THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF SANJOY KUMAR AND SINEAD O'MALLEY-KUMAR

We, Sanjoy Kumar, and Sinead O'Malley Kumar will say as follows:

INTRODUCTION

1. We are Sanjoy Kumar and Sinead O'Malley-Kumar, parents of Grace O'Malley-Kumar.

2. This witness statement is intended to reflect our experiences of and concerns arising from the events 13th June 2023, which resulted in the tragic loss of our daughter, Grace. This statement is also made on behalf of our son, James O'Malley-Kumar and his experiences will be referred to throughout.

3. This witness statement is made to assist the Nottingham Inquiry (the Inquiry) with the matters set out in the Rule 9 Request dated 30th July 2025 (the "request").

4. 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

5. The impact of the events of 13th June 2023 is immeasurable and infinite. Our lives have been ruined and changed forever. There are tears each day of our lives. Our future as a family unit has been impacted and broken. Our son, James, has lost his best friend, confidante and role model. He is heartbroken. His education has been significantly impacted. James was awarded an academic and sports scholarship to Whitgift School which he found he was

unable to take up, directly because of the timing of when he lost his sister. We as a family have lost faith in humanity.

6. We have lost faith in medical institutions. We have worked in the NHS for 30 years and are ashamed of the lack of care, accountability and transparency. We have little regard for "independent" inspectorates and state bodies including the Police, His Majesty's Crown Prosecution Service Inspectorate (HMCPSI), Independent Office for Police Conduct (IOPC), the Care Quality Commission (CQC) and NHS England.

7. We have lost our beautiful and brave daughter and know that the events of 13th June 2023 could have been avoided. There is corruption and complacency in these institutions. Our life for the past 2 years has consisted of heartbreak for our loss and abject disappointment. We have had to fight hard to have our voices heard regarding the failings and we do this in Grace's name. She was a beacon of kindness, empathy, resilience, intelligence and full of common sense, attributes that should, but do not exist in our state organisations. As parents, we too are heartbroken forever, as our future happiness is embedded in the happiness of our children. As a doctor, and anaesthetist dealing with life and death situations, Sinead cannot anymore be part of this process and profession with the final moments of Grace in her mind. We as parents, spent almost every weekend since we can remember bringing our children to sporting events. We were blessed with children who were exceptional at sports and academia. Grace played girls county cricket and was an accomplished batter. She won county awards for batting and was voted batter of the season for the u16s Essex girls' team. Alongside cricket she played hockey and represented her country at the u16 & u18 England girls' team. Every weekend was spent taking Grace to a sporting event whether that be training sessions midweek or matches at weekends. We also travelled abroad with her when she played international matches representing the England team. Friends always commented at our absence at social occasions and gatherings because we were always away somewhere in England, staying overnight where Grace would be representing county or country. We very much enjoyed being supportive parents and this was our mission for life.

LEARNING OF GRACE'S DEATH

8. On 13th June 2023, we woke up expecting an ordinary day. Grace was away at university. She had achieved her wish by excelling academically, getting her place at medical college in Nottingham. She had just completed her first year at medical college and was celebrating the end of her exam period. Sanjoy went out to work, and James had a GCSE exam, which Sinead dropped him off for. We both saw reports in the news regarding a suspected terrorist attack in Nottingham. Due to our concern, Sinead posted a message in our family group chat asking Grace to let us know she was safe. When Grace didn't respond, we both tried to call her repeatedly.

9. Sinead was at home with rapidly escalating anxiety. We spoke briefly over the phone and Sanjoy initially thought Grace had probably just overslept. Sinead called the hospital to check whether anyone had been admitted under Grace's name but was not provided with any information. Sinead then called the police helpline number displayed on the TV and gave our details. The advisor took all of her contact details and simply said that they would "*look into it*."

10. Sinead picked James up from school at around 11am, by which point she was in a state of complete panic, having spent the entire morning trying to reach Grace. At around 11:30am, one of Grace's local friends contacted Sinead and said that Grace's university friends were trying to get hold of us. She said that Barney was dead and that Grace had been with him. At this stage, we spoke again, and Sanjoy left immediately and came home from work. We remained in disbelief, particularly because we knew Grace would have had photo identification with her, including her driving licence, and we had not been contacted through any official channel. Shortly after, we received a call from one of Grace's university friends who said they had gone to her accommodation and that she was not there.

11. With no response from the police or the hospital, we were about to drive to Nottingham ourselves. We were standing on the driveway when we received a call from the police suggesting that they would send two officers to our home

but by then, we were in a state of unbearable distress and could not have waited hours for someone to arrive. We decided to drive to Nottingham ourselves.

12. We were given directions to the police station. Sanjoy drove the three of us whilst Sinead had to make the devastating calls to our family and close friends to tell them Grace was almost certainly one of the victims of the attack. The journey was awful; we felt frozen in time, hoping and praying that there had been a mix-up. When we arrived, we met our Family Liaison Officers (FLOs), Detective Constable (DC) Fiona McVey and DC Gillian Cutts, for the first time. Fiona then informed us that, based on the name badge and description we provided, Grace was one of the deceased victims. It is very difficult to recall what happened after that – we were hysterical and in a state of complete shock. We drove all the way back home where we were met by our family.

13. Reflecting on the way we were informed of Grace's death, we have long wondered what could have possibly justified such a significant delay. We knew that Grace always carried her university lanyard with her photo ID and she did indeed have this on her person. She had her phone, which we understand had our phone numbers stored as emergency contacts, and her driving license. On the basis that we now know she died at around 4am, the fact that we were not informed until the afternoon was unacceptable. We were left to sit at home and work, with escalating fear gradually becoming reality, as we received partial information from Grace's distressed friends. When Sinead called the helpline and the hospital to request information and provide our details, no information was provided. We now realise that they must have known exactly who Sinead was and exactly what had happened to our daughter. Despite this, there seemed to be no compassion or attempts to escalate contact with us.

<u>CONTACT WITH THE POLICE AND CPS</u>

14. Over the next couple of days, we were functioning in a state of total disbelief. We travelled back and forth to Nottingham, attending the vigils held in honour of the victims. The first took place on 14th June 2023 and was organised by the University. We were given limited information about the vigil, and we were

informed only at the very last minute. We recall rushing into the car to make the journey all the way back, whilst Sanjoy was left to attend in his work clothes and James, in his school uniform. We had expected some students, but instead, thousands of people gathered to lay flowers and pay their respects. It was there that we met the Webbers for the first time. Kate Meynell (the Chief Constable) was in one of the University rooms where we were asked to go for some refreshments and quiet time. It was here that she stated that the Police would be doing everything for us, that the perpetrator was in custody and that they had "*got him*". She told us that the police were going to charge VC with murder.

15. The second vigil was held on 15th June 2023. We had received no specific invitation by anyone from the council and had been informed by the FLO's that there was a town hall vigil to be held if we wanted to attend at Market Square. It was attended by numerous officials, religious leaders, and Members of Parliament. It was at this vigil that we briefly met the family of Ian Coates. We would like to commend our FLO, DC Fiona McVey, who was very helpful with directions and arranging parking in the city centre for us and our family members. At the Market Square in Nottingham, there were thousands of people gathered to lay flowers and pay their respects. If we had had the time, we would have thanked each person individually for being there and supporting us.

16. During the initial phase of the investigation, all communications consistently indicated that the police were pursuing charges solely related to murder and attempted murder. This was the only outcome conveyed to us, and we were repeatedly informed that the police possessed compelling evidence to support these charges. Due to the fragile state of our mental health at the time, we are unable to recall the precise timeline of interactions with the police. However, our FLOs acted as our primary points of contact from the outset until February 2024. In the immediate aftermath of Grace's death, they too, informed us that VC had been arrested on suspicion of murder.

17. On 15th June 2023, Nottinghamshire Police issued a press statement which was provided to us by Fiona via email [HMCP0000017]. It confirmed that the force had applied to the Magistrates' Court on 14 June 2023 for a further 36

hours to question a man on suspicion of murder. The press statement made reference to an IOPC referral due to marked police having followed the van for a short distance before it had collided with two pedestrians. However, the statement omitted any mention of prior contact between the police and VC, as well as any reference to suspected mental health concerns. We now know that the police would have known about this and the outstanding warrant immediately and as soon as VC was brought into the custody suite, booked in and identified. We now realise that, at the time of the press release, they were not forthcoming with the public or with us. We later came to believe that some of the information contained in the press release was inaccurate, though we had no reason to recognise this at the time. For example, it stated that police detained VC after he abandoned the van and that a taser was deployed as he approached officers with a knife. We understood from images released by the media that VC was in the van at the time of his arrest.

18. A further press release was sent to us on 16th June 2023 [HMCP0000027] which stated that VC had been charged with three counts of murder and attempted murder. The charges were reported locally and nationally by the press. The Chief Constable then said the following publicly: "*these charges are a significant development and arise as a result of our thorough investigation into these horrific incident*s." She acknowledged "t*he deep emotion being felt around these tragic events and the high level of interest, not only in Nottingham, but across the whole country*". However, she continued with a warning that posting prejudicial information online about an active case could amount to contempt of court and in the most serious cases have the potential to cause the collapse of a trial. We considered this to be ironic because the media was our main source of information at the time, having been told that the police's ability to disclose information was limited by the ongoing nature of the investigation.

19. Due to the limited information provided to us by the police we became reliant on the media as our main source of information. We would like to say that information in writing would have been preferable because conversations in the context of our grief are unreliable to recount. We believe it was via the media

that we first became aware that VC had mental health issues and of prior interactions between Nottinghamshire Police and VC.

20. A letter was sent to us electronically by Fiona on 18 June 2023 stating that there was enough evidence to support a murder charge. This was from the CPS [HMCP0000153]. There was then an initial court hearing which we did not attend. After the first hearing, we were provided with an update from our FLO and do not remember a mention of any psychiatric assessment. We were simply told that we needed to await the plea and if a guilty plea was entered then the court would adjourn the case to await the evidence of the probation services and if not, they would adjourn for trial.

21. We would like to add that from the 13th June 2023, Fiona was so supportive. Fiona acted as our victim support throughout until she was removed as our FLO in February 2024. Fiona gave us great advice and was instrumental in helping with the arrangements for Grace's funeral. Fiona assisted with official letters when we had to cancel travel plans as it was of course the summer holidays. She liaised with James' school to assist in protecting him from the media. She informed us of her experience as a FLO. She was kind, empathic and most sensitive. Fiona was always on the end of the phone and was genuinely looking after our best interests. She liaised with our priest and came to know all our family. Fiona attended University of Nottingham halls of residence with us to collect Grace's belongings and helped arrange for Grace's friends to take keepsakes and items for their new house as Grace had plans to share a house in Lenton with some friends the following year. Fiona and Gill brought Grace's belongings including the jewellery she was wearing on that fateful night to our home. At the pre-trial hearing and the hearing in January 2024 Fiona helped with transport and admission to the court. She kept us abreast of media reports that she knew of in order that we be prepared emotionally. Fiona assisted with the facilitation of Grace's friends being admitted to court. We do not know what we would have done without her support. We feel that the CPS and investigating officers are blaming the FLOs for their own poor communication which should have been in writing. The FLOs are not legally trained and were not investigating the murder and attempted murder of the victims. It was not their responsibility.

22. Notification was received by email in February 2024 to inform us as a family that Fiona was removed as our FLO [NGPF0007168 and WITN000002 NGPF0007166]. Sinead was moved to tears, feeling a huge loss of support given the bond that had been built between Fiona and our family. Sanjoy wrote an email to the Chief Constable expressing his utter disappointment at the action of removing Fiona as our FLO. The Chief Constable stated that this was procedural and had to be done.

23. Sanjoy in fact recommended that Fiona be awarded a 'Chief Constable's commendation' for her actions and dealings with us and our family. She had conducted her duty as a FLO and additionally as a family welfare officer in an exemplary manner.

24. On 22nd August 2023, Senior Investigating Officer (SIO) Detective Superintendent (D Supt) Leigh Sanders visited us at home. We asked him about VC's mental health and previous contact with the police, but both were downplayed. FLO logs disclosed by the IOPC record that we asked about the investigation and that D Supt Sanders advised the evidence was strong and "*Not until PTPH will we get an indication of a plea and then he will do work around MH if that is raised as defence – very alive to that possibility. Further discussion re mental health*." We recall that it was during either this visit or another home visit that the SIO told us expressly that VC was going down for murder because there was nothing wrong with him and he admitted to everything he had done. SIO Leigh Sanders conveyed that there was no doubt in his mind about VC's mental health being of any question because of how he was in custody and how he admitted to everything relating to the crime of murder. Leigh Sanders stated time and time again that "he has admitted to us, what he has done". On this basis, we had no reason to believe that VC's mental health was of sufficient severity for it to be relied upon in legal proceedings. The defence of diminished responsibility was never brought up with us and therefore we did not consider or think about this.

25. During this visit, we asked about VC's background, and we were told that he was a "*sofa-surfer type of person*". We found out in December 2023 that he had a tenancy until the point of his eviction by his landlord, who had spoken to him, whilst evicting him on 11th or 12th June 2023 for not paying his rent. We were told that on 12th June 2023, he had visited London to attend a family barbeque and to visit someone from his own country. This was inconsistent with information provided to the Webbers that he was visiting a co-worker.

26. A media article subsequently alerted us to the facts about who he really visited – reportedly a drug dealing, gang member in East London [WITN0289006]. When we read this, we were shocked and realised that the SIO had provided us with a very sanitised version of events. This caused us a huge amount of alarm and immediately our thoughts were directed to whether the SIO had considered drug use over the night of the 12th of June 2023.

27. The FLO log suggests that on 22nd August 2023, we were informed about the outstanding warrant for VC's arrest. We believed that we found out about this much later. As a suggestion going forward all communications should be shared in writing after a meeting to avoid confusion. The takeaway message for us was based on the terminology used by D Supt Sanders that VC "*was bad, not mad*".

28. During our interactions with the IOPC, it was put to us that we told our FLO we were not ready to hear details surrounding the investigation or the circumstances. When we said this, we were referring only to the savagery of the attack itself, and we believe this was made very clear in our communication. The only reason why the SIO visited us was to explain more about the investigation, so there was no justification for the lack of information provided.

29. We first heard about the potential mental health defence ahead of the PTPH. We cannot recall the precise timing of this. FLO logs disclosed by the IOPC indicate that we were informed of the outcome of the defence psychiatrist's report on 3rd October 2023. This is plausible to us, though we cannot be certain.

30. We attended a remote meeting with Sam Shallow CPS, counsel Karim Khalil KC and SIO Leigh Sanders, as well as our FLOs, the Webber family and their FLOs on 24th November 2023. It is notable that this meeting occurred approximately four days before the PTPH and that we were initially invited to attend on the morning of that hearing, which we declined. We were advised that the CPS expected VC to plead not guilty to murder, but guilty to manslaughter by reason of diminished responsibility. Although we cannot recall in intricate detail, the discussions that occurred during that meeting, we both recall that we and the Webbers raised serious concerns about the trajectory of the criminal proceedings, the lack of focus on VC's state of mind at the time and the retrospective assessment of Dr Blackwood which occurred five months after the attacks. On this basis, we vociferously objected to acceptance of the mental health assessment carried out. Sanjoy followed this up in writing on 27th November 2023 [HMCP0000353]. Shortly before Sanjoy sent this email, we received an email from Fiona confirming that the CPS would instruct a fourth psychiatric expert, Dr Latham.

31. Following this meeting and up until the criminal proceedings, we continued to raise concerns, and we attempted to influence a more robust approach from the fourth expert. We were fearful that the report would simply be a peer review, something which we clearly expressed we wanted to avoid. We insisted that the assessment focus on VC's state of mind on the day of offence and that collateral statements from witnesses who encountered VC within the 24 hours of the index offence be obtained.

32. We suggested speaking to the landlord who evicted VC on the 12th, people who he came across on the 12th and 13th, including friends from London was essential. We also emphasized that psychiatrists needed to speak to VC's brother who we understood VC had calmly called after he carried out the initial attacks. We understood that he had told VC not to do anything stupid to which VC had replied that it was "*already done*" and that the brother should prepare to get the parents out of the country. The security guard who VC had quite a long conversation with at Seely Hirst House was another essential witness. We knew that VC did not attack him. We considered that this was an important encounter

as it occurred between the attacks on Grace, Barney and then Ian Coates, almost an hour later. His demeanour in custody was also to be reviewed as he was in a CCTV cell for the 4 days he was in custody.

33. We were advised that the CPS would not accept his pleas because they needed more time to consult with the bereaved victims, to take us through the report of Dr Blackwood, instructed by the CPS and to seek the opinion of a fourth expert.

34. We recall that we were told it would be surprising if Dr Latham, once instructed, didn't reach the same determination as the other psychiatrists, and that in the event that this occurred, the CPS would have to accept VC's plea. It felt like the outcome was already known and that the attempt to engage with us lacked any real substance, as the outcome would not change regardless of how we felt about it. We recall that following the hearing, the press reported widely on VC's mental health. We were concerned about the impact that this would have on a potential jury. It felt clear to us that the police and CPS knew that this was not a consideration they needed to make.

35. We attended two further meetings; the first took place on 7th December 2023 at Avon and Sommerset HQ. We attended with the Webbers and our FLOs. SIO Leigh Sanders, DC Asif Stevens-Garrib and Sam Shallow were also in attendance. The purpose of the meeting was to go through the timeline of events from the evening of 12th June 2023 until the morning of 13th June 2023. At that meeting we, once again, asked Sam Shallow if the 4th psychiatrist should look at the mental state of VC at the time of the offence. Ms Shallow said under no circumstances would the CPS ask such specific questions of an expert witness; this was beyond the scope of the CPS. The Webbers left the meeting early, but we stayed behind and the general gist of Dr Blackwood's report was conveyed to us. We asked for a copy of the report, as to take in all the information verbally was very difficult considering the CCTV timeline we had been presented with. We were told by the CPS that a copy would be made available to us at a later date. We were never provided with a copy (although we understand it has been disclosed to the Inquiry and is now available to us).

36. The second meeting took place on 13th December 2023, via Teams which we attended with the Webbers and our FLOs. The purpose of this meeting was to have the psychiatric reports read to us because our requests for disclosure had been declined.

37. During the first meeting, we raised concerns about the sudden emergence of the defence, expressing that we did not understand how the trajectory of the investigation could change so quickly, given what had been communicated to us throughout. The SIO wanted to take us through the timeline to provide us with more understanding, though the further this progressed, the more concerned we became and the more questions we raised. When the psychiatric reports were read to us, we were equally concerned.

38. We went into those meetings with a multitude of questions but left with many more. Not only did we consider that there was a striking inconsistency between the mental health defence and the reality of the premeditated behaviour observed in the timeline, but we also noted significant flaws in the approach of the psychiatrists. We raised many of these concerns during the meetings and Sanjoy also put these concerns into written correspondence [CPSE0009937, CPSE0009936].

39. From the review of our own records, we note that we sent written correspondence to raise concerns on 1st December 2023 [HMCP0000367], 10th December 2023 [HMCP0000385] and 19th December 2023 [CPSE0000702]. Sanjoy sent a letter to the SIO and to Sam Shallows regarding the content of the timeline as presented to us and the content of and approach to the psychiatric reports.

40. The meeting on 7th December 2023 was extremely lengthy and there was a significant amount of distressing information which we were forced to rapidly internalise. Some of the content was so distressing that Sinead and the Webbers had to leave the room.

41. During the meeting, we realised that we had previously been misinformed about VC's background. We had previously been told that VC was a sofa-surfer, but during this meeting, we were told that he had a tenancy in Nottingham until 12th June 2023 when he was evicted. We felt strongly that insufficient regard had been given to the eviction which would have without doubt, had some impact on VC's mental state. The psychiatrists did not provide any information as to how he processed and responded to this. We had also been informed that VC's friend in London, had trusted him enough to leave him with a key to his home, suggesting to us that he was not displaying any clear signs of psychosis whilst present at his friend's address. Despite this, we understood that face to face interviews had not been conducted with those he had spent time with before his return to Nottingham.

42. We were also informed by police that whilst VC was in London, the reason he left his friend's flat was because he stated that he was threatened/attacked by someone wielding a machete. We were told that VC had stated that this incident was reported to the police via a call to 999. Knowing that all calls to 999 are recorded and can be reviewed, we asked if this had been verified and whether there was a crime number, but the SIO was surprisingly unable to provide an answer. We asked them to revert back to us with clarification, and it was confirmed two days later that no such incident or call was ever reported or recorded. We believe it was our FLOs who informed us of this information via telephone. We now recognise that it would have been more appropriate to notify us of this mistake by the SIO in writing. We were all very surprised that a senior police officer, a detective, had not already checked the veracity of this information provided by VC and simply just accepted the word of a detainee without investigation. The readiness of the officers to blindly accept the account of a murder suspect was deeply troubling for us. This was the case exactly when we questioned the SIO about drug use. He believed the word of a person who had just committed multiple crimes over our requests for drug sampling.

43. It became apparent to us during the presentation of the CCTV timeline that VC displayed no indication of altered mental state or thought disorder. We had observed that VC appeared calm, deliberate, and calculating in his actions,

selecting vulnerable victims. Barney and Grace were barely out of childhood and Ian was an elderly man, who appeared to be frail. We believe that it is therefore significant that VC avoided confrontation with a security guard. Whilst the psychiatrist had suggested impaired judgment, we observed clear, intentional conduct. Again, this prompted us to push for an assessment of VC's mental health which we considered more important than just a mental state examination 5 months down the line.

44. We even tried to explore whether VC profiled our children and Ian Coates; visually, our children and Ian looked like IC1s, whereas the security guard seemed to be IC3/4. For the benefit of clarity, we refer here to identity codes used by the police to visually describe a person's ethnicity. The police gave no thought to this as an avenue to explore, they were shut off to our suggestions.

45. VC's behaviour throughout the timeline was seemingly normal. At St Pancras Station, he bought food, purchased a train ticket and navigated the transportation system without issue. There was no indication of erratic behaviour and there was no record of any of the hundreds of people who he came into contact raising any concerns. He maintained self-control throughout a lengthy train journey and his normalcy continued when he waited for and boarded a tram, interacting with staff and behaving calmly amongst other passengers.

46. We considered it to be an astonishing contradiction that VC headed to Nottingham armed with an organised backpack of weapons. VC had also purchased a knife sharpener long before he committed the atrocities. Prior to the attacks, he rested in a park, hidden away from other people and CCTV. When he reemerged, he had discarded the remainder of his belongings, with the exception of his weapons. He also changed his clothes. The large additional holdall bag he carried with him had been disposed of, never to be found by the police. We were told that he had also withdrawn money from a cash machine.

47. He had clearly gone somewhere to drop off his bag, get changed into boots, put on a different pair of trousers and jumper along with a black hat. It was as if he

got changed and ready for the crimes he was about to commit. We considered that he may have dropped his bag off at a friend's house and got changed there before heading out with his backpack. We wonder whether this is why multiple property raids were held in Nottingham to find where he had left his bag and got changed. We were never to this day informed by the SIO as to why the multiple searches were conducted and who the people were in relation to VC. Once ready, VC then hid in a shadowy area before he selected Grace and Barney as his targets. We raised that these were well considered actions, demonstrating clear and strategic thinking. We were told in response, that it was not the role of the police and CPS to question the expertise of an eminent psychiatrist. As medical professionals, we took issue with the overuse of the term 'eminent doctor' which was continuously repeated. We felt the criminal proceedings had turned into a trial by doctors and we were disappointed in the CPS's unwillingness to scrutinise the evidence.

48. We were told that following the attacks, VC walked away from the scene calmly. He called his brother and warned him to get their family out of the country. This shows a level of insight and awareness that contradicts the notion of clouded judgment. He clearly had sufficient understanding of the difference between right and wrong, and he knew that there would be significant consequences to his actions. His bother asked him if he was going to do something "*stupid*". VC said "*It is already done*" asserting his insight. We had enquired as to whether VC's brother had called the police when he received the phone call from VC as we were keen to find out if a phone call to alert the police could have saved Ian Coates' life, as he was murdered almost an hour after the attacks on our children. We felt a 999 call by his brother may have saved Ian's life. This was never verified by the SIO for us.

49. We were told that VC then tried to gain entry, via a window, into Seely Hirst House, a home for vulnerable adults. However, he retreated following an

interaction with a security guard. We noted that the interaction as seen on the timeline, appeared calm and controlled. VC made no attempt to attack him. We raised that the security guard was not a vulnerable target, as Grace, Barney and Ian were. He could have quite obviously overpowered an elderly man and two youngsters, but the same could not be said in relation to the security guard. We also questioned whether VC had racially profiled his victims, but again, our concerns were dismissed by the SIO.

50. Shortly after he murdered Ian, VC stole his van and drove away calmly, slowing down for speed bumps and stopping at traffic lights, until he deliberately targeted his remaining victims with calculated precision. He manoeuvred onto pavements and islands with the intention to cause maximum harm.

51. We were concerned to learn whether following his arrest, a mental health assessment was or was not conducted whilst VC was in custody. This is something we explored with the SIO and the CPS in both the November and December 2023 meetings. We were told that they had no concerns about VC's mental health until the matter was raised by the defence. It seemed unusual to us that despite coming into contact with multiple police officers, solicitors and nursing staff, it appeared that no concerns were raised about his mental state whilst he was in custody. It was subsequently confirmed via an email sent to the Webbers on 19th January 2024 [NGPF0002572], that he was seen by a nurse and a paramedic, but no arrangement was made for him to have a formal mental health assessment. This only reinforced our existing concerns as we considered that a health professional would have ensured such an assessment was carried out if VC had been suffering with a severe psychotic episode.

52. VC was not only deemed fit to be detained, but his period of detention was extended to four days. He was also deemed to be fit to be interviewed and had clearly had the benefit of legal advice to consistently provide no comment. Sanjoy highlighted that in the 4 days of detention at the police station, VC would have come across three shifts of different officers, custody officers, gaolers and senior officers who would have had to attend to him face-to-face to explain that his detention was being extended. It appeared to us that no-one, not a single

officer, had stated that they were concerned about VC's mental health in a way which would justify a formal mental health assessment. This was unprecedented as so many officers came into contact with him, provided him food and drink, had to interact with him to extend his detention that someone would have noticed something if his mental health was at all a concern.

53. Similarly, we asked whether interview footage and CCTV observations of VC whilst in custody, had been sent to the experts. We were told that the interview was audio recorded only. We were then informed by the Webbers that they subsequently received an email from their FLO, advising that it was in fact, video recorded. The SIO did not seem to know whether VC had been under CCTV observations whilst in custody, something which we felt he ought to have known as the SIO responsible for the investigation. It was later confirmed to us by the custody log disclosed by the IOPC that he had been under such observations.

54. It was during the 7th December 2023 meeting that Sanjoy asked whether VC had drugs in his backpack and the SIO did not know the answer to this. He said he would check and revert back to us. We were seriously concerned that the SIO of an investigation involving multiple homicides did not know the answer to such a basic question. It was also confirmed that a blood sample was not taken due to VC's refusal to consent. The SIO did not seem to know whether a full cache of non-intimate samples had been taken. Sanjoy raised that these aspects of the investigation should have formed part of the SIO's basic knowledge, available at his fingertips to provide to the families. Sanjoy raised during the meeting that hair root and strand testing was essential to understanding whether there was any relevant drug use and that it remained an available option ahead of the criminal proceedings. However, we recall being told by the SIO that this was not going to be his line of enquiry as there was no previous evidence or arrests with regards to drug use. He also said that the expert had asked VC whether he was a drug user and that VC had told him he was not. Implicit in this was a suggestion that we ought to be reassured by the words of a man guilty of multiple homicides.

55. The position regarding toxicology only became increasingly concerning during subsequent email exchanges. We received an email from our FLO on 16th January 2024 [HMCP0000454], which confirmed that neither hair strand nor nail clipping samples were taken from VC. Sanjoy had written again to the Chief Constable to ask if the nail clippings could be sent for drug testing, to our surprise even the Chief Constable did not know which samples were taken from VC. After a few days we received the information from the Chief Constable that only nail scrapings were taken and not nail clippings [NGPF0007583 and WITN0312002].

56. We were concerned that the potential drug use of VC had not been adequately explored by the investigation team. Sanjoy raised concerns about this in an email to the SIO dated 16th January 2024. The SIO responded on 17th January 2024, that "*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*" [HMCP0000454]. He failed to provide any further detail in relation to the independent review, and he further failed to elaborate on how exactly he believed this to have been tested by legal teams or the judicial process, something which was not possible in the absence of samples.

57. In response to our suggestion of hair strand sampling, he stated he was aware of what could be done. He refused because of the limited use and unreliability of hair strand testing and because there were no grounds to suspect that VC had ever taken drugs. We were perplexed, given that he had considered there to be reasonable grounds to request intimate samples whilst VC was in custody. The approach was at best lethargic and at worst, incompetent. He said he was "*completely content*" with his forensic strategy which had followed local and national advice. He then tried to patronise us, referring to his strategy as "*self-explanatory*". He went onto suggest that there had been a "*complete absence of any inference as to drug taking*". It was incomprehensible to us that he was maintaining that toxicology was unnecessary when it had clearly been a part of

his initial forensic strategy. From Sanjoy's experience, there was simply no justification for the lack of non-intimate samples, given that the police did not require consent. We were then told that we were not to make contact with him again and that all future correspondence should be sent via our FLOs.

58. We expressed concerns regarding the substantial delay in Dr Blackwood's assessment of VC. We knew that he had not been assessed for a significant period following the attacks. It was subsequently confirmed via email that Dr Blackwood had not assessed him until 14th November 2023, five months after the attacks [NGPF0002572]. Despite his assessment with the defence psychiatrist taking place on 4th July 2023, he remained remanded in a prison setting until 1st November 2023, and he remained un-medicated until mid-September 2023. This was incomprehensible to us, given the severity of diagnosis alleged.

59. Key witnesses, particularly the security guard, his brother and his friends in London, were not interviewed by the psychiatrists. We remain unaware of the position in relation to VC's friends and we have subsequently been informed that the security guard was interviewed, but only by police officers who are not medically qualified. As a result, we feel strongly that insufficient regard was given to the significance of these accounts - the only accounts capable of providing vital insight into his mental state at the time of the attacks. In our view, there should have been a more robust approach, given that relying solely on police interviews and statements was not sufficient in a case of this gravity. This was questioned by Sanjoy and in a letter to the CPS. A response from Dr Blackwood was received [HMCP0000405]. He stated that taking a collateral history from people the perpetrator came across within 24 hours of the index offence was not his usual practice and he will not be revisiting this as per our suggestion.

60. An even bigger disappointment was that even though we specified to Samantha Shallow (CPS) that we were not going to accept this assessment and that we wanted a contemporaneous time assessment, Ms Shallow did not respect our request. We felt that she was dismissive of our concerns both in discussions

with us and in the way she relayed them to the psychiatrists. She asked Dr Latham to carry out a peer review when she had already stated she would consider it surprising if he was to reach a different opinion from Dr Blackwood.

61. We made it very clear that we were very unhappy with this situation and had not asked for a peer review but a fresh set of eyes on VC's state of mind based on what was known about his presentation at the time of the index offence. This was never procured by the CPS for us and left us in a very unsatisfactory state of mind.

62. The repeated use of the word *"likely"* throughout the reports felt speculative and lacked the certainty we needed to accept that VC had a defence available to him. We highlighted that a diagnosis made months after his crimes, was not sufficient to justify his actions on the day. It is of particular concern to us that the experts had a significant focus on culpability. As medical professionals, we know that this is not the role of a doctor, it is the role of the court. Dr Blackwood's report felt more like he was directing the Judge, rather than providing an opinion. A large proportion of the report focused on the proposed treatment regime in hospital. Dr Blackwood stated that VC was treatment resistant and would need a hospital type setting to administer and monitor Clozapine, the drug of choice for treatment resistance. He stated that this is why a hospital order would be appropriate. In our experience there are National Institute of Clinical Excellence (NICE) guidelines that define treatment resistant Schizophrenia and VC's condition did not fill this definition. VC simply did not adhere to his treatment regime and he became violent on multiple occasions as a result, resulting in his sectioning under the Mental Health Act. This was further proven because when he was sectioned and forced to take his treatment his symptoms improved. Despite acknowledging that VC knew right from wrong, the need for a punitive element was not reflected in the recommendations of the report.

63. It stood out to us that VC was described as an intelligent man, who was a graduate in engineering, and we feared he had manipulated the psychiatric process. We noticed that he appeared to use clinical terminology fluently, for example, terms like "*thought insertion*" and "*persecutory thoughts*", yet he

presented himself in a way that suited his own self-serving narrative. It has subsequently been evidenced that he had a history of manipulation and was disingenuous with his medical team. He was able to obfuscate and manipulate his symptoms as an outpatient to be non-adherent to his treatment by choice. He had had immunisations but chose to refuse injectable treatment, citing a dislike for needles; for schizophrenia which would have controlled his symptoms more effectively.

64. When Dr Latham's Report was read to us, we felt that there was a failure to challenge or expand upon Dr Blackwood's report. There was an evident missed opportunity to uncover the truth. The report was simply a peer review which added nothing other than endorsement of the findings of the previous expert. It did not provide new insights or address the gaps in previous reports. Instead, it reinforced existing narratives without critical evaluation. This approach did not serve justice for our daughter or offer us the reassurance we needed. We had specifically requested a fresh set of eyes and a concentration on 'state of mind' on the day of the index offence. We categorically stated that the report should **not** be a peer review, and this is exactly what Dr Latham provided. We asked that he speak to witnesses and review CCTV footage to assess VC's mental state at the time of the offence, but this did not materialise in practice. He too, continuously used the word 'likely' throughout the report. The overreliance on historical diagnosis, at the expense of scrutiny of his state of mind at the time, meant that robust conclusions were impossible to draw.

65. We had a further meeting on 15th January 2024 with Karim Khalil KC, Peter Radcliffe, Alan Murphy, Sam Shallows, Leigh Sanders, our FLOs, the Webbers and their FLOs. We raised our concerns once again, to no avail. We were given an overview of what to expect from the court process and of the available sentencing options. Throughout the meetings and the proceedings, we considered Mr Khalil KC to be rude, dismissive, sarcastic, condescending and patronising. When Sinead asked specifically if the mental health of VC at time of offence would be examined, he said "*well that's what we are here for, THAT'S WHAT THEY DO!*" Sanjoy recalls feeling enraged. This was witnessed by our FLO, Fiona, in court and we remember that she was also taken aback by Karim

Khalil KC's level of rudeness and dismissiveness towards Sinead. At the most difficult time of our lives, not only did he lack compassion and a willingness to address our concerns, but he also displayed a total lack of respect for Sinead, a senior clinician. The FLOs in the room were very surprised at his conduct and commented that he did not have the best "*bedside manner*". Retrospectively, we should have registered a formal complaint against Karim Khalil KC for his rudeness and the dismissive way in which he treated families of victims. His actions would have been corroborated by the FLOs present at the time.

66. The court proceedings were extremely difficult. There was no one there to represent our interests and the focus on sentencing seemed to focus far more on the public and the potential rehabilitation of VC than it did on justice for our beloved daughter, Barney and Ian.

67. Fiona was supportive and helpful in securing space for our friends, family and Grace's friends and teammates to be accommodated in the court room. It was during the early stages of the hearings, that we also heard rumours regarding misconduct hearings for servicing police officers in Nottingham relating to social messaging offences.

68. We had to endure the evidence and questioning of three expert witnesses: Dr Blackwood, Dr Mirvis and Dr Mc Sweeney. We found Dr Blackwood's evidence to be particularly distressing. Whilst he had a predominant focus on culpability, something which we knew to be outside of his remit, he maintained that recommending a punitive element within the sentence was not. Whilst the CPS argued for a Hybrid Order, arguments surrounding premeditation seemed to be dismissed as a symptom of VC's illness. Even the historical purchase of a knife, a knife sharpener, his planning of the attack and his getting changed just prior to it seemed to be dismissed. There was acknowledgment that he knew right from wrong and had the intention to kill, but it was stated that psychosis prevailed at the time of the attacks. This was difficult to accept from someone who knew nothing about VC until several months after the attacks.

69. Throughout the proceedings, there were repeated references to VC's failure to adhere to his medication regime. There was reference to him stockpiling medication in his home. Instead of reflecting this in his retained level of responsibility, it was simply deemed symptomatic of his illness. It was only via the later disclosure of the Nottinghamshire Healthcare NHS Foundation Trust (the Trust) Serious Incident (SI) Review and the NHS England Review that we learnt that VC's expressed reasons for declining injectable medications were that he did not like needles and his desire to study. We questioned then at that later stage that he must have had his immunisations, a BCG immunization, childhood immunizations, school leaving immunizations, as required by university admission departments and travel vaccines. We do not recall that this was ever mentioned in court.

70. We had asked to see the letters of instruction provided to experts and particularly, Dr Latham and it was subsequently confirmed that material available by means to conduct his review included the police case summary, counsel's brief case summary and also prosecution evidence which included the CCTV compilation including the majority of the offending and a sequence of events charts that contain the timeline, the relevant movements and activity. In addition, we were told the expert was provided all disclosed unused material which includes custody records, a summary of the health care records while in custody, extensive disclosure of police reports relating to material obtained from a download of the defendant's mobile including messages he sent to his brother the night before the attacks [HMCP0000367]. We didn't feel that the instructions provided effectively conveyed our concerns. In essence, these instructions were that any material Dr Latham feels is appropriate to assist with his instruction will be provided. Of great concern to us was the fact that there was no express reference in the instructions to complete medical records being provided, even though the SIO confirmed with us that the full medical records were provided to the experts.

71. All professionals present within the court seemed to blindly accept the notion that VC's condition was "*treatment resistant*". It was stated throughout as an uncontested fact, and we believe this was the result of the expert assessments.

We had doubts about this at the time, given the continuous references to non-compliance made throughout the court hearings. However, when we received the NHS related investigation reports, it became abundantly clear to us that the evidence in support of treatment resistant schizophrenia was lacking. We had always made our feelings clear and challenged Karim Khalil KC on this, but we believe he never searchingly questioned the experts on accuracy of diagnosis, nor did he concertedly relay our challenges in Court. His questioning was neither effective nor was it to our satisfaction.

72. As medical professionals, we understand that in order to be considered treatment resistant, a patient must be prescribed two anti-psychotic drugs from different groups for a period of four to six weeks, without remission in symptoms along with other criteria that was not filled by VC. We have scrutinised all reports received and cannot see that it could be possible for this to have occurred, given that we know the extent of his non-compliance in a community setting. Indeed, the longest period that VC was hospitalised for was for 6 weeks, during which, he commenced Haloperidol and was then transitioned to Aripiprazole midway through this stay. It is also noteworthy that on one of the sectioning events, due to VC's violent uncooperative behaviour that Haloperidol was administered by injection by the admitting consultants and ward staff and this was done by force when VC was admitted under section 3 of the Mental Health Act.

73. We gained further understanding as a result of the comments of VC's brother during the Panorama documentary. He said that he feels there has been such a significant improvement in VC's symptoms since medication commenced, that he now feels he has got his brother back. On this basis, it remains integral to us to understand what the experts had sight of and to what extent they considered it.

74. We understand that the Judge considered VC's treatment resistance as a major part of his decision on sentencing, noting that his diagnosis of treatment resistant schizophrenia meant he would likely never be released. It is now essential for us to understand how such a decision could be reached on a basis that appears to us to be unproven.

75. We were also deeply disappointed regarding the insufficient consideration of VC's potential drug use during the hearings. Although it was briefly mentioned that VC had refused to provide toxicology samples by the CPS, the focus on why he had done so was lacking; for us, that was self-explanatory. The lack of history of drug use was referenced in support of VC's limited culpability. This was insulting to us as his drug use had never been ascertained. We were so concerned about this that Sanjoy emailed the SIO on 28th January 2024 to inform him that all evidence should be preserved even if considered minor.

76. We received a letter from the Chief Constable on 29th January 2024 inviting us to meet with her [NGPF0007175]. Sanjoy replied on our behalf to accept that invitation, highlighting that we had serious concerns about the investigation and requesting to be put in contact with the IOPC. Sanjoy also expressed concern in relation to (Assistant Chief Constable) ACC Griffin's public comments. Following the attacks, he had said that there was nothing more the Force could have done to prevent the attacks. Once the warrant was referred to in court, he changed his stance, acknowledging missed opportunities, but maintaining that it would unlikely have changed the outcome. This comment was insulting and patronising coming from the second most senior officer of the Nottinghamshire constabulary.

77. On 30th January 2024, we received a further email confirming that Nottinghamshire Police had referred itself to the IOPC, something which the Chief Constable described as a 'pro-active step'. However, it was subsequently confirmed that this referral was limited in scope and involved only prior contact. Sanjoy had to reiterate that flaws in the investigation following the attacks needed to be addressed. On 6th February 2024, the Chief Constable confirmed that a further complaint had been recorded about this. We made the decision, together with the Webbers, that we would not meet with the Chief Constable until after the conclusion of the investigations. We made further requests for disclosure, but the Chief Constable refused them. It felt to us like this was because we had complained to the IOPC. By this point, we had lost confidence in the Chief Constable, causing Sanjoy to make a separate online submission

to the IOPC, to ensure that all matters including the totality of the investigation and not just police conduct complained about were referred to them.

78. On 7th February 2024, we received a further letter from the Chief Constable to inform us that our FLOs would be replaced by DC Cumberbatch. We expressed our disappointment that Fiona would no longer be our FLO as she had been a helpful source of comfort to us at such a difficult time. As we referred to above, Sinead was brought to tears when we received this news due to the support that Fiona had provided.

79. On 22nd February 2024, we were informed by Emma Webber that the Chief Constable was planning to hold a non-reportable media briefing. We understand that Emma had been alerted to this by one of her contacts in the media, who had been asked to sign to agree that the content would not be disclosed to the public. If we hadn't found out in this way, the Force would not have informed us it was occurring. Following the briefing, we learnt of new information surrounding previous allegations of stalking made against VC. We were advised that it was unprecedented in the circumstances that they could be asked to sign a non-disclosure agreement, given that the criminal proceedings had concluded.

80. We were subsequently informed by the press that the Force had made a complaint to IPSO regarding the Nottingham Post's disclosure of information following that briefing. We feel strongly that this was yet a further attempt from the Force to conceal issues from the public and from us as families. When this was identified, they chose not to take responsibility, but instead to berate another organisation for doing the right thing.

<u>REFLECTIONS ON OUR CONTACT WITH THE POLICE AND CPS</u>

81. As professionals, and particularly given Sanjoy's experience as an FME, we believed we could make a meaningful contribution to the case. However, our perspectives were neither acknowledged nor respected. Demonstrated by the

lengthy letters of concern sent to the police and CPS all the way through the investigation and case handling.

82. We are deeply concerned about the lack of compassion and clarity demonstrated by the SIO. Sanjoy recalls being told by the SIO that he should be proud of Grace's heroic actions in her prolonged fight with VC and for not running away, for intervening, and for putting up a fight against VC. This comment was profoundly offensive and grossly insensitive.

83. The SIO also described the attacks as a "*sliding doors moment*", suggesting that Grace and Barney were simply in the wrong place at the wrong time. This, too, was deeply hurtful, especially in light of the institutional failures that were known at the time. These deaths were not random or coincidental; they were the result of repeated and serious systemic failings. In our eyes, this attack was preventable.

84. In circumstances where young lives have been lost, such remarks are not only insensitive but also dismissive of the gravity of the situation. Grace and Barney should have been able to walk the streets safely, free from the threat posed by someone who should never have been at liberty due to the risks he presented.

INTERACTIONS WITH OTHER ORGANISATIONS

Police and Crime Commissioner

85. When we first made contact with the PCC, Caroline Henry, we raised a number of serious concerns [WITN0312003]. These included her failure to keep us informed about key developments, the disciplinary proceedings related to data breaches within Nottinghamshire Police, the referral of the case to the Court of Appeal, and the status of the HMCPSI investigation.

86. We consider that the PCC must have been fully aware that we were deeply concerned about misconduct, systemic failings, and missed opportunities to prevent the deaths of our loved ones. Despite this, she chose to refer the matter to the College of Policing, a body without statutory powers to investigate or enforce accountability, rather than to the IOPC. This decision signalled to us that

the referral was intended as a learning exercise, not a route to justice or accountability.

87. When we met with the PCC, we were dismayed to discover that she had limited knowledge of our case. More concerning still, she admitted that the case was not even a regular item on the agenda of her meetings with the Chief Constable. This lack of oversight and engagement is unacceptable given the gravity of the issues at hand. The more we engaged with the PCC, the more we realised that we had no confidence in her ability to hold Nottinghamshire Police to account or to act impartially in the interests of justice. Her actions, or lack thereof, have been profoundly disappointing and have failed to meet the standards expected of her office. Our engagement with PCC Gary Godden has been much more constructive. He has taken our complaints seriously. He is the opposite to Caroline Henry from our perspective. We recently requested that a charge of corporate manslaughter be considered in relation to the Trust. PCC Godden referred this matter to Northamptonshire Police for investigation.

HMCPSI

88. We also raised concerns in relation to HMCPSI. During our initial meeting with them on 9th February 2024, we shared our concerns in full including our request for scrutiny of the input and direction by the CPS with the investigating team at the early stages of the investigation. We were given strong assurances that the review would be thorough and impartial. However, by the time we reconvened on 25th March 2024, it was evident that the process had not lived up to the promises made. Prior to the meeting, we were informed that the report would be published at midday and given less than one hour to digest and discuss the findings and recommendations. This was not a genuine attempt to engage with us meaningfully, but rather a procedural gesture that left us disadvantaged. To compound matters, the media had already been briefed, leaving us unprepared and unable to respond effectively. What was promised as a robust investigation ultimately resembled a bureaucratic exercise, one that failed to deliver truth, accountability, or meaningful change.

89. Following our review of the HMCPSI report, we remained deeply concerned about the adequacy and integrity of the investigation into the CPS's handling of the case. Whilst the report acknowledged the existence of psychiatric evaluations and procedural steps taken, it failed to address the core issues raised by the families and instead reinforced a narrative that appears to rely heavily on retrospective assumptions and unchallenged expert opinion. The review failed to address the disproportionate weight given to the expert evidence and the lack of consideration of the state of mind of VC at the time of the attacks. The lack of toxicology sampling was not sufficiently addressed but simply taken at face value with no scrutiny referencing the email provided by the SIO. The previous interactions between the CPS and the police in relation to VC were also inadequately addressed. The report did not reflect a rigorous or impartial investigation. The concerns raised by the families remain unresolved, and the process has left us with more questions than answers.

90. Sanjoy drafted a letter [WITN0312004], with a list of questions and considerations on behalf of the families, outlining our serious concerns and the many unresolved questions that remained. This letter was copied to Ministers in office at the time, including Laura Farris (Minister for Victims), Victoria Prentis (Attorney General), and Emily Thornberry (Shadow Attorney General). Despite the gravity of the issues raised, HMCPSI have failed to provide a response to date.

<u>IOPC</u>

91. We have submitted a formal complaint regarding the conduct of IOPC staff during the Operation Penhallow investigation. From the outset, the process has been deeply flawed and distressing for us and the other families. It is notable that we were not properly informed and consulted on the Terms of Reference and we did not understand the full nature and scope of the allegations before the process began.

92. We received the report and determinations in November 2024. Upon reviewing it, we were alarmed by both its content and its conclusions. The report revealed

significant failures and missed opportunities to intervene in the month leading up to the tragic events of 13th June 2023. Yet, the report stated that officers were not responsible and nor could the attacks have been prevented by any intervention. The IOPC cannot determine this with certainty.

93. The investigation was clearly riddled with evidential gaps. The report was not provided with the accompanying disclosure, and we hoped that this would relieve our concerns, but once we received this, it only elevated our concerns. For example, it was alleged that Officer A had failed to conduct intelligence checks. The IOPC accepted this at face value, despite Officer A's own account stating: "*I had to ask my tutor for help in how to add the suspect's details to NICHE, what classification to record him as. I believe that when I did this, I had a look at some of the previous investigations linked to him.*" This contradiction was not probed further during interview. Even more troubling was the IOPC's conclusion that it was "*speculative*" whether checking the PNC would have changed the outcome, despite the existence of an outstanding warrant for VC's arrest. We believe that this conclusion was entirely unreasonable as it is inevitable that some form of intervention would have occurred had officers acted appropriately. Officers had failed to follow up with a recruitment consultant who had relevant information about further contact with VC. Officers had also failed to search VC's locker. It seemed to us that the IOPC had not taken this into account.

94. Other serious matters remained unexplored at the conclusion of the investigation. A witness stated that VC had reached for a knife at the scene, yet officers failed to record this. They later contradicted themselves, claiming they were not told about the knife whilst also stating that they considered that as the witness was not an eye witness her account could not be relied upon. This matter had not been addressed during interview and had been dealt with in an email exchange. There were also inconsistencies in officers' accounts regarding who used BWV to record CCTV and witness statements. This matter remained to be determined at the conclusion of the investigation. We are concerned that the issue of Body worn Video and how it was saved (or ought to have been saved), including to any central server automatic back-up, has not been yet

effectively explored by the IOPC. Logs also suggested that officers were considering arrest, yet officers had subsequently claimed that they needed witness statements prior to arrest. Despite these contradictions, the report and determinations were made on the basis of officers showing "*reflectiveness, remorse, and a willingness to learn*."

95. The tone of the IOPC interviews was wholly inappropriate. At the end of Officer A's interview under caution, the interviewer remarked, *"Wasn't too painful, was it?"* Officer A was also congratulated on passing her exams. This was deeply upsetting for us, and we considered it to be unprofessional, coming from a professional investigator conducting an investigation into possible misconduct and poor practice by police officers, which if found, would render the subject implicated in three deaths.

96. We repeatedly raised these concerns via our legal team. We pleaded with the IOPC to account for investigative gaps and provide assurance that our concerns had been considered. Unfortunately, we were met with only dismissal from the decision maker, Derrick Campbell, who repeatedly downplayed the seriousness of the officers' conduct. In his letter dated 24th January 2025, he claimed the IOPC had "*objectively*" applied its tests, despite overwhelming evidence of investigative failings. He apologised only for the actions of VC and failed to acknowledge any of the concerns raised in relation to the conduct of the officers and his organisation. He went onto state that "*whilst there may have been missed opportunities within Leicestershire's investigation, there is no way of knowing whether the tragic events on 13th June 2023 could have been avoided*." We felt totally the opposite to this as we continue to believe that the smallest change in VC's course would have deviated him away from our children.

97. Throughout the correspondence, he repeatedly attempted to dismiss our concerns in relation to intelligence checks. He continued to reiterate that the officers would face a misconduct meeting for failing to check the PNC, but it was evident that the IOPC did not consider whether checks were completed on the Niche or Genie systems. They repeatedly deferred to there being a decision to

refer the officers to a misconduct meeting, despite severity assessments already being completed on the basis of the flawed investigation, ruling out any more serious misconduct hearing. We were concerned that the gravity of the situation could not be properly addressed in a misconduct meeting rather than a hearing.

98. Our legal team had to push for further audits, which were only provided at the last minute. These audits revealed that the IOPC could not be certain whether Officer A had reviewed some of the linked investigations, undermining the basis of their earlier conclusions. The misconduct proceedings were adjourned only as a result of a decision of the Chair of those proceedings and following the expression of our very significant concerns regarding the vast gaps in the information available to us and the other families. We were notified of the adjournment only one day prior to the scheduled meeting.

99. On 7th March 2025, we received a letter stating that the IOPC had decided to reopen the investigation, citing "*new information*" that could have led to different decisions [WITN0312005]. This was deeply insulting. We had spent months highlighting these very issues, only to be ignored and told there was new information, when in fact, the IOPC investigation was inherently flawed in their investigation and conduct.

100. We have recently received notification that the subject officers involved in the investigation have made a complaint against IOPC staff. It is now being alleged that IOPC investigators told these officers that the investigation was not related to the events of 13th June 2023 but was instead politically motivated and driven by us and the other families. It is further claimed that officers were advised the interview process would be concluded within weeks, and that the likely outcome would be reflective practice. These revelations have only reinforced our longstanding concerns that the IOPC failed to take our complaints seriously from the outset and throughout their investigation process. This is something we consider to be profoundly disrespectful to our daughter, to Barney and to Ian. We are alarmed at the evidence of inherent bias and lack of independence present within the investigation which has only confirmed our belief that the

institution itself is institutionally corrupt and not fit for purpose. There was a predetermined outcome.

NHS

101. We also raised serious concerns regarding the conduct of the NHS Trust during its internal investigation process. Initial contact from the Trust was not made until December 2023, six months after the death of our daughter. Despite the investigation having already commenced, we were neither informed nor consulted on the Terms of Reference. It has now been confirmed that this was the result of Nottinghamshire Police delaying the commencement of the investigation and advising the Trust that they should not engage with those involved. It is our position that the Trust should have done more to push back on this, something which the Senior Leadership Team have acknowledged.

102. On 21st May 2024, the Trust confirmed that its review had been completed and that a detailed summary was being prepared for the families. However, there was a significant delay in providing this, and our legal team had to intervene to prompt its release. The summary report we eventually received was wholly inadequate. It failed to reflect the gravity of the matter it was intended to investigate and contained more omissions than substantive findings. There was an absence of crucial clinical detail to enable us to understand the true extent of the alleged or possible wrongdoing of the Trust. We were not provided with a timeline of events, records of appointments attended or missed, actions taken or not taken by the CPNs, or the rationale behind discharge decisions.

103. We met with the Trust, their legal representatives, and our legal team on 6th August 2024 and we obtained the full report. Whilst this provided more detail, the clinicians and care workers involved in VC's treatment were not identified, and their identities and actions continued to remain unknown to us at this time (although we understand they are being disclosed to the Inquiry and to us through that process). The outcome of the review is similarly unclear, and we have not been informed whether any disciplinary action will be taken.

104. None of the professionals or staff members who failed us were identified in any of the reports. As families, we remained in the dark about whether one individual failed us repeatedly, or whether multiple professionals failed us at different stages. We request that all teams and staff members be clearly identified. This continued obfuscation must end immediately. Even after we submitted further questions to the Trust, evasive answers were frequent and relied on the subsequent completion of the NHS England Report to answer our questions, which it has not.

105. Sanjoy wrote to Ifti Majid to ask further questions. On 2nd June 2025, we received a response stating that it was not appropriate to answer our questions due to the commencement of the Inquiry. We have formally requested that charges of corporate manslaughter be considered against the Trust. This request stems from our deep concern over the level of incompetence and systemic failure we have witnessed throughout this process. We feel that with the findings of the CQC along with our own highlighted findings that the Nottingham Trust is an organisation guilty of serious management failure and a gross breach of duty in the way its activities were organised resulting in the deaths of Grace, Barnaby and Ian.

106. Sanjoy has raised further concerns on behalf of the families regarding the NHS England Independent Homicide Investigation, specifically in relation to the commissioning of Themis Consulting, the quality and integrity of the investigation, the findings presented, and the transparency of the organisations involved. Sanjoy, on behalf of the families, wrote to Claire Murdoch (National Mental Health Director) and Dr Jessica Sokolov (Regional Medical Director) to formally raise these concerns.

107. During early meetings with NHS England, we were once again, assured of a robust investigation. However, the published report fell significantly short of these assurances. It lacked detail, left critical questions unanswered, and failed to deliver the transparency that had been promised.

108. Whilst each report gave us partial knowledge of the failings, as victims, we feel we should have been provided with full disclosure of the circumstances which resulted in the loss of our daughter.

109. It is particularly relevant that we had to exercise persistence in pushing for the report to be released to the public. Once again, the confidentiality of our daughter's killer was cited as a justification for concealing these failings from the public. It took significant efforts from all bereaved families, our legal representatives and wider support teams and it was only when the Secretary of State for Health and Social Care, Wes Streeting intervened, that NHS England made the last-minute decision to publish the full report.

110. Since, we have been concerned about the process by which Theemis Consulting (since wound up) were commissioned to conduct the review, the experience of the reviewers and the process followed during the review. When we found out that Theemis Consulting would be conducting the review, Sanjoy was unable to find many examples of serious case reviews they had previously conducted.

111. In the CQC report, Chris Dzitiki (Executive Director of Operations) had previously stated that NHS England would conduct a broader review of Valdo Calocane's interactions with mental health services, which might identify further failings. However, the NHS England report did not identify any individuals or hold anyone accountable, directly contradicting the expectations set. The report fails to clarify whether VC had a single Responsible Clinician overseeing his care or multiple clinicians across different settings. It does not specify whether these clinicians changed between community care and hospital settings, or whether one was appointed throughout. There is no clear background provided as to VC's mental health history prior to 2020. The report also fails to adequately address multi-agency interactions, particularly with the police, during each sectioning event. It does not comprehensively explain what health professionals were considering during treatment or whether they reviewed previous clinical notes.

112. Withholding such critical information is unacceptable. These failures directly contributed to VC becoming a non-compliant, unmonitored patient who went on to murder Grace. Her death was preventable, and we have a right to understand the systemic failings involved. The response we received from NHS England was evasive and failed to address the majority of our concerns. Instead, they cited the ongoing Inquiry as the mechanism through which answers would be provided. This deflection is deeply frustrating and undermines the purpose of the report.

113. NHS England states that it may commission independent investigations into serious incidents, including mental health homicides, with the aim of preventing recurrence through learning. However, the reports we have reviewed are often superficial, filled with generic "*cut and paste*" learning points, and devoid of meaningful accountability.

114. This approach is not only ineffective but also insulting to the families of victims who only desire the truth. The continued recurrence of such tragedies is a damning reflection on the inefficacy of these investigations. NHS England must reassess the purpose and impact of its commissioned reports. If independent investigations uncover failings in clinical standards or systems, it is the responsibility of both the Trust and NHS England, as commissioners, to refer these matters to the appropriate regulators, such as the GMC or CQC.

115. We remain in the dark as to the disciplinary action taken by the Trust. We met with the Secretary of State for Health and Social Care, Wes Streeting on 9th June 2025 to discuss this matter after repeated failed attempts to engage with the Trust and NHS England. We remain deeply concerned that there appear to have been no referrals to any regulators made arising from the findings of the Trust Review, the work of the CQC and the Theemis NHS England Report. Whilst we are aware that such considerations are ongoing, we know that referrals to the GMC and NMC remain limited at this time. More concerningly, we have no information about exactly who and what action this relates to.

DATA BREACHES

116. Since the conclusion of the criminal proceedings, we have had to come to terms with a multitude of data breaches occurring across a number of organisations; Nottinghamshire Police, Nottingham Council, His Majesty's Courts and Tribunal Service (HMCTS), His Majesty's Prisons and Probation Service (HMPSS) and Nottingham. Each and every one of these breaches has only added to our anguish and we have been sickened at the desire of professionals to breach our daughter's privacy in such a grossly inappropriate way.

117. The first breach we became aware of related to a WhatsApp group consisting of a number of officers from Nottinghamshire Police. We became aware that a message exchange had occurred within that group in the immediate aftermath of our daughter's death. Not only was sensitive information in relation to the investigation shared, but vulgar and derogatory comments were made about both Grace and Barney. We remain horrified at the officers involved and have suffered immeasurable pain as a result of their conduct and emotional indifference.

118. Our pain was exacerbated further due to the disrespect displayed towards us in the Force's handling of the breaches. We were not directly informed of the data breaches by Nottinghamshire Police. It was the Nottingham Post who first picked up on a small press release which followed the concluded misconduct proceedings. Emma Webber received a message via social media, from a person present at the misconduct proceedings. At around the same time, we also read a news article reporting that an officer had been dismissed for gross misconduct. Whilst we cannot now recall which of these came first, we are certain that this occurred either during the criminal proceedings or shortly thereafter.

119. We later learned that the misconduct proceedings were initially scheduled for March 2024 but were brought forward to coincide with the sentencing hearing. Although we cannot recall the precise timings, we are absolutely certain that we

were not informed of these hearings before they had concluded, nor were we invited to attend.

120. We were particularly alarmed to learn that the Chief Constable's son was allegedly a member of the WhatsApp group. We seem to recall that this information came from Emma's contact on social media. If this is accurate, it raises serious concerns about the Chief Constable's handling of the matter. Given her senior position, we believe it is wholly inappropriate for her to have any involvement in disciplinary decisions concerning her own children. This represents a clear conflict of interests. We also recall hearing that her ex-husband had approached someone to ensure their son was not implicated. It was suggested that the Meynell family contacted the individual who informed Emma, urging her to remain silent. To this day, we remain without clarity as to these allegations and this continues to be an ongoing source of anguish.

121. Following the revelation of the WhatsApp data breach, we were made aware of several other breaches. However, it is notable that it was Sanjoy who raised this with the Chief Constable, before she brought it to our attention. She claimed that she wanted to discuss it in-person, but we found this explanation questionable. On 20th February 2024, we received a letter from the Chief Constable apologising for the failure to inform us of the Professional Standards Department investigations. The letter disclosed that an audit had identified 179 staff who had accessed material related to the case, with 22 who may have done so without a legitimate policing purpose. We found it incomprehensible that over 150 staff would need to view material relating to this investigation. To this day, we cannot understand how such widespread access could be justified.

122. We were informed that of the 22 staff identified, 11 were able to provide explanations deemed to meet the criteria for a valid policing purpose. The remaining 11 had no legitimate reason to access the records [NGPF0007214. Despite this, only three officers were dealt with under police misconduct regulations, something which we have found difficult to understand.

123. We were informed that a Special Constable had viewed body-worn video footage of Grace and Barney receiving medical care. He was dismissed from the Force and barred from future service following an accelerated misconduct hearing chaired by the Chief Constable. We were told this hearing was held in private to avoid prejudicing any criminal proceedings.

124. The second incident involved the WhatsApp group chat. It emerged that PC Gell was not only a member of the group but had also accessed police systems without a proper purpose on seven occasions. The officer who originally posted the WhatsApp message was found to have acted unprofessionally and received management intervention. Officers who merely received the message were investigated by PSD but were not found to have breached professional standards.

125. We were deeply troubled by the Force's response to this conduct. We were aware of similar incidents in previous cases and felt that lessons had not been learned. We struggled to understand why only PC Gell was held accountable for sharing the messages. Our understanding is that the use of WhatsApp for operational matters is strictly prohibited, making the conduct of all officers involved unacceptable. When this was raised with the Chief Constable, she acknowledged that WhatsApp should not be used for operational matters. We were concerned that if such officers did not act upon receipt of this content, they should have been held accountable.

126. DC Cumberpatch had told us that he was unaware of the content of the message and that it was sent to warn officers of a potential busy shift. It is now obvious that he knew this message was not sent for this purpose, as the message we have seen could not possibly coincide with this explanation.

127. The third investigation concerned a member of police Front Counter Staff who had accessed evidence on police systems in several high-profile cases. We understand that she was arrested and interviewed, and we were advised that no further information could be shared due to the ongoing investigation. On 5th April 2024, we were informed that she had been dismissed. When we requested

further information, the Force went into intricate detail about the fact that she had researched the perpetrator, and yet they refused to provide any of the further information requested about the WhatsApp group. They even said that she was making searches that were related to her own personal circumstances. Sanjoy highlighted that he didn't need to know about any of this and that all he cared about was her breaches that related to Grace. There was a huge disparity in the willingness to provide information between this incident and the WhatsApp incident.

128. Additionally, eight officers were found to have accessed information relating to the investigation without proper authorisation. This included viewing incident records, crime records, and intelligence records, though the information accessed was considered by the Force to be of lower sensitivity. We were informed that three officers were subject to PSD interventions, three partner-agency staff members received management intervention, and one officer and one staff member were subject to both management intervention and negative performance records. On 18th March 2024, we received a letter from the Leader of the Council, David Mellen, apologising for the fact that three staff from the Community Protection Service had accessed case material without a proper purpose. It is notable that this letter was only sent after we specifically requested the identity of the partner agency.

129. We were later provided with extracts from the WhatsApp conversation [WITN0312006]. Sanjoy raised several questions on our behalf, including a reference suggesting that VC had been wanted in Derbyshire. On 22nd March 2023, the Chief Constable responded, confirming that this was not true. Sanjoy asked how many people were in the WhatsApp group and for their identities, but she declined to answer [WITN0312007]. We had many questions about the disciplinary proceedings, about who set them up, who was part of the investigation or decision making process and whether the Chief Constable's friend was appointed as a legal expert, who had worked on the terms of reference, and why the families were not asked to consult on the terms of reference. All of our questions have remained unanswered, and we have great doubt in the voracity of the investigations conducted by Nottingham Police,

professional standards department (PSD). We believe an independent organisation should have conducted these investigations as the PSD at Nottingham police had got things wrong time and time again. We likened the actions of the Nottingham PSD as marking one's own homework and stated it, as such, at the time.

130. We are repulsed by the abhorrent conduct of officers involved in these breaches. Sinead has not viewed any footage in relation to the attacks and the prospect of anyone else wanting to view it is disturbing. We consider such conduct to be voyeuristic. We are sickened at the content of the vile messages written about our beloved daughter and Barney. Reading what was written about our child has added immeasurably to our trauma. The fatigue and apathy towards human suffering within the police is staggering. The behaviour was disgraceful and showed a complete lack of compassion for what the victims have endured.

131. Furthermore, we consider that the Force's handling of the incidents was inappropriate. We were told by the Chief Constable that the Force had not notified us earlier because they believed we had "*a lot on our plates*". We reject this as a reasonable excuse; it was not their decision to make. We believe their failure to inform us was a deliberate attempt to conceal misconduct and we question whether we would have ever been informed if the Force itself had been left to inform us.

132. On 19th December 2024, our legal representatives informed us of correspondence received from the South East Regional Organised Crime Unit (SEROCU) [WITN0312008]. This correspondence revealed that Nottinghamshire Police had been notified of suspected data breaches involving personnel from HMCTS and HMPPS. We understand these breaches took place during court proceedings and involved unauthorised access to case file materials, including images in some instances. Since then, SEROCU officers have been providing us with monthly updates regarding the progress of their investigation. However, despite these updates, we still lack clarity about the full scope and specific details of the breaches at the time of writing this statement.

133. Following the initial notification, we did not receive any direct communication from either HMCTS or HMPPS. It was only through enquiries made by our legal team that we learned the breaches had first been identified in January 2024, almost a year before we were informed. We were also told that this discovery led to an internal investigation, which resulted in a referral to Nottinghamshire Police on 21st May 2024, seven months before we were notified [WITN0128005].

134. Subsequently, on 28th March 2025, we learned through media reports that two court staff members had been dismissed for viewing video footage. Knowing that no footage existed of the attack on Ian, we were left to assume that the footage in question related to the assaults on Grace and Barney. We contacted the investigation team to raise our concerns and request further clarification but were only told that SEROCU had not been responsible for the disclosure.

135. On 8th April 2025, our legal team contacted the MOJ directly and requested clarification regarding the nature of the breaches, a timeline of organisational responses, dates of any resignations and dismissals and confirmation as to whether a full system audit was conducted and whether the breach was referred to the ICO [WITN0312009]. On 11th April 2025, we received an email from the MOJ stating that they needed to ensure that any response they provide was fully in line with relevant legal, regulatory, and privacy requirements. We found this insulting, given that their organisation was responsible for breaches of our daughter's privacy and that information had been leaked to the media before it had been disclosed to us.

136. We received a further email on 2nd May 2025 which once again, justified a lack of response to many of our questions on the ongoing investigation. The email did confirm that the breaches were discovered as part of a routine audit and that 'a total of three people associated with this matter are no longer employed by HMCTS. One person left HMCTS' employment last year, and two further people left employment this year.' It was also confirmed to us that the incident was not referred to the ICO, something which we cannot think of any logical justification

for. As of the date of this statement, we remain uncertain about the exact nature and extent of the breaches or whether self-reporting to the ICO has taken place since we were told no report had been made. We are unaware if any staff will face any criminal charges for their illegal actions.

137. On 20th February 2025, our legal team received further communication from Nottingham University Hospitals NHS Trust, notifying us of what was described as a "*potential data breach*" identified during an initial audit [NUHT0000100]. It is important to note that we had previously met with the Senior Leadership Team from Nottinghamshire NHS Foundation Trust and their legal advisors on 6th August 2024. During that meeting, Sanjoy specifically asked whether any audit had been carried out, and we were informed that, at that time, no such audit had taken place. We now wonder whether it was only our request which prompted this process. We are appalled by the lack of transparency and the lack of depth of the Trust's internal investigation.

138. As we prepare this statement, we are still awaiting the findings of the Trust's internal investigations. Although we have been receiving periodic updates throughout the process, these have often lacked clarity and have been difficult to interpret due to the absence of comprehensive information. We have been told that a total of 98 individuals accessed the records of Barney, Grace, and Ian. Of those, approximately 50 were deemed to have done so with legitimate justification. As medical professionals, we are astounded by the suggestion that such a large number of medical staff could have possibly needed to access the records. This is particularly the case given that we were notified that the victims did not require hospital treatment.

139. On 9th August 2025, we were provided with the report of Robin Hopkins, which we understand was intended to provide additional scrutiny as to the robustness of the Trust's stage 1 investigation, to ensure that all individuals who had potentially accessed data without legitimate purpose had been identified and progressed into stage 2. We raised concerns about the content of the report which was yet another instance of drip-feeding us limited information, whilst raising more questions than it answered. We note that reference is made to a

confidential annex which we have not been given access to. We have subsequently instructed our legal team to attempt to obtain a copy of this, but we understand that this request has been met with challenge, ambiguity and delay.

140. The stage 1 report was drafted in very broad terms. There is no detail provided in relation to the identity of the individuals or their specific roles and justifications for accessing the data. It has been inferred that data was accessed for the purposes of ward and departmental transfers, but we understood that this would not have been required for any of the victims.

141. There is a significant number of administrative tasks cited within the report, some of which we question the legitimacy of. It is our understanding, after working within the NHS for over 30 years, that audits for blood and medications are conducted without access to patient records. Instead, they are conducted via the blood bank and pharmacy stock takes. Consideration of bereavement support was also noted as a reason for access, but we do not recall that we were offered this, nor do the other families. It is particularly troubling for us that many of the staff were noted not to have made entries on the record. We understand that staff should all have made entries on the records regarding the purpose of their access.

142. We were astonished to discover that access had been granted for educational purposes and for the consideration of research purposes. We understand that access for educational purposes was pre-authorised. This is deeply concerning as no consent was provided, and we understand that patient records must be anonymised before use for such purposes. The report does not tell us who authorised this nor does it tell us how the data was used for such purposes.

143. This is deeply troubling for us given that Grace was a medical student on a programme led by the Hospital. She would have undoubtedly had personal connections within the hospital, and the report was incredibly vague in this regard, stating as follows: '"*where she had or may have had connections with any individuals who were under consideration, this was specifically considered*

and acted on where appropriate." Because of the incident and attack, being reported nationally in the media it would have been impossible to keep Grace's information or identity anonymised.

144. We feel strongly that a full audit should be provided in this instance with a detailed and thorough explanation provided in relation to who accessed the records and the specific reason for doing so. Sanjoy is a GP and Caldicott Guardian for a medical practice covering some 10,000 patients. When the practice receives a SAR request, it is unlawful to redact the names of medical staff who have accessed the records. We will not be satisfied until we have received full unredacted records containing a digital footprint clearly identifying all staff who accessed the records, whether or not they made any contributions to them.

KEY CONCERNS

145. We have outlined throughout this statement, a multitude of concerns which have never been resolved. There are a small number of matters that we would like to reemphasise including the lack of accountability across almost all organisations, but particularly in relation to the psychiatrists responsible for treating and discharging VC. We also need to understand whether the University could have done more to manage VC's risk, and if so, why they didn't. We understand that during VC's time at the University, VC was responsible for incidents of assault and stalking and yet limited action was taken, and no charges were brought to protect the students and the wider public.

146. Of particular concern to us, is the response of the emergency services following the attacks. Sanjoy needs to understand more about the emergency care provided to Grace and the adequacy of this care.

REFORM

147. We are asked to reflect on recommendations for that the Chair of the Inquiry to consider. We will have more to say when the Inquiry concludes its

investigation and we have seen and considered all of the evidence. However, our experiences mean that we do consider that change is critical.

148. The current framework for homicide in law lacks clarity and consistency. We urge a review of how homicide is defined, prosecuted, and sentenced, to ensure justice is served and victims' families are respected throughout the process.

149. There must be reform in how mental health patients are treated following the commission of serious criminal offences, including in the consideration of charges. The current use of no further action (NFA) decisions often results in individuals avoiding both the criminal justice system and forensic mental health pathways. In our case this meant VC did not have a Police record even though he committed crimes on multiple occasions previously. We understand that in at least some of these instances, no further action was taken by Nottinghamshire Police. This gap must be closed to protect the public and ensure appropriate treatment and accountability.

150. The Code of Practice for toxicology in custody settings must be updated to reflect modern standards and ensure accurate, timely assessments that can inform investigations and legal proceedings.

151. The current warrant recall system is not fit for purpose. It fails to protect the public and undermines the integrity of the justice system. We urge a full review and redesign of this process.

152. We support a full review of the Code of Practice for forensic psychiatry, especially regarding mental health assessments at the time of the index offence. This is critical in cases involving homicide, attempted homicide, violent disorder, and life-endangering behaviour.

153. When a homicide is committed by a mental health patient, there must be clear accountability for any failures in care. We invite the Inquiry to recommend the introduction of new codes of practice and protocols to guide risk assessment

and treatment decisions and to ensure that poor practice is quickly identified and addressed. Psychiatrists who have treated, managed, and discharged patients into the community who go onto commit serious crime must be held accountable for the management of their patients.

154. We propose the creation of publicly accessible grading for NHS mental health trusts, tracking complaints from families, poor outcomes, suicides, homicides, and incidents of violence. Transparency will drive improvement and restore public trust.

155. In the event that a homicide does occur, victims' families deserve clear, compassionate, and consistent communication throughout investigations and prosecutions. The current system allows for confusion and neglect. FLOs are often scapegoated, masking deeper systemic failures. We call for reform in how the CPS and investigative teams engage with families, with accountability built into every stage.

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: Sanjoy Kumar	Print Name: Sinead O'Malley-Kumar
Signed: GRO-B	Signed: GRO-B
Dated: 7th January 2026	Dated: 7th January 2026

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No.	Inquiry URN	Document Description
1.	HMCP0000017	Email from Fiona McVey to Sanjoy Kumar, re: Press Release 12.30 15 June 2023
2.	HMCP0000027	Email from Fiona McVey to Sanjoy Kumar, re: 14.42 Press Release 16 June 2023
3.	HMCP0000153	Letter dated 16 June 2023 from CPS to Dr Sanjoy Kumar MBE and Dr Sinead O'Malley-Kumar, Re: Criminal Investigation Update
4.	NGPF0007168	Email from Kate Meynell [NGPF] to Sanjoy Kumar, re: Letters from CC Meynell
5.	NGPF0007166	Letter from Kate Meynell [Nottinghamshire Police] to Sanjoy Kumar and Sinead O'Malley-Kumar re: Family Liaison Officers
6.	WITN0289006	BBC News article – Thurrock C17 gang members banned from wearing hoodies
7.	HMCP0000353	Email from Fiona McVey [NGPF] to Sanjoy Kumar and Sinead O'Malley-Kumar, re: RE: UPDATE RE PTPH 28/11/2023
8.	CPSE0009937	Letter from Dr Sanjoy Kumar to Samantha Shallow [CPSE] and Leigh Sanders [Detective Superintendent] re: Sharing Concerns re mental state of VC on the day of the attacks
9.	CPSE0009936	Letter from Dr Sanjoy Kumar to Samantha Shallow [CPSE] and Leigh Sanders [Detective Superintendent] re: Sharing Concerns re mental state of VC on the day of the attacks.
10.	HMCP0000367	Email from Fiona McVey to Leigh Sanders, Samantha Shallow and Alan Murphy, re: FW: 01/12/23 - Update
11.	HMCP0000385	Email from Fiona McVey to Gemma Piggott, Gina Farrell and Gillian Cutts, Re: FW: IMPORTANT

		CONSIDERATIONS FOR CPS
12.	CPSE0000702	Email from Sanjoy Kumar to Samantha Shallow, Leigh Sanders, Emma Webber and others, re: External Email - Concerns about Psychiatric reports
13.	NGPF0002572	Email from Gemma Piggott to Emma Webber Re: Questions and answers
14.	HMCP0000454	Email from Leigh Sanders [LPF] to David Webber, Sanjoy Kumar, Samantha Shallow [CPS] and others, re: RE: SAMPLES
15.	NGPF0007583	Email from Sanjoy Kumar to Kate Meynell [NGPF], Neil Hudgell [Hudgell Solicitors], Tim Moloney [Doughty Street Chambers], and others, re: Toxicology - fingernails
16.	WITN0312002	Email chain between Malcom Turner [Head of Legal Services, East Midlands Police Legal Services], Neil Hudgell and others RE Request for further Forensic Testing
17.	HMCP0000405	Note re Information for Family - Answers to Questions
18.	NGPF0007175	Letter from Kate Meynell (NGPF) to Sanjoy Kumar and Sinead O'Malley-Kumar, re: to arrange a meeting for concerns re police management of response following sentencing hearing
19.	WITN0312003	Email chain between Sanjoy Kumar, Caroline Henry [Nottinghamshire Police] and others, re Letter from Nottinghamshire PCC Caroline Henry
20.	WITN0312004	Letter from Dr Sinead O'Malley-Kumar and Dr Sanjoy Kuma to Rt Hon Victoria Prentis KC MP
21.	WITN0312005	Letter dated 7 March 2025 from IPOC to Mr Neil Hudgell [Hudgell Solicitors], re IOPC Operation Penhallow
22.	NGPF0007214	Letter from Kate Meynell to Sanjoy Kumar and Sinead O'Malley-Kumar, re: NGPF Professional Standards Department Investigations
23.	WITN0312006	Email chain between Sanjou Kumar, Sinead O'Malley-Kumar, Kate Meynell and others Re: Letter Regarding PSD Matters
24.	WITN0312007	Letter from Kate Meynell [Nottinghamshire Police] to Sanjoy Kumar dated 22 March 2024
25.	WITN0312008	Letter from Mark O'Brian [South East Regional Organised Crime Unit] to Dr Sanjoy Kumar and Mrs Sinead O'Malley Kumar
26.	WITN0128005	Letter from Mark O'Brian [South East Regional Organised Crime Unit] to Mr Hudgell, re: Investigation into the death of the victims
27.	WITN0312009	Email from Emma Webber to Andrew Hobden [Thames Valley Police] and others re URGENT – Court staff dismissal
28.	NUHT0000100	Letter from Miss Manjeet Shehmar [NUHT] to Dr Sanjoy Kumar & Dr Sinead O' Malley Kumar, RE: Request to meet regarding potential data breach investigation

Statement of Dr Sanjoy Kumar and Dr Sinead O'Malley-Kumar - 07.01.26

Final Audit Report 2026-01-07

Created:	2026-01-07
By:	Lindsay Allison GRO-B
Status:	Signed
Transaction ID:	CBJCHBCAABAAGVMUptHLTsluvFXVxmb1eztZV2qWO4cA

"Statement of Dr Sanjoy Kumar and Dr Sinead O'Malley-Kumar - 07.01.26" History

- Document created by Lindsay Allison GRO-B
  2026-01-07 - 11:47:53 AM GMT

- Document emailed to Sanjoy Kumar GRO-B for signature
  2026-01-07 - 11:48:00 AM GMT

- Document emailed to Sinead O'Malley-Kumar GRO-B for signature
  2026-01-07 - 11:48:00 AM GMT

- Email viewed by Sanjoy Kumar GRO-B
  2026-01-07 - 12:11:52 PM GMT

- Document e-signed by Sanjoy Kumar GRO-B
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