

Witness Name: Emma and Dave

Webber Statement No: WITN0289001

Dated: 17.12.25

## THE NOTTINGHAM INQUIRY

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### FIRST WITNESS STATEMENT OF EMMA AND DAVE WEBBER

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We, Emma and David Webber will say as follows:

#### INTRODUCTION

1. We are Emma and Dave Webber, parents of Barney Webber
2. This witness statement is made to assist the Nottingham Inquiry (the Inquiry) with the matters set out in the Rule 9 Request dated 30<sup>th</sup> July 2025 (the “request”).
3. Throughout this statement, we will refer to ourselves as ‘we’ when referencing collective experiences. We will refer to ourselves by first name when referencing individual actions or experiences.

#### IMPACT

4. We first address the impact of the catastrophic events which occurred on and following the 13<sup>th</sup> June 2023, in which our son, Barney Webber tragically had his life taken from him.
5. At the conclusion of the criminal proceedings, we provided victim impact statements to the court [CPSE0000078, CPSE0001117] and we ask that those statements be considered as part of our impact evidence. In those statements, we did our best to convey the immeasurable pain and profound devastation that losing Barney has inflicted upon our lives. At the time of producing this statement, nineteen months have now passed since we stood before the court and spoke those words, and yet our suffering remains unrelenting. The loss of Barney is the most harrowing event we have ever

endured, and it has irrevocably altered the course of our lives. When we first provided those statements, we believed we had reached the limits of our pain. We could not have imagined that our trauma would deepen further. Yet what followed has felt like an unending ordeal, each new revelation compounding our grief, each delay adding another layer to our anguish. By the time the criminal proceedings concluded, we had begun to grasp that Barney's death was not simply tragic, but preventable. We had some awareness that organisational failings had contributed to our loss. What we did not, and could not anticipate, was the staggering scale of institutional failure that would later come to light.

6. We have been repeatedly appalled by the extent of missed opportunities and systemic negligence which could have prevented Barney's death. The release of the NHS related investigation reports compounded our devastation, revealing truths we had never been told. The man who took Barney from us had been sentenced largely on the basis of his 'treatment resistant' condition, a statement repeatedly made by the CPS expert psychiatrist, Dr Blackwood. It was only via the investigations into his care that we discovered that he was treatment resistive, rather than his condition being treatment resistant – there is a fundamental difference. He had in fact made deliberate choices to refuse medication; not because it failed him, but because he disliked needles and wanted to continue studying. This was not only a refusal, but an attempt to mislead staff and create reasons. We are aware that he had his covid vaccination and had blood tests taken during admission [NHFT0000451, see p17]. When properly medicated during hospital admission, he had also displayed signs of improvement.

7. We had understood he was under the close care of the NHS, but we were unaware that staff had ceased visiting his property alone to protect themselves, with no apparent consideration for the danger he posed to the public or to our son. They had considered the long hallway as a barrier to their exit, admitting that they did not feel safe and would struggle to leave promptly. Only through these reports did we begin to understand the extent of the powers available to those professionals: that enforced treatment was

possible, that it was discussed, and that it was ultimately withheld. The weight of what could have been done and wasn't, is something we now carry every day. We are in no doubt that multiple staff members at the Nottinghamshire Healthcare NHS Foundation Trust failed to do their jobs properly - because of this, our son is dead.

8. Equally distressing has been the conduct of the organisations involved in response to the attacks. Institutions we should have been able to trust have instead chosen to conceal, deflect, and delay; deepening our trauma and eroding any remaining faith in the systems meant to protect families like ours. We expected transparency, compassion and remorse but instead, we were met with obstruction, evasion and disrespect. Information has been withheld and drip-fed to us in fragments. There have been countless occasions in which it has been the result of only our persistence and forensic analysis of each and every document, letter and email sent to us, that we have uncovered the aberration of conduct. This has forced us into cycles of disbelief and fury. This cycle has become so regular that periods of quiet have become equally intense, filled with anxiety of what is next to come. Even independent organisations responsible for investigating the events have caused us to feel let down and disrespected. We had to battle with the NHS Trust for sight of their full internal investigation report. We had to battle against NHS England for publication of their report. These institutions cited the privacy of our son's killer as a reason for non-disclosure. It was only when the Secretary of State for Health and Social Care, Wes Streeting, intervened, that we managed to prevent the catastrophic failings from being buried not just from the public, but from us as the victims' families. The support and scrutiny of the media and the public was also crucial in this fight – it has been paramount in our fight against every failing agency and institution we have had to battle with. The threat of exposure appears too often to be the only route to answers.
9. Perhaps the most significant further trauma we have had to endure is our discovery that a large number of staff across multiple organisations may have breached the privacy of our son by unlawfully accessing his personal data

after his death. Some of the breaches are potentially so serious that they have progressed to investigation by the police and CPS. We found out about some of the breaches only because of our own diligence and hard work. The attempted concealment of these breaches has left us in a state of shock. At the time of writing, we still do not understand the true extent of these breaches and the prolonged speculation regarding such a devastating event has left us in a state of constant distress. Whilst losing Barney was bound to profoundly alter our lives, we are now not only left with grief, but with the enduring psychological toll that continues to shape our everyday. What began as an acute trauma has evolved into a complex and persistent struggle. We have each been diagnosed with suffering from prolonged episodes of depression, anxiety and PTSD, conditions which have severely disrupted our ability to function and engage with the world. There are times when the completion of even the most basic daily task feels impossible.

10. Before our lives were upended, Emma was a career focused professional who had been headhunted for senior roles across marketing, communications, and public relations, having just secured a permanent role within the NHS. After a significant period of time spent on leave, finances necessitated a phased return to work. Sustaining this commitment felt almost impossible, not only because of the unmanageable grief but also because of the continuous battle that has occurred throughout the legal process. By the time we reach the conclusion of this process, we are very mindful that Emma will be in her mid-fifties and as such, the loss of her professional identity is something which is unlikely to ever be recovered.

11. As an entrepreneur focused on building a business to support our family, Dave now struggles equally to maintain even the most minimal engagement. Due to a complete absence of motivation and capacity for concentration, attendance has been impossible to maintain. The inability to continue to lead and delegate has come at significant cost as it has necessitated hiring senior staff who were not intended to be a part of the business plan. In the long term, this has resulted in an office closure and redundancies which have only caused worsening feelings of helplessness. The long-term consequences

have extended far beyond temporary absence and returning the business to the state it was in prior to June 2023 now feels impossible. What was once a source of purpose and achievement now feels precarious and overwhelming. This tragedy has not only impacted our lives, but the lives of extended family, friends, employees and colleagues. Whilst we continue in pain, the main concern of the institutions responsible for our pain is to prioritise concealment and deflection over responsibility.

12. We do not believe that there is any scope for improvement to our lives. What we have endured has irreversibly altered the course of our futures, dismantled our sense of safety, and stripped away the identities we once held with pride. We continue to hope that this Inquiry will finally provide us with the answers we have long been denied; answers that honour Barney's memory and acknowledge the harm inflicted upon our family. We are seeking truth as this is the only form of justice we can now hope to receive.

#### **LEARNING OF BARNEY'S DEATH**

13. On 13<sup>th</sup> June 2023, we were staying at our lodge in Cornwall. Barney had briefly returned to university ahead of the summer holidays and Charlie was away on a school trip to Torquay. We woke up to what we thought would be a normal day. We were both working remotely but Dave was planning to meet a client later on. Whilst we were working, we turned on the TV and saw a broadcast containing breaking news in relation to attacks which had occurred in Nottingham. We checked Barney's location on our Find My Phone App and could see that he was near his Halls of Residence. We texted and called him multiple times and didn't receive a response. Barney usually responded quickly, so we were becoming increasingly panicked at this point.
14. Emma called the hospital and Dave called the police. When Dave provided Barney's name to the police, the lady on the phone went quiet and explained that, as it was an active investigation, she would need to get someone to call back. We then saw Ilkeston Road displayed on the broadcast which matched Barney's location. We had the Find My Phone App loaded up and watched as his phone moved towards the police station.

15. We got into the car with the intention of driving to Nottingham. We were approximately 5 miles into that journey when the phone rang. It was an officer from Nottinghamshire Police who was soon to become one of our Family Liaison Officers (FLOs). She asked us to pull over somewhere safe, and we stopped in a pub carpark. That is where we were told the worst news of our lives. She explained that they had Barney's driving licence and believed him to be one of the deceased victims. Everything that occurred after that remains to be a blur – we were in a state of shock. Dave recalls ending the call explaining that he needed to find Charlie, whilst Emma was screaming in disbelief.
16. We drove to Charlie in Torquay. He too learnt of the news in a car park. Dave recalls Charlie saying "*I just knew Dad, I just knew*". He screamed and ran off. As parents, we felt entirely devoid of what to do and powerless to help him. We drove back to Taunton. We recall that the media arrived very quickly along with friends and family. The police attended later that day, at around 5pm.

### **CONTACT WITH THE POLICE AND CPS**

17. Our FLOs were Detective Constable (DC) Gina Farrell and DC Gemma Piggott. They acted as our main points of contact from the outset and until after the conclusion of the court proceedings. DC Farrell seemed to be in touch with us more frequently, whilst DC Piggott played more of a supporting role. We were in regular contact with them and at the time, we felt that they provided a positive support network, displaying compassion towards us and going above and beyond on occasion.
18. After further reflection, we do have some concerns as we recall asking about the Coates family on various occasions and whether we could be provided with their contact details, but we were actively discouraged from contacting them. We were advised that they were a private family with a complex

dynamic, who wanted to be left alone. It was only when we started to interact with the Coates family during the criminal proceedings, that we realised this was untrue. This meant that the Coates family were denied the support of the only people who could relate to their grief. We consider this to be unforgivable, particularly in light of the essential support that the O'Malley-Kumar family have provided us. It has also become clear to us that crucial information was withheld from us. We struggle to comprehend this as we felt we had a positive relationship with our FLOs. During the Independent Office for Police Conduct (IOPC) investigation, we have also been provided with disclosure of the FLO logs and there are very worrying discrepancies between what is recorded and our recollections of what was communicated.

19. The first visit we had from the police was at around 5pm on 13<sup>th</sup> June 2023, when the police visited our home. DC Farrell and DC Piggot were present at this visit. We recall that we were told how Barney had died. We had already heard that Grace had been killed but the FLOs would not confirm this. We were however told that there had been another death and that they believed the deaths were linked. We were also told that a suspect had been arrested, but that they did not understand the suspect's motive at that time. We were handed a homicide manual and the remainder of the meeting mostly focused on next steps in terms of the coronial process

20. On 14<sup>th</sup> June 2023, we attended a vigil held in Nottingham to honour the victims. We can recall that at least one of our FLOs was also present with us. We do not recall meeting many other officers on this day, except Chief Constable Kate Meynell ("the chief Constable"). We recall that we met her at the Orchard Hotel ahead of the vigil at around 2pm. She gave Emma a hug and said, "*we've got him – he is going down for murder.*" Due to the scale and severity of the incident and the comments of the chief Constable, we had every reason to trust in the system to deliver justice.

21. Between the time of the vigil and September 2023, we do not recall having contact with officers from the Force other than our FLOs. We recall feeling that the FLOs were supportive both practically and emotionally. They

attended the scene visit with us and they assisted us in visiting Barney at QMC; they drove us as well as Barney's godparents to the hospital and they were supportive. They helped to facilitate contact with the Victim Support Service, and they assisted in referrals for trauma therapy and sent us material to help us understand grief reactions and traumatic loss. They also assisted us in matters such as retrieving Barney's property including his phone and his wallet. We recall that one of them personally drove some of his belongings to Charlie's godfather's house on the way to a holiday destination, so that we did not have to receive them. They also assisted in retrieving Barney's car. We recall that they made efforts to ensure it was returned to us and entered his room to retrieve his key. However, they sent it back to us via an independent transportation company. When he arrived, he explained that he would not accept a fee for the delivery and had instead, asked the police to donate it to Barney's foundation. However, we do not believe that the foundation ever received this money. Overall, our FLOs were a strong source of support. However, they seemed to play more of a pastoral role, and they did not provide us with any significant information surrounding the investigation.

22. We were in a very poor mental state, and we wanted to protect ourselves from the finer details, so we left the police to do their jobs without asking any intrusive questions. We did not attend the initial court hearings. We also decided that after the early media coverage, we could not face viewing any further media. Due to this and the lack of significant updates from the police, we remained unaware of the issues surrounding VC's contact with various organisations and of any potential mental health defence. Initially, there was no reason for us to believe that the police had any significant prior contact with VC. It is not something that officers were forthcoming about. We had seen Assistant Chief Constable (ACC) Griffin in the media, and he had expressly stated that there was nothing that Nottinghamshire Police could have done to prevent the attacks. We had taken this at face value. However, we became aware that the Telegraph and the Mail were doing investigative work surrounding VC's history. We started to hear rumours from friends and family, which they had picked up from the media about VC's past, for example,

regarding an incident where VC had put someone in a headlock. Dave had also heard through friends, that there was an incident which involved VC frightening a girl who had jumped out of a window as a result. Sanjoy informed us that he had heard VC was wanted by the police at the time of the attacks. As a result, we started to ask more questions in relation to VC's criminal history.

23. We were given multiple responses which were all lacking in detail and which were equally unhelpful. On one occasion, we were told that VC had no offences recorded against his name. We were also told that he had "no criminal history". At the time, it was not made clear that officers were referring to a lack of charge, rather than conduct, when they said this.
24. The first time we met the Senior Investigating Officer (SIO), Detective Superintendent (DSupt) Leigh Sanders, was on 12<sup>th</sup> September 2023, when he visited us at home with our FLOs. During this visit, he maintained the same strong stance as the Chief Constable had when we had met her at the vigil, that VC would "*go down for murder*". We recall that during these visits, we discussed whole life orders as a potential outcome. This provided us with false reassurance. He referred to VC as a "*vile and evil individual*". There was certainly no indication that he was mentally unwell or lacking in culpability for his actions. When Dave asked why the police did not shoot VC at the scene, the SIO stated that he was surprised he had not been shot and this was likely because 'he is black'.
25. During this visit from the SIO, we also asked for more information about VC's life circumstances, and he told us that he was a "*sofa surfer*" who moved around a lot without a fixed address. He said that he lived a nomadic life and had family all over the country who he would visit. It was not until we met with the police and the CPS on 7<sup>th</sup> December 2023 that we were told he had an address in Nottingham. We asked where he worked, and the SIO said he "*didn't really have a job*". The FLO logs record that we were informed of the possibility that the defence would be requesting psychiatric reports at the next hearing, but this is not true.

26. We asked about VC's whereabouts prior to the attacks, and we were provided with detail about VC's trip to London on 11<sup>th</sup> and 12<sup>th</sup> June 2023. We were told that he had been to visit a former coworker. When we probed for further information, we were provided with only a limited response that in the opinion of the former coworker, VC was quiet but there were no obvious concerns about his behaviour.
27. We recall that during this visit, we directly asked about VC's criminal history. We were given a convoluted answer about a time when he was in custody but advised that it was not considered to be in the public interest to charge him. The answer was difficult to make sense of. As we trusted in the police at the time, we did not question it, but in hindsight, we now consider it to be an attempt to minimise and evade. Dave asked him directly whether VC was wanted by the police, and he said this was not true. As a result, we were left without this knowledge for a significant period of time. Confirmation regarding the warrant was provided to us via email on 19<sup>th</sup> January 2024 [NGPF0002572].
28. We had heard via the media about the incident which occurred in September 2021 when VC assaulted an emergency worker. Our FLO log records that we were told about this during the meeting with the SIO. This is not true. It may have been touched upon in the 7<sup>th</sup> December 2023 meeting. We recall that from December 2023 onwards, vague information was drip-fed to us in increments, leaving us without sufficient detail. However, we did not receive any real clarification about what had happened until DC Piggott's email on 19<sup>th</sup> January 2024 [NGPF0002572]. The disclosure of information was provided in such a fragmented way, that we remained uninformed.
29. We also heard about the assaults in Leicestershire which occurred in May 2023 via the media. Further detail was provided during court proceedings, but never directly communicated to us in sufficient detail. We did not understand the full extent of the wrongdoing until March 2024, when we met with the IOPC. We recall feeling surprised at the detail subsequently provided as it

was not something we were told previously. This again, reflects the lack of clarity and transparency in the information provided by the police and CPS.

30. Dave had heard a rumour, either via the media or friends and family, that VC had been involved in an incident resulting in someone jumping out of a window. The history is addressed briefly in the sentencing remarks made in January 2024 and in part in the judgment of the Court of Appeal in May 2024. However, it wasn't until August 2024, following the airing of the Panorama that we understood the significance of the injuries caused to the student when she jumped out of that window. We learnt that she sustained a fracture to her spine which required surgical intervention and that she had jumped out of the window as a result of VC breaking into her flat. We learnt more about the incident where VC had placed his flatmate into a headlock following the Panorama and via NHS investigation reports.
31. As victims, we deserved and required more detail at an earlier stage. However, we were only ever provided with scant information, and this was always at our request. This was entirely inappropriate given this information related to the investigation of our son's murder.
32. The first interaction with the police which involved any disclosure of VC's mental health occurred on 4<sup>th</sup> October 2023. We were in the car on the way to a concert when DC Farrell called. We placed the phone on speaker whilst she informed us that *"the defence had played their hand and were going down the diminished responsibility route"*. During the call, she reassured us not to worry because *"they wouldn't be having any of that"*.
33. We recall asking at a later date what diminished responsibility meant and our FLO said she would need to check and revert back to us, because she was concerned, she may explain it in the wrong way. The significance of the defence on the outcome of the criminal proceedings was never explained to us, and we now wonder whether it would have been more appropriate for the CPS to have these initial discussions with us. As professionals with

knowledge of the investigation, they were the only people with the foresight to ensure that we were well-prepared for what was to come.

34. It is recorded in our FLO log that on 16<sup>th</sup> November 2023, Emma sent a text message to DC Farrell to raise concerns about the timings of updates and the level of contact we were receiving from our FLOs in comparison to the O'Malley-Kumar family. It is noted that DC Farrell responded to us stating that they had intended to step back because they believed we had the right support in place, and they wanted to allow us to process events without unnecessary interruption. They maintained that although there was a disparity in timings of updates given to each family, there would be no difference in the overall contact provided [WITN0289002, p25, WITN0289003]. This is something we do vaguely recall, though we cannot confirm any further detail at this time.

35. Ahead of the plea hearing, when we were in the dark about the process and our fears regarding the outcome were forming, we accepted an invitation to meet with the CPS. We were initially offered a Teams meeting on 28<sup>th</sup> November 2023, approximately one hour prior to the plea hearing. We refused to accept this as we knew it would be too close to the hearing for us to have any real impact. Despite our lack of experience within the legal system and our absence of awareness of the dramatic change in outcome, we recognised that this was not suitable or fair. We were then offered a meeting on 24<sup>th</sup> November 2023, which we accepted. Emma had requested that Julian Hendy attend the meeting with us but the FLOs explained that this was not allowed. We had to push back as we felt strongly that we required support at that meeting [CPSE0002419]. It was subsequently confirmed on 22<sup>nd</sup> November 2023 that he was allowed to attend [HMCP0000312]. We also seem to recall that it may have initially been intended that separate meetings occur for our families.

36. The meeting occurred via Teams. We attended with the O'Malley-Kumar family. We recall asking why the Coates family were not present and we were told that they chose not to be. We have since been told by the Coates family

that this was untrue and that they had not been invited. During that meeting we were advised that the CPS had received all expert reports and as a result of the conclusions, they planned to accept VC's plea to manslaughter by reason of diminished responsibility. We were in a state of shock and used the limited time offered during that meeting to try and obtain more information about how that conclusion had been reached. We were told that the case was in the hands of the psychiatrists who had reached the same conclusions about VC's mental health. We raised concerns based upon the brief overview of the assessment process and the timescales. Sanjoy, Sinead, and Julian each brought additional experience to the meeting: Sanjoy and Sinead both have medical backgrounds, with Sanjoy also serving as a Forensic Medical Examiner, while Julian has extensive experience in case disposals involving defendants with mental health issues.

37. It may have been during this meeting, or at a subsequent meeting, that we were given some vague information about the significant delays of almost five months in transferring VC to hospital in November 2023, and of three months in commencing medication in September 2023. The CPS instructed psychiatrist had assessed VC around two months after he had commenced that medication. We also became aware that the psychiatrists had not reviewed CCTV footage or spoken to witnesses and we raised concerns about this, though we are unsure of the precise timing that we were provided with this information.

38. Ahead of the hearing, we raised concerns and insisted that the CPS instruct an additional psychiatrist, independent to the others. We asked that the psychiatrist interview all relevant parties and focus on VC's state of mind at the time, rather than on historic diagnosis. What we emphasised the most was that the report should not be a peer review. Whilst the police and CPS publicly stated that they instructed the expert to ensure the correct conclusion had been reached, this was not the case. This action was only taken as a result of the insistence of our family and the O'Malley-Kumar family.

39. The hearing took place on 28<sup>th</sup> November 2023. Emma chose not to attend, and Dave attended remotely. During the hearing, Dave was told by DC Farrell that VC was referred to as Adam Mendes because this is a name he also used. During the hearing, Peter Joyce, representing VC, was critical of the need for a further report and stated that the timeframe available to provide it was short. This is something we also raised but despite this, we recall that Dr Latham had approximately two weeks to carry out his review and produce the report. After the hearing, Dave recalls expressing concern that the prosecution team didn't seem to be fighting for us. Although we were continuing to refrain from viewing any media, we recall that following the hearing, the O'Malley-Kumar family raised concerns about the widespread reporting in relation to VC's mental health in the media, which they considered would undermine the independence of a jury. For us, it felt like the outcome had already been decided before consideration was given to the additional report.

40. We requested an urgent meeting with all relevant staff members due to our concerns. We attended a meeting at Avon and Somerset HQ on 7<sup>th</sup> December 2023, which lasted for the majority of the day. Our FLOs provided with a note [WITN0289004] and Dave made some handwritten notes during the meeting [WITN0289005]. Sanjoy and Sinead attended with us, but we have come to understand that, once again, the Coates family were not invited. Sam Shallow attended from the CPS and the attendees from the police were as follows: SIO Leigh Sanders, DC Asif Stevens-Garrib, DC McVey, DC Cutts and DC Piggot. The SIO commenced the meeting by advising us that he had put together a CCTV timeline to assist us in understanding the events and relieve our concerns regarding the plea. We explained that as families, we did not understand how VC could suddenly raise this defence given what had been communicated to us throughout the investigation. We had requested further information to help us understand why there had been such a significant U-turn. We were provided with some limited information surrounding VC's background but, as is recorded in the note, it was stated that he had no criminal history. The CCTV timeline focused on the evening of 12<sup>th</sup> June 2023 until just before he attacked Barney and Grace. We found the meeting

extremely difficult. It lasted for around 6 hours, and we had to leave the room at certain times due to the distress. This was not only due to the traumatic detail provided, but also because of the inconsistencies in what we were told and the outright dismissal of our concerns. To describe this meeting as torture would be an understatement. However, we were provided with significant new information.

41. During the meeting, we learnt that VC carried a rucksack, which contained a number of weapons, whilst he travelled by train from London to Nottingham. We learnt that he was able to complete this journey unassisted, navigating busy stations, trains and trams. He spoke to a tram driver and sat near a number of young people during his journey. He displayed self-control from his psychotic thoughts throughout this entire period, and then further, for several hours whilst he walked around Nottingham. During this period, he must have passed hundreds of people, whilst he managed to control his allegedly uncontrollable violent behaviour. We asked if any reports had been made by members of the public regarding his behaviour but received no affirmative response. From what we could see, VC had behaved calmly and purchased food. He also withdrew money from a cash machine prior to the attacks.
42. It seemed to us that he had waited to select victims who were vulnerable targets; an elderly man who was alone and two young people who were walking home in the early hours of the morning. It was clear that he was stronger than his victims and could have overpowered them all easily. He interacted with a security guard in between the attacks and did not attack him. We felt that this may have been due to his build. We were also concerned that VC may have racially profiled his victims. We raised this but it has never been addressed.
43. We learnt that prior to attacking Barney and Grace, VC had disappeared from CCTV for a significant period of time, which he spent in a park known for anti-social behaviour. He re-emerged after changing his clothes and disposing of his holdall bag. We learnt that police had never recovered his holdall bag and

had no awareness of the contents, something which appeared to be of little interest to the SIO.

44. After his vicious and brutal attack on Barney and Grace, he left the scene calmly. He walked for around an hour before he attacked Ian. He swapped sim cards and used his phone to call his brother. He told him he had done something, advising him to get his family out of the country. This demonstrated a high degree of insight and understanding that what he had done was wrong. We were told that the psychiatrist had not spoken directly to VC's brother but had instead relied on witness statements taken by the police. We remain concerned about this given that the police are not mental health professionals. We still remain in the dark as to whether or not his brother was formally interviewed about the contents of the call and about the extent to which this interaction was considered to be relevant to VC's state of mind. We also remain unaware of what action his brother had taken, if any, prior to or in the aftermath of the attacks.

45. We also understood that following his attack on Ian, he stole his van and drove calmly away from the scene, stopping for red lights and speed bumps. This clearly demonstrated insight, intention and the ability to function and make decisions. We felt a profound sense of injustice that he could possibly have a defence, when his actions seemed premeditated and carefully considered.

46. We were also concerned about the investigative gaps which came to light during the meeting. We became aware that officers had been unable to locate his holdall bag, were unaware what he did when he disappeared from the CCTV and did not know what he spent the £10 on, which he had withdrawn from a cashpoint. We have become aware via a custody log disclosed to us by the IOPC, that the £10 may have been within VC's property [CPSE0000005. P54]. We consider this to be information which could have been provided easily at the time when we asked, and we are concerned that the information was not known at the time. This is reflective of the way in

which our questions were dealt with – they were either ignored, evaded or partially answered.

47. Furthermore, when Sanjoy asked about toxicology sampling, he was told that VC's consent was not successfully obtained for blood samples, so we were very aware that any potential intoxication from alcohol and drugs had not been accounted for. Officers and CPS staff were unaware of which non-intimate samples had been taken.

48. During that meeting, we had to push for acknowledgment of the premeditation described. We spent significant time highlighting concerns as well as obvious gaps and inconsistencies in the evidence surrounding VC's mental state. We were repeatedly told that it was not the job of the CPS to question, challenge or influence the experts. Every concern we raised was dismissed. Both the police and CPS were unable to answer many of the questions we were raising. We recall Sanjoy highlighting that he was seriously concerned regarding their inability to provide answers which should have been at their fingertips, given their seniority and significance to the investigation. Instead, they were floundering around, awkwardly scrolling up and down their screens in an attempt to answer basic questions, such as whether or not non-intimate samples were taken from VC.

49. We were informed for the first time that VC was not a sofa-surfer and that he had been evicted on 11<sup>th</sup> June 2023 from his home in Nottingham. We also received new information about where VC had spent the night of 11<sup>th</sup> June 2023. We were told that he had visited an old friend named Bil Monterio and that he had spent the night in Lewisham. Despite the previous information provided that he was VC's former coworker, we did not understand that he is the same age as VC and that he came from the same West African country. It subsequently materialised via the media that VC's acquaintance may have been a drug dealing gang member [WITN0289006]. We also discovered through the press that he had been the subject of an injunction banning him from making violent drill rap music to provoke rival gangs, wearing face coverings and hoodies and associating with C17 members online. The article

claimed that the gang were responsible for unprecedented levels of crime in the Thurrock area including acid attacks, stabbings and robberies. There was a further article reporting that VC's neighbour had said he used to sit in the garden with his top off drinking and smoking. We felt particularly disheartened that toxicology testing was not conducted. We had been provided with further information regarding an alleged attack against VC with a machete whilst he was in London. We recall the O'Malley-Kumar family asking whether there was a crime number in relation to VC's report to the police and that they were unaware of this. Confirmation was subsequently provided that there was no report in relation to that incident.

50. When we questioned the CPS and police staff about VC's criminal history, we were given some level of detail, but it was made clear that the prior offences did not reach the threshold for prosecution and that VC had not been considered as dangerous. We were not advised of the outstanding warrant for VC's arrest, despite those in attendance clearly having knowledge of that detail. When we asked whether footage during VC's time in custody would provide further insight into his mental state, we were told that interviews were audio recorded only. This materialised to be untrue.

51. We cannot emphasise enough how distressing this meeting was. Both Dsupt Sanders and Samantha Shallow were extremely defensive and dismissive of our concerns. On a number of occasions, we were told as the SIO, DSupt Sanders was there to investigate the most serious part of the crime, rendering attempted break-ins and the details that could have been obtained from the security guard as unimportant. The same approach was taken to our suggestion that VC should have been breathalysed.

52. We recall that following the meeting we, along with the O'Malley-Kumar family, felt that we had entered the meeting with a few questions and left the meeting with hundreds of questions as well as grave concerns. There were so many things that did not make sense to us. The mental health defence was difficult to accept due to the clear premeditation present in VC's actions. It seemed clear from the timeline as explained to us, that VC had the ability

to exercise control prior to the attacks. We recall that when Sanjoy emailed the SIO to raise concerns on 10<sup>th</sup> December 2023, he responded that he was busy on another matter and would read our email after he had dealt with this. As the SIO of the investigation, we would have expected him to prioritise it. In response, Emma sent a further email on our behalf to endorse the concerns raised by Sanjoy. Emma emphasised that we were concerned regarding the time lapse between the attacks and the prosecution assessment as well as the insufficient time provided to Dr Latham to complete his report. We requested clarification surrounding VC's treatment regime. We also expressed that it had become clear to us that VC knew what he was doing and that it was wrong [WITN0289007].

53. We requested access to the psychiatric reports, but we were told we could not obtain these until after the criminal proceedings, following which they would be made available. We were instead, offered the opportunity to have the reports read to us. This occurred on 13<sup>th</sup> December 2023, during a Teams meeting with our FLOs, the O'Malley-Kumar family and their FLOs. A note was subsequently provided to us and is exhibited at [NGPF0004150]. During that meeting, they read Dr Blackwood's report to us. We were extremely concerned about the content of this report, particularly regarding conclusions about the extent of VC's culpability. The report seemed to be a treatment plan designed to help VC, rather than a document designed to accurately reflect his state of mind at the time of the attacks. A considerable proportion of the report focused on VC's recovery within a hospital environment, emphasising that there was a potential that he could be released into the community, and how rehabilitation should be approached. We raised that the report relied on historic diagnosis rather than state of mind at the time, but we were simply told that the CPS could not and would not challenge the expert.

54. Dr Latham's report was also read to us during the meeting. There were several factors we had asked Dr Latham to consider e.g. state of mind at the time of the attack which, from our perspective, could only be ascertained by speaking to witnesses who could account for this. The exploration of these matters did not materialise in practice, and the report was merely a peer

review which did not involve any fresh assessment of VC or his state of mind at the time. It did not address our concerns or effectively scrutinise the conclusions of Dr Blackwood. In that sense, it felt like a wasted opportunity and was more of a tick box exercise than a genuine attempt to ascertain state of mind and respond to our concerns. We believe it was following this meeting that Sanjoy submitted a list of questions to the experts.

55. On 17<sup>th</sup> December 2023, DC Farrell provided us with the notes from the meetings and the responses to our questions [NGPF0002498]. She offered us a further meeting, but we declined this, recognising that there was no real hope of changing the outcome. We asked a number of further questions about VC's mental health, and it was established that VC had first been assessed by a psychiatrist on 4<sup>th</sup> July 2023 but was not provided with medication until September 2023. This was of major concern to us as we did not understand how a psychiatrist could deem VC to be severely psychotic whilst allowing him to remain unmedicated for two months. We had also asked whether VC's interview was video recorded, and we were told that it was not. However, in a further email dated 19<sup>th</sup> January 2024, DC Piggott confirmed that the interview was in fact video recorded [WITN0289002]. She confirmed that new custody suites have audio and video capabilities but maintained that this made no difference to the transcripts of interview. This was shocking to us, as we considered that observation of VC's behaviour on video was essential to establishing state of mind. We were also concerned as to how significant details such as the recording of an interview can be unknown to officers.

56. On 19<sup>th</sup> December 2023, a letter from the CPS was hand delivered to us, notifying us that VC's pleas would be accepted. On the same day, Sanjoy sent a comprehensive account of our concerns in relation to the psychiatric reports. Emma contributed to the email chain which included the SIO, our FLOs and the O'Malley-Kumar's FLOs to express our agreement with all concerns raised.

57. We had organised a call with the then Minister for Justice, Alex Chalk. He commented that he did not understand why the CPS were rushing. He

advised us that we needed to assert our rights to formally ask the CPS to pause in accepting the plea as it would become almost impossible to alter the outcome after this had occurred. On 20<sup>th</sup> December 2023, Emma emailed Sam Shallow on our behalf requesting that the CPS hold off on communicating this to the court and to VC as the families felt “*rushed, hastened and railroaded*” and that the most recent psychiatric report failed to address the concerns raised by the families. Despite this, it was confirmed that the decisions had already been provided, stating that they had already met with us twice to discuss acceptance of the pleas [NGPF0002505].

58. On 4<sup>th</sup> January 2024, Emma emailed our FLOs to request a further meeting with the CPS [CPSE0001046]. We had previously not wanted to have a further meeting but had considered this to be necessary due to our concerns. At this stage, the court dates had still not been confirmed to us, and we were experiencing anxiety. On 8<sup>th</sup> January 2024, Emma had to send a further email to emphasise the importance of this meeting and ask that it be confirmed as soon as possible. In this email, further concern was expressed with regards to the continued lack of confirmation as to the court dates. The meeting was subsequently confirmed to take place on 15<sup>th</sup> January 2024 via Teams.

59. We attended this meeting with Karim Khalil KC, Peter Radcliffe, Alan Murphy, Sam Shallow, Leigh Sanders, our FLOs, the O’Malley-Kumar family and their FLOs. During the meeting, we were advised of the sentencing options and informed that the prosecution would be arguing for a Hybrid Order. Dave asked how VC’s refusal to provide toxicology samples would be used in the proceedings, and Mr Khalil explained that he would refer to this in his opening.

60. Whilst we continued once again to raise concerns, we only endured further dismissal during this meeting. We found Mr Khalil KC and his junior to be arrogant, elitist, rude and dismissive throughout the proceedings. We seem to recall one occasion where Mr Khalil was eager for the hearing not to go beyond the allotted times because he was going on holiday. The team did not seem to be trained to empathise and communicate effectively with grieving families. We did not get any sense that they cared about what we thought,

and it was clear to us that they were not there to represent our interests, which ultimately meant that no one represented us. We were provided with a very brief explanation as to the sentencing options and recall feeling that we did not fully understand the potential outcomes and the reasoning for them. We had previously thought that the Judge and the CPS team would have had a much greater influence over the court process, but it soon became clear that the criminal proceedings rested entirely on the opinions of the psychiatrists.

61. On 16<sup>th</sup> January 2024, we were copied into an email sent to the O'Malley-Kumar family by DC Cutts in relation to the samples taken from VC whilst in custody. The email confirmed that the police were unable to establish whether VC had used drugs before committing the offences because he did not consent to having blood samples taken. Sanjoy explained that in addition to this, a full set of non-intimate samples had also not been taken. The email further provided a refusal to conduct hair strand sampling stating "*S/O – No this will not be done. The defendant has no history of drug abuse*".

62. Dave responded to this email expressing our shock [WITN0289008]. We had seen some media reporting that VC may have been involved in drugs. We had also seen an article in which VC's neighbour referred to him sitting out the back of the house with his top off smoking and drinking. We were horrified by the response of the SIO which we considered to be unnecessarily defensive, arrogant and dismissive. He commenced the response with "*as an experienced SIO, I deal with facts and evidence which I follow to undertake reasonable lines of enquiry. There is no evidence of drug taking or misuse by the defendant throughout this investigation (which itself, at my instruction, has been subjected to independent review, with outcomes tested by the courts, legal teams and judicial process)*". He continued to refuse hair sampling and maintained that he was "*completely content*" with his forensic strategy, the results of which were "*self-explanatory*." He went on to say that there was "*a clear absence of any reasonable ground to suspect that the defendant is involved in drug-misuse by any rational and reasonable standard exists*". He then told us to direct future correspondence to our FLOs, seemingly rendering himself inaccessible to us. This made us feel, not only dismissed, but it also

seemed to indicate that our concerns were irrational. At the time, it felt to us that the police had failed to properly investigate the circumstances that led to the attacks and in doing so, had given VC a defence that they could never be sure was applicable to him. It was particularly difficult to tolerate the confirmation regarding sampling, given that we had found out via our FLO, DC Piggott that toxicology samples had been taken from Barney.

63. On 19<sup>th</sup> January 2024, a further email was sent from our FLO which caused additional concerns with regards to the robustness of the psychiatric assessments. She confirmed via email that the initial assessment occurring in July 2023 was a defence assessment, that Dr Blackwood's assessment did not take place until November 2023 and that VC was not transferred to hospital until 1<sup>st</sup> November 2023. It was again surprising for us to hear that a man who was deemed to be so psychotic that he was considered to have a defence to murder, remained out of hospital and without medication for such a significant period of time. We had requested further details in relation to the assault of an emergency worker and whether or not a warrant was outstanding for VC's arrest. Details were provided and it was confirmed that there was a warrant out for his arrest at the time. We asked about the inconsistencies between VC's name and residential status, and it was confirmed that he had changed his name to Adam Mendes in 2022 via deed poll. It was also confirmed that he had a tenancy for six months prior to the attacks in the name of VC which he had been evicted from shortly prior to the attacks. This raised concerns for us, given that we had been told that VC was a sofa surfer. When we look back and reflect on correspondence such as this, we realise that we should not have been placed in a position whereby in the week prior to the sentencing, we were having to raise so many questions due to serious gaps in our knowledge.

64. The days prior to the sentencing hearings were deeply distressing. We were liaising with our FLO in order to ensure that there was sufficient room to accommodate our friends and family in the court room. They were all attending in order to support us, and because they had a close relationship with Barney and our family. We provided a list of attendees, and we were

aware that our FLOs were working to establish the capacity for seating within the court. They had contacted us to let us know about the seating capacity of court 1 and to arrange a private space for lunch for us.

65. However, a few days before the hearing, we then received an email to inform us that the hearing had been moved from court 1 to court 2 [WITN0289009, which was a much smaller room with limited seating capacity. We were told that this was because of two other cases taking place at the time. As a result, both media access and capacity for our support was intended to be limited.

66. Emma raised serious concerns about this. It appeared to us, to be an attempt to limit the extent to which a potential injustice would be exposed. This was raised with the Minister for Justice once again and some hours later the hearing was moved back into a larger court. Even today, we are yet to learn of any cases being heard at the time which were as significant and high-profile as this one. We had requested that additional victim impact statements be allowed from other people who were close to Barney, but the FLOs advised that the opportunity to provide a statement was limited to Charlie and the two of us. Charlie was only sixteen years old at the time. He asked if we could video record his statement for him, but this was refused and the FLOs advised that it would only be shown if they recorded it. They attended our home and recorded the statement in a separate to us. A close family friend had gotten in touch with the FLOs and insisted on sending an impact statement from her children, who were close friends of Barney's. These were accepted and provided directly to Judge. The O'Malley-Kumar family were allowed to provide additional statements, but our request was denied, demonstrating an unfair inconsistency in approach.

67. The sentencing hearings commenced on 23<sup>rd</sup> January 2024. New information came to light during the proceedings e.g. about VC's mental health history as well as an incident where VC had attended MI5 HQ and pleaded with them to arrest him. We still have no details in relation to any escalation which followed this incident. We also recall learning that he was known to be stockpiling his medication. We remain confused about why VC was referred to in this way given that the police informed us that he had changed his name to Adam

Mendes via deed poll, though we have never seen any evidence to confirm this.

68. We remain particularly concerned about the CPS's handling of the case. Whilst they attempted to secure a Hybrid Order, there seemed to be a real absence of fight from them, in comparison to the defence team. We feel strongly that the refusal of VC to provide toxicology samples, whilst mentioned, remained underemphasised. During the hearing, we recall reference to case law about retained responsibility, and it seemed to be accepted with limited challenge that VC was not considered culpable for his actions. Adverse inferences were not made regarding the lack of testing and links to gangs heavily involved in drugs remained unexplored. We left feeling extreme disappointment that his refusal to take medication was not reflected in the sentence.
69. To this day, we remain deeply troubled by the conclusions reached and processes followed by Dr Blackwood and the other experts. He did not assess VC until nearly five months after the attacks, yet he still delivered a strong and definitive opinion regarding VC's state of mind at the time of the attacks. He asserted a complete lack of culpability, despite clear evidence of premeditation. We are also concerned about the scope of the medical records he received and the thoroughness with which he reviewed them. Whilst the experts concluded that VC's non-compliance with medication was symptomatic of his illness, no mention was made of his conscious decisions to avoid treatment, such as his claimed aversion to needles or his desire to focus on his studies. This omission is significant.
70. Furthermore, that VC's condition was allegedly treatment resistant was repeatedly highlighted throughout the court proceedings. It remained as an uncontested fact which was accepted by the Judge. At the time, we were confused about this as issues of non-compliance were raised throughout the proceedings. However, after reviewing NHS related reports, we have learnt that VC was not taking his medication long enough to be properly diagnosed as treatment resistant; certainly not in circumstances where non-compliance

could be ruled out. We are deeply concerned that this was falsely presented as fact.

71. We were horrified at the willingness of the CPS and the Judge to blindly accept the conclusions of the psychiatrists. We recall the Judge commenting that VC would unlikely ever be released, citing his alleged "*treatment resistant schizophrenia*". We also know that a significant proportion of offenders sentenced to a hospital environment, are in fact released. We have been advised that a significant proportion of those subject to Hospital Orders are released within ten years.

72. At the end of the Panorama programme aired in August 2024 and made in conjunction with VC's family Elias C had said he had "*got his brother back*". This contradicts the notion of treatment resistance further and is indescribably difficult to tolerate, to the point we feel strongly that the criminal proceedings were entirely misdirected. We feel strongly that the criminal process can be fairly summarised as 'a trial by doctors.' Nobody in the court or wider criminal justice process was willing to challenge those doctors. This meant that nobody fought for justice for our son, for Grace and for Ian.

73. It was particularly difficult to accept the sentence given to VC, because we were led to believe by Mr Khalil and his team that the attempted murder charges were significant enough to require a penal element, given that diminished responsibility did not apply as a defence to these charges. This led us to believe that, even though VC would go to hospital instead of prison, he would have to serve a custodial sentence eventually. However, we recall that the attempted murder charges seemed to disappear into the background during the hearing.

74. The conduct of the police and CPS during the proceedings was also difficult to tolerate. They did not acknowledge us when they entered and left the court and they offered to meet with us only following the case disposal. We were only seven months on from losing our son and we felt the case had been speedily progressed through a system that had failed us at every hurdle. We

remain of the view that we were rushed, hastened and railroaded into a trial by doctors.

75. Due to references made in court to VC's criminal history and prior police contact, following the conclusion of the proceedings, ACC Griffin made a further media appearance where he stated that there was more that could have been done but that it would unlikely have altered the outcome. Knowing what we now know about the extensive involvement which Nottinghamshire Police had with VC prior to June 2023, we find these comments reprehensible. They had knowledge of VCs past criminal conduct, but only told the truth when faced with public scrutiny. We recall that during the proceedings, we were introduced to a member of the Nottinghamshire Police media team, who expressed his condolences to us. When the outstanding warrant was referred to in court, we saw him abruptly leave the room, presumably to make a call prompting a change in stance. We also noticed that Rob Griffin had a Leicestershire Police email address and covered serious crime in the East Midlands area. On that basis, we suspect he must have been aware of the contact VC had with Leicestershire Police, only one month prior to the attacks. We subsequently became aware that ACC Griffin was involved in preventing the progression of the Trust's internal investigation and their engagement with us as bereaved families. We remained unaware that the police had prevented interaction with us until 27<sup>th</sup> October 2023, when Julian Hendy confirmed to us via email that he had met with the Trust on our behalf and confirmed this. Due to our concern, we asked that this matter be escalated to the SIO [HMCP0000542, HMCP0000282].

76. On 29<sup>th</sup> January 2024, we received a letter from the Chief Constable offering to meet with us and ACC Griffin [NGPF0007209]. In response, we expressed our regret that this had not been offered sooner. We subsequently decided that it would not be appropriate to meet the Chief Constable due to our ongoing concerns which only worsened in the period after the trial due to our discovery of the data breaches which had occurred within Nottinghamshire Police, and which we will further elaborate on below. During the process of information sharing in relation to such breaches, it is notable that it was also

suggested that VC may have been wanted in Derby. We asked for clarification surrounding this and we were told that this was untrue.

77. We were raising concerns and requesting a referral to the IOPC. We received confirmation on 30<sup>th</sup> January 2024 that Nottinghamshire Police had referred themselves to the IOPC in relation to prior contact they had with VC [WITN0289010]. On 2<sup>nd</sup> February 2024, we received a letter confirming that the IOPC referral had been completed in relation to prior contact and that our concerns in relation to the subsequent investigation would be completed by the College of Policing [NGPF0007142]. We were dissatisfied with this because we understood the College of Policing review to be a learning process only. We felt strongly that action needed to be taken, and we recall that Sanjoy contested the PCC's commissioning of the review on behalf of the families.

78. On 9<sup>th</sup> February 2024 we contacted the Chief Constable to raise further concerns in relation to the investigation itself [WITN0289011]. We referred to inconsistencies in information that had been provided to us by Nottinghamshire Police including the discrepancy surrounding whether audio or video interviews were conducted; inconsistency surrounding VC's residential and employment status; as well as the failure to inform us about the attacks on his co-workers in Leicestershire in May 2023. We were concerned about the refusal of the Force to allow us to access the timeline and psychiatric reports, despite them being read to us previously. We also raised concerns about the comments of ACC Griffin [WITN0289011].

79. We received confirmation on 13<sup>th</sup> February 2024 that these matters had also been referred to the IOPC. This followed further complaints we made to the Chief Constable on 10<sup>th</sup> February 2024 when we alerted her to more media articles indicating that VC had visited a member of a gang heavily involved in drugs on 12<sup>th</sup> June 2023. We told her what the SIO had said to us in relation to sampling and explained that this had a traumatising impact on us. As a result of the IOPC investigation, we were also informed that our FLOs would no longer be able to support us [WITN0289011]. At the time, we were

disappointed and concerned about how we would continue to navigate police interactions, given that we already felt sidelined. We were provided with a new FLO named Kelly, though we never met her, and following this time we were contacted by Phil Cumberpatch who we understood was acting in the capacity of an FLO.

80. We believed that the IOPC investigation would mark a change in trajectory; that openness and transparency would be achieved. However, as is detailed below, this has not been the case and the lack of transparency only continued. On 22<sup>nd</sup> February 2024, the Chief Constable held a closed briefing for the media in relation to prior contact with VC. Journalists were asked to sign in agreement not to disclose the information provided on entry to the briefing. Despite the non-disclosure condition, the Nottingham Post published several articles and social media posts in February and March 2024, questioning the Police's handling of the case and the nature of the briefing. It is notable that when we were informed of the briefing (via the media), Emma emailed the Chief Constable's office immediately. We were reassured that there would be no disclosure of information which we did not already know of [WITN0289012]. Despite this, we were subsequently informed that previous incidents of stalking had been reported to the police in relation to VC; something which we were unaware of. We felt misled once again and cannot understand how it is considered acceptable for us, as grieving families, to receive information in this way. Even today, we have very limited awareness of the details in relation to such incidents. Despite this, we now understand that the Force made a lengthy complaint to IPSO with regards to the conduct of the press, which was rejected by IPSO as unfounded.

81. Since this time, we have continued to try and resolve major gaps and inconsistencies in our understanding via the Force and the IOPC investigation, often to no avail. Many aspects remain difficult to reconcile due to inconsistent information. On 29<sup>th</sup> April 2025, Emma contacted the Force to request information in relation into property searches conducted. This once again stemmed from a conversation with a journalist from the Nottingham Post who saw officers searching properties on Ilkeston Road. We received a

response on 16<sup>th</sup> June 2025 stating that two addresses on Ilkeston Road had been searched in connection with the investigation as well as eight other addresses in Nottingham, one address in London and two addresses in Derby [WITN0289013].

82. This has raised many further questions for us and the other families. Firstly, we note that when we received disclosure of the custody log from the IOPC, we requested that Alison Hollas check the redacted references to property searches within that log to confirm whether a London address was searched. She confirmed that a London address was not present in that log.
83. We are also unclear as to why only one property was searched in London, as our understanding is that VC spent time at two addresses in the 24 hours preceding the attacks. We do not understand what necessitated so many searches in Nottingham, particularly given VC's residential position. Given the previous conflicting information provided in relation to VC being wanted in Derby, the reference to the search of a Derby address has only caused further anguish. Despite requesting clarification with further FOI requests, this information has still not been forthcoming.
84. Over two years since Barney's passing, we continue to grapple with several critical concerns that remain unresolved. We seek clarity on how and why VC's condition was classified as treatment-resistant. Specifically, we are trying to understand why none of the NHS reports acknowledged this classification. On the contrary, the reports appear inconsistent with the criteria for treatment resistance, namely, there is no identifiable period during which VC was documented as taking two antipsychotic medications without remission, and where non-compliance could be definitively ruled out. We also need to understand the basis on which Dr Blackwood concluded that VC's culpability was low, and that his failure to take medication was symptomatic of his illness. We do not recall any reference from Dr Blackwood indicating that VC made a conscious decision to avoid medication due to a disliking of needles or a desire to focus on his studies. This omission raises concerns about whether Dr Blackwood had access to VC's complete medical records.

If he did not, we would like to understand why. If he did, we need to understand why these factors were not addressed in his assessment. We would also like to understand why if VC was considered by the defence psychiatrist to be so severely psychotic, that he remained unmedicated for a period of two months following the first assessment on 4<sup>th</sup> July 2023.

85. In this regard, we note an email sent to Dave from our FLOs on 1<sup>st</sup> December 2023 in which it was stated that Dr Latham would have access to summaries prepared by the police and counsel, including the CCTV compilation and disclosed unused' material, including custody records and a summary of the healthcare records whilst in custody [WITN0289014]. The email did not expressly refer to complete medical records.

86. In addition, we are seeking clarity on the forensic strategy. We found DSI Sanders' email on this subject lacking in detail and substance, and we still do not have a clear understanding of what the strategy entailed. Specifically, we would like to know why fingernail clippings and hair strand sampling were not included among the non-intimate samples taken, particularly given that our son was drug tested. We are troubled by the defensive approach of the SIO in continuing to assert that his forensic strategy was robust; if forensic samples were not required within that strategy, we question why they were requested in custody. We are also concerned about the way in which VC's lack of a documented history of drug use was presented during the criminal proceedings. It appeared to be treated as a mitigating factor, despite the fact that his claims in relation to drug use had never been properly examined or determined.

87. Our concerns regarding VC's time in custody extend beyond the absence of toxicology sampling. We are deeply troubled by the decision to deem VC fit for detention and interview, given the reported severity of his mental illness. This presents a significant contradiction. The CPS cannot reasonably assert both that VC was experiencing psychosis and simultaneously that he was fit to be detained and interviewed. If he was indeed psychotic, we would expect that he would not have been considered fit for these procedures. Conversely,

if no concerns were raised about his mental health while in custody, it is difficult to reconcile this with the retrospective claim that his mental state was sufficient to support a defence of diminished responsibility. We have recently become aware, via the IOPC, of a reference within the custody log indicating that on 13 June 2023, the Trust had advised that VC would not be admitted to a mental health facility and that no formal MHA assessment was necessary.

88. In terms of the morning of 13<sup>th</sup> June 2023, we remain concerned about the initial labelling of the incident as a terrorist incident. We would like to understand the rationale behind this and particularly whether there was any suggestion that VC's actions were motivated by political, religious or ideological aims. We would like to know whether any concerns about VC's behaviour were reported by those who interacted with him that morning. We are particularly confused about the phone call with his brother, during which VC reportedly stated he needed to get his family out of the country. This raises questions about his mental state and whether he was able to distinguish right from wrong at that time. We also wish to understand whether VC's brother contacted the police, and if so, when that contact was made.

89. Reflecting on our interactions with the police and the Crown Prosecution Service, we do not feel we were treated with the respect we deserved. Rather than being placed at the heart of the process, as victims, we felt reduced to a management exercise. We understand that staff had a job to do but, it is we who have borne the deepest impact. We lost our child, just as the O'Malley-Kumar family lost theirs, and the Coates brothers lost their father. Senior officers, including the SIO, restricted contact and made themselves largely inaccessible. In hindsight, our FLOs now seem to have served more as a mechanism to sideline us than to support us; often relaying no significant information and lacking meaningful engagement. Being pushed aside during the most devastating period of our lives was deeply hurtful. We were not adequately communicated with, protected, supported, or kept informed. Requests for disclosure were repeatedly denied, despite arising from an urgent and overwhelming need to understand what had happened. Despite multiple reassurances that this would follow the criminal proceedings, much

of it has never materialised and to this day, we remain in the dark. This approach must change, for the sake of future victims.

90. We note that we were offered a meeting with the CPS earlier than November 2023, which we did not accept due to our significant mental struggles. However, if the police had informed us of the prospect of a mental health defence, and its significance, we absolutely would have engaged sooner. If we had been made aware of even a minimal realistic prospect of an alternative disposal outcome, we would have demanded a meeting immediately. Whilst we are disappointed about this, we now know that it would not have made a difference as when we did meet with the CPS, our voices were not considered relevant to the process. We do not believe that any amount of concern from us could have altered the outcome. We also emphasise that we were given no direct means of communicating with the CPS. It was made clear that we were not able to liaise with them directly and any engagement with them had to take place via our FLOs. This was extremely unhelpful and sent a clear message to us, that the CPS did not place themselves with the victims.

91. We trusted in these organisations to achieve a just outcome whilst allowing ourselves to begin to grieve. However, the nature of the interactions changed on 4<sup>th</sup> October 2023 when the defence of diminished responsibility was raised with us. After that, everything else seemed to unravel and we were entirely underprepared and ill-equipped for what was to come. We lacked even the minimum time required to mentally process that potential outcome. Whilst it would have always been difficult to tolerate, it may not have been quite so unbearable had we known from the outset that a murder conviction was unlikely to occur.

### **INTERACTIONS WITH OTHER ORGANISATIONS**

92. We were given renewed hope of justice following the announcement that independent bodies such as the IOPC and His Majesty's Crown prosecution Service Inspectorate (HMCPsi) would review the conduct of the institutions which failed us.

## HMCPST

93. When we met with HMCPST on 9<sup>th</sup> February 2024, we relayed the full extent of our concerns to the investigation team. We were assured that their investigation would be rigorous and uncompromising; that they would “*leave no stone unturned.*” At that time, we raised concerns about the CPS’s prior involvement with VC as this did not appear in the Terms of Reference (ToR) and requested that the scope of the investigation be expanded. This request was acknowledged and confirmed via email. It was also confirmed that this broadening of the scope would not impact upon timeframes.
94. When we reconvened with HMCPST on 25<sup>th</sup> March 2024, the reality of their process fell far short of the promises made. Firstly, ahead of that meeting, we were informed that the report would be released to the public at 12 noon, and offered a mere 45-minute window, commencing at 11:15am, to read, absorb, and discuss a 118-page document. This was not a meaningful attempt to prepare and engage us, but an opportunity to work against us whilst ensuring compliance with a formality. To make matters worse, the media had already been briefed ahead of our meeting, leaving us blindsided and unprepared to respond publicly.
95. We felt exploited by a process that failed to protect or empower us. We did not have formal legal representation, and we believed that this vulnerability was taken advantage of. We are grateful to Julian Hendy, who strongly advocated for us to receive the report a week in advance. However, his efforts were ultimately dismissed, with Anthony Rogers stating he had done all he could. That was not enough.
96. Once we had time to properly review the report, it became painfully clear that many of our concerns remained ignored or inadequately addressed. Crucial omissions, such as the lack of emphasis on VC’s refusal to consent to toxicology testing were deeply troubling, particularly given that evidence of drug use could have undermined the defence of diminished responsibility, potentially altering the legal outcome and reinforcing VC’s culpability. There was a finding regarding the wrongful use of the word ‘*consult*’ when referring

to notifying victims of acceptance of the plea. The recommendation made in response did not centre around improved rights for victims to be properly consulted with but, instead, it directed the CPS to ensure that staff knew when use of the word was appropriate. After all we had been through, HMCPSP seemed to recommend that the lack of victim's rights be further crystallised, rather than remedied. We were promised a thorough investigation. What we received was a bureaucratic exercise that failed to deliver truth, accountability, justice or change.

97. The families of Grace and Ian shared our horror at the contents of the report. Sanjoy took the time to draft a letter on behalf of the families, that outlined our serious concerns and the many unanswered questions that remained following the review. This letter was shared with Ministers who held office at the time, including Laura Farris, Minister for Victims, and Victoria Prentis, Attorney General. It was also shared with Emily Thornberry, Shadow Attorney General. Despite our collective efforts and the gravity of the issues raised, we understand that HMCPSP never provided any response.

#### Court of Appeal

98. When we received notification that the sentence was to be referred to the Court of Appeal as a result of potential undue leniency, we finally had hope that justice would be done, but we were left with anguish and disappointment. It did not assist that, at this time, we continued to have to make sense of major investigative gaps and shortcomings. Despite assurance that access to disclosure would be provided after the initial criminal proceedings, this had been denied on multiple occasions, and we struggled to understand how this state of affairs was allowed to continue.

#### IOPC

99. By this point, the promise of answers via the IOPC investigations was the only hope that remained. Indeed, this had been expressed on multiple occasions by senior officers of Nottinghamshire Police. Despite such assurances, we have been let down during the course of each investigation.

100. When we first met with Derrick Campbell and the team in March 2024, we were once again, assured that the investigation would be thorough. We were told that our concerns would be reflected within the ToR and assured that the team empathised with the profound loss we had suffered. What we have seen since is the opposite approach and we now feel that Derrick Campbell was putting on a PR performance for us. It was inappropriate for him to commence the meeting with a moment of reflection.

101. When the ToR were received in relation to the Nottingham investigations (Operation Astwell, Operation Copthorne and Operation Longdale) they did not reflect the extent of our concerns. Whilst Operation Astwell considered some prior contact with VC, the timeframes were inadequate and there was limited reference to our concerns stemming from the adequacy of the investigation which followed the death of our son. The period that Valdo Calocane was in custody was, for example, excluded from the investigation. Our concerns had been placed in an Appendix which was attached to correspondence, the status of which was unhelpfully not made known. We now consider that this may have been an attempt to mislead us. In hindsight, while we appreciate that the IOPC must act within the scope of its powers and that some of our concerns go beyond these, it feels incredibly patronising and unjust for an independent body to sideline the concerns of grieving families into an Appendix; refusing to place them in the ToR themselves or to explain the status of the Appendix.

102. We attended a further meeting with the IOPC on 1<sup>st</sup> July 2024. By this time, we had instructed our current legal team and they attended with us. During that meeting, Derrick Campbell stated that if we wanted the IOPC to investigate the full extent of our concerns, then we would have to go to the Court of Appeal. He did however, appear to make some concessions and we left expecting some amendments to the ToR, which we left with our legal team to manage. We were notified of correspondence in which the IOPC acknowledged that they knew it was not what had been discussed, but ultimately, they could not adopt the amendments we had requested. Our legal team had to have a separate meeting with the Director General several

months later before the investigation was expanded to cover toxicology sampling.

103. In relation to the contact with Leicestershire Police, the Operation Penhallow investigation was established. We were not given the opportunity for consultation in relation to the ToR. Derrick Campbell and the team appeared to act surprised at our lack of awareness of the investigation and explained that it was almost complete. We confirmed that we wanted to become IPs to the investigation and began to receive updates.

104. When we received the investigation report and determinations in November 2024, we were horrified by the investigative gaps which were jumping off the page. There were areas which had been entirely unexplored during interview, such as the presence of a knife at the scene. There were also inconsistencies in the officers' evidence which had not been investigated further. The IOPC had operated on the basis that the officers had not conducted intelligence checks. However, in her account, the officer responsible for conducting these checks had contradicted herself and suggested that she may have looked at some of the investigations linked to VC. This remained unchallenged and without further investigation from the IOPC, which we considered to be a significant omission.

105. Over the months which followed, we had to send a multitude of letters, via our legal team, highlighting the evidential gaps to Derrick Campbell and pleading for the decisions to be reconsidered. Despite this, he stubbornly maintained his position throughout all correspondence he sent to us. His conduct and tone were extremely offensive and patronising as he made special efforts to note that *"I would like to reiterate my condolences to the families of Grace, Barnaby and Ian, and I recognise the distress and trauma VC's actions have caused them. Whilst there may have been missed opportunities within Leicestershire's investigation, there is no way of knowing whether the tragic events on 13 June 2023 could have been avoided"*.

106. Our legal team persisted with requests for further disclosure and for additional audits to be conducted to highlight flaws in the investigation. All this while planning for the misconduct meeting which had been directed by the IOPC continued. The families were told that the officers were seeking for the families not to be allowed to enter the room where the meetings were taking place, but would instead, to listen via an audio stream in a separate room to protect officer anonymity. This process only caused further anguish. The Chair rejected the officers' request to exclude the families and the misconduct meeting remained scheduled until the day before it was due to go ahead. We were already on our way to Leicestershire when our legal team called to tell us that the Chair had adjourned them. It was only following this that the IOPC admitted that, in light of "*new information*", the investigation would be reopened. This was insulting given the concerns we were raising months earlier over material flaws in the investigation.

107. The further distress caused by the Operation Penhallow investigation is difficult to put into words. Throughout the process, we have been met with suggestions that what had occurred was not linked to the loss of our son. Despite the outstanding warrant for VC's arrest, we have been told that if he had been apprehended, it would have unlikely changed the course of events. We have felt strongly throughout that there has been serious bias present within an organisation who are, by definition, supposed to be independent.

108. We recently received an email from Danny Simpson at the IOPC alerting us to complaints made by the subject officers within the investigation. It is now alleged that IOPC investigators told them that the investigation was not connected to the events which occurred on 13th June 2023, but rather that it was politically motivated and driven by us and the other families. Officers were allegedly told that the interview process would be completed within weeks and that the likely outcome would be reflective practice. This has only confirmed what we have suspected all along, and our position is that, if proven, this constitutes institutional corruption at the highest level. When we first engaged with the IOPC, we could never have envisaged that we would

be treated so poorly. We strongly believe that this organisation is not fit for purpose. We have no faith in it or any of its staff.

#### Care Quality Commission (CQC) and NHS England

109. We also had to endure the additional trauma of disclosures of information via NHS-related investigation reports. These reports revealed catastrophic failings amongst health professionals at all levels, including nurses, GPs and psychiatrists, as well as mismanagement from the senior leadership team. When we digested the findings of these reports, it became unarguable that institutional failure was responsible for Barney's death. We found liaison with the agencies responsible for these reports, with the exception of the Care Quality Commission, difficult and traumatic. There was an evident reluctance to allow us to learn of the extent of the failings. As noted above, we had to fight with the Trust to receive disclosure of the report and with NHS England to achieve its publication. This experience once again demonstrates to us a lack of willingness to aid transparency, accountability and change.

#### Other Organisations

110. It is not only the organisations directly involved in the response to the attacks who have let us down. We also felt deeply let down by the BBC's handling of our concerns surrounding the Panorama broadcast, *The Nottingham Attacks: A Search for Answers*, which aired in August 2024, and was made in conjunction with the perpetrator and his family. From the outset, our engagement with the editorial team was marked by a lack of transparency, sensitivity, and meaningful consultation. Despite the programme's focus on events that had devastated our families, we were not invited to contribute, nor were we given the opportunity to view the programme in advance. We were given only limited information, which was incredibly anxiety provoking. Our repeated requests for a disclaimer, simply to clarify that we had not been involved, were ignored.

111. Instead, we were forced to absorb new and distressing information about the deaths of our loved ones at the same time as the general public, without

warning or preparation. We decided, due to our profound distress, that we could not face watching the show. We do not speak VC's name and just over a year following the loss of Barney, the prospect of his story being aired on TV made us feel sick to our stomachs.

112. Despite not watching or engaging with the programme, we still found out significant new information from others who had watched it. It is notable that we had been denied access to VC's records, which would have allowed us to gradually understand and come to terms with his history. We learnt that access to the records was granted to Panorama and extracts from them were revealed to the whole country during the broadcast. The extracts included, according to Panorama, that a psychiatrist had identified a risk that he would go on to kill. A request to see the records provided to Panorama was made to VC's family via our legal team. That request remained unanswered [WITN0289015 and WITN0289016]. We also learnt of the extent of the injuries which the student who had jumped out of the window had sustained. It was upsetting for us to learn that images of VC as a child, with heartfelt music, had been displayed for all to see, whilst his mother's profession as a nurse was not disclosed to the public. The family's alleged lack of awareness of VC's diagnosis is something which now appears contradictory to the NHS related investigation reports.

113. When we raised these concerns formally, the BBC's responses felt dismissive and defensive. Our detailed letters, which outlined breaches of editorial guidelines and the emotional harm caused, were met with justifications that prioritised editorial independence over basic compassion. We were told that the programme's focus did not warrant our involvement, despite its reliance on medical records and footage which directly led to the death of Barney.

### **DATA BREACHES**

114. We have been made aware of various instances of possible unlawful access to and misuse of data by staff at Nottinghamshire Police, Nottinghamshire Council, His Majesty's Courts and Tribunal Service (HMCTS), His Majesty's

Prisons and Probation Service (HMPPS) and Nottingham University Hospitals NHS Trust. It has made us feel sick to our stomachs that any person would want to breach our son's privacy following the horrific attack he endured. It has been almost impossible for us to comprehend that hundreds of professionals across multiple organisations may have a desire to unlawfully access data of this nature and breach the privacy of victims in this way. This kind of conduct is dehumanising and from our perspective, it amounts to abhorrent voyeurism on the part of professionals we should have been able to trust. We are deeply traumatised by each and every breach which has occurred.

115. In relation to Nottinghamshire Police, multiple data breaches have been uncovered. We are now aware that an audit was conducted and that 179 officers/ staff had accessed information relating to the case. Of these 179 people, 22 were identified as potentially having accessed material without a legitimate policing purpose. Of the 22 officers, 11 were able to provide an explanation which met the criteria for a valid policing purpose. The remaining 11 were identified as having no policing purpose to access the information and were subject to further action [WITN0289017].

116. We are aware that a Special Constable was found to have accessed BWV footage of the police and paramedics at the scene of the deaths when providing care to Barney and Grace and after they had passed away. We understand that the misconduct proceedings were held in private in August 2023 and that he was dismissed and barred from working as a police officer. We are sickened by the voyeuristic nature of the conduct of this officer, and we cannot comprehend why anyone would have a desire to watch this footage.

117. There was a further incident involving multiple officers in a WhatsApp Group on the day of the attacks. They made derogatory comments about Barney and Grace which were extremely disrespectful and hurt us profoundly. The messages also contained details regarding VC and the police response.

118. We were informed that PC Gell, a member of the group chat, was found to have shared a WhatsApp message externally, with his family and friends. The message was initially said to have been posted by his colleague. He was also found to have accessed police systems in relation to the case on seven occasions without a legitimate policing purpose. He was given only a final written warning and his colleague who was found to have sent the original message was dealt with via management action.

119. A member of police front counter staff was also confirmed to be under investigation for accessing material in relation to a number of high-profile cases including this one. We were informed that she was arrested and was found to have accessed records and looked up details in relation to the case as well as other cases.

120. We were informed of a further 8 officers who were found to have accessed material without a proper policing purpose. We were told that the material accessed was thought to be at a lower level of sensitivity, but from our perspective any wrongful access to data which relates to this tragic event is unforgivable. We were told that only three officers were subject to investigation, as well as three partner agency staff, who have since been identified as staff of Nottingham City Council, working within the Community Protection Service. One officer and one staff member were subjected to management interventions and negative performance records.

121. The handling of these breaches by the Force is of serious concern to us. As can be seen from the documents provided, we did not learn of much of the detail until we received the Chief Constable's letter on 20<sup>th</sup> February 2024. The lack of candour and respect displayed has only exacerbated our trauma. Not only was information withheld from us; we feel strongly that there were active attempts to conceal what had occurred. In relation to the Special Constable's access of BWV footage, we were not aware of this incident until around February 2024, despite the conduct occurring in August 2023. We were not informed of the misconduct proceedings which occurred until they were over. We have become aware that the position of Nottinghamshire

Police is that the SIO informed us of the Special Constable's breach on 15<sup>th</sup> January 2024 during a meeting with the police and the CPS ahead of the criminal proceedings. We have no recollection of this and to the contrary, we recall that this was disclosed after we became aware of the breaches which had occurred in the WhatsApp group. We do not recall being invited to attend any misconduct proceedings.

122. In relation to those breaches, to the best of our recollection we believe we first became aware of them via the press. We understand that these matters were made public only because the press became aware of a limited press release published by Nottinghamshire Police in relation to misconduct proceedings which had already concluded by the time we knew about them.

123. We believe that Nottinghamshire Police actively attempted to cover up what had occurred. On 14<sup>th</sup> February 2024, we received a message via Emma's Facebook from a source who was present at the misconduct hearing of PC Gell [WITN0334005]. She told us that when asked whether the families had been made aware of the incident, a representative of Nottinghamshire Police had said that we hadn't because "*we had enough on our plate*". She said that the hearing had been scheduled in March 2024 but had then been brought forward to the same week of the criminal proceedings so it could fall off radar. She provided further information that the family of the officer subject to the misconduct hearing were vocal that the reason why the other officers had not been held to account was because one of them was the son of the Chief Constable. She later confirmed that she had checked again with PC Gell's family who had confirmed that this was the case.

124. In light of the delays in informing us of what had occurred, and the messages received, we do not accept that the decision was made to protect us because we had "*enough on our plate*". The Force did not have the right to make decisions for us in that regard. We feel certain that was an instance in which the Force simply use a convenient day to bury this dreadful news whilst the victims were preoccupied with criminal proceedings. Sanjoy and

Emma contacted His Majesty's Inspectorate of Constabulary Fire and Rescue Services (HMCFRS) on 13<sup>th</sup> February 2024 to state the same.

125. The WhatsApp messages were sent to Sanjoy, and he shared them with Emma who responded to the chief Constable's letter on 21<sup>st</sup> February 2024. Emma explained that she was heartbroken and considered it to be no coincidence that we were not informed. The Chief Constable apologised and admitted this should not have happened. She claimed that the date of the hearing had not been moved, and the proceedings were conducted by an independent and legally qualified chair. DI Luke Waller then confirmed that the message had been shared by PC Gell. He also stated that there was "*only one*" message which related to Barney and Grace, as if that were a consolation.

126. Emma emailed on our behalf to express our horror at the content of the messages. We asked a number of further questions about how many staff members were in the group; whether they had made any comments; and, whether contact between her and the officers could be made. We were told that further information could not be provided. It was once again reiterated that the investigation had "*only identified a single message*" and that the IOPC would investigate this matter. We felt misled when we were informed of the limited scope of the IOPC investigation in this regard.

127. In relation to the breaches of Community Protection Service Officers at Nottinghamshire Council, we received a letter of apology from the Leader of the Council, David Mellen on 18<sup>th</sup> March 2024 [WITN0289019]. This occurred after we had been informed of the breaches by Nottinghamshire Police. It felt very much like an afterthought which we suspect would not have occurred had we not been informed by Nottinghamshire Police. We were alerted to the final outcome of misconduct proceedings in relation to the police staff member referred to above on 5<sup>th</sup> April 2024, the same day as the hearing took place.

128. It is however, notable that we have not been made aware of the precise data accessed by many of the officers, nor do we know which victim this related

to. In relation to the WhatsApp group, we have been provided only with very limited extracts of the exchange and remain unaware of the wider context of the discussion. As the victims of this conduct, we feel strongly that we had the right to know.

129. On 19<sup>th</sup> December 2024, we were contacted by our legal team alerting us to correspondence from the South East Regional Organised Crime Unit (SEROCU). In that correspondence, we were informed that Nottinghamshire Police had received a report regarding alleged data breaches of staff from HMCTS and HMPPS [WITN0289020]. We know that these breaches occurred during court proceedings and related to wrongful access of case file material and in some cases, images. Since this time, we have been receiving regular monthly updates from SEROCU officers with regards to their investigation. Despite this, we remain unclear about the precise nature and extent of these breaches at the time of producing this statement.

130. Following this correspondence, we received no direct communication from either of the organisations. Our legal team had to ask questions on our behalf in order to establish that the breaches had been discovered in January 2024 (11 months prior to when we were notified). We were informed that this triggered an internal investigation which had resulted in a referral to Nottinghamshire Police on 21<sup>st</sup> May 2024 (7 months prior to when we were notified). This correspondence is exhibited at WITN0128005.

131. We were then made aware via the media on 28<sup>th</sup> March 2025 that two members of court staff had been dismissed for viewing video footage. We knew that there was no footage of the attack on Ian which led us to conclude that this footage must have been of the attacks of Barney and Grace. We emailed the investigation team to express concern and request an explanation, but we were unable to obtain any significant further information other than assurance it was not SEROCU who released the details to the media. Our legal team made contact with MOJ staff directly but they refused to provide further information. At the time of producing this statement, we remain in the dark as to the precise nature of the breaches.

132. Our legal team received further correspondence from Nottingham University Hospitals NHS Trust on 20<sup>th</sup> February 2025 alerting us to “a *potential data breach*” which had been discovered during a preliminary audit. This correspondence is exhibited at [NUHT0000101], It is notable that we had met with the senior leadership team at Nottinghamshire NHS Foundation Trust and their legal representatives on 6<sup>th</sup> August 2024. During that meeting, we recall that Sanjoy queried whether such an audit had been conducted and we were informed that at that time, it had not.

133. At the time of producing this statement, we still await the outcome of the investigations conducted by the Trust. We have received regular updates throughout the investigation process, but these have at times been vague and difficult to understand due to the absence of complete information. We have learnt that 98 people accessed the records of Barney, Grace and Ian and that of those, 50 individuals were deemed to have accessed the records legitimately. It is of course, difficult to comprehend why so many individuals would have needed to access their records.

134. We feel strongly that, despite the seriousness of these breaches, the Trust continues to demonstrate a lack of candour, a tendency toward evasion, and a troubling indifference to our needs. Most recently, we were provided with the Trust’s Stage 1 Report, which addressed staff members who were found to have accessed records legitimately. However, it is deeply concerning that, during the disclosure process, the Trust has still not provided access to the confidential annex.

135. The report itself was generalised and abstract, offering only a distant and incomplete view of what actually occurred. Without access to the annex, we remain unable to fully understand the scope of the record access, the rationale behind it, and the identities and roles of those involved. The absence of specific dates, roles and explanations has made it impossible to reconcile the scale of access described. Rather than offering clarity, the report has generated further confusion, particularly around ward transfers, which we

were previously told would not have been necessary for any of the victims, who were allegedly not treated in hospital. There was also a reference to access to records for the purposes of bereavement support, which we do not recall ever being offered.

136. We are especially concerned by mentions of audits and administrative reviews which, according to medical professionals within our group, would not typically require access to patient records. The lack of entries by many individuals who accessed the system, combined with vague references to roles such as flow coordinators, has only deepened our discomfort. The justification for access on the grounds of research and education is equally troubling. Key details are missing, including who authorised the access, which records were involved, and the criteria for inclusion. Without this level of transparency, we cannot reasonably be expected to accept the report's conclusions or feel reassured about the integrity of the process.

137. This experience is sadly consistent with our interactions across multiple organisations. However, we remained shocked at this example of institutional arrogance in which the Trust do not seem to recognise the need to provide full and frank disclosure, despite informing us of data breaches on such a significant scale. Once again, we feel we have been drip-fed fragments of information, forcing us, through our legal team, to send detailed pleas in which we are required to justify why full disclosure is essential. We await the outcome of stage 2 of the investigation, which considered those deemed to have potentially accessed the records without a legitimate purpose. We both carry a profound sense of dread as we await the findings. The prospect of any professional wanting to breach the privacy of our son is incomprehensible. We cannot stop thinking about the potential that such data will one day be shared.

## **REFORM**

138. We hope that this statement has conveyed our profound sadness and disappointment at the mistreatment we have received from all organisations involved. Every institution, from those responsible for managing VC's risk

prior to the attacks, to those responsible for investigations into wrongful conduct, have left us with a sense of letdown and devastation. This will remain with us for the rest of our lives. We hope that change is the one thing that will come from our pain. Due to our experiences with multiple organisations, we hope that learning will occur, so that no family will ever have to go through what our family has had to go through. We anticipate learning further from the Inquiry's investigation, disclosure and hearing of evidence and we expect that we will invite the Inquiry to make recommendations at its close which will be designed to save others from experiencing such pain as we continue to endure.

139. The death of Barney could have been prevented and it is unarguable that the NHS had significant potential to alter the outcome had they taken a robust approach to the management of VC's risk. On that basis, the first area we believe reform is urgently needed is in mental health care. In 2024, we met with the Department of Health and Social Care and NHS England on several occasions to share our insights into proposed reforms under the Mental Health Bill.

140. We remain deeply concerned that the Mental Health Bill places excessive emphasis on patient autonomy and the least restrictive practice, often at the expense of public safety and in the absence of thought as to how practice on risk assessment and risk management can be improved. The care provided to VC illustrates how these principles can lead to missed opportunities for intervention and a failure to protect the wider public. We believe clinicians already possess the necessary powers under existing legislation, yet for a reason not yet known to us, they failed entirely to utilise them.

141. As Barney's parents, we will never come to terms with NHS staff allowing prolonged non-compliance with medication. We cannot comprehend the level of autonomy granted to VC, who was permitted to stockpile medication and decide whether to take it based on his claimed personal discomfort with needles and his desire to study. Had depot medication been administered without delay or a Community Treatment Order put in place, the lives of

Barney, Grace, and Ian could have been saved. We remain concerned that decisions around VC's management appear to have been shaped by social goals and fears of perceived bias, rather than objective assessments of risk.

142. We feel the same concern regarding his release without proper evaluation. This cannot continue to be left to the discretion of individual medical staff. If there is any doubt about a patient's compliance, they must not be allowed to remain unsupervised in the community. The proposed changes to raise the threshold for detention, increase discharge reviews, and introduce additional procedural safeguards for patients will only worsen the problem. We say this with full awareness of the importance of liberty, but in recognition of the three innocent lives that were lost due to lenience and institutional complacency. We know this case is not unique. There are many others. Public protection must come first, and professionals must be empowered and expected to act decisively.

143. We are also deeply concerned about the removal of police stations as designated places of safety and the increased reliance on second opinions without any change of provision or practice to better manage risk or to increase alternative provision for places of safety to be used in the face of risks to the public. These changes risk further fragmenting care and delaying necessary action. VC's case demonstrates how poor inter-agency coordination and reluctance to use available powers can result in devastating consequences. We urge lawmakers to reconsider provisions that create barriers to timely intervention and instead focus on enabling professionals to protect lives through swift and decisive action; placing robust consequences on them when they fail to manage patients as a result of incompetence, laziness or ineffective management.

144. Multi-agency working must also become more robust. We already know that liaison occurred between the police, the NHS and the University, but it is clear that there were deficiencies. We also feel strongly that mental health must not be used as a reason to avoid pursuing charges or prosecutions against individuals who display violent behaviour. The criminal justice process offers

not only the opportunity for sanction, but also for intervention and continued oversight. Inaction in this case had tragic consequences, and this must not be allowed to happen again. The police have a vital role in safeguarding the public, as do the courts.

145. We believe strongly that there needs to be further oversight where there is a warrant outstanding for an offender's arrest. This should be subject to regular review and steps should be taken to ensure the offender is located and appropriately dealt with. There is no justification for a warrant to remain outstanding for a period of nine months and action must be taken to ensure this does not happen again.

146. We do not believe that perpetrators of crime suffering with mental health issues should be afforded with the leniency they are currently offered within the criminal justice system. Whilst we are aware that mental illness can cause or contribute to criminal conduct, we do not feel that the system achieved justice in this instance. Matters surrounding retained responsibility should be rigorously explored and scrutinised, to ensure that a penal element is always reflected where it ought to be. Whilst mental health can be a reason, it should never be an excuse.

147. We are also passionate about improving the rights of victims within the criminal justice process. As we have outlined in this statement, we were treated very much as a management exercise when we should have been at the heart of the process. This must change as victims must be central to justice. We understand the pressures faced by the public sector, but we felt sidelined throughout the criminal proceedings. Our concerns were not reflected in the investigation or the courtroom. The CPS appeared to represent the views of the experts, not ours. When victims lose their lives in such circumstances, their loved ones are the only people who can truly speak for them. Justice depends on their active participation.

148. In this regard, we wish to draw the Inquiry's attention to Section 395 of the German Code of Criminal Procedure. Under this provision, victims of serious

offences such as homicide, sexual violence, bodily harm, unlawful detention, and stalking may join criminal proceedings as accessory prosecutors. Bereaved family members, including parents, children, spouses, and siblings of victims killed through criminal acts, also have standing to participate. We understand that this model was briefly considered in the UK in 2010, but the proposals were never fully explored. Based on our experience, we strongly advocate for victims to have clearly defined procedural rights, including the ability to participate actively at all stages of proceedings, submit evidence, question witnesses, and contribute to legal submissions, closing statements, and sentencing proposals through legal representation.

149. We are also deeply troubled by the dominant role of expert evidence in criminal proceedings. We felt that the safeguards of the justice system were replaced by a process led by doctors, who appeared to exert undue influence over the entirety of the case. While we recognise the importance of medical evidence in cases like this, we are concerned by the lack of scrutiny applied to the experts involved. In this instance, the system did not work for us as families, or for the loved ones we lost. The lack of scrutiny resulted in a profound injustice, where key aspects of culpability were left inadequately explored.

150. The conduct of institutions in response to tragic events such as this must also change. We are also of the firm view that organisations such as the IOPC must undergo further scrutiny. Consideration must be given as to whether this institution is fit for purpose. Any organisation that claims to be independent, must not be there to bolster bad decisions of police forces. Accountability must be at the forefront and any individual found to have violated their statutory duty must not be allowed to remain in their position.

151. As we have outlined, we have also struggled to comprehend that large numbers of professionals across a multitude of organisations may have unlawfully accessed sensitive data relating to our loved ones after they were killed. Safeguards must be put in place to ensure this never happens again.

Deterrence must also be a priority: organisations and individuals involved in abuses of power must be held accountable for their actions.

152. Where inaction on the part of institutions such as the police and the NHS results in death, support and transparency needs to improve significantly. Whilst NHS Trusts claim to be operating openly and respecting the duty of candour, that remains to be seen, and they are regularly citing respect for the confidentiality of the killer as a reason not to disclose information. This has not only happened to us; we are sadly aware of others who have been left in the dark as to what caused the death of their loved one, and the role in that such organisations played. We are aware of cases where internal reviews have never been disclosed and, several years on, families are battling to ascertain basic facts. It is unacceptable for any organisation to hide its failings behind arguments of confidentiality, when the victim of their wrongdoing experienced death or serious injury. Such institutions must be held accountable.

153. We have worked closely with Julian Hendy in relation to the Victims and Courts Bill, the provisions of which we remain deeply concerned about. We understand that each year, around 100–120 homicides are committed by individuals with serious mental illness. Yet, victims are rarely given the information or support needed to cope and recover. The Bill currently gives probation services and hospital managers wide discretion to decide what information victims receive, without any statutory rights, consultation, explanation, or right of review. This lack of transparency and accountability risks sidelining victims further.

154. We remain deeply concerned and disappointed by the response to our representations on the Victims and Courts Bill. Whilst we welcome the Minister's recognition of the pain and injustice families face, and her commitment to improving the Victim Contact Scheme, the current proposals still fall short of what is needed. The Bill continues to give wide discretion to probation services and hospital managers without creating a clear statutory duty to consult with victims, explain decisions, or offer a right of review. We

are particularly disappointed that the response does not acknowledge the imbalance in how victims' needs are considered compared to those of patients; nor does it commit to the transparency and accountability we have consistently called for.

155. We appreciate the steps taken to allow Victim Personal Statements at Mental Health Tribunals, but this alone does not achieve the parity we seek with the Parole Board process. We believe that victims should be granted status as Interested Parties in tribunal proceedings. These changes are essential to ensure that families affected by these devastating events are treated with fairness, dignity, and respect.

**Statement of Truth**

I believe the content of this statement to be true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Print Name: Emma Webber	Print Name: David Webber
Signed: <b>GRO-B</b>	Signed: <b>GRO-B</b>
Dated: 18/12/2025	Dated: 18/12/2025

## Index to First Witness Statement of Emma and Dave Webber

No.	Inquiry URN	Document Description
1.	CPSE0000078	Witness Statement of David Webber dated 19/01/2024
2.	CPSE0001117	Witness Statement of Emma Webber, 16/01/2024
3.	NHFT0000451	Report dated 15/06/2023, compiled by Jackie Craissati, Joanne Parry, Rachel Lees, NFT, Re: Level 2 Comprehensive Investigation Report
4.	NGPF0002572	Email from Gemma Piggott to Emma Webber dated 19/01/2024 Re: Questions and answers
5.	WITN0289002	Operation Hendrix FLO LOG
6.	WITN0289003	Email from Gina Farrell to Emma Webber and others, dated 16/11/2023 re Your text message last night
7.	CPSE0002419	Email from Gina Farrell to Leigh Sanders, Alan Murphy, Claire Gould and others, dated 22/11/2023 re: Fwd: The meeting on Friday 24th No
8.	HMCP0000312	Email from Gina Farrell to Emma Webber, David Webber and Gemma Piggott, dated 22/11/2023 re: Update re Mr Hendy joining the meeting on Friday
9.	WITN0289004	Minutes of meeting dated 07/12/2023
10.	WITN0289005	Dave Webber notes of meeting on 07/12/2023
11.	CPSE0000005	Custody record, dated 19/06/2023, Nottinghamshire Police
12.	WITN0289006	BBC News article – Thurrock C17 gang members banned from wearing hoodies
13.	WITN0289007	Email from Emma Webber to Leigh Sanders, Sanjoy Kumar, Samantha Shallow and others, dated 10/12/2023 re: External Email - Re: IMPORTANT CONSIDERATIONS FOR CPS
14.	NGPF0004150	Minutes of Meeting re: Meeting held with bereaved families on 13/12/2023 to discuss Dr Blackwood and Dr Latham psychiatric reports, Nottinghamshire Police

15.	NGPF0002498	Email from Gina Farrell to Emma Webber, David Webber, Gemma Piggott and other dated 18/12/2023 re: Notes from family meeting and question and answer document
16.	NGPF0002505	Email from Gina Farrell to Emma Webber, David Webber, Gemma Piggott and others dated 21/12/2023 re: Urgent (regarding plea decision)
17.	CPSE0001046	Email from Gina Farrell to Kessie Pochin, dated 08/01/2024 re: FW: CPS / Barrister meeting
18.	WITN0289008	Email chain between Leigh Sanders, David Webber, Sanjoy Kumar, Samantha Shallow and others, re: RE: SAMPLES
19.	WITN0289009	Email chain between Emma Webber, Gemma Piggott and Dave Webber dated 17/01/2024 re RE: VPS
20.	HMCP0000542	Email from Emma Webber to Gina Farrell, Gemma Piggott, Julian Hendy and others, re: Fwd: Nottinghamshire NHS
21.	HMCP0000282	Email from Gina Farrell (NGPF) to Emma Webber (Webber Consulting) , David Webber (Yahoo) and Gemma Piggott (NGPF), dated 09/11/2023 re Further to the call from Gemma on 7th Nov re Nottinghamshire Healthcare.
22.	NGPF0007209	Letter from Kate Meynell (NGPF) to Emma Webber and David Webber, re: following the sentencing hearing to arrange a meeting on any concerns the family has on the police's management of response
23.	WITN0289010	Email from Luke Waller dated 30 January 2024 re Further Update from Nottinghamshire Police
24.	NGPF0007142	Letter from Kate Meynell (NGPF) to Emma Webber and David Webber, re: responding to concerns raised by the Webber family
25.	WITN0289011	Email chain between Kate Meynell (NGPF), Emma Webber, re RE: Webber family response
26.	WITN0289012	Email from Luke Waller [NGPF] on behalf of Kate Meynell [NGPF] to Emma Webber, re: Today's media briefing

27.	WITN0289013	Email chain between James Bateman, Emma Webber and others re Re: FOI request
28.	WITN0289014	Email from Gemma Piggott to Dave Webber cc Gina Farrell dated 01/12/2023 re Update and offer of two meetings 01 12 2023
29.	WITN0289015	Email from Neil Hudgell to Elias Calocane dated 27/08/2024
30.	WITN0289016	Email chain between Elias Calocane, Neil Hudgell and Lindsay Allison dated 04/10/2024
31.	WITN0289017	Letter from Chief Constable Kate Meynell to Emma and David Webber dated 20/02/2024
32.	WITN0334005	Facebook messages sent to Emma Webber re misconduct hearing of PC Gell
33.	WITN0289019	Letter from Cllr David Mellen, Leader of the Council to Emma, David and Charlie Webber dated 18/03/2024
34.	WITN0289020	Letter from Mark O'Brien [South East Regional Organised Crime Unit] to David and Emma Webber dated 19/12/2024
35.	WITN0128005	Letter from Mark O'Brien [South East Regional Organised Crime Unit] to Mr Hudgell, re: Investigation into the death of the victims
36.	NUHT0000101	Letter from Miss Manjeet Shehmar [NUHT] to Mrs Emma Webber & Mr David Webber, re: RE: Request to meet regarding potential data breach investigation









# First Witness Statement of Emma and Dave Webber 18th November 2025

Final Audit Report

2025-12-18

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