might be asked.

23 For example, it's much more reasonable to ask about
24 whether someone is fit to be interviewed which does have
25 some very clear criteria, rather than trying to

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1 treating of him.

2 **A.** Thank you.

3 **Q.** If we can go, please, to your statement, your first
4 statement at paragraph 6.10, so it's CPSE0000484.0010.

5 I should say first report, not statement to the
6 Inquiry.

7 **THE CHAIR:** Do you have that? It's coming up on the screen.

8 **MS LANGDALE:** It's coming up on the screen for you,
9 Dr Mirvis.

10 **A.** Yes.

11 **Q.** 484, paragraph 6.10, and you said:

12 "At his house, on 3 September, he asked a male
13 officer to step forward after negotiation around being
14 assessed."

15 And so it continues.

16 Did you ever see the video footage about that at the
17 time of writing this?

18 **A.** No.

19 **Q.** So you were relying on what you were told by VC about
20 that?

21 **A.** Yes.

22 **Q.** Paragraph 6.14, please:

23 "... January there was an altercation with his
24 flatmates who called the police and reported that he
25 refused to allow them to leave."

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1 second-guess an issue that really is going to come up in
2 a trial later on.

3 **THE CHAIR:** Yes, thank you.

4 I have no further questions, so thank you. We'll
5 rise now for another five minutes. Thank you.

6 **(3.35 pm)**

7 **(A short break)**

8 **(3.49 pm)**

9 **MS LANGDALE:** May I call Dr Mirvis, please.

10 **THE CHAIR:** Yes.

11 **DR ROSS MIRVIS (sworn)**

12 **Questioned by MS LANGDALE**

13 **THE CHAIR:** Yes.

14 **MS LANGDALE:** Dr Mirvis, can you give us your
15 qualifications, please?

16 **A.** Yes, my name is Ross Mirvis, I'm a Consultant Forensic
17 Psychiatrist.

18 **Q.** You have provided for the Inquiry a statement dated 7
19 November 2025, and you prepared two reports in respect
20 of the criminal proceedings dated 14 January 2024 and a
21 second report, 14 April 2024; is that right?

22 **A.** Correct.

23 **Q.** You are VC's treating psychiatrist; is that right?

24 **A.** I am.

25 **Q.** I'm not going to ask you any questions today about your

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1 Again, you didn't see a video footage of that event,
2 did you?

3 **A.** Not at the time, no.

4 **Q.** No. So you were relying on the description, were you,
5 of others in respect of an altercation.

6 **A.** So I had access to the other psychiatric reports and
7 then things like the MG5 documents were provided to me.

8 **Q.** What did you ascertain from the information you had at
9 the time about that? What did you think that event's
10 significance was or otherwise?

11 **A.** Well, I think it demonstrated that again there was this
12 pattern of violence that appeared to be closely
13 associated with mental illness and deterioration, the
14 fact that VC was admitted to hospital in relation to
15 that episode, in my mind, seemed to reinforce that
16 association.

17 **Q.** That's actually a different altercation. If we look,
18 it's not when he goes to hospital, but be that as it
19 may, it's the altercation with flatmates?

20 **A.** So there was the altercation not in January 2022?

21 **Q.** Yes, January 2022, yeah.

22 **A.** And then he was admitted to hospital on 28 January 2022.

23 So my impression was that, you know, around that time,
24 there appeared to be, again, an escalation in violence,
25 and he was then later admitted to hospital the same

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1 month.

2 **Q.** So you didn't look at the details of the account or how
3 that came about or the conversations between the
4 flatmates beforehand?

5 **A.** Well, I didn't have any evidence to further scrutinise
6 that.

7 **Q.** Understood. If you go, please, to paragraph 7.5, this
8 is when he's in prison, and he's transferred to Care and
9 Separation Unit due to concerns about his presentation:
10 "He was shouting and appeared to be responding to
11 unseen stimuli, and believed there was a man in his
12 cell." (*As read*)
13 Is that right?

14 **A.** Yes.

15 **Q.** So he had deteriorated, hadn't he? We know from records
16 in custody he wasn't responding to unseen stimuli then.
17 At this stage he was and thought there was a man in his
18 cell?

19 **A.** I think his presentation changed, so yes, those
20 experiences were noted in custody. But as we've heard
21 earlier, there were still concerns when he was in police
22 custody that he was suffering with prominent psychotic
23 symptoms but displaying them in different ways.

24 **Q.** Well, the Chair has the records of him in custody. If
25 we go to 9.3, please. We see there, this is your

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1 **A.** So I --

2 **Q.** -- when he'd left home or anything like that?

3 **A.** So I did interview his mother and in that interview she
4 did say that I think she'd last seen him in 2022. She'd
5 made attempts to try and see him after that, but he
6 hadn't sort of met up with her. He'd been the one that
7 meant that they weren't able to have further in-person
8 contact, but they did have telephone contact.

9 **Q.** Paragraph 9.8, please, and at the top of the next page,
10 if we can:
11 "He said that he drank alcohol 'every now and then':
12 estimating ... every few weeks. The only illicit
13 substance he has ever tried was cannabis once when he
14 was 28."
15 Can you tell us what he said the effect of that was?

16 **A.** So he said that it "... made him believe that his arm
17 had been cut and that he thought he was going to lose it
18 and die".

19 **Q.** Did you explore that further?

20 **A.** I didn't get any further detail, but I thought that was
21 a reasonable description of that experience, and the age
22 that he experienced it --

23 **Q.** What, 28?

24 **A.** Yes, that's what he told me.

25 **Q.** So a reasonable response aged 28, would that be what

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1 interview with him. 9.3:
2 "He enjoyed school ... got into one or two fights
3 but was never suspended and thought he had quite a few
4 friends ... He has a younger brother who is a computer
5 engineer ... sister ... He said he had good
6 relationships with everyone in the family."
7 Was that your understanding? Is that what you
8 accepted to be the case?

9 **A.** Well, I, as part of the process, I also interviewed his
10 mother prior to my report, and I didn't get any
11 impression from that that there was significant familial
12 discourse and her account did corroborate that as
13 a child there weren't any sort of major developmental
14 issues. He did have friends, and his schooling wasn't
15 characterised as someone that was getting into lots of
16 trouble, being suspended, those sorts of things, so it
17 seemed to -- (*overspeaking*) --

18 **Q.** What about being bullied or --

19 **A.** I asked about being bullied, and I don't think -- at
20 least earlier on he was not bullied. I think he talked
21 about the language barrier being an issue later on. But
22 I'm not aware of a sort of significant issue around
23 bullying.

24 **Q.** Were you aware whether he saw his family regularly or
25 not --

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1 you'd expect?

2 **A.** For someone to have that experience?

3 **Q.** Yes.

4 **A.** Or try at 28 to experience?

5 **Q.** Yes. For the --

6 **A.** No, I think that's quite a -- quite an extreme or
7 distressing reaction to using cannabis a single episode.

8 **Q.** But did you accept that that was an accurate
9 description?

10 **A.** Well, I don't know how I could have in any other way
11 challenged it or investigated it, but that's -- I mean,
12 I thought that the fact that he actually told me about
13 this, I couldn't think of another motivation for him to
14 tell me about it, if it wasn't true, really.

15 **Q.** Could you challenge where -- or ask more questions about
16 where he got the substance from, and that that seemed
17 quite a dramatic reaction, and whether it was cannabis,
18 or something like that? It does seem an extreme
19 response, doesn't it?

20 **A.** I suppose at the time he was also experiencing psychotic
21 symptoms, they could have heightened whatever underlying
22 paranoia he already had at the time. I did consider,
23 you know, was this -- well, what was the relationship to
24 his illness starting and his cannabis use?
25 And I asked him specifically about what he first

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1 noticed when he developed psychotic symptoms. He gave
2 a description of believing that his -- he was being
3 monitored, his bank details were being hacked, and that
4 felt quite different to the description of the one time
5 that he said he used cannabis. So I was quite satisfied
6 that cannabis in this instance wasn't a significant
7 precipitant or perpetuating factor.

8 **Q.** Were you in the Inquiry hearing earlier when I went
9 through what was on his phone and the zip files, and the
10 letter to the Investigatory Powers Tribunal that he'd
11 sent in May 2022? Were you in the hearing for that?

12 **A.** Yes.

13 **Q.** Was there anything in that material that surprised you
14 or that you weren't aware of, in terms of what he'd been
15 viewing about shootings and generally?

16 **A.** I mean, I wasn't aware that he'd been viewing things
17 about shooting, but I've had a little bit of time to
18 reflect on that, and I would highlight, looking at my
19 second report, that VC has a habit of trying to analyse:
20 "why is this experience happening to me? What's going
21 on?" And in that shooting incident, from looking at the
22 document that I was sent, it seemed like it was someone
23 else who was -- he thought was being controlled by
24 something.

25 In the past he's talked to me about other sort of

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1 asked him about them.

2 **Q.** One of them was a dagger, described in the police
3 interview as nearly a foot long, the one that he used.
4 So a reference to one knife doesn't really deal
5 adequately with the issue of the purchasing and holding
6 onto of weapons, does it?

7 **A.** Well, I think from the information I had I did explore
8 it as carefully as I could to find out when he purchased
9 the knife, how he purchased the knife, whether he ever
10 took the knife out to sort of protect himself in public,
11 because I'm mindful that it's something important to ask
12 him about. But I do acknowledge if there were multiple
13 weapons, you know, that does need exploring as well, if
14 you're aware of that.

15 **Q.** Why?

16 **A.** Well, I think it would be helpful to find out the same
17 sorts of things: why he purchased them, you know,
18 et cetera. Whether --

19 **Q.** When?

20 **A.** Yes.

21 **Q.** With what -- with a view to what?

22 **A.** Yes, exactly.

23 **Q.** 9.24: "The Account of Index Offences." We see you:

24 "... asked if he had made any preparations or plans
25 for the index offences which he denied".

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1 notable episodes like Havana Syndrome. So I think that
2 instance of him looking those sorts of things up is an
3 attempt to maybe try and investigate in his mind what's
4 going on and how has it happened to other people, and,
5 you know, what they have done? That side of things,
6 from the contact I've had with him.

7 **Q.** 9.11:

8 "In 2021 voices began to tell him to harm others.
9 They said that if he did not do this, they would kill
10 his family."

11 What was your evidence base for that: him telling
12 you that that's what the voices said, or anything else?

13 **A.** Well, I think this section of the report, this was my
14 interview with him so --

15 **Q.** So it's him?

16 **A.** -- I would putting down, yes, what he was telling me in
17 the interview.

18 **Q.** 9.16, please.

19 "He thinks he purchased a knife at the end of 2021
20 or early 2022."

21 That's one knife. Did you know, at the time of
22 writing this report and meeting him, how many weapons
23 were found in the rucksack?

24 **A.** So I'm -- I must acknowledge that I hadn't realised that
25 there were multiple weapons, otherwise I would have

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1 How much information did you have when you were
2 interviewing him? Did you, for example, know of the
3 timeline, the CCTV timeline, and that he'd hidden in
4 a shaded area before he came out unexpectedly in respect
5 of the first two victims, for example?

6 **A.** I don't think I did. I was aware of certain things, for
7 example, turning off the mobile phone which I asked him
8 about, and then I think he turned it back on. But I'm
9 not -- off the top of my head, I don't think I was aware
10 of specific hiding prior to the violence.

11 **Q.** It is significant, isn't it, hiding?

12 **A.** It's an important thing to ask him about.

13 **Q.** What about changing clothes, changing footwear so you
14 remove footwear with a brighter sole, for example? Did
15 you know anything about that level of detail?

16 **A.** I don't think I knew specifically about that. I mean
17 I asked about preparations, which, you know, in general
18 might have captured that side of things, but I didn't
19 specifically ask on footwear.

20 **Q.** Why might it have captured that?

21 **A.** Well, that might have been a preparation that he might
22 have made.

23 **Q.** So if he was telling you about the plans he'd made on
24 the night, that was something he may remember; is that
25 what you mean, that he'd changed his footwear?

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1 **A.** Potentially, I mean he told me that his recollection was
 2 limited but potentially that might have been something
 3 that he might have talked to me about if I'd asked
 4 specifically.

5 **Q.** At 10.1 you say:
 6 "VC has a diagnosis of treatment-resistant
 7 schizophrenia."
 8 Just so we know -- take that down -- can I ask that
 9 we have RLIT000013, page 4. This is actually a 2026
 10 piece of guidance from the Royal College
 11 of Psychiatrists. You're doubtless familiar with it.
 12 We see the definition of treatment-resistant
 13 schizophrenia. So it's RLIT000013, page 4.
 14 "Treatment-resistant schizophrenia ... is defined by
 15 the presence of at least moderate to severe psychotic
 16 symptoms ... associated with functional impairment and
 17 are persistent despite serial trials of at least two
 18 antipsychotic medications that were adequate in terms of
 19 dosage, duration and level of adherence. It should be
 20 noted that whilst it is generally referred to as
 21 'treatment-resistant' schizophrenia, it is more
 22 appropriately termed 'medication-resistant'
 23 schizophrenia."
 24 Is that the definition you're using in the
 25 diagnosis?

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1 prominent psychotic symptoms despite that and, as you
 2 can see in that guidance, there's a real -- a real push,
 3 in treating psychotic symptoms, to try and treat with
 4 clozapine assertively because we know that the longer
 5 people are untreated when they have treatment-resistant
 6 schizophrenia, the harder it is to treat the more
 7 prominent the symptoms that can still remain. So I was
 8 weighing that up and I felt the most important next step
 9 really was to try and assertively treat his psychotic
 10 symptoms.

11 **Q.** Looking at this guidance again, level of adherence is
 12 significant, isn't it, and in the community we know in
 13 VC's case he was resistant to taking the medication,
 14 wasn't he? He didn't want to take the medication and
 15 didn't believe he was mentally ill.

16 **A.** Yes.

17 **Q.** And they are not to be confused, are they,
 18 medication-resistant and somebody who is resistant to
 19 treatment, doesn't want to take the treatment?

20 **A.** No.

21 **Q.** Can we go to your second report. That can come down,
 22 please. WITN0073002, page 1. It's paragraph 5.11,
 23 which is page 12.
 24 You say in the second report:
 25 "His offences on 13 July ... appear to be chaotic

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1 **A.** Yes, I mean there's a broad number of specific diagnoses
 2 for treatment-resistant schizophrenia, but that idea of
 3 trying two antipsychotic medications and still having
 4 symptoms is one I recognise.

5 **Q.** And of course, as far as the Inquiry is concerned and
 6 the events we're examining, it is very difficult to see
 7 what he took, when and for how long. That's relevant
 8 when looking at this issue, isn't it?

9 **A.** Well, I appreciate the trial with aripiprazole, you
 10 know, there's -- we don't have a definitive answer but
 11 my impression was this was a man who was prescribed, my
 12 understanding is Olanzapine first, then aripiprazole,
 13 had four admissions, some of them lasting over a month,
 14 and reported to me that he was still suffering symptoms
 15 the entire time, apart from possibly a few weeks I think
 16 in 2022 when he said the voices abated, although whether
 17 all of the residual symptoms had gone, you know, I'm not
 18 sure about.

19 But my impression is that actually, aripiprazole had
 20 been trialed quite considerably, and at Ashworth I had
 21 the opportunity of trialing him on the medication
 22 Olanzapine. So both of those types of medications are
 23 what we call second generation antipsychotics, and I had
 24 him on the maximum dose of Olanzapine for well over
 25 three months I think in the end, and there were still

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1 and in keeping with someone suffering with psychotic
 2 symptoms. He does not appear to have targeted any
 3 specific group in selecting the victims. When he was on
 4 foot witnesses have observed him to walk 'calmly'
 5 between the sites, rather than taking steps to avoid
 6 detection."

7 You hadn't seen all of the evidence, had you, all of
 8 the prosecution evidence to be able to comment on
 9 whether there was planning or the extent of planning
 10 versus "chaotic" on the night; is that fair?

11 **A.** I mean I hadn't seen all of it but there were aspects
 12 of it that I would say still seemed to be quite chaotic
 13 and indiscriminate in the way he acted that night, but
 14 I do appreciate I hadn't had the sort of the depth of
 15 prosecution evidence that some of the other experts were
 16 provided with.

17 **Q.** And it's important isn't it, for example you say he
 18 walked "'calmly' between the sites, rather than taking
 19 steps to avoid detection." So you are presumably not
 20 aware that after the killing of two people, he went
 21 somewhere else, spoke to a caretaker, and was avoiding,
 22 at Seely Hirst House, with steps and movements, cars
 23 seeing him. So the very type of behaviour you're
 24 referring to there, avoiding detection from people who
 25 drove past him as he was walking in to Seely Hirst

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1 House.

2 **A.** Well, I have seen the Seely Hirst House CCTV footage
3 afterwards and actually, I thought after he's tried to
4 gain access and is repelled, his behaviour is quite an
5 keeping with someone not trying to avoid detection. He
6 saunters, walks very slowly kind of away in broad
7 daylight, you know, with his bag, and to me doesn't
8 appear to be really trying to evade being detected. So
9 I would suggest that maybe his approach seems to
10 fluctuate that evening.

11 **Q.** Because there's an earlier bit in the forefront of Seely
12 Hirst House where he is seen to do that as a car goes
13 past, which is different from when he is on the street.
14 I appreciate you are referring to him walking along the
15 street. But you would say, in any event, it is relevant
16 if you do see signs of somebody avoiding detection in
17 any way or trying to avoid detection.

18 **A.** Yes, I mean I don't think it would change my overall
19 view around whether it was being driven by psychosis,
20 I think that can still provide an explanation, but of
21 course the more information in building up the story is
22 important.

23 **Q.** Well, it may -- and I don't want to ask you to comment
24 on culpability, but it may in fact impact on the
25 responsibility, the retained responsibility that someone

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1 **Q.** Do psychiatrists have any particular training in
2 questioning, particularly forensic psychiatrists, what
3 might be the next question? For example, you say he
4 told you about a knife, when he bought it. Many people
5 might think: well, if you bought one knife, I'm going to
6 ask you what else you bought, other weapons. But it's
7 obviously something you genuinely didn't think to ask or
8 thought was necessary to ask.

9 If we're trying to determine what is in somebody's
10 mind about particular events, do you think it's helpful
11 to challenge what they're saying and see if they're
12 trying to hide something from you?

13 **A.** Well, I did challenge him actually during my interview
14 for the assessment. So for example he said he got on
15 well with his housemates, and I highlighted an argument
16 over the plate, I think cleaning a plate. So I did,
17 with the information I had, challenge him on things
18 that I thought were helpful to talk to him about. So,
19 you know, I agree it's important to, you know,
20 scrutinise things when you're interviewing someone.

21 **Q.** The phrase "masking", that's used, we see a lot of
22 medical records talk about masking and we'll hear from
23 a psychiatrist about that. Rarely does one see, not
24 told as the truth, or sometimes a lie about that. Is
25 that difficult to acknowledge when patients, because

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1 has for events, doesn't it, if they are taking steps and
2 measures to protect themselves and to continue in their
3 crimes?

4 **A.** Well, I think also if someone is very paranoid and
5 believes they're under general threat, maybe because
6 they're hearing voices and they feel they're being
7 persecuted, that that may drive their behaviour in
8 regards to sort of hiding in shadows in that respect.
9 So I don't think it's necessarily clear-cut.

10 **Q.** Does it start to become a little bit speculative either
11 way when you speak like that, hiding in shadows and, you
12 know, trying to avoid people or not? Do you find this
13 easy to suggest what may or may not have been in his
14 mind at that point?

15 **A.** Well, I think overall, in my view, I think it's clear
16 that he was suffering with psychotic symptoms and
17 I think it's helpful that we have a lot of information
18 beforehand, and a lot of information afterwards. The
19 nature of this work means that we don't have a running
20 commentary of someone's mindset when they're at -- you
21 know, when they're actually commissioning violence. But
22 I do think we've got, you know, a reasonable amount of
23 information to try to help, you know, in this instance
24 to help the court around what was going on and what was
25 driving him to act the way he does.

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1 they're unwell, you justify what they say and never say,
2 "Well that's a lie for the following reasons"?

3 **A.** Well, I think in general, masking is helpful because
4 it's explaining a specific, you know, example why
5 someone is not revealing their symptoms and, you know,
6 in this case that was I think because he didn't have
7 insight, he was hearing voices not to tell other people
8 to reveal symptoms.

9 So I suppose, in general, when we describe that, if
10 we use the term "lying", with mental health patients in
11 general that potentially could be stigmatising, whereas
12 I think "masking" with regards to specifically talking
13 about symptoms is helpful because it's a little bit more
14 specific. But I acknowledge that, you know, lying is --
15 the term can be used, but that's why, I think, in
16 general maybe there might be that distinction or
17 selection of that word instead.

18 **Q.** I think it's important to direct oneself why someone
19 might be lying, there might be all manner of reasons,
20 but actually not acknowledging that with the patient,
21 I just wondered why that's always the case, instead of
22 confronting them with the fact that you don't accept
23 that and you know that it's not right, what they're
24 saying?

25 **A.** I mean is this with regards to --

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1 Q. No, I'm not asking about you and VC, just generally in
2 psychiatry.

3 A. No, sometimes you do have to be frank. You have to
4 balance it, though, when you're interviewing someone, to
5 ensure that you can still have an interview that's
6 conducive, that allows people to feel like they can be
7 comfortable and forthcoming. So if you take a very
8 confrontational approach to the way you interview
9 someone, that comes at the risk of potentially not being
10 able to access as much information from the person as
11 possible. But I do think, yes, you know, you can call
12 them out in a manner that is still conducive, and
13 sometimes that's a bit of a skill.

14 Q. Can we go, please, to the sentencing document. That one
15 can come down, and it's CQCM0013355. It begins 0039.
16 If we go to 39, Dr Mirvis you give evidence, examined by
17 Mr Joyce, King's Counsel. If we go to page 41, we see
18 at the bottom below F the question:

19 "Question: A later part of his history was that the
20 dreadful events of June 2023 had been because the voices
21 that you've described were saying, if he didn't do as he
22 was told -- part of doing as he was told was to kill
23 more after the first three deaths -- they would kill his
24 family."
25 You say:

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1 again about --

2 A. I've --

3 Q. You've seen it?

4 A. Yes.

5 Q. You know it? You're familiar with it, are you?

6 Different domain commenting on culpability, do you
7 think here that you have said that? You've commented on
8 his culpability?

9 A. Well, I've been asked to assist the court around
10 culpability.

11 Q. True, no one stops the question, I see that. No one
12 interrupts that question. So carry on.

13 A. So, you know, I would feel generally obliged to answer
14 the question if that's what the courts are asking me to.
15 I did comment on culpability, I think in a very
16 qualified manner in my report, and I outlined quite
17 explicitly that ultimately, you know, that was a matter
18 for the court, and I did talk about the specific things
19 from my perspective that I thought would be helpful for
20 the court to hear about with regards to insight, and his
21 access to therapy in the past.

22 So I acknowledge that, in that transcript, I gave
23 a one-word answer, but I did think about culpability and
24 commenting on it quite carefully in my report and
25 elaborated on it in a way that I think is in keeping

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1 "Answer: Correct".

2 "Question: You've heard the other two doctors. But
3 for his clinically recognised condition -- for a long
4 time as a condition -- but for his condition of
5 treatment-resistant schizophrenia, do you share the
6 opinion of the other two who have given evidence this
7 morning that, but for that, he would not have committed
8 any of these dreadful acts?"

9 "Answer: I agree with them on that, yes."
10 Is what you say.

11 "Question: You know your duty to be utterly open,
12 frank and honest with the court.

13 "Answer: Yes.

14 "Question: In the light of that, do you take the
15 view that, so far as this man is concerned, his
16 culpability falls very, very much at the lower end of
17 culpability for what he did?"

18 And you say:

19 "Answer: Yes."

20 And you're questioned:

21 "Question: Are there any factors that you can see
22 that point against that?"

23 And you say "no".

24 You no doubt saw me refer this morning to CR193
25 [RLTI000012] and would you like me to turn that up

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1 with the guidance that we discussed earlier.

2 Q. But you hadn't seen, as I say, the detailed history of
3 the events or matters that pointed to planning and
4 calculation and the like. That's not what you were
5 looking at, were you? You spoke with him and provided
6 this report. You weren't going through prosecution
7 material to look at dates, times, and details?

8 A. I hadn't seen those, but I hadn't seen anything in the
9 material I had to suggest that there were any additional
10 factors that I needed to comment on or bear in mind.

11 MS LANGDALE: Those are my questions. There will be some
12 more questions.

13 THE CHAIR: Yes, thank you. Mr Moloney.

14 Questioned by MR MOLONEY

15 MR MOLONEY: Only very briefly, please, Dr Mirvis. Could we
16 please just look at your report, which is CPSE0000484
17 and to page 3, please. There we see you made reference
18 to "I only saw documents such as the MG5", and
19 paragraph 2.4, you set out the documents that -- the
20 information that you did have, and that is the MG5, as
21 you said, and a copy of the prosecution's opening note
22 dated November 2023.

23 So you didn't have witness statements, you didn't
24 have CCTV, you didn't have body-worn video footage, none
25 of that, that's what you had, those first two things, in

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1 terms of prosecution papers?
 2 **A.** Yes.
 3 **Q.** Yes, thank you. Can I take you to 9.19 of your report,
 4 please, which at page 23. This is your questioning in
 5 relation to the incident on 5 May 2023. We know that,
 6 as you say there, the two employees at Arvato warehouse,
 7 and you give the description there:
 8 "... he heard voices [continually] telling him he
 9 should do something about it."
 10 When his co-worker had told him expletives and:
 11 "He was also experiencing headaches and burning
 12 sensation ... He tried to resist the voices but 'lost
 13 control' and punched a male co-worker. He thinks a
 14 female intervened but does not have any further
 15 recollection around [that]."
 16 Did he mention, just for the sake of completeness,
 17 that he felt that the man had pushed him?
 18 **A.** I don't think to me.
 19 **Q.** He's asked about the evidence he was asking recruitment
 20 consultants to delete him from their records, and he
 21 said that that was because he was wary about giving out
 22 personal information?
 23 **A.** Yes.
 24 **Q.** At paragraph 9.20, lead-up to the index offences:
 25 "He lost several jobs because he was not able to
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1 flat?
 2 **A.** If that's what I've written down, I think that's --
 3 **Q.** Yes.
 4 **A.** -- that's what he would have told me.
 5 **Q.** Then just finally this: Ms Langdale King's Counsel asked
 6 you about the shooting incidents on his phone. Do you
 7 know the nature of those shooting incidents? Do you
 8 know exactly what they were?
 9 **A.** Only based on the sort of small footnote that was
 10 detailed in that document, yeah.
 11 **Q.** So they were essentially live streams of the shootings?
 12 **A.** Okay.
 13 **Q.** Yeah?
 14 **A.** I wasn't aware of that.
 15 **Q.** Right. You didn't know about them and so you didn't ask
 16 him about them?
 17 **A.** No.
 18 **Q.** They were essentially mass killings in Christchurch and
 19 Buffalo, and given that VC was engaged in acts of
 20 multiple and random killings, and attempted killings in
 21 the same way, would you have asked him about them if
 22 you'd known about them?
 23 **A.** Well, I would have asked him about them. I think, from
 24 my understanding -- or from my speaking to him, he is
 25 someone who has been trying to explain and understand
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1 concentrate on work."
 2 Now he lost the Avarto job because of violence,
 3 didn't he?
 4 **A.** Yes.
 5 **Q.** Did he make you aware of any other jobs he might have
 6 lost because of violence?
 7 **A.** I don't think so.
 8 **Q.** Then just over the page to 9.21, please, we see that:
 9 "He spent one night sleeping in his friend's
 10 bedroom. He drank two beers and a glass of whisky a few
 11 days before the index offence with his friend. This was
 12 the last time he had drank alcohol and denied any other
 13 substance use. His friend went to see his partner and
 14 their child so left him at the property. He went to
 15 introduce himself to the housemates and one of them
 16 immediately became confrontational and told him to 'fuck
 17 off' and seemed 'not in the mood'. [He said to the man]
 18 that he did not need to be rude. The man then tried to
 19 stab him with a 'zombie sword'. He threatened to kill
 20 him. The police were called although [VC] did not
 21 encounter them directly. He collected his possessions
 22 and returned to Nottingham."
 23 You're confident that that's what he told you?
 24 **A.** Yes.
 25 **Q.** Yes, and it was a flatmate rather than a neighbouring
 90

1 these explanations. So whilst I think it's speculation
 2 on both of our parts why he would have looked those up,
 3 I wonder whether he was trying to look for someone else
 4 who'd had a similar experience who felt they were being
 5 controlled, because that's how he feels, and he's
 6 described, you know, other instances in the news where
 7 people have felt controlled, like Havana Syndrome, which
 8 is not a violent sort of -- have any violent
 9 connotations, but sort of evidence around that same kind
 10 of theme of looking things up and trying to work out
 11 what's going on and how it applies to me, but
 12 I appreciate it's speculation.
 13 **Q.** Speculation, really, without knowing the nature of the
 14 video that he was watching, because these were live
 15 streams of killings, is that something that is really
 16 there that you could venture the opinion today when
 17 Ms Langdale asked you that he was trying to investigate
 18 what has happened to other people with potentially the
 19 same problems as him without actually asking him?
 20 **A.** Well, I don't think we can -- any of us can know for
 21 sure if it's helpful to the Inquiry, that's why I've
 22 shared that information, but I've acknowledged that's
 23 just my opinion on it.
 24 **MR MOLONEY:** Thank you very much.
 25 **THE CHAIR:** Yes, thank you.
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1 Yes, Mr Straw.

2 **Questioned by MR STRAW**

3 **MR STRAW:** Dr Mirvis, in your report you say VC's index
4 offences were highly attributable to his mental
5 disorder. Do you stand by that?

6 **A.** I do.

7 **Q.** What were the key sources of evidence you relied on to
8 come to that conclusion?

9 **A.** Well, I had the MG5 document, I had other summaries of
10 the investigation, I had the reports from several other
11 psychiatrists, and I also had the benefit of being the
12 person that spent the most amount of time with him,
13 interviewing him daily, observing him in a very focused
14 setting, to come to that conclusion.

15 **Q.** Did you triangulate that post-offence evidence with
16 material that was available from before the offences, so
17 the reports from psychiatrists, other psychiatric
18 nurses, for a period of May 2022, August 2022?

19 **A.** *(The witness nodded).*

20 **Q.** From his family, and from Elias Calocane, for example,
21 of the calls that he had with VC on 12 and 13 June. Did
22 you triangulate what VC was telling you with that
23 earlier information?

24 **A.** Yes, I managed to obtain records from the hospital as
25 well as speaking to his mother personally as well.

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1 that he was under mental health services and that time
2 period when he was under assessment in the prison in
3 Ashworth, I think they were all quite consistent with
4 schizophrenia and I think that's why the other experts
5 were very aligned in that view.

6 **Q.** Moving on to medication, is it your view that VC's
7 illness led him to stop taking medication?

8 **A.** Yes. He describes that -- so, you know, he was trying
9 to work out what was going on, and he had a very clear
10 description that these experiences, this advanced
11 technology, the voices, were driving his illness rather
12 than a condition like schizophrenia. He said that he'd
13 tried the medication, but it was ineffective and that
14 led him to conclude that, you know, he wasn't suffering
15 from mental illness and that the medication was
16 ineffective, and the medication side effects were also,
17 you know, impairing him as well. Yes.

18 **Q.** So are some of the features of his illness which led him
19 to stop medication, firstly he believed the
20 hallucinations he had were real, so he didn't need
21 medication? Is that one of them?

22 **A.** That's correct, yes.

23 **Q.** And another one, he had the paranoid or persecutory
24 delusions that the medical staff and others were
25 involved in a conspiracy against him; was that also

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1 **Q.** I think you were in court earlier when I described some
2 of the information that was available very soon after he
3 was arrested, so 13 and 14 June 2023 in custody, some
4 police officers didn't recognise any symptoms he was
5 unwell, but healthcare professionals and other police
6 officers did.

7 Did that provide you with some support for your
8 conclusion in this respect?

9 **A.** Yes, I felt that his presentation was, you know, in
10 keeping with someone that might have a psychotic
11 illness. We've heard earlier that there's different,
12 you know, manifestations of that in police custody and
13 I myself have assessed someone after a homicide that
14 didn't engage, didn't appear to be overtly unwell. So
15 I was familiar with that presentation still meaning that
16 they can be suffering with psychotic symptoms just
17 because they're not maybe as overt as they might be in
18 other presentations.

19 **Q.** Overall, is it your view that there has been
20 a consistent picture of schizophrenia maintained now for
21 several years with the symptoms described being
22 essentially consistent over that period?

23 **A.** Yes, I can't comment about more recent treatment because
24 of patient confidentiality issues, but from the
25 information we had in the lead-up for the four years

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1 relevant?

2 **A.** Yes, so he'd incorporate them into his paranoid system
3 as well, which meant that engagement with them as well
4 as, you know, following their instructions about taking
5 medication, I think he was, you know, wary of.

6 **Q.** And so did you consider then that his decision not to
7 take medication was a culpable or manipulative act of
8 someone unconnected to his mental illness?

9 **A.** Well, I thought it was helpful to highlight in the
10 report that, you know, his not taking medication was due
11 to his lack of insight rather than driving anything
12 else, which is not uncommon with people that take any
13 medication -- well, sorry, that take medication for, you
14 know, a condition like schizophrenia.

15 **Q.** So in other words, it was due to the illness rather than
16 being a sort of culpable act of a mentally well man?

17 **A.** Yes.

18 **Q.** Drugs. Have you seen any evidence that VC had taken
19 illicit drugs, except for the one-off incident of
20 marijuana?

21 **A.** No, and my report outlines, you know, the measures that
22 we had in place to try to scrutinise this, but in
23 conclusion, I haven't got any evidence that he'd used
24 any other drugs.

25 **Q.** You say in your report that the various measures were

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1 put in place while he was in high security hospital to
2 see if he was taking any drugs, and those came to the
3 conclusion that he -- it was highly unlikely he was; is
4 that right?

5 **A.** Yes.

6 **Q.** Did you consider that illicit drugs were a complicating
7 factor in his illness?

8 **A.** Well, I knew it was very important to consider that, but
9 I didn't think it was, ultimately, no.

10 **Q.** What was the key reason why you concluded that they
11 didn't complicate -- they didn't induce or exacerbate
12 his illness?

13 **A.** Well, I think I'd already established that his illness
14 had started before then, from his description of when
15 things started. He told me that he'd used it on
16 a single episode and that, you know, his symptoms
17 continued years afterwards and that wouldn't be
18 consistent with a pattern of using cannabis on a single
19 episode.

20 **Q.** Is it right you took number of urine screens, including
21 for illicit substances while he was in high security
22 hospital and those came back negative?

23 **A.** Correct. We also did drug dog screening to ensure that
24 there was nothing on his person, in his room, as well.
25 So there were a number of different measures to look

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1 aggressive towards prison officers, and we didn't have
2 that level of aggression mirrored at Ashworth.

3 **Q.** Now, you indicate in your report you considered him to
4 have schizophrenia, treatment-resistant. Is it right
5 you didn't -- you don't diagnosis him with a personality
6 disorder?

7 **A.** We didn't at that stage, no.

8 **Q.** Why was it that you consider that he doesn't have
9 a personality disorder?

10 **A.** Well, when we treated him with antipsychotic medication,
11 his aggression improved, his interactions with others
12 were warmer. So at that stage, I was -- I felt the
13 priority was really to treat his psychotic illness.
14 More broadly speaking, you wouldn't assess someone for
15 a personality disorder that also has a psychotic illness
16 until their psychotic illness was better treated, but in
17 general at that time the indicators were that things
18 were improving with antipsychotic medication and that
19 his presentation could be attributed to that.

20 **Q.** Final question. You were asked earlier about masking
21 and I think you indicated that he tended to mask or
22 tried to mask his symptoms, in part because he was
23 deluded that he wasn't ill, in part because the
24 hallucinations commanded him not to disclose his
25 symptoms; is that right?

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1 into that.

2 **Q.** One or two questions about the impact of the
3 antipsychotic medication on him. I think in your report
4 you indicate that that had a clear benefit and since
5 he'd been reliably taking antipsychotic medication in
6 hospital after the offences, there were no incidents of
7 violence; is that right?

8 **A.** That's correct. So he never had any episodes of
9 violence around that time. He'd already been
10 established on a sort of intermediate dose of Olanzapine
11 at HMP Manchester which was increased, and throughout
12 our time there was sequential improvement and we didn't
13 have any overt sort of aggression that required any
14 additional measures or anything like that.

15 **Q.** So I appreciate you can't talk about the current picture
16 but is this a fair summary: that antipsychotic, it
17 appeared to remove his threat of violence, but it may
18 not have completely removed his symptoms, his psychotic
19 delusions and so on?

20 **A.** So, yes. So it didn't completely treat his psychotic
21 symptoms but it did improve them. In terms of the risk
22 of aggression, that seemed to lessen, but we were -- we
23 are in a very secure, controlled environment, which is
24 different to, you know, other settings but, for example,
25 in prison where there are some similarities, he had been

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1 **A.** Yes.

2 **Q.** So is it your view that his masking was caused by his
3 illness?

4 **A.** I think in part of it, it was driving it, yes, because
5 his -- the voices who were telling him not to reveal
6 information, yes.

7 **MR STRAW:** Okay. Thank you very much.

8 **THE CHAIR:** Thank you.

9 Yes, any questions, Ms Carey?

10 **MS CAREY:** Just two, thank you.

11 **Questioned by MS CAREY**

12 **MS CAREY:** Dr Mirvis, I ask questions on behalf of the Crown
13 Prosecution Service.

14 I'd just like to clarify a couple of matters with
15 you, if I may. I think firstly this: that the report of
16 14 January 2024 was a report that was requested by the
17 defence solicitors acting for VC?

18 **A.** Yes.

19 **Q.** It was they, presumably, that provided you with the
20 documentation that you set out in your report at
21 paragraph 2.4?

22 **A.** I'd already obtained the hospital records, but the MG5
23 and the council's summary, they supplied.

24 **Q.** You've been asked some questions which may impinge on
25 whether VC had the partial defence of diminished

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1 responsibility available to him, but that was not, was
 2 it, the purpose of your report?
 3 **A.** No.
 4 **Q.** As you set out at paragraph 2.3, were you:
 5 "... asked to '[prepare] a brief report on [VC's]
 6 current state in hospital and the treatment he is
 7 getting and how that is affecting him as well as
 8 sentencing options, namely consideration of a hospital
 9 order [versus] a hybrid order'"?
 10 **A.** Yes.
 11 **Q.** Were your questions of him, and indeed the detail that
 12 you set out in that report, very much with a view to
 13 assisting the court as to sentence, rather than
 14 assisting the court as to whether the partial defence
 15 was available?
 16 **A.** Yeah, they were focused on addressing instructions.
 17 **MS CAREY:** Thank you very much.
 18 Thank you, Chair.
 19 **THE CHAIR:** Thank you.
 20 **Questioned by THE CHAIR**
 21 **THE CHAIR:** Yes, just to clarify, Dr Mirvis, we've
 22 effectively taken you up to the point at which you
 23 prepared your report for the court --
 24 **A.** *(The witness nodded).*
 25 **THE CHAIR:** -- and not the current state. But I just want

1 to be clear, because obviously I have to make a report
 2 on -- which might not be on a false basis. So when you
 3 were asked about whether he had had a personality
 4 disorder, and you said you didn't diagnose at that
 5 stage, was that careful -- was that a careful answer?
 6 **A.** Yeah, that was a careful answer, but I'm sorry, I've
 7 just -- having to weigh the fact that I can't reveal
 8 current --
 9 **THE CHAIR:** No, I understand that.
 10 **A.** -- information, but there was no concern during that
 11 period of a personality disorder being an issue, and if
 12 there was an issue around personality disorder, either
 13 way, I can't reveal it at this stage, but that might be
 14 something that the Inquiry could write to the Trust
 15 about to clarify if it was important.
 16 **THE CHAIR:** Yes, thank you.
 17 Well, I think I'll just leave that there and
 18 consider that. Thank you.
 19 **A.** Sure.
 20 **THE CHAIR:** Right, I think that we finish there for today
 21 and we'll start again tomorrow morning at 10.00, thank
 22 you.
 23 **(4.37 pm)**
 24 **(The hearing adjourned until 10.00 am the following day)**
 25

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