Wednesday, 6 May 2026

(9.59 am)

THE CHAIR: Thank you.

MR BLAKE: Good morning, Chair. Can I please call Anthony Rogers?

ANTHONY ROGERS (sworn)

Questioned by MR BLAKE

THE CHAIR: Yes.

MR BLAKE: Mr Rogers, you are His Majesty's Chief Inspector of the CPS Inspectorate; is that correct?

A. That is correct.

Q. You were officially appointed I think in February 2025.

A. Yes.

Q. Although you held the role on a temporary basis in 2024; is that right?

A. That is right.

Q. You previously held roles in the Civil Service and since 2003 at HMCPSI.

A. Yes, but I left HMCPSI in 2012; went to become the first Head of Compliance in the Crown Prosecution Service. I then was Area Business Manager in the Crown Prosecution Service for the London area. I then left the Civil Service in 2016, took up some consultancy work and then returned back to HMCPSI in 2018.

Q. Thank you. Could I ask you perhaps to come slightly closer to the microphone, if possible. Thank you.

You're giving evidence today in respect of the HMCPSI report into the CPS's actions in the prosecution of VC. Your evidence is taken slightly out of order in respect of our overall timetable.

I just make it clear at the very beginning that the Inquiry has obviously been gathering evidence for over a year now, and there's nothing in our Terms of Reference that would prevent the Chair from reaching conclusions that are different to those set out in your report, and it's for that reason that I'm not going to take you to a particular document and ask you if that will have changed your opinion, and I'm not going to ask you to give evidence as some sort of expert on prosecution matters. What I want to ask you today concerns essentially the sufficiency of the inspection and the report.

Could I please ask you to turn to HMCP0000625. Thank you. So this is the report. If we could start, please, on page 99.

A. Yes.

Q. This is the beginning of HMCPSI's involvement and that is a letter from the Attorney General, the then Attorney General, to your predecessor, Andrew Cayley King's Counsel; is that right?

A. That's right.

Q. And the request is that:

"Following the sentencing of [VC], [she] would like the Inspectorate to undertake a thorough and rapid inspection of the CPS actions in [that] ... case."

And the report was due by Easter time; is that right?

A. That's right, yeah.

Q. How long do your inspections usually take?

A. A normal inspection would, depending on whether there is a file examination, could take anything up to, from beginning to end, six months.

Q. Six months. So this is considerably quicker than your ordinary inspection.

A. Yes, I conducted two Covid inspections after the pandemic, when I was Deputy Chief Inspector, and I managed to deliver those in 12 weeks, from beginning to end.

Q. And here it's envisaged approximately two months, so approximately eight weeks.

A. Eight weeks, yes.

Q. So quicker than the Covid ones, considerably quicker than an ordinary inspection.

A. *(The witness nodded)*.

Q. "Thorough and rapid" are not necessarily good friends with one another when it comes to an inspection; is that something you would agree with?

A. Not -- in this case, as it's a single case, I think that is possible, and I think we did conduct a thorough and rapid inspection. Obviously I, in my statement, have some reflections on if we were asked to do it again, what I would do differently.

Q. Because broadly there is a tension between the two.

A. There is. Especially when you're trying to engage with bereaved families in an inspection of this nature.

Q. And at this particular time, I think Andrew Cayley King's Counsel had recently stepped down.

A. Yeah, Andrew resigned to go back to the International Criminal Court. He'd announced that resignation in January. I was appointed -- you can only have one Chief Inspector because of the Act, and I was appointed to take up post on 27th February. Andrew was still Chief Inspector but he wasn't with the Inspectorate, he'd actually gone over to the Hague. So I was running the Inspectorate but I wasn't officially the Chief Inspector because you can only ever have one.

Q. And he had stepped down after a three-year term, so not serving the full term.

A. Yeah.

Q. Am I right in saying that there wasn't at that time

a succession plan prior to his --
A. No, Andrew's term would have been five years -- sorry, four years, apologies. It was five years with me, it was four with Andrew. So Andrew would have had -- he stepped down actually after about 25 months, I think. He'd got into his third year.
Q. Thank you. You've also said in your witness statement that HMCPSI was fully committed in respect of the existing inspections that were taking place at that time; is that right?
A. Yes, absolutely.
Q. You put together a team, that included Richard Whittam King's Counsel, Former First Treasury Counsel, presumably he had other cases on at the same time?
A. He was on Horizon, but actually Horizon was stood down at that time, so Richard had time to be with us. So he was counsel on Horizon representing, I think, Fujitsu.
Q. I think the Inquiry wasn't sitting at that particular time --
A. It wasn't.
Q. -- but that was resuming in March/April time?
A. Yes, that's right.
Q. Jo Milner is a name we'll come across.
A. Yeah.
Q. She's a legal inspector, former prosecutor?

A. Yes.
Q. I think we've seen on emails or we will see on emails that she was working on a temporary basis, I think Monday to Wednesday; is that right?
A. No.
Q. Certainly that's what appears on the emails that -- *(overspeaking)* --
A. Right. Jo was part-time at the time but I think for the VC inspection she came back to be full time.
Q. Emma Jones, legal inspector, former CPS prosecutor for 20 years?
A. Yes, and she'd worked on the homicide team in London, CPS London, so she obviously did have some experience of dealing with homicide-type cases, murder cases.
Q. Is she the individual who you've described in your witness statement as coming back from retirement or is that somebody else?
A. No, that's James Jenkins.
Q. James Jenkins. Who was James Jenkins?
A. James Jenkins was an ex-inspector. He'd been with the Inspectorate for six years. He was a legal advisor in the Attorney General's Office and had also previously been a senior manager in the CPS.
Q. I think we may see him listed somewhere as an associate inspector?

A. Yes, that's what we call those who we bring back on associate terms, yeah.
Q. I think you personally led the inspection; is that right?
A. I did.
Q. Sticking with this document, if we could please turn to page 7, we'll have a look at the remit of your investigation.
A. Yeah.
Q. It's set out at 1.3. Halfway through that paragraph, it says:
"Our remit was to examine whether the decision not to proceed to trial for murder but to accept pleas to manslaughter was correct and whether the approach taken by the CPS in engaging with the families during the case met the standards and expectations as set out in The Victims' Code and its own Bereaved Family Scheme."
This could potentially be quite a wide remit, albeit a single case; do you agree with that?
A. Yes, which is why I developed a scope, as in all inspections, following our methodology and I outline in my statement at paragraph 21 the inspection question and in paragraph 22 the scope of the inspection.
Q. Do you see the difference between an inspection and investigation and, if so, what is the difference between

the two?
A. We're an Inspectorate, we inspect, so we inspect against the standards there are expected to be had. We don't investigate, so we don't actually go behind the evidence to try to take our own evidence or find our own evidence. We actually look at what is available and what, you know -- in line with our scope. So we're not investigatory, we don't have those powers. We actually inspect against the standards expected.
Q. So, essentially, you look at existing documents, for example, and assess those against standards, rather than seeking witness statements --
A. Yes.
Q. -- or additional information?
A. Yes, although we do interview as part of evidence gathering but it's not interview as per investigation.
Q. If we could please turn to WITN0245006, we start on page 3, we can see that, I think, you met with families of the bereaved on 9 February 2024; is that correct?
A. That is correct, yes.
Q. Then on the 26 February, you have received, from Dr O'Malley-Kumar some thoughts regarding their interaction with the CPS, which may have affected the acceptance of the plea of diminished responsibility. Can we turn to WITN0245008, and I think this is the

attached document; is that right?
A. Yes, we also received, I think, documents similar to this in the meeting. They were handed over in the meeting on 9 February by the families.
Q. Thank you. I'll just read to you a few sections from this complaint. The heading there is "Discussion with Samantha Shallow at Avon and Somerset police and fire headquarters", and it says as follows, it says:
"Myself and my husband specifically requested that the 4th psychiatrist report should focus his assessment of [VC's] state of mind on the day and leading up to the killings. We were aware through previous mental health history that self-reporting by [VC] was unreliable. He is documented as being misleading and duplicitous to clinicians in the past for his own agenda as per the previous reports."
I'll just skip down to the penultimate paragraph, please. The third sentence there says:
"We told Ms Shallow about advice we had received from a colleague who is a forensic psychiatrist regarding the importance of collateral history from others and irrespective of this she discounted our concerns as unworthy of consideration and said that she flatly refused to instruct or specify a line of enquiry upon them, even an educated and informed line of enquiry

that we had specifically requested.
"We were adamant we felt a fresh set of eyes should review [VC]."
Over the page, please, there's another section, headed "CPS engagement with the Police", if we scroll down, and a section below that regarding a discussion with Mr Karim Khalil KC and the CPS. I'm going to take you back now to that series of emails that we just looked at and that's WITN0245006. If we start on page 2, we can see that Dr O'Malley-Kumar's email is then followed by, if we look at the bottom email, an email from Emma Webber, she says:
"We have read and noted all of the comments that Sinead makes here. We were present at the meeting on 7 December we confirm and agree with everything that she has said."
Then goes on to provide further comment.
If we go up, please, we can see that James Coates has also followed on 27 February, and he says:
"As a family we fully stand behind the other victims' families with the issues that have been previously raised concerning the way the CPS have dealt with the whole [VC] debacle."
Then to the top email, please, on page 1. Emma Webber has sent a further email on 28 February 2024, and

then I'll take you to one further email, that's WITN0245011, 6 March, and this is about the case that we know --
A. Yeah, the stalking case. Yeah, yeah.
Q. -- as Sebastian, further information regarding VC's stalking.
If I could please now take you back to the report, HMCP0000625, thank you, this is page 1. The report is dated March 2024. We see at the top of the page that it's embargoed until 25 March. I think it was published on 25 March.
A. It was, yes.
Q. Can you assist us with how long before the publication it would have been sent to the printers for --
A. It was sent to the printers on the Saturday.
Q. Thank you. I --
A. Sorry, it was printed on the morning; it was sent to the proofreaders on the Saturday.
Q. Are you able to assess what date that would have --
A. 23rd. I think, sorry, either the 22nd or 23rd. I can't remember whether the 25th was a Monday or Tuesday.
Q. Because reports like this -- I mean, it's quite lengthy -- would require --
A. We have printed in-house at the Ministry of Justice and bound, we have an arrangement with them and we only ever

have now -- because actually we relay electronically -- we had enough for the families and enough for the team. So we had, I think, probably no more than a dozen reports printed on that morning in the print room.
Q. But in respect of the finalisation of this, it is normal to have, for example, proofreading type settings --
A. Yeah.
Q. -- and that kind of thing?
A. Yes.
Q. What would have taken place on the Friday or earlier?
A. It took place over the weekend. We worked the weekend to proofread the report.
Q. If we could please bring on to screen HMCP0000618. This is the letter that was sent to the families of the bereaved.
A. Yeah.
Q. "HMCPSI inspection plans for publication and offer of a meeting on 25 March ..."
In that second paragraph you say there:
"I was clear when we met on 9 February that, given the timescales of the inspection, it would not be possible to provide copies of the final report prior to a meeting on 25 March."
Can you assist us: by this date, so 15 March, was the report pretty much there in terms of finalisation?

A. No, it wasn't.
Q. No?
A. Not at all.
Q. So you were still going with the investigation?
A. Yes. We were still inspecting, we were still drafting, and we were still working. Now we had assessed the evidence but we were certainly in the report-writing stage at this stage. It wasn't complete on the 15th March.
Q. In terms of the timing then, I think you said 23 March or thereabouts.
A. It was certainly -- if somebody can remind me, if somebody can remind me if the 25th was a Monday and I'll be able -- I'm not --
Q. But thereabouts, quite soon before the final publication, it was completed. It's still under two months from being asked to conduct the inspection; is that right?
A. It was very rapid, yes.
Q. And during that time, am I -- is my understanding correct that you had to assemble that new team from scratch? You led the inspection --
A. *(The witness nodded)*.
Q. -- presumably alongside your other work at the time?
A. Well, I was Chief Inspector. I don't inspect. So I --

Q. No. You had managerial responsibilities that presumably you were also doing during that period?
A. Yes, it's quite small Inspectorate and my dedication was actually to this report, so actually I had other colleagues. My Deputy Chief Inspector stepped up and took on some of the other aspects of work that I naturally would have done, so I must admit my focus was entirely on this inspection.
Q. You had during this period met with the families.
A. Yeah.
Q. Interviewed witnesses.
A. Yes.
Q. Produced a report that's 116 pages in length.
A. Yes.
Q. Is there a Maxwellisation process or any sharing of a draft report with anybody?
A. No.
Q. No? And then prepared it for publication.
A. Yes.
Q. And I think you said in your witness statement that it was sufficiently rigorous, or words to that effect. I mean, looking at the task that you were asked to do and the amount of time in which it was conducted, do you think it was less rigorous than your usual inspections?
A. No, I don't.

Q. And the reason I ask you is I want to look at certain materials, and I'll take you through them, and insofar as there is any criticism of the rigour of your inspection, are we therefore to read that across to all HMCPSI reports in the sense that you conducted this in the same way you conducted all other reports?
A. Absolutely. Absolutely.
Q. If we could go back to the report then, HMCP0000625, and we'll start on page 7.
If we could look at paragraph 1.4, please. You've said:
"To conduct this inspection, we had access to all material relating to the case and were able to interview all who had dealt with the case on behalf of the prosecution, including the first prosecution psychiatric expert."
Can you assist us, what did you mean by "all material relating to the case"?
A. So we had access to the full file of evidence, which the CPS had access to, which obviously includes the police papers. We had access to Crown Court DCS where actually all of the papers are lodged for the case with the court, and we also helpfully had access to all of the FLO logs, the Family Liaison Officer logs, relating to the bereaved families.

Q. What about things like internal emails, which -- *(overspeaking)* --
A. All of those, yeah, everything.
Q. You had full, free access to --
A. Absolutely.
Q. -- all of the CPS's internal emails.
A. Yes, absolutely. We -- it's one of the things that HMCPSI is very lucky. We sit -- we have full access, bar those cases that are closed to normal people, as in normal prosecutors. We have full access to everything on the CPS case management system.
Q. And you've been provided with a bundle of materials prior to coming today. That included documents such as the report by DC Beddoe.
A. Yeah.
Q. It included phone analysis --
A. Yeah.
Q. -- documents, picture of a dead animal, for example --
A. There are only two -- certainly in the supplementary bundle that I got on Friday evening, which I think at the front had about 50 documents in, 50-odd documents, I think there are only two documents that we don't think -- and it's "think", I can't absolutely clarify -- that we haven't seen, and they are documents, I think, 54 and 55.

Q. And are those, I think, witness statements?
A. No, no. They are -- the witness statements we hadn't seen, obviously, because they were written after the inspection. They are related to two aspects of probably a mental health assessment at Rampton I think, or wherever VC was. And it's two pages within this document, this bundle, which we may have seen them because actually, as you may have realised, doing an inspection like this, not every inspector sees every document, and the only inspector who is left in the Inspectorate, Jo Milner, didn't actually look at the mental health aspect; Richard Whittam looked at the mental health aspect.
Q. Thank you, so Richard Whittam was charged with looking particularly at the mental health aspect, you'd say?
A. Yeah. Emma Jones looked -- we all look at all -- sorry, not all documents, but most documents. But Emma Jones had specific responsibility to look at the case, the previous CPS case which is covered in chapter 7 in the report: the assault on emergency worker.

Richard Whittam was looking at mental health, along with James Jenkins, because they were the two who were more experienced in that, of course Richard being First Senior Treasury and a KC, and Jo formed and looked at, you know, sort of the handling, the Victims's Code

element, you know.
Q. Was one treated as more senior than the other of those two?
A. Of Jo --
Q. Richard Whittam and the investigator?
A. Than the Associate Inspector?
Q. Yes.
A. No, it's a team. We all -- you know, we all muck in and just get on with it, you know.
Q. You say in 1.4 that you have been able to interview the first prosecution psychiatric expert.
A. Yeah.
Q. Is there a reason why, for example, Dr Latham wasn't interviewed?
A. Yeah, we made a decision based upon -- and I think it's worth saying at the outset, it actually mattered to me in terms of the values that the Inspectorate has and my own values, that we actually listen to the family. You know, we met them on 9 February because actually their experience of the system had let them down. I was aware of what they were feeling; I'd been told, I'd seen, I'd heard.

So as part of that, there was a real concern expressed at that first meeting about some of the issues around the psychiatrist reports. And obviously we read

the Blackwood, Professor Blackwood's report. But obviously there was an issue which the families raised about, it's termed in James Jenkins's interview note, of the Blackwood interview of the "back calculation" how he presented on the 13th.

So we decided as a team it was worth putting the questions the family was so keen to understand to Blackwood. I felt that was the right thing we needed to do. I didn't think we needed to do that with Latham. The report from Latham was on a different basis, and we outlined that in our report. But I did think it was probably quite helpful to talk to Professor Blackwood about some of the family concerns, to actually allow us, within the report, to set out with clarity, I hope, and in detail, and try to give the family -- families some understanding of actually what they said they hadn't been able to see because people weren't talking to them, weren't giving them the full picture. That was mentioned a lot in that meeting of the 9th February, and I thought it was incumbent on the Inspectorate to set out, hence why we decided, as a team, to go and see Professor Blackwood.
Q. Now in terms of the interviews you carried out, if we could start with the first in time, so that's HMCP0000551, the interview with Samantha Shallow on

13 February. We then go to HMCP0000552, that's with Alan Murphy on 14 February.
A. Yeah.
Q. We then go to HMCP0000575, that's an interview with Michelle Mannion on 14 February.
A. Yeah.
Q. Then HMCP0000576, an interview with both prosecution counsel.
A. Yeah.
Q. And then HMCP0000629 we get to Dr Blackwood's on 29 February. And then HMCP0000609, an interview with Janine McKinney on 5 March.

In terms of our timeline, Samantha Shallow, Alan Murphy, Michelle Mannion, and both prosecution counsel have been interviewed before the time that we saw that very first email from Dr O'Malley-Kumar. I appreciate that you had met them already on the 9th, but you hadn't yet received those emails, at the time --
A. Well, we had to have papers handed to us in that meeting by the family.
Q. Yes, but that wasn't the question. The question was you hadn't received those emails?
A. No, I hadn't received those but we had similar -- we had similar points being raised in papers that were handed to us in the meeting.

Q. Because one of the concerns raised and detailed in-depth in one of those emails was concerns about, for example, Ms Shallow, and that was in the email of 26 February.
A. *(The witness nodded)*.
Q. She had been interviewed by the time that had been received, that is a factual --
A. Yes, that is a fact.
Q. -- position.
A. Yeah.
Q. Were there follow-on interviews after that information had been received?
A. *(The witness shook head)*.
Q. No. Further questions posed in writing?
A. No.
Q. I think, as we saw in that letter to the families about the publication, in fact, other than that 9 February meeting, there was no further meeting, other than on the day of publication --
A. No.
Q. -- is that right?
A. That is right.
Q. Is it still your position that this inspection was as rigorous as your usual?
A. Yes, it is.
Q. If we can go back, please, to the report, I'm just going

to look at the findings now, HMCP0000625, we start on page 7. We have at 1.5 "Headline findings", so the first headline finding relates to "The charge" and that's essentially that the charging decision was correct?
A. Yes.
Q. We then get to "The acceptance of pleas to manslaughter" and, essentially, again, the acceptance of the plea, your finding was that that was correct?
A. Absolutely.
Q. It says:

"The CPS could not have proceeded on the murder allegations because of the clear and unambiguous findings of the prosecution and defence psychiatric reports that the offender's actions were because of pure psychosis that substantially impaired his ability to form rational judgements and to exercise self-control."

If we scroll down to 1.10, you set out there, essentially, that it would have been a different position if the law had been different.
A. Yes.
Q. Do we read into that final sentence there, in 1.10, that you consider, or HMCPSI considers, that the law should change?
A. It's not a matter for HMCPSI. What I was setting out

was the view that it is very difficult, I think, for anybody to accept in the circumstances of this case, and others that I've been written to since, that their loved ones have been killed by someone and it is a manslaughter. You know, that word "murder" is something that is very important to people, you know, people -- as I say, since this case, I've been asked by a number of families to look at the cases of very similar circumstances but it's a matter for Parliament whether they adopted this.

But I think what I was pointing out was that, actually, it's a very difficult legal concept for ordinary people outside of the system to understand, and it would have possibly been more understandable and a little bit more -- "acceptable" is the wrong word but that's the word I'm going to use -- if it had been second degree murder, not manslaughter.
Q. The conclusions then address CPS engagement with the families.
A. Yeah.
Q. The first paragraph there, 1.11, generally you found that the CPS met their obligations to the bereaved families --
A. *(The witness nodded)*.
Q. -- under the Victims' Code and the Bereaved Family

Scheme; is that right?
A. That's right.
Q. Then you address some things that you consider could have been handled better?
A. Yes.
Q. I'll just take you through those. So the first one, the first bullet point there:

"[The] Introductory letters included standard paragraphs about the legal proceedings which may not have been understood or well received by grieving families."

Over the page, please:

"The Family Liaison Officer is the conduit through which all CPS engagement is handled. In this case, the first CPS letter to the families was dated before the first hearing date but was delivered after it to each family by the FLO and thus was out of date when received."

Then:

"Where FLOs are being asked to explain legal concepts to bereaved families, it would be good practice for the CPS to provide them with case specific written guidance. In this case the families' understanding of diminished responsibility may have been aided at an earlier stage had the CPS provided a form of words for

the FLOs to use."

Just looking at those top two on the page, is this conclusion a criticism of the FLO or is it a criticism of the CPS, so far as you see it?

A. So actually having read the statements in the additional bundle, I am now aware that, actually, I think it was DCI Gould's statement said that actually the letters were delivered late because of the FLO problem. But looking at this through the eyes of my inspection from the CPS I thought, you know, given the circumstances, the CPS could have worked with the police to make sure those letters were delivered in a timely way, also understanding, though, that it was Father's Day, I think, the weekend when those letters were being delivered.

Q. So in respect of that first bullet point, where it says --

A. I think what I would expect is better liaison between the CPS and the FLO to be able to get it right.

Q. Does that suggest, therefore, that there is implied in that a criticism of the FLO for not --

A. No, I think it's a criticism of the joint prosecution team, as I see it, which the police and CPS are a prosecution team.

Q. Thank you.

A. And I don't -- I think the second one is a clear point to the CPS to consider, which is providing case-specific written guidance for difficult concepts. FLOs are not always -- and you see it in the -- again, DCI Gould's statement, the experience of some of those FLOs was not as great as she would have liked herself, I think, and asking them to explain legal concepts, I think, is probably asking a lot when their expertise is support, not the law.

Q. We then have two further conclusions:

"Two of the families were invited to a meeting with the CPS and prosecution counsel on 24th November to discuss the psychiatric evidence. There were further meetings on 7 December and 15 January with the same two families. There was no record of the third family having been specifically told about those meetings, which led to a feeling of being left out and overlooked."

Is the focus there on the CPS rather than the FLOs?

A. Yes.

Q. Then the entry below:

"The CPS used the word 'consult' on a number of occasions when referring to engagement with the families ..."

And, essentially, there is no obligation to consult

and it should have been "inform" and "explain".

A. Inform and explain, yeah.

Q. Then we see below that the recommendation.

A. Yeah.

Q. The recommendation is:

"By October 2024 the [CPS] must undertake a review of all guidance relating to victims' engagement to ensure that all staff are aware when use of the terms 'consult' or 'consultation' is appropriate."

Have you had contact with the CPS subsequent to that, to ensure that that recommendation has been taken on board?

A. Yes, we have a recommendation tracker for all recommendations in the inspectorate, which we follow up all recommendations quarterly. That recommendation has met. I have evidence that they changed all legal guidance where that word was used inappropriately or incorrectly. So, yes, we did follow it up and, yes, the CPS have met it. It was a closed recommendation on our tracker.

Q. Can you assist us with why there's only one recommendation? I mean, we've seen, for example, the conclusion that case-specific written guidance should be provided in respect of something like diminished responsibility. Why doesn't that feature as

a recommendation?

A. Because it's case specific. The recommendations are wide reaching across the whole of the CPS. This was case specific. So each case should be on its merits. It may not be warranted to be doing it in every case and to make a recommendation would make the CPS have to do it because obviously they have to respond to our recommendations. So --

Q. So is your suggestion not that in every case of diminished responsibility there should be further investigation --

A. I think in every case where diminished responsibility is raised and it is necessary to explain, either the prosecutor should -- of course, the families in all cases can meet prosecutors. You might not want the FLO -- the report goes on later to say it might be a good idea for prosecutors to meet the families and do it. So therefore, actually, it's a case specific, so therefore it doesn't warrant a recommendation.

Q. Is it your view, then, that that can't be formulated in some way that could form a recommendation?

A. Yes, it is my view. That's why we did not make a recommendation.

Q. I want to look, then, at the first substantive issue in respect of matters raised with you, and that is the

complaint we got in the psychiatric reports.
A. Yes.
Q. If we stick with the report that's currently on screen, please, and if we turn to page 17. This section is headed as follows, "Concerns relating to the CPS decision to accept guilty pleas to manslaughter", and it says:
"Whilst the bereaved families acknowledged that the four psychiatric experts found that the offender was suffering from a recognised mental illness at the time of the commission of the offences, which afforded him the partial defence of diminished responsibility, they had concerns that this was not a properly reached conclusion based on the following ..."
Then there's a series of bullet points. The first is:
"The psychiatric experts did not adequately consider and assess the offender's presentation at the time of the commission of the offences, but placed too much weight and emphasis on the offender's presentation when they interviewed him some months later and at a time when his mental state may have deteriorated due to his incarceration."
The second relates to:
"The fact that a mental health assessment was not

deemed necessary whilst [he] was in police custody ..."
In particular, that first bullet point, is that something, following the conversation with the bereaved families, you were aware was a significant concern of theirs?
A. Absolutely, which is why it's in the report.
Q. That criticism isn't actually just of the CPS, is it? That's a criticism also of the experts that carried out the assessment?
A. Yes, it is, yes.
Q. Who did you interview to determine that issue?
A. Well, we interviewed Professor Blackwood on that very issue and obviously saw the papers from the CPS, which then asked the question in November, after it was raised again, about how he had -- why he didn't interview witnesses, how he'd made and whether he'd considered the presentation at the commission of the offences.
Q. As we've already discussed, you didn't interview Dr Latham?
A. No, we didn't.
Q. You didn't interview, for example, any independent psychiatrists --
A. No, we didn't.
Q. -- because that's not the way you go about it.
A. That's not inspection. That would be an investigation,

yes.
Q. The interview with Dr Blackwood then was presumably quite important in the overall context of determining that issue?
A. Yes, which is what I said earlier.
Q. Because, I mean, his methods were being called into question?
A. Yes, they were.
Q. Could we please return then to HMCP0000551.
This is the interview with Samantha Shallow and we see there, in terms of who is present, we see Richard Whittam, Samantha Shallow and then you have your investigator, I think --
A. Inspector.
Q. Your inspector, thank you very much. Is that --
A. So we have three inspectors in there: Richard Whittam, Jo Milner and Emma Jones. Scarlet Johnstone is a CPS note taker.
Q. If we go to the next interview, HMCP0000552, the Alan Murphy interview, similar cast list. You have Richard Whittam, Jo Milner, James Jenkins --
A. Jo Milner -- actually, we have all four inspectors in that one.
Q. Yes. HMCP0000575 again, Michelle Mannion, again Richard Whittam, Jo Milner, Emma Jones --

A. No Emma Jones on that one.
Q. Oh, thank you. Jo Milner and James Jenkins.
A. Yes.
Q. HMCP0000576, the interview with prosecution counsel: Richard Whittam, James Jenkins, Emma Jones. So three members of your team?
A. Yeah, one taking notes.
Q. Then HMCP0000629, this is the interview with Dr Blackwood?
A. Yeah.
Q. It's described as a conversation with Dr Blackwood. Can you assist us with why it's described as a conversation?
A. I presume the note taker, Jo Milner, has called it that, rather than an interview.
Q. Was it over the phone or in person, as far as you can recall?
A. I think it was over the phone.
Q. Over the phone. We have there James Jenkins, Jo Milner taking notes. Richard Whittam is not present at this one?
A. No, he's not.
Q. I think you had previously said that Richard Whittam --
A. And James Jenkins were leading on mental aspects --
Q. Yes, but Richard Whittam was involved in the psychiatric side of the complaint?

A. He was, of the report, yeah.
Q. Can you assist us, then, in respect of such a significant witness, in fact the only psychiatric witness that is being interviewed, why Richard Whittam isn't there, and why it's a smaller cast list?
A. It's availability of Dr -- Professor Blackwood and Richard Whittam. There was a clash. It didn't work. Richard actually was on holiday at that point and it couldn't be changed. We had obviously the pressure of time, and actually all inspections, the reason for a note and the reason, actually, for the interview, we come together and we discuss the evidence together as a team, so actually Richard would be fully appraised as part of the inspection process.
Q. Yeah --
A. And he will have helped, I know James and Richard prepared the questions together and actually they were provided to Professor Blackwood before the -- as Professor Blackwood's statement said to the Inquiry -- before the interview.
Q. As Former First Treasury Counsel, it would have been helpful to --
A. It would, but he was, as I say, on holiday.
Q. Then I'll just read to you a couple of the questions. Mr Jenkins starts:

"Before we start with the specific questions I have previously sent you, is there anything you want to mention you think is important and not covered in what I sent to you?"

Can you assist us with that? Are interviewees provided with the questions in advance?

A. Sometimes; sometimes not.
Q. Is it usual in your investigations for --
A. Inspections. -- *(overspeaking)* --
Q. Inspections -- for a significant witness to be provided with the questions in advance?
A. Depends. Sometimes -- it's not unusual.
Q. Professor Blackwood then responds and he says:

"Just that the families concern also seemed to be the delay between me being instructed and me seeing and assessing the offender".

So he raises a further issue that wasn't addressed in the questions that had been sent.

Did you obtain any independent evidence in respect of whether it would have been beneficial for Professor Blackwood to have seen VC earlier?

A. No.
Q. And if we go over to page 2, please, I'll just read to you an exchange between the interviewer and Professor Blackwood. He says:

"Regarding the materials -- you were given a lot of material from the CPS. Do you essentially make your own judgement of what to read or do you read it all?"

Then Professor Blackwood says:

"No I look at everything I am given. You are not immune to error so you may miss the odd line etc but that would be pointed out by barristers or further questions posed from the CPS. As here, the families pay particular focus to the defendant speaking to the security guard outside Seely House. I had obviously been aware of this interaction but I was further prompted to consider this by the CPS. I was asked if the security guard should be further interviewed by the police or should I myself interview him? So this is an example of where I was prompted by the CPS to look at the materials again. I responded that I did not seek to interview him. I have never done so in the past, and cannot think of colleagues who would speak further to such a witness like this."

Then the interviewer says as follows, he says:

"Is it fair to say that you were quite satisfied from all the material you had plus speaking to the offender that you were in a position to make a rational and reasoned assessment to his mental state at the time he committed the offence?"

Is this typical of the kind of question that might be posed by HMCPSI in an interview?

A. Yes, it is.
Q. It may be suggested, that's not a particularly probing question.
A. It may be. That's why -- you know sort of, we find from all our interviews that actually conversation, as this note is actually titled, is much more able to actually get to the nub of the issue, because not only does it put the person at ease but it also allows you to follow hooks as the evidence comes out. That's how -- that's the approach. If you came on our interview training course within the Inspectorate you would -- that is one of the techniques we use. So we don't -- we try not to cross-examine and we don't purposely cross-examine, and we don't try also to trip up.

Now if the person being interviewed becomes difficult we obviously change our technique, but generally this is the sort of question, and you'll have seen it in the other interview notes, that actually these are the general -- it's a general approach in HMCPSI when we are talking to people to gather evidence, that we do it in a very open and constructive way.

Q. So is that again something that distinguishes you from an investigation --

A. Absolutely.
Q. -- in the sense that this is a -- it's in fact called a conversation, and the questions are not particularly probing?
A. Well, I wouldn't say they are not probing. I think we were getting to the heart of actually some of the issues that were raised, which actually also, you know, tried to address some of the family concerns. Did Dr Blackwood, from the material, make a rational and reasoned assessment to his mental state at the time that the defendant committed the offence? That was one of the concerns that the family absolutely had, and we asked a question about it.
Q. I mean that summary, though, provided, that I've just taken you to, is it fair to say, I mean that's essentially summarising what Dr Blackwood has said and said: is that right?
A. And he also said it in further papers that we had seen after he'd been -- had that question posed in November.
Q. And if we look overall at this conversation, it's only four pages long.
A. Yeah.
Q. Do you have an idea of how long --
A. Yeah, I think the interview was about half an hour.
Q. About half an hour. If we go back to the report,

please, so that's HMCP0000625, page 52. Page 52, you have findings in respect of the psychiatric expert.
A. Yes.
Q. It says as follows, it says:

"In relation to the first prosecution psychiatric expert's report and finding that the partial defence was available to the offender, the expert confirmed to us:

"[1] He had been retained at an early stage of proceedings ...

"[2] His approach was guided by the material that was made available to him."

If we scroll down please, thank you:

"[3] He's considered whether the offender had either fabricated his mental illness or that his illness had deteriorated whilst he'd been in custody ...

"[4] Even if the offender's condition deteriorated later, his psychosis persisted at the time of the offences.

"[5] There was no inconsistency with the offender being assessed as fit to be detained and ... later diagnosis of diminished responsibility."

The next one:

"Three of the expert psychiatrists, including himself, had concluded that the offender was not insane."

Over the page, please:

"He [has] ... taken into account the evidence that suggested that the offender could exercise some self-control ..."

And there are further bullet points that I think -- perhaps I'll read to you the very final one:

"The first prosecution psychiatric expert had taken into account previous assaults including the assaults [of his] ... co-workers, police and housemates. These all occurred when the offender was under the influence of untreated psychosis."

What seems to have occurred here is that Dr Blackwood has -- it says here "the expert confirms to us", he has essentially been asked to provide his account.

Am I right in understanding that HMCPSI are, perhaps because of your role, perhaps because of your resources or some other reason -- please do tell me -- don't set out to test the account that is given to them by what is identified there as the psychiatric expert?
A. Yes, I think the point is, he is the psychiatric expert; we are not. We're inspectors, lawyers. And, you know, in a way, it's very difficult, I think in any sphere of life, to be saying, "I've now become an expert in psychiatry so I'm going to test you on your findings."

And so we challenged Professor Blackwood on the basis of the family's concerns, some of those concerns which are outlined in chapter 3 of the report in detail, to try to understand whether he had considered some of the things that the families said to us they were concerned hadn't been considered.

We are not psychiatric experts. None of my inspection team who spoke to Professor Blackwood, and none of us are psychiatrists.

And it's the same for any expert, I think, in any walk of life. You know, we are doing a job trying to test the evidence the CPS had. We've seen all the evidence the CPS had, and we have come to the point -- and again, I take you back to the fact that I wanted the families, it was at the heart of this inspection for me, to know what had been said. Because they said on numerous occasions they were in the dark. We tried to outline what Professor Blackwood had done and what he thought, and that is why this is in this report.

This report could have been probably a lot shorter. I purposely made the decision to actually do a very full report to try to set out what happened in this whole case, so that the families could understand.
Q. What you're essentially doing, though, you're putting the families' case to the expert, but what you don't

have is the sufficient material to test the expert's own response, do you?

A. No, I don't.

Q. And if we look at page 54, paragraph 6.35, the finding there is:

"The first prosecution expert was an eminent forensic psychiatrist. His conclusion was clear and unambiguous. A plea of guilty to manslaughter by virtue of diminished responsibility was appropriate. That report considered countervailing arguments. It is clear to us, as a result of our meeting with this expert, that he had taken into account the concerns that had been raised by the bereaved families about the assessment of the offender's mental state on the day of the attacks."

Are we really to read into that the caveat we've just discussed?

A. We asked about that, James Jenkins's interview note, as you see, talks about a back calculation. You know, I am not going to get behind and I don't think anybody should, you know, saying that Dr Blackwood wasn't the expert in his field. He told us he'd done it. We're not experts. We don't -- you know, we don't investigate. We didn't ask an independent psychiatrist.

So what, you know, that is our judgement. That is the judgement that actually he'd thought about it, he

said he'd done it, and we therefore made that finding.

Q. As we discussed towards the beginning of your evidence, though, part of the complaint wasn't just about the CPS's handling of the complaint; it was also actually about how the expert reached his own opinion.

Realistically, that's not something that --

A. That's out of the scope of this inspection. Realistically, you know, that would, I presume there will be some governance of psychiatry, you know. I don't know who does it, but if that's the issue that somebody is saying that Blackwood has got it wrong then actually they should be investigating through the line, through -- and it is not nature -- that is not the scope of this inspection.

Q. Thank you. And then moving on to a second topic, briefly, and that's the Family Liaison Officers. If we could go -- sticking with this report, if you could go to page 9, please. We saw there that those first two bullet points in the headline findings relate to the FLOs.

A. Yeah.

Q. And I think you've said really it's not actually a criticism of the FLOs themselves. Could we please turn to page 61. We have here the section relating to the "Crown Prosecution Service obligations to victims

and bereaved families".

A. Yeah.

Q. If we go to page 65, we see at the bottom of that page "The role of the family liaison officer ..."

A. Yeah.

Q. At page 67, please, this the beginning of the section of the "Crown Prosecution Service engagement with the bereaved families before the decision to accept pleas to manslaughter". And if we have a look, please, at page 69, paragraph 9.10, you say:

"We have considered the contact that the CPS had with the bereaved families, both directly and indirectly, including via the family liaison officers ... from 13 June, the date of the offences until 24 November."

Now it's right to say that you didn't speak to the FLOs themselves.

A. We didn't.

Q. You were working simply from their logs; is that right?

A. That is right.

Q. If we continue down section 9, over the page please, there are repeated references throughout this section to the FLOs. If we look at 9.21, for example, it says:

"In the aftermath of losing a loved one in horrific circumstances, bereaved families will understandably be

in a high state of shock, disbelief, and grief. This is where the FLOs are vital in being the conduit and can reinforce to bereaved families, as the days and weeks move on, that the offer made in the CPS introductory letter to meet with the prosecution team remains an ongoing offer. The CPS cannot force bereaved families to meet with them and are heavily reliant on the FLOs, who are in regular contact with the bereaved relatives, to keep them updated about the family's position and views on if, and when, they are ready to meet the prosecution team."

We can see there, below that, plenty of mentions of the FLOs and their role, and their involvement. If we keep on scrolling down, please. Just to give some more examples. Perhaps if we go to page 73, 9.39. It says there:

"Following the request for a meeting that was made by [Barney's] ... mother to her FLO on 7 November, the FLO informed the reviewing lawyer of this on 13 November. The FLO informed the reviewing lawyer that the request was for a meeting with the CPS and counsel, preferably before the PTPH, as [Barney's] ... parents wished to understand fully the partial defence of diminished responsibility and the possible outcome of the PTPH on 28 November. The FLO said that she and her

fellow liaison officers felt that they did not have the necessary experience and knowledge to explain [the] ... legal concept and would be more comfortable if the reviewing lawyer and counsel could do so. We note that this request was made six weeks after the reviewing lawyer had requested that the FLOs liaise with the police investigation team regarding a strategy for communicating the contents of the first defence psychiatric expert's report to the families."

A bit of a criticism of the FLO, or an implied criticism there, isn't it?

A. I think obviously the FLOs know the families. That's their role. I think throughout the logs, we see quite a lot, understandably, of the families not really wanting to engage with some of this. However, actually, in the case of the Webbers, David Webber had asked about diminished responsibility earlier than this. So it's not really an inferred criticism because obviously each case -- the FLO is close to the family and you've got -- they know when people are ready or not ready to talk about it.

It was interesting, though, that the reviewing lawyer naturally was concerned about starting to explain some of the issues which the family later became -- families later became very concerned about, as early as

they possibly could, to start getting that out and talking about it, and it didn't happen for six weeks.

Q. If we continue, please, if we keep on scrolling down, let's go to just another example, 9.49.

"However, in the police FLO logs we examined, we did not find any reference to Ian's son specifically saying that he and his brothers did not wish to meet with the CPS prior to the PTPH. There is nothing in the logs to suggest that the FLO discussed the CPS offer of a meeting with Ian's sons between the date of the first Crown Court hearing on 20 June ... and 24 November, when the FLO called Ian's son to inform him that the first prosecution psychiatric report had been received and that it was likely the CPS would accept pleas to manslaughter."

If we keep on scrolling and go perhaps to 9.54 and 9.55:

"Regarding [Barney's] parents' concern that they did not think they would have a meeting with the CPS prior to the PTPH had they not initiated it, we found evidence to the contrary. As far as the CPS were aware, from information received on 2 October from [Barney's] parents' FLO, a meeting was to be held after the PTPH as they were unable, at the time, to hear details of the offences ... The reviewing lawyer acknowledged this but

told the FLO that if the family changed their mind, the CPS would meet with them. We found no record in the FLO logs to indicate that the message was relayed to [Barney] or Grace's parents but as far as the CPS were concerned, from information they had received and then imparted back to the FLO on 2 October, the offer of a meeting with the CPS was a continuing offer that had been extended to both [Barney] and Grace's parents.

"Up until 13 November, the CPS had been unaware that [Barney's] parents had not understood the partial defence of diminished responsibility as they had not been told by the FLO. Likewise, if the other bereaved families had not understood it, the CPS had not been informed."

We then move on to the findings, over the page, please. 9.57:

"We found that written guidance on diminished responsibility should have been provided by the CPS to the FLOs."

9.58:

"We found no record that the request by [Barney's] parents on 9 October for clarification on diminished responsibility had been communicated by the FLO to the CPS."

And 9.60:

"These points highlight the importance of a proactive and probing approach being taken by both the CPS and FLOs when communicating with each other."

Now, looking at those passages that I've taken you to and the findings, as a matter of basic procedural fairness, do you think that the FLOs should at least have been asked for their response in advance of publication?

A. No, I don't.

Q. Why is that?

A. So we obviously had access to the very extensive FLO logs. We had a timescale which was tight and, as a team, we discussed at length whether we needed to think about speaking to the FLOs. And actually, now having seen in the supplementary bundle that was sent on Friday evening the statement from DCI Gould and PC Baxter, I actually think there is nothing in this report we would have had which actually would differ from our findings. And --

Q. Have you received all of the FLO statements to this?

A. Yes, we have -- sorry?

Q. All of the FLO statements to this Inquiry --

A. No, I haven't --

Q. We have obtained statements that --

A. The only ones I received were the two I got on Friday.

Q. So based on the two that you have read, you wouldn't have changed anything?
A. No, but actually I also would want to say that, actually, I'm the CPS Inspectorate. The FLOs are police staff. I do not have the remit to interview -- I could have requested -- they didn't -- they would not have to accept but it is outside of the remit of the inspection for me to be interviewing police staff because I was looking at the CPS here. But what we felt, to be able to do this properly, was we needed to see the FLO interaction with the families to give us a full picture. And, as I say, I don't -- I haven't seen all of the statements but the two I've seen, there is nothing in them that actually is contrary, I think, to our findings in this report.
Q. Simply thinking in terms of fairness to the FLOs, you have clearly criticised the FLOs here, haven't you? You may not have named them but there is something they would have wished to have responded on, isn't there?
A. Well, the statements that I've seen in the supplementary bundle, actually -- and I didn't know this until I saw those -- admits that they were at fault.
Q. All right. I don't think you've read all of the statements.
A. No, but I've read the two that I've been provided with.

Q. You also -- I think you've given an explanation in your witness statement that one of the reasons you didn't contact the FLOs was that you understood that the relationship had broken down?
A. Absolutely.
Q. Did you ask the FLOs about that?
A. No, I didn't.
Q. Aren't these findings really just low-hanging fruit?
A. I don't think so.
Q. If you had more time, looking back at this again, because we've discussed how quickly this was produced, if you had more time, would you or should you have contacted the FLOs to at least see if they had a response to the allegations -- *(overspeaking)* --
A. I would not -- having considered it since being asked to come to give evidence, I have considered that question carefully. If we did this inspection again, I would not -- we would probably make the same decision not to interview the FLOs.
Q. Very finally, I want to ask you about engagement with the bereaved and also engagement with the survivors. Let's stick with this report. If we could please turn to page 16, paragraph 3.4, please. You say there:
"We invited members of the bereaved families to meet with us so that we could hear directly from them about

their concerns over the CPS's handling of the case. The invitation was also extended to the three surviving victims, but they did not respond. Ian's partner declined the offer of a meeting, confirming in a telephone call to us that she had no concerns about the CPS's engagement with her and was complimentary about the service she had received."
Looking back at this and, again, looking at the amount of time and how quickly this was produced, do you think that more effort could have been made to engage the survivors, recognising, for example, that there were serious injuries, whether it be a brain injury, whether it be PTSD?
A. Possibly. I think, actually, on reflection, obviously I wrote to them in a similar way that I wrote to the bereaved families, through the contacts we had. I do wonder whether, actually, if I did this again -- and I think it's on the reflections -- obviously, I've got the reflections on the end of my statement -- that actually more -- we could have tried to reach out again to try -- but I'm not sure, really, given the time we had, what more we could do, over and above what we did.
But on reflection, if we had more time, like the other -- the IOPC and the CQC, which had a much less demanding timescale, I think probably I -- I probably

would because it obviously sits with my values. I think I would like to have asked -- I'd like to have spoken to them to see how they felt through the process.
Q. The letter of 15 March 2024 -- I won't bring it back up, but the one we saw notifying the bereaved of the draft report or the report that was being finalised or the publication of the report -- were similar letters sent to the survivors, so far as you were aware?
A. They weren't.
Q. They weren't?
A. No.
Q. I mean, it would have been --
A. Yes, it would. On hindsight, it would, yeah.
Q. If we could go, please, to page 68 --
A. Can I just say though, you have to remember the commission from the attorney was from the bereaved families. The commission for this inspection was on the basis of the meeting with the Prime Minister with the bereaved families. But, you know, again, for fairness, I didn't want to exclude the survivors but the commission actually was quite clear.
Q. Did you ask the Attorney General whether you could have more time?
A. No, I didn't. Well, I was made aware I wouldn't have more time. I didn't ask the direct question of Baroness

Prentis but I was made aware that Easter was the hard cut.

Q. Page 68, paragraph 9.2, this addresses Elaine Newton, it says:

"Ian's partner declined to meet with us but confirmed in a telephone call that she had no concerns regarding the CPS's engagement with her and was complimentary about the service she had received."

Again, could you have done more to have engaged her? I mean, she wouldn't have known the concerns that perhaps you shared?

A. I had that -- I had the telephone call with Elaine and she was very clear in that telephone call. She was very grateful for the call, she was very grateful for what we were doing but she was very clear she didn't want any contact about this in that telephone call to me.

Q. In none of your inspections do you inform those who were affected in advance of a summary of your findings?

A. We don't do inspections like this. This is a unique inspection. There has only ever been, in the history of the Inspectorate, two specific-case inspections: one was on the Jubilee Line Inquiry, and this one. This is a very, very unique inspection. We do not look, and have not looked, bar this and Jubilee Line, at individual cases.

Q. Looking back at this, just as a criticism may be made of the CPS and their engagement, do you think that HMCPSI could have spent a bit longer and have engaged a bit more?

A. Yes, I do, which is why I said it at the end of my statement.

MR BLAKE: Chair, I don't have any further questions. There are questions from Core Participants.

THE CHAIR: Yes, thank you.

Mr Moloney.

Questioned by MR MOLONEY

MR MOLONEY: Morning, Mr Rogers.

A. Morning.

Q. Just three topics, if I could, please. First of all, the report of DC Beddoe; secondly, Dr Latham's instruction; and, thirdly, the publication of the reports.

If I could take each of those in turn, you've already set out what the remit of your report was at paragraph 1.3, Mr Blake having asked you questions about that. I'll ask you about Mr Beddoe's report, if I may. Have you watched any of the evidence, did you watch any of the evidence, of Mr Murphy, Ms Shallow, Ms Mannion or Mr Khalil, King's Counsel?

A. I have read the transcripts of all of those.

Q. You read the transcripts of all of them.

A. I have.

Q. Thank you very much. You were aware, from your inspection of the events, during the course of the investigation and prosecution that you were concerned with, and having written your report, that the family raised numerous concerns to the effect that insufficient regard had been paid to the apparently rational actions of VC on 12 and 13 June. Did you -- and I think you've already said you knew about Mr Beddoe's report in answer to the question from Mr Blake --

A. *(The witness nodded)*.

Q. -- during the course of your -- the formulation of your report?

A. Yes, we saw the evidence, we saw the Beddoe report, we saw Alan Murphy's response on that and we saw the correspondence that followed that report and where it came and, you know, whether it was requested or not. We saw all of that evidence.

Q. So you saw all of that and, indeed, having read the transcripts, you've seen that some of that correspondence has been gone through with Mr Murphy and various others?

A. Yeah.

Q. Now, that report of Mr Beddoe was placed on the schedule

of sensitive unused material?

A. Yeah.

Q. As the head of HMCPSI, did -- is it your view that the Neil Beddoe report should have been on this schedule of sensitive unused material?

A. It is. Communication between the police and CPS and, as a natural course, that's where it would live. It would live on a schedule of unused material.

Q. So I just want to explore that with you. The disclosure of Mr Beddoe's report. How would that give rise to a real risk of serious prejudice to important public interest, so as to justify it being placed on the schedule of sensitive unused material?

A. I think Alan Murphy actually answered that question, as did Sam Shallow, and, you know, sort of in a way, we were inspecting -- this was -- we did not get into the management of disclosure as part of this inspection. What we thought about was actually what was in that report and actually the issue that related to that, and whether, obviously, the psychiatrists had considered some of the issues which I think we all realised that they did understand the issues that was raised in that Beddoe report. We were not doing an inspection of disclosure on this inspection.

Q. You said Alan Murphy answered that question --

A. I think he did.
Q. -- and of Sam Shallow. I was actually asking you, Mr Rogers, what would be the public interest that would be serious prejudiced -- an important public interest that would be seriously prejudiced by that disclosure of that report?
A. I'm sorry, I don't think I can answer that question. One, I'm not a lawyer.
Q. It shouldn't be on the schedule of communication like that, should it?
A. It's --
Q. And if it was on any schedule it should be on a non-sensitive schedule, shouldn't it?
A. It's a memo between -- the norm is -- to my understanding, the norm is -- I'm no disclosure expert -- that a memo between the police and the CPS of that nature would live on a sensitive schedule.
Q. Can I ask you to have a look at an email, which is CPSE0009097. This is an email in response to Mr Murphy's email, which I'll describe in shorthand as a critique of Mr Beddoe's report?
A. Yes.
Q. You saw this email?
A. We did.
Q. Yes. You see there that it reads:

"Hi, Alan

"I entirely agree with the below. I am also far from convinced with Leigh's response. If it wasn't to set out the police view as to the acceptability of the pleas then I don't understand the point of it, and specifically the 'it is not possible to say with any certainty' opinion aspect.

"I hope that your last sentence got the message across to the police about sharing this view with the families. I am very concerned that this may have been or will be done -- whether in the form of the 'report' or in discussion."

Did you ask junior counsel about that email?
A. I'd have to look at the notes of the interview. I'm sorry, I don't -- can you bring up the notes of the interview that we did with junior counsel and Mr Khalil, please?
Q. We can check that. Do you recollect asking?
A. I recognise this email. I can -- let me have a look at the notes, sorry. I don't know if we did.
MR BLAKE: The URN is HMCP0000576.
THE CHAIR: Mr Rogers, it's going to come up on the screen.
A. Thank you. Can you scroll up, please, or down. Whichever way it goes, sorry. Keep going, sorry. Keep going.

It doesn't appear we did.
MR MOLONEY: No. But does that email not -- did that email not concern you, that counsel was concerned about the police sharing this view with the family?
A. I think, given the concern that was expressed where that report had come from, nobody was clear why the report had been produced and, actually, it was contrary to what the issues in the case were. I think it probably would have caused more disquiet, confusion and upset. So I actually think it was inappropriate not to share that with the families because I'm not sure the report actually --
Q. I didn't ask you that, Mr Rogers. I asked you whether or not it concerned you, whether or not you thought at the time, "Actually, this might reveal a little bit of tension about the families and part of my remit", if I can just read, is that to:

"... whether the approach taken by the CPS in engaging with the families during the case met the standards and expectations as set out in the Victims' Code and it's own Bereaved Family Scheme."

Were you not concerned by this, that there might be an apparent tension as perceived by junior counsel, in terms of the -- firstly, what the police were trying to do; and, secondly, revealing information to the family?

Not what you think now about whether or not it was right but whether or not those tensions emerged from that email.
A. I'm not quite sure how that would actually sit within the scope of the inspection, looking at actually meeting the Bereaved Family Scheme or the Victims' Code of Practice. So which may be -- so I may be misunderstanding your questions, so please forgive me.
Q. Were you concerned about the relationship between the families and the CPS during the course of this investigation and prosecution?
A. I was concerned that ... I was concerned that, actually, the CPS -- as part of the inspection, it was very clear that the CPS had tried their best to engage, inform, consult, speak to the families throughout. And it was quite obvious, I think, as part of this inspection, that there were different expectations and understanding of a lot of issues.
Q. Right. So if the CPS had been seeking to -- you reached that conclusion, that's what you've said now -- the CPS were concerned to engage the families and I don't want to -- I haven't got much time --
A. I'm not saying we were concerned to engage the families. I didn't say that. That's not my words, I don't think. If I did, I certainly misspoke --

Q. "It was very clear that the CPS had tried their best to engage, inform, consult, speak to the families throughout."
A. Yes.
Q. "Engage" was the word used?
A. I did.
Q. Did this not show a concern about further engagement with the families on the part of the police by telling them about DC Beddoe's report?
A. I don't think so, no.
Q. Right, okay. I'd better move on because I've got -- if I can just ask you very briefly about the publication of the report. Did you arrange -- inform the families of the date of the publication of the report, 25 March?
A. Yes, I did.
Q. Yeah. You offered a face-to-face meeting with the families on that date?
A. Yes, I did.
Q. You declined to provide them with advance copies of the report because of embargo considerations?
A. No, because it was physically impossible to do so.
Q. Are you sure it wasn't embargo --
A. No, it wasn't the embargo basis. It was physically impossible to do, as I said to Counsel to the Inquiry.
Q. All right. You're sure about that?

A. Absolutely.
Q. Now, you met them on the morning of the date of publication?
A. I did, we did.
Q. The report is 115 pages in length with appendices, isn't it?
A. Yes, it is.
Q. You allowed them less than an hour with the report before meeting your team, didn't you?
A. No, I didn't.
Q. They --
A. We had a meeting for over an hour and three-quarters. That meeting actually delayed my speaking to the press -- my briefing to the press was delayed by two hours and we spent an hour and three quarters trying and going through the report with the families as a team.
Q. I'll put to you that you allowed -- that after that time of just short of an hour, they went straight into a meeting to raise any questions that they had and then, at the end of that meeting of about 45 minutes, you did your press conference, didn't you?
A. I did my press conference at 1.30, having left that meeting, with the family speaking to the press outside of the building.
MR MOLONEY: Thank you very much, Mr Rogers.

THE CHAIR: Yes, Ms Cartwright.

Questioned by MS CARTWRIGHT

MS CARTWRIGHT: Good morning, Mr Rogers.
A. Good morning.
Q. I ask questions on behalf of the survivors.

Could I go first of all, please, essentially, to the request for the inspection that you undertook. So it's in HMCP0000625, at page 99, please, which is the commissioning and the inspection, thank you. Now, you've indicated that the remit was only for the bereaved families, not for the survivors. Looking at this request from the Attorney General, why do you say it did not apply to the survivors, bearing in mind this was a rapid inspection of CPS actions in the VC case, the survivors were part of that VC case --
A. *(The witness nodded)*.
Q. -- and you see it says:

"This inspection should address the concerns raised by the victims' families about the charging decision and the approach taken by the CPS in engaging with the families."

A. Yeah, I said that because, actually, the commission and the conversations had related to the conversation that the bereaved families had with the Prime Minister, and the Attorney General and others at the time. But

obviously I agree with you, which is why we wrote to the surviving families to ask if they wanted to engage with this inspection.
Q. Well, you say that you wrote to them. There's not been provided in the disclosure the letters --
A. We did write to them.
Q. Well, one would have expected, if the Inspectorate has complied and provided full disclosure to this Inquiry, they would be there?
A. I don't know why that wasn't.
Q. So certainly the report records at paragraph 3.4 --
A. Yes, it does.
Q. -- that they're invited to contribute. But certainly those I represent and their lawyers have no evidence of any invitation to engage with the inspection, and so it would first of all be of assistance if those letters or the approach could be disclosed, but because certainly from our perspective there is no evidence whatsoever of any contact with the survivors to engage with this inspection, and would you agree that even if you are correct that a letter was sent, which we'd not received and not received in disclosure, that one of the failings in this inspection is you have to failed to capture the input from survivors who have some very real evidence and input about the CPS engaging with them as victims?

A. I think I answered the Counsel to the Inquiry that actually, in hindsight, I think I would have done it quite differently.

Q. No. Well, again it doesn't require hindsight. And perhaps whilst we're looking at that, just to contextualise what you've said in your witness statement, please, if we could just disclose your paragraph 52, I think it is, in the witness statement where you effectively -- thank you, could we move to, I think it's paragraph 52, you say:

"I consider that the ... inspection report fully addressed the concerns raised by the bereaved families in respect of both the CPS decision-making and the CPS communication with them. There is nothing further that I consider we could or should have done. This is in respect of responding to the remit of the commission received from the Attorney General, addressing the families' concerns, and in reaching the clear findings that we did."

Would you agree or would you now, therefore, amend your paragraph 52 that essentially there is more that the Inspectorate should have done in respect of the remit of the commission?

A. Yes, I would.

Q. And I think even leaving aside the complete failure to

engage with the survivors, can I just push back on your paragraph 52 in terms of that observation, bearing in mind you yourself have said you were given limited time to complete this inspection, there was no pre-publication discussion or disclosure, and therefore would you agree that those two are also failings in this inspection that really don't deserve the pat on the back of "There is nothing further that I consider we could or should have done"?

A. Well, I do consider what more we could have done and I set those out in paragraphs 53 and 54. But yes, I agree with you, on reflection, if we had had more time, we would have engaged -- I would have probably tried to engage with the survivors in a more meaningful way than sending a letter and not getting a response.

Q. Well, then can we then perhaps just look at the purpose of inspections. It's document WITN0245002. Thank you. Certainly in terms of the principles for the inspection, if we look at principle 1, "The purpose of improvement".

A. Yeah.

Q. I'm going to suggest to you that a rushed inspection or inspection where there plainly were significant issues from those that I represent, in respect of communication, that are not just fact specific, that will assist more broadly the CPS engagement with victims

who have traumatic brain injuries, post-traumatic stress disorder and physical disabilities as a result of the attacks on them, that there was a real opportunity for improvement more broadly as to how CPS engaged with victims if this Inspectorate had undertaken what we say should have been done, the views and specific look at the perspective of the survivors; would you agree?

A. Yes, I would.

Q. If we can just go down please. Again, in terms of an inspection, what is key is the "user perspective", principle 3:

"Inspection should be delivered with a clear focus on the experience of those for whom the service I proved, as well as on internal management arrangements. Inspection should encourage innovation and diversity and not be solely compliance-based".

I think you've already accepted that this inspection completely fails to have the perspective of the survivor-victims as to how the CPS engaged with them; would you agree?

A. I do, but these principles are actually about what I would call usual inspection. As I've said already, this is a unique inspection looking at one case. Inspection actually is very unusual of this nature. We normally focus on the experience of a cohort. So be it,

you know, we've just published an inspection on the CPS performance of those involved in knife crime, or crimes against older people.

So the user perspective is a much wider -- and these principles, these 2003 principles, what you're saying I agree with from the point that I could have engaged with the survivors, but that user perspective I think is not as you've just set it out, because of the unique nature of this inspection.

Q. Well, what I'm going to suggest to you is not just fact-specific matters but one of the matters you've robustly said in questioning today: there would have been no purpose in speaking to the FLOs.

A. Yeah.

Q. Essentially they are police individuals in any event, so they may not need to cooperate with our Inspectorate.

A. No, I don't have a remit to inspect them. I didn't say not cooperate. They may -- they could have refused. I can't make them talk to me.

Q. Because what I'm going to suggest is, it was a real opportunity for the Inspectorate to look at how the CPS rely or absolve their responsibilities by saying, "Well, that was for the FLO to sort". Because perhaps if I give you a context, the -- those that I represent were asking for meetings, along the way, to understand, and

in particular Wayne and his partner, and the evidence that's ultimately been given about those requests for those meetings is "Well, the FLO should have sorted those meetings."

And so where the CPS rely upon the FLOs as a conduit to discharge their communication responsibility, there's a very real issue --

A. There is.

Q. -- that affects nationally --

A. It does.

Q. -- how CPS essentially are discharging their obligations in the Victims' Code relative to essentially saying: well it's down to the FLO.

A. Yeah.

Q. So that's why I'm going to suggest this Inspectorate lost a real opportunity to provide national learning about the CPS not being over-reliant on FLOs.

A. I don't actually entirely agree with that because we published a report on meeting the needs of victims, a joint report with HMICFRS, the police Inspectorate, only two years ago, pointing to the exact issues in this case.

So I don't agree -- we did miss an opportunity here, I agree, from the survivors, we missed an opportunity. But actually I don't think, because of the work that we

do, generally thorough inspection, we published a report only two years ago highlighting the issues you're just talking about.

Q. Well, even more so, though, in the context of the fact specifics of this and the failings in the system --

A. I agree.

Q. -- there was a real lost opportunity, because again, even in this opening to this Inquiry, the CPS wrongly, in their opening, indicated the survivors had two FLOs.

A. *(The witness nodded)*.

Q. There was one FLO for three cohorts --

A. Yes.

Q. -- of survivors. And again, lots of evidence of ways where actually the guidance could have been better given to assist victims.

A. *(The witness nodded)*.

Q. And particularly victims who sustain cognitive injuries --

A. *(The witness nodded)*.

Q. -- brain injuries and physical disabilities; would you agree?

A. Yes, having read the statement of DCI Gould now, yes, I think there are opportunities, but I don't think that's entirely a matter -- I think that's more a police matter than a CPS matter, if I'm perfectly honest; the

allocation of the FLO.

Q. Well, I'm going to suggest that's just why in this case there was rich learning on the facts of this case if the FLOs had been spoken to, and particularly the single FLO who, all of her records were not in the FLO logs you saw, they've been lost and destroyed in Teams meetings and who described herself as on the outer circle of the FLOs.

A. Right, okay.

MS CARTWRIGHT: Thank you.

THE CHAIR: Thank you.

Ms Carey?

MS CAREY: *(Unclear -- off microphone).*

Questioned by THE CHAIR

THE CHAIR: Yes, Mr Rogers, I just wanted to ask about one thing. You had, you said here: this wasn't a usual type of inspection --

A. No, it wasn't.

THE CHAIR: -- because it was one of two different, as you've said, unique inspections. One was the Jubilee Line, very different to this.

A. It was, yes.

THE CHAIR: Yes, and this was a complex case involving murder, the defences, and attempted murder --

A. *(The witness nodded)*.

THE CHAIR: -- and the intersection of that, so you've got different groups, haven't you, that you're looking at --

A. Yes.

THE CHAIR: -- and the treatment of those groups: the victims, the bereaved and the survivors, all of whom have different needs and interactions with the police and the CPS because of the nature of their involvement.

And you make one recommendation.

A. Yes.

THE CHAIR: You were asked by Mr Blake about whether it would have been possible and right to have made a recommendation about written advice being given to the FLOs.

Now why can't that be done? It may be that you have a number of different, as it were, short cards that they have. So the difference, for example, between the position of those who were the victims of attempted murder, because that still affected them, the decision in relation to diminished responsibility would affect the outcome in terms of the sentence.

A. Of the sentence, yes, yes.

THE CHAIR: So that would have been something which could have been explained, really relatively simply, although these are complex matters, aren't they?

A. They are. I think I tried to explain to Counsel to the

Inquiry, Chair, that this is quite a unique case and, if we make a recommendation like that, the CPS obviously, through the processes we have, superintendence of the Attorney, would be obliged to do that in every case. And I'm not convinced that there is enough evidence in this case for me to be able to say, as chief inspector, that we should recommend it as national -- as CPS policy. Now, I think --

THE CHAIR: Why not? Because I'm interested in why not, obviously.

A. I think this Inquiry could lead to that, I just think that, actually, I would like to have seen, in the Manchester bombing, in some of the Southport case, I'd like to have had some other evidence about whether that issue was so core, in multi-murder, multi-survivor, multi -- you know, cases of this nature, before I made a recommendation.

Making a recommendation, now the one on "consult" was clear to me and was a recommendation the CPS were wrong in that. You know, around evidential issues, they're not consulting; they're informing. But, actually, I would have wanted a bit more evidence before I made a recommendation that the CPS should but, actually, there's obviously -- in your Inquiry, there is nothing to stop you from making that recommendation.

I think why we put it in that narrative is we thought it was a very sensible thing to do as a finding but I didn't go as far as a recommendation for the reason I've outlined.

THE CHAIR: Well, I'm interested as to the process whereby you didn't because, obviously, it's a question of your remit because, in one sense, this was a paradigm case in which you could have done that, couldn't you?

A. Possibly, but as I've just said, I would probably, to make a recommendation, I would have liked a little bit more evidence.

THE CHAIR: Yes. All right. Thank you.

A. Thank you.

MR BLAKE: Thank you, Chair.

Just as a matter of technicality, I think in my rush to get on this morning I don't think I asked Mr Rogers to confirm the truth of his witness statement.

Could I just ask you: you produced a witness statement, WITN0245001, dated 27 February 2025. Is that true to the best of your knowledge and belief?

A. It is, thank you.

MR BLAKE: Thank you very much.

THE CHAIR: Mr Rogers, just before you go, I don't want to have to make a specific request but, if you do have letters that were sent to the survivors --

A. I will check.

THE CHAIR: -- will you provide those to the Inquiry?

A. I'm very surprised they're not in what we provided because I think I asked for everything to be shared.

THE CHAIR: Thank you, well --

A. But I will check again.

THE CHAIR: -- perhaps you can do another search to make sure we have everything.

THE WITNESS: Sure, no problem.

THE CHAIR: Thank you.

(11.33 am)

(A short break)

(11.51 am)

THE CHAIR: Yes?

MS LANGDALE: Chair, may I call Dr Lloyd, please?

DR TUHINA LLOYD (affirmed)

Questioned by MS LANGDALE

THE CHAIR: Yes, Ms Langdale?

MS LANGDALE: Dr Lloyd, you've prepared a statement for the Inquiry dated 18 December 2025, can you confirm the contents are true and accurate, as far as you're concerned?

A. There are two small areas of inaccuracy, paragraph 342 there's a date inaccuracy, a date that reads 4 July 2022, which should be 4 August, when Mr Carter and Paul

Robinson did their visit and there is a further inaccuracy in paragraph 346 when I mentioned that Gary Carter was present at the meeting on 22 September 2022 --

Q. The discharge meeting?

A. That's correct, at that meeting. But, in fact, I have come to learn that he was not present.

Q. How have you come to learn that?

A. It was through reading his witness statement.

Q. Thank you. But subject to those amends, you're content that it is true and accurate as far as you're concerned?

A. Yes.

Q. Can you tell us, please, your qualifications and experience and indeed your role at the time of dealing with VC?

A. Yes. So I qualified as a medical practitioner, gaining my Bachelor of Medicine and Bachelor of Surgery in 1995 from the University of Nottingham. I have also got a Bachelor of Medical Sciences and Master of Medical Sciences Degree, in addition to that, and my membership exams, Membership of the Royal College of Psychiatrists, was obtained in 1995 -- sorry, that's incorrect. In 1999, I do apologise.

And I am currently a consultant psychiatrist. My role as a consultant commenced in 2004 and I was

initially a community consultant in the north part of Nottinghamshire area, covering Newark and Sherwood, working with the Assertive Outreach Team, the Early Intervention in Psychosis team, and also I had quite a lot of patients with complex psychosis at the time and, in 2018, I left that role and moved to the city of Nottingham to work with the Local Mental Health Team covering the south part of that city. And, again, that was working with the Early Intervention Service and the Local Mental Health Service, looking after patients with psychosis.

Q. So how many years' experience had you had looking after patients with psychosis at the time of dealing with VC?

A. As a consultant, I will have had just under 23 years and, prior to that, as a higher specialist trainee, I was an academic trainee undertaking both research and teaching in psychosis, as well as doing clinical work.

Q. You mentioned Gary Carter. He gave evidence the other day, did you hear his evidence?

A. I heard most of his evidence.

Q. He made reference to being at a meeting with you, Diane Hull and Dr Thangavelu, and him saying something to the effect of "Do you think we missed something? Could we have prevented this?" His evidence was:

"All of them said no way we could have predicted or

prevented this."

First of all, do you remember that conversation or something similar with him?

A. Not at all.

Q. So it's not something, whether you could have prevented this or predicted this, that was discussed amongst yourselves because it wouldn't be unreasonable to do so after the events of 2023, June 2023?

A. As a team?

Q. Mm.

A. We were told very clearly, after the incident, that we should not be talking to any member of the team whatsoever, both within the service and out of the service. And I stuck to that very much. That was something that was being told to every single person who was involved.

Q. Who did that message come from and when?

A. I'm trying to remember now. I think the message originally, originally came from -- I think it was the clinical lead at the time.

Q. Who's that?

A. I'm pretty sure it was Sharon Heath that came into the office and said we should not be discussing this case, not even amongst each other in the team.

Q. That was in June, you say, straight after the attacks or

later than that?

A. I think that was a lot, lot later. I can't remember exactly who said that at the beginning.

Q. Because if you lived in Nottingham, the attacks themselves were so prevalent, weren't they, on the news and information, it would be perfectly natural, wouldn't it, amongst yourselves, before getting such a message, to have a conversation about it and say, "This was one of our patients", have a look and think about what had happened? A normal reaction, I'm suggesting, in the circumstances --

A. It is a normal reaction and I remember --

Q. So did you do it?

A. No, I remember at the time thinking how difficult it was that we had been all told that we could not talk to anybody about the incident whatsoever, that we had to keep it all within ourselves. It was incredibly hard.

Q. You were interviewed, weren't you, by a number of reports, investigations, reviews? So you were all going along.

A. That's right.

Q. So it was your evidence you'd go along not having supported it with others and give your own evidence?

A. That is right.

Q. Was there nobody that you discussed it with?

A. There was nobody.

Q. In terms of whether it could have been predicted or prevented, what would your answer be to that? What is your answer to that?

A. It's a difficult question to answer, but what I will say is that knowing a little bit around risk assessment, and I think particularly risk assessments for rare events like homicide in psychosis, we know that clinical judgement, risk assessment tools, that are currently out there, have really quite low predictive validity and that predicting violence, particularly homicide, which is a rare event, is really hard at an individual level. And that's in literature, that's something I have read about, I have been to conferences, and we know that.

Q. Risk assessment tools by themselves may be limited in assessing risk, but clinical judgement in combination with them can be very effective in assessing risk.

A. They can be effective in assessing risk across a large group of individuals -- of, you know, sort of group data. But what is very, very difficult is assessing individual risk. And what I can say is, if I look at my caseload, there are individuals who, on paper, in terms of both clinical judgement and risk factors, have got significantly more risks than VC, and have not gone on to commit homicide.

Q. What is your caseload now?
A. How?
Q. How many people on your caseload now?
A. Now, I would say just over 100.
Q. How many at the time of dealing with VC?
A. Just less than 150.
Q. We know you met him once, didn't you, in a consultation?
A. Only had the opportunity, unfortunately, to meet him once.
Q. We'll go through the notes in due course. So you meet him once and you're relying very much on reading the notes of others, aren't you, in between, at Multi-Disciplinary Team meetings?
A. That's correct. Reading the notes, Multi-Disciplinary Team meetings, discussions with his care coordinator and supervision with Dr Burri.
Q. And there are no notes of those Multi-Disciplinary Team meetings.
A. *(The witness shook head)*.
Q. Why was that?
A. When I first started in Nottingham City team, I asked that question to the team manager and the response that I got -- I was actually surprised because the team that I had come from, MDT notes were made and minuted, and the response that I got back was that it's generally the

responsibility of the care coordinators to jot down the actions of any discussions that we don't have any admin support, unfortunately, that's just a resource that isn't available, and that essentially this is normal and usual within the -- you know, across all of the LMHTs, the Local Mental Health Teams.
Q. And did you suggest it shouldn't be that way?
A. Yes, I did. I said, you know, that I thought it was really important that we should be recording MDT minutes, but I was told that the resource was not available.
Q. Who told you that?
A. We could not have, we do not have admin support.
Q. Who did you raise that with?
A. That was -- I think that was the team leader at the time when I first started with the LMHT.
Q. A Clinical Team Leader?
A. Yes.
Q. So is that an admin position or a --
A. A managerial position.
Q. -- *(overspeaking)* -- technical person. A managerial, but were they also somebody skilled in the clinical work?
A. Yes.
Q. Did they agree with you?

A. They didn't agree or disagree. They just said that was how it was.
Q. But if you thought that was wrong and not in patients' interests and might not lead to actions being followed, or continuity of care, didn't you want to push that further? Because it does seem astonishing, frankly, that we can't see the contents of key discussions relating to a patient.
A. I became aware, sort of at my consultant peer group meetings, that very few teams had that administrative support. There seemed to be only one team and that was the Early Intervention Team in the north that had admin support, and that was for other reasons: it had been especially put in. So I could see that resource issues were really tight.
Q. Is there admin support now for that?
A. Yes, there is, and as soon as this incident occurred, admin support was put in place immediately after that.
Q. Why does it take an event like this to bring that focus? Because if the resources are there now, they were there before, presumably?
A. I can't answer that question.
Q. But were you, as somebody who looks at risk, able to point out at an earlier stage why it's important to make people accountable for actions, and in discussions?

It's important, isn't it, so people know what their responsibility is going forward and they can't shake it off?
A. Sure.
Q. Can I ask you to look first of all at documents you will not have seen at the time relating to VC.
A. Of course.
Q. If we can have INQY0000003. This is a complaint that VC brought to the Investigatory Powers Tribunal, which is concerned and deals with complaints about the conduct of the intelligence service and whether there's been any infringement in his case. He was arguing for human rights.

Have you seen this document? It was sent with a number of documents and you may not have looked at it properly, but we can go, please, to page 2 and we see at paragraph 6, if we can enlarge that:

"He complained ... organisations ... had carried out 'continuous intrusive surveillance and harassment and recorded information about all aspects of [his] ... life'. ... said to have taken place 'primarily in Nottingham'."

Paragraph 9:

"'The conduct began around September 2019 at the accommodation on Salisbury Street.'"

Then "it continued at Brook Court".
So these are places there he is living, or was living:
"'From 2021 onwards again surveillance ... again ... at the accommodation ...'"
So describing being surveyed at his accommodation.
And if we go to page 3, please, paragraph 12 the bit in italics:
"The experience consists in part of a constant hostile communication (with no intermissions) with the complainant whenever he is awake that has lasted for the following two years. In conjunction with this all aspects of the complainant's life were recorded ... telecommunications, personal electronic devices and email accounts were accessed and monitored."
Then paragraph 14 at the bottom:
"[He] linked the complaint of his conduct to mental health and criminality [by saying the following]:
"'Throughout this period the complainant was repeatedly told via this communication that the personal information acquired was being passed to local authorities and even members of the public, to entice him to harass them and be detained. To ensure that the complainant had little recourse to substantiate his claims and seek redress the system created an experience

that could 'plausibly' be dismissed as a sudden mental illness. The objective of the activity as far as the complainant can ascertain is to harass and misinform him, so as to drain him mentally to coerce him to commit criminal activities that retroactively justify the illegal surveillance that the agencies committed. The complainant asserts that the local police department is aware and involved in the illegal activity and as such that avenue for resolution is non-viable'."
This was May 2022 that he sent it, at a time he was a community patient under your care. It wasn't sent to you by the Investigatory Powers Tribunal. Would it have been helpful to see this document?

A. Yes, it would, yes.

Q. Why is that?

A. I think one of the things that I've realised in sort of watching all the Inquiry hearings is that each organisation seemed to have small pieces of a jigsaw puzzle, and none of us really had the full picture at all, and so much information is now being revealed that us as a Community Team would have absolutely no idea existed. And I think it's so important that when we make judgements, when we, you know, make really important decisions, that we should have all of that information available. So yes, every piece of

information is another piece of that bigger picture. So I think it is important.

Q. And we know that he'd -- I don't take you to them all -- written many times about communication requiring technology, a system communicating in his mind.
The significance of what's on the screen, if I can take you to it again in the italics at the top:
"... so as to drain him mentally to coerce him to commit criminal activities ..."
Would you have to picked that up as high risk? Can you see at the top?
It's actually the second paragraph.

A. Oh sorry, the second paragraph, yes.

Q. Yes, move down, sorry. So he says:
"... and misinform him, so as to drain him mentally to coerce him and commit criminal activities ..."
So he's describing that's the effect.

A. Okay that's --

Q. Would you have picked that up? I mean I'm drawing it to your attention. Tell us if you wouldn't. But that's what is being stated. Would you have read that and what would you think about that?

A. He's essentially saying that there are these systems in place that are forcing him to commit a criminal activity or criminal activities. He doesn't specify what that

is. But he's suggesting that there is -- there's a process in place that is somehow having some kind of control over him. So yes, that is concerning.

Q. And when we go to the notes you know as early as May 2020 is when he is going into properties, smashing doors down, causing a woman to jump out of a first-floor window. That's what he's doing: committing criminal activities. You know that.

A. *(The witness nodded)*. And that was very much in response to auditory hallucinations, I understand, rather than some sort of mental coercion, as he describes here.

Q. Is there a difference if the activity is the same, whether it's an auditory hallucination from the victim's perspective or a coercion through mind control? It's the impact, isn't it, of whatever it is?

A. But it's also something about intent, isn't it? So in the incidents where he kicked down a door, my understanding, having read the notes in a lot of detail, was that he did not actually have any intent to harm anyone. He was responding to auditory hallucinations. He could hear his mother screaming on the other side of the door and he wanted to go and help. So there was no actual violent intent there. There was no intent to harm anyone. The kicking of the door was an action that

needed to take place so that he could help someone on the other side, and the unintended consequence, the devastating unintended consequence, was that a student jumped out of a window. But that wasn't what VC had intended to do.

Q. In terms of risk and risk assessment, whatever his intentions were are of no significance to the person who has jumped out of the window, are they? It's a fact: unintended consequences have the same risk to the victim, devastating risk?

A. To the victim, yes.

Q. Well, that's important, isn't it, in assessing risk to others? What your motivation is is neither here nor there for those who are impacted. It might be relevant to you, as the psychiatrist --

A. Yes.

Q. -- looking at your patient, but also relevant to you is the risk to others and members of the public, isn't it? And whether he was going in with a deluded but laudable motive, as opposed to a deluded but criminal motive, expressly intending harm, is neither here nor there in terms of assessing risk; do you agree?

A. But there's a difference, isn't there, between going in with a laudable motive and actually going in to commit a crime? And I think you asked me what the difference

was between this and the previous incident, so I was just trying to explain that to you.

Q. This suggests no laudable motive at all, does it?

A. No, that's right.

Q. So this, you would say, is even more serious in terms of risk because there's no suggestion it's to help anyone else; it's a pure criminal endeavour?

A. That's right.

Q. That can come down, please. Can we have a look, please, at NHFT0000168, the medical notes, page 21. This is one of many medical records but I just want to see if you were able to ascertain from this one, the messages that Dr Seedat was purporting to encapsulate.

So page 21. Take your time, please, to read how Dr Seedat summarises evidence of texts. In effect, he says in that fourth paragraph:

"... telling my thoughts to someone else. He said that people would not mock him in person and made some remark to wanting to hurt these people he was hearing."

So the context, unless you're not already aware, is that Dr Seedat has received a document from VC's brother and he's purporting to summarise the messaging that's contained within it here.

What would you assess, reading this, in terms of the risk of the texts and what they mean, just looking at

the document there?

A. In terms of risk to --

Q. To others.

A. To others?

Q. Yeah, what would that tell you, if anything, about VC? So assuming you're always interested in your patients' thought processes --

A. Sure.

Q. -- and what's happening in their mind, you don't have the benefit of physicians to be able to immediately --

A. No, absolutely.

Q. -- corroborate it, so this is perhaps the best you can get from the person. What are you taking from this summary about risk to others?

A. It sounds as though he wanted to hurt the people that were talking about him, that were making the derogatory comments, but it doesn't specifically identify who these people are or a person in reality. These are individuals who exist within his perception. So yes, I think there is some risk but, if you actually look at risk assessment and the literature on risk assessment, risk becomes really significant when you have clear identified individuals who you either know or is known to the patient, who they can identify. That's when risk becomes significant. This is a little bit more quasi,

as such.

Q. A bit more generic?

A. Absolutely.

Q. So fixation or stalking, they're high-risk behaviours, aren't they?

A. Yes.

Q. So if you're fixed on a particular person or following a person, that's the kind of thing you would be concerned about for that person?

A. Absolutely, if we knew there were specific individuals who were being stalked or targeted then, yes, I would be a lot more concerned.

Q. There's a theme, as we go through the years, of it being neighbours, people that he's living with, that he is targeting. Did you pick that up at the time?

A. No, not really. I don't think we had any of that information. So that -- you know, I was sent the bundle. I read quite a lot of the witness statements from the neighbours and students but that information was not made available to us, as a clinical team.

Q. Can we have a look, please, at NGPF0002527. We've identified from Dr Seedat's notes the remark "wanting to hurt these people" but I just want to ask you about these remarks and whether they would have heightened any concern about risk, page 14, please, and we see at 17:02

VC making reference:

"Because I know that they are watching. I know that I can break their heads with my hands."

That's a particularly graphic phrase. Would that concern you, that description?

A. It sounds violent. So, yes, again, if we start to add together all of the little bits and statements and get a sense of a bigger picture, then, yes, you know, it's more concerning --

Q. Page 17, please, 14:52 and 14:54.

"That previous night I felt immense anguish, paranoia, anger, hatred, couldn't sleep ... darkest thoughts could imagine wanted to hurt ... permanently ..."

What about that?

A. It's more of the same, isn't it, of what we've seen.

Q. Page 18, please, 15:19:

"... why do I feel like this now? I know I didn't work myself into this state of mind. I was thinking about red rum not 120 minutes ago."

Would you know what "red rum" suggests?

A. Yes.

Q. What does that suggest to you?

A. "Murder" backwards.

Q. So if you saw that text, what do you think about that?

A. Again, it's another piece of information that adds to all the others in terms of informing risk.

Q. Do you think the summary I took you to earlier, adequately conveyed those messages, the risk element of those messages?

A. No.

Q. Dr Seedat, of course, uploading all of these documents to RiO, no doubt if he'd wanted to do that, that's quite a difficult task, is it, or time-consuming task, or not?

A. It's usually the medical secretaries that do the uploading.

Q. So you can ask a medical secretary to upload something like that?

A. Yes, you normally would.

Q. If you were given something like that from a patient's family member who wanted to assist and were quite happy for you to use it as you saw fit, in terms of sharing the information, what would you do with it?

A. It's very difficult for me to comment on that. I don't know the circumstances of the situation at the time, what Dr Seedat had been told by family, if they were worried or concerned that releasing that information might have impact for them. It's not a question I could answer without being actually in that situation myself.

Q. Well, even if they were, either way, you still have an

obligation, don't you, to share information relevant to risk. If you consider these were relevant and you identified someone saying, "I was thinking about murder not 120 minutes ago", would you share that information, whether it's actually uploading the whole document or making a more vivid summary in the notes?

A. Because I understood the meaning of "red rum" as being "murder", yes, I probably would have. But I'm not sure that everyone would necessarily understand. You would have to have watched the film The Shining or seen it in some other -- you know, some other meme or context, whereas, you know, if you hadn't, it could mean anything, really.

Q. But your evidence is, despite the fact you didn't have admin support for Multi-Disciplinary Team meetings, there would be support for a task like that --

A. Yes, there would be --

Q. -- if a doctor wanted assistance, a consultant in having material made available --

A. Yes.

Q. -- for the rest of the team; and it's perfectly feasible, isn't it, that some people if they can't read all the notes might just use a control function and search for what you've said, for example, as the consultant? It's possible, isn't it?

A. *(The witness nodded)*.

Q. If someone thinks: I can't read everything, I'll just see what the consultant thinks, or the Consultant Psychiatrist.

A. It is possible to do that, yes.

Q. And probably quite useful for trainees and others to see what you do think on occasion, yes?

A. Yes. That's right.

Q. So you do say you have the right support in the event you want to do that.

Thank you. That can go down and can we have please WITN0428001, and this is a statement from a woman who lived in the same premises as VC between 2014 to 2015.

I think we've sent you this as well, have we, Dr Lloyd? Have you seen this statement? If we go, please, to page 2. Her impression:

"... he was quiet, unfriendly ... did not appear to want to socialise with other people living in the house. ... sometimes try to start conversations ... usually met with one word answers and [so] he would often leave the conversation as soon as possible."

Paragraph 5, if you read that, she refers to:

"... frequently [waking] ... up to the sound of someone in the kitchen, which turned out to be him [at night] ... I remember wondering how he was able to sleep

if he was often so up during the night and during the day.

"On other occasions, during the early hours of the morning, I heard repetitive noises and what I can describe as screaming coming from his room. A friend who was staying with me also heard these noises."

Then if we go to paragraph 8, page 3, an incident where food had gone missing, her housemate asked everyone about it:

"When she asked [VC] ... raised his voice ... asked why she was accusing him, which [she] ... found intimidating. He ... walked away and the issue was not discussed further."

And then we see, please, paragraph 14, page 4.

"... I gave them a factual account of my time living in shared accommodation with [VC]. I described behaviours I had observed, including unusual patterns of activity during the night, loud noises ... and ... interactions with housemates."

So she was concerned about his mental health then, when she saw he was in the news, and had concerns back to 2014 to 2015. Were you aware of any earlier concerns about his mental health?

A. No.

Q. Would -- again, would that have been helpful in

assessing him at the time that you did?

A. It would have been helpful, I think mainly because it would have given me a much better idea of the sort of natural history of his condition. If there had been potential signs of unusual behaviour and psychosis as early as 2015, it puts a very different slant on the diagnosis.

Q. Can that come down, please, and can we go to the documents now at NHFT0000168 file, starting page 11. And Dr Lloyd, I'm going to begin in 2020. We know he's had a Mental Health Act Assessment on 24 May, and this is a ward round on 28 May with Dr Seedat, and VC's mother present on the phone.

And we see, under "Feedback/Ward round discussion", two paragraphs down:

"[VC] has been speaking to his brother for some time, saying ... he has been hearing voices since January 2020."

So in terms of the duration and nature of VC's illness, whilst nobody was saying anything about 2014 to 2015, it was a matter of months, wasn't it, right from the off, that Dr Seedat was alerted to the fact that he's been heard voices.

Sorry, you nod. It doesn't pick up a nod, the transcript.

A. Yes, yes, sorry.

Q. Can you see that?

A. I'm just reading, I do apologise.

Q. No, take your time. It needs to go further up, so you can read it:

"[VC] has been speaking to his brother ..."

Under "Family/Carers involvement".

A. Yes, I can see that, yes.

Q. And then further down a few lines in the same paragraph if it can be scrolled further up, please, again just a little bit:

"Dr Seedat explained ... the real test for [VC] is when he is back in the community where he will be followed up by a Community Team. Dr Seedat says that based on what Mrs Calocane has said, it would appear that [VC] may be suffering from some sort of mental illness. However, only time will tell."

His mother offers to send a journal to Dr Seedat.

When you read the notes, I know you read the notes, you tell us, did you spot that a journal had been sent or was available that might assist you?

Can you see it?

A. Yes, I can, yeah. I can't remember specifically because it was some time ago.

Q. Is it the sort of thing you'd ask for if you'd noticed

it?

A. Yes, potentially.

Q. Because a journal straight from the horse's mouth, isn't it, what they're thinking, feeling?

A. Yes.

Q. And not expecting you, as the clinician, to be reading it later on?

A. *(The witness nodded)* Yes.

Q. Likely to give you some insight.

A. Yes, yes. It would be helpful.

Q. Did you ever have a conversation with Dr Seedat in detail about VC?

A. No, I didn't.

Q. Did you have any conversation with him?

A. Not about VC -- *(overspeaking)* --

Q. We've seen emails, which we'll go through later, between him --

A. Yes.

Q. -- but no conversation?

A. No actual conversations with Dr Seedat about VC, no.

Q. Wouldn't that have been beneficial, when we look at what information he had, even at this date?

A. When VC was first taken on by our team, shortly after this second admission, it was my higher specialist trainee Dr Bilal Burri who had VC on his caseload and

was doing the initial assessments, and the diagnosis, and so in actual fact, it was Dr Burri that had the sort of more of the lead medical role and responsibility at that stage, and --

Q. He might have been more reluctant about phoning another consultant though, mightn't he, than you could have been as a consultant --

A. Possibly.

Q. -- to say, "Is there anything I need to know about this patient? What was your experience of him?"

A. Yes. No, I can appreciate that, but at the end of the day, we have really clear systems in place, in terms of ward liaison, and it's our care coordinators that have that really important role of liaising with the wards when we have patients who are inpatients --

Q. I'm sure Claudia Birtles will liaise with the ward and attend ward reviews et cetera, but she's not going to phone Dr Seedat. And I'm really asking why two consultants at your respective levels of experience, where we know we speak to others at the same levels of experience, in a different way, a more effective way, in terms of having to explain our reasoning and having shared experience of many, many cases over years, wouldn't that have been wise, prudent and indeed should have happened at some point in the duration of VC's time

in the community?

A. Yes, I agree it would have been helpful, yes.

Q. Does that mean you agree you should have done it? Phoned him?

A. I think ideally, if there had been time, I would have done that, but there are so many patients who are in a similar position coming into the EIP team from inpatient wards, and we have really clear processes in place which involve the care coordinators doing that liaison work, mainly because, as the consultant, there often isn't time to do everything, as much as I'd like to, and I've already made it very clear in my statement, that I had one and a half days allocated to the EIP team, that's 12 hours per week.

Q. Did you ever say, "I can't do justice to these cases? You need to get someone else in. I can't look at the detail, can't make calls to find out the information I need"?

Did you raise that with anyone?

A. Absolutely.

Q. Who did you raise that with?

A. It's been raised over and over again to clinical lead, clinical directors, and this happens regularly at monthly forums, and it's not just me, it's all of my colleagues.

Q. So at the time, this is 2020, 2021, would you have written emails about this kind of thing?

A. It wouldn't necessarily be emails, but if you look through the minutes of consultant forum meetings you'll see that all of my colleagues are constantly raising concerns about the time that we have, the allocated caseloads that we have, what we're expected to do. It's a continuous and repeated issue which we bring up pretty much in every single meeting. And we're all in the same boat. It's not just me on my own. You know, some of my colleagues have got in excess of 300 people on their caseloads.

Q. In terms of reading these notes, we're going to go through them in some detail, did you read them at the time?

A. Yes.

Q. So it's fair for me to ask you about them because you've read them?

A. Absolutely.

Q. So in terms of the journal, you haven't picked that journal up but here we see VC in the next paragraph, "MDT discussion", Dr Ludvigsen asked him what he was thinking about, he said "capital punishment", and didn't say what the "solution" was, and her evidence to the Inquiry was that was concerning, it was worrying.

Were you worried when you saw that?

A. I don't believe I was particularly worried by that.

Q. Did it raise any questions in your mind, in what context is he thinking about it?

A. I can't remember.

Q. Sounds like --

A. This is such a long time ago, I honestly can't remember. But I do recall reading the notes and particularly the medical entries.

Q. If we go to page 12, this is a continuation of this entry at the very top, Dr Seedat is explaining to VC:

"... the most likely cause of the psychotic breakdown is sleep deprivation/[and]stress. [VC] explained ... he would want to seek a period of being medication ['free', that should be] so that he could better understand [where] ... he is."

So we see at the bottom, under "MDT plan", a bit further down from where we've cut off at the moment, please. "MDT plan", we see "Stop regular medication".

So Dr Seedat agrees to a medication-free period, but we see from the ward review on 2 June, page 17 in the notes, page 17 under "Patient comments":

"Thinks people have been following him/watching him probably since last October".

And we see at this stage he says:

"[He] Believes it is a matter of control ..."
Under "Patient comments":
"... never wants to experience anything similar again or cause distress to others".
And the effect of it is, if we go to page 28, 9 June, VC is back on medication and he's disappointed about that. So if we go to 9 June, page 28, under "Patient comments", please. We see:
"[VC] is disappointed ... he is going to have to be on the ward for longer. He is disappointed ... he will need to take medication."
So very early on, he doesn't want to see that he is ill and he's disappointed to be taking medication, isn't he?
A. Yes.
Q. "He denies feeling depressed about his illness. He [hadn't thought] ... about hurting himself or others."
But he appears at this early point, five lines down:
"He believes ... it has been helping him."
The aripiprazole. "He believes ... it has been helping him."
The Inquiry has received evidence that the earlier the treatment is provided, the better for outcome.
A. That's correct.
Q. And at this stage, this admission was really important,

wasn't it, in terms of offering psychotherapies, understanding and communicating with him?
A. Yes.
Q. At this stage, he is accepting it may be helpful to him, and appears at least open to the idea, in that consultation. That's not the picture we see as we move through time, is it? It's a very different picture where that initial resistance to medication comes back fully on nearly every occasion?
A. That's correct.
Q. Just so we can be clear, there's no question that it was well understood in the Community Team that he wasn't taking medication and he was non-concordant?
A. Yes, there were periods where we absolutely believed that he wasn't taking medication. But then there were other periods where we thought he was. It fluctuated.
Q. But the illness was going to fluctuate too. Even if he took some medication, it was never going to keep the illness under control, was it? He needed regular medication, regular antipsychotic medication?
A. Yes.
Q. So knowing that phrase "non-concordant some of the time" and dancing on the heat of a pin whether he took it one week or another week, it wasn't going to help, was it? He needed a proper treatment regime to control it?

A. That's correct.
Q. It does appear indeed, when we go through different entries, there's an over-elaborate consideration about whether he has taken it on one occasion, spit it out on another occasion, why he's got 14 -- a strip of 14 aripiprazole, as opposed to 28, et cetera, et cetera, but, in the end, it amounted to the same effect: it was well known he wasn't taking his medication as required?
A. So during the first year that he was under the service, under the Early Intervention Service, and he was seeing Dr Burri and Claudia Birtles, my understanding was that he generally was taking his medication and that there might be -- I think from the feedback that I got in MDTs and from supervision, that he may have missed just one or two doses very occasionally. So I certainly did not have the information that a lot of medication was being missed.
Q. You knew that he'd stopped taking medication after his first admission, requiring the second --
A. Yes, I knew about that.
Q. -- admission in less than a month.
A. Yes.
Q. And he admitted that?
A. Yes.
Q. He admitted it during his second admission?

A. Yes, so I knew about that.
Q. He is discharged from the second admission, 31 July 2020. He told Professor Blackwood he'd never had any medication or he'd stopped medication by October 2020?
A. And I didn't know that.
Q. But by knowing that the rapid readmission was required, didn't that tell you all that you needed to know about likelihood of not taking further medication? He doesn't take it after the first admission, goes back on the second admission.
A. Yes.
Q. So your starting point should have been he's not taking medication, in other words he needed to actively demonstrate he was. Seeing him take that medication, whether it was a depot or swallowing a tablet, seeing him take medication was essential, not just to rely on what he said, given he hadn't done it before, even when he appeared to recognise some benefit, from the notes in 2020?
A. With oral medication it's just not possible. You know, the Community Team would have been seeing him weekly at most, or fortnightly, and it would be for a brief period. They would get a snapshot. But what we didn't have was the ability to see him every day and watch him take his medication, which was something that, for

example, the Crisis Team would have the resource to do. So, you know, whilst in an ideal world, yes, it would be good to see him take his medication, but it just wouldn't be possible.

Q. Did you ever question, then, whether he was suitable for referral to the EIP team at all, given that after the second admission, taking his medication was key, and you say you don't have the capacity to test if somebody actually is or to observe it, that he should have stayed with the Crisis Team, there's not an Assertive Outreach Team we know, but that kind of monitoring was required that you were not fit for purpose for those purposes?

A. The Crisis Team only sees people, individuals, for a very short time-limited period, whilst they are admission vulnerable or in crisis, when they've got active symptoms and risk. That is very much their criteria. And so, again, it would not be a long-term option for them to continue to see VC for however many years -- *(overspeaking)* --

Q. During that Mental Health Act Assessment in September 2021, Amie Staples, making a note on the day of the assessment, recorded that there was seven months' of medication that was found in his premises?

A. That's right.

Q. Medication that had not been taken, months of it. So

you certainly knew at the end, or the beginning of that admission, that this was someone who was not taking medication to any effect at all; is that fair?

A. Yes, I think myself and Claudia Birtles had a long conversation about that and it really was at that point where we felt he ought to be on a depot and a CTO.

Q. So what did you do to secure that? We know Claudia Birtles spoke at one Teams meet, when he was at the Cygnet in the third admission, but you don't speak to anyone; you don't speak to a consultant you don't attend any ward review when he's an inpatient anywhere. Why not?

A. It's just not possible, because my one and a half days does not allow me to attend ward reviews. We just wouldn't have -- my timetable just would not give me that sort of flexibility. The ward reviews can take place at very different times and it's very unlikely to correspond to the times that I actually worked within EIP and, essentially, as I've explained several times before, it's for that reason that the care coordinator has this role of liaison and they are expected to work flexibly and be able to attend ward rounds. I wouldn't be able to do that. It is just not possible within my job plan.

Q. Could you ask a medical secretary to communicate that

message that you, as a community consultant, thought he needed to be on a depot and it wasn't possible for the EIP team to ensure that he was compliant or concordant with medication?

A. I actually think Claudia Birtles as a clinician is in a much better position to be communicating that message, rather than it coming from a member of admin staff.

Q. Communicate the message from you, I mean. If an admin staff wrote the letter or email from you. You're a Consultant Psychiatrist; that presumably carries weight. You've got immense experience. If you had formed the view, as you said you had, that this man needs a depot, your service is not able to monitor him for non-concordance or compliance, why not make that clear to inpatient teams, "We cannot do this"?

A. I believe that's what Claudia did. I think she did make it clear that it was our wish, it was our strong wish that -- and that was coming from me as the consultant working with the team, that we wanted this man on a depot. That's my understanding and that was the conversation that we'd had prior to her contacting the ward. And I think she also mentioned it in a ward round. She also had a conversation with VC asking if he would be prepared to have a depot and I think, at that point, he said it was something he would consider but it

would depend on the side effects.

Q. Do you think his views should have been determinative, one way or the other, given the illness and his lack of understanding in respect of his illness?

A. I don't know what his capacity was at that time.

Q. Why don't you know? You were responsible in the community for him. Did you ever think a capacity assessment as to whether he understood treatment and could weigh the benefits of treatment was beneficial?

A. In the community --

Q. Yes.

A. -- yes. But I was never able to actually see him afterwards, so once VC was discharged at the end of October 2021, there were five consecutive appointments that were not attended by him. One of them was a home visit. I couldn't see him to do that capacity assessment. Had I seen him, yes of course that's something that I would have done. But -- and also it would have been during that time where I would have personally had a conversation with him about starting a depot. But that again didn't happen for the same reason: that he actively avoided every one of my appointments.

Q. Can we have a look at the discharge summary, please, at NHFT0000223. Going back to 2020, June 2020. If we

look, please, page 2, the bottom paragraph of page 2 and the top paragraph of page 3. The discharge makes it clear -- you see the bottom line at the top:

"It is unclear whether this forms part of a greater illness or it is isolated and his follow-up in the community will be crucial in this regard."

Top of the next paragraph:

"[VC] was initially started on olanzapine by the Crisis Team which he continued with in hospital. Olanzapine was then stopped in order to allow us to assess his presentation without medication. When it became clear that he was displaying psychotic symptoms, aripiprazole ... was then started."

So this was then the discharge into the community, isn't it, and it says in terms again "unclear greater illness" and "follow-up crucial". What's your understanding of the role your service was going to have in the follow-up?

A. The Early Intervention in Psychosis team is a service that's very much been set up to work with patients that have had a first episode in psychosis, following clear NICE guidelines. And so, as part of our follow-up, we try to ensure that those NICE recommended treatments are offered to patients, that they are followed up weekly, if necessary, which is the most sort of intense

follow-up that we can offer, but once somebody is perhaps showing a bit more stability, that can be reduced down to fortnightly. You know, we do it based on clinical judgement, stability, symptom profile, how recovered they are. So there's a whole --

Q. So you don't assess him? You didn't get the opportunity to assess him for the purposes of whether he would be catered for in the EIP team? Is that not how it works; you just accept the discharge?

A. Assess him on the ward?

Q. Yes, or assess him before you say the EIP team can take over this role of follow-up in the community for this particular patient?

A. We have a criteria of who we would take and who we wouldn't take, and VC would have very clearly met that criteria. Having had a first-episode psychosis, he didn't have any of the exclusion criteria that would have meant that we wouldn't take him, for example, a substance misuse induced psychosis, you know, clearly caused by intoxication or a substance or an organic cause. So there are a whole series of other --

Q. Can a one-off use of substance -- sorry to cut you off there but can a one-off use of a substance precipitate a psychotic episode?

A. It can, yes. It can.

Q. Because VC describes a very dramatic experience when -- and we know he was taken to A&E about it, with shaking of his body, tremors, feeling his mind was taken over. What's your view about that? Could that be precipitated by substance misuse?

A. That particular episode that he had, where he was shaking?

Q. Mm-hm.

A. I suppose substance misuse and taking of a substance can have very individual effects so, yes, it's possible that he had a very severe reaction to the substance that he'd taken. I believe it was cannabis, wasn't it?

Q. There's no evidence of whether he did or didn't take a substance, so I'm not suggesting he did. I'm saying is it possible, as far as you're concerned -- does it require repeated use of substances or can a single episode, if it has a dramatic effect, do that?

A. A single episode could but it's more unusual. It's more unusual to result in psychosis. Again, what we know from the evidence base is that it's individuals who start early and have a chronic and repeated use of substance that are --

Q. More typically represented?

A. Absolutely.

Q. Can we go, please, to NHFT0000168, page 54. So this is

Claudia Birtles and we see, at the top of page 54, this is her meeting June 2020, and straight from the off, Ms Birtles having to address medication, and she said and gave evidence that VC told her he had couple of doses left, didn't appear clear how he was going to get -- to ensure he gets a further supply.

She said in evidence:

"Patients are usually concerned to know how they're going to get their medication and, right from the off, this wasn't a promising beginning, was it?"

If we go down on the same sheet, 3 July:

"[VC] stated he has no medication remaining, he does not appear to have taken steps to contact his GP about this ..."

So straight from the off, you say you're not the most equipped because you can't go every day, people from the EIP will watch medication being taken. But this is the issue, isn't it?

Again, we see on 9 July, page 55, she's having to ask him again:

"[VC] confirmed he'd received his medication, everything was okay."

Then on 11 July we see there's a phone call, Mr Jackson takes it into the EIP team, setting out that VC's mother was concerned his mental state may be

deteriorating, his conversation wasn't making much sense and she thinks he may not be taking his medication as prescribed.

So this cycle continues, doesn't it? If we go over the page, page 56 in the notes, 14 July, if we have the whole of the box of 14 July, another police incident. You, of course, were due to see him on 14 July, weren't you --

A. That's correct.

Q. -- but you didn't and he, in fact, is going into residents of a flat nearby, banging on the door and he's actually restrained by a number of residents. So his mother has raised concern about not taking the medication, he's deflecting Claudia Birtles and this episode arises. When you saw this combination of events, were you concerned about him not taking medication and the impact again on his behaviour?

A. Yes, it was concerning that, you know, very early on he had deteriorated. There was essentially a two-week period between his last admission and this one, just over two weeks, and he's back in again. So yes, that's concerning.

I think sometimes, though, in the very early stages of a psychotic disorder, you know, particularly when an individual perhaps hasn't really accepted fully that

they've got a condition which is going to be relatively enduring, they may feel, once they're a little bit better, that they may try to just see, well, what is it like to come off medication? It's not unusual, you know, just to sort of test things out. And I wondered if that's what was happening here: that he felt better, he hadn't perhaps appreciated the importance of taking his medication --

Q. Well, he should have done because he did that when he was an inpatient, didn't he, with Dr Seedat? Dr Seedat permitted that and said, "See how you are for a few days" and then he was psychotic and went back on the medication. So to pick that up, he'd already had the benefit of that experience, if indeed he was capable of -- had the insight to learn from it. So asking for it again was very worrying, wasn't it?

If we go to page 58, we see at paragraph 4:

"Clear from today assessment he decided to stop making his medication 2 weeks after his discharge from hospital."

So this is the second admission confirming what had happened since the first admission.

A. That's right. So this is the -- essentially that period of two weeks, where he's out but then he's in again. And in actual fact, for the majority of that two weeks,

he is under the Crisis Team and they are monitoring him closely, almost every day, and --

Q. It still happens.

A. And it still happens. So it just goes to show that even with an intense service like the Crisis Team, it has still happened.

Q. So did it need an Assertive Outreach service? Are you saying the Crisis Team, your service, couldn't manage this situation because of the rotas, the lack of flexibility, in terms of being there when you had to be three times a day if necessary to make sure you saw it happened, that you don't have the resources and capacity to respond like that?

A. We certainly didn't have the resources or capacity, as an Early Intervention in Psychosis team. I can't really comment for the Crisis Team.

Q. On 13 July, if we can have NHFT0017977, page 2. You're trying to arrange that appointment that he doesn't attend on the 14th, and you send it to Ms Birtles:

"Hi Claudia, I think if you can't attend and there is nobody else to sit in we need to change [it] ... back to a telephone appointment ... I can do a face to face next time when you are present."

Why was it important for you to do a face-to-face when Ms Birtles was there?

A. It's really important, I think, when I see a patient, that I have a care coordinator who knows the patient well, that has been in contact with that patient on a regular basis, to be there to inform me of any issues of anything that they've observed, any risks, and also be involved in the decision-making.

And that's how we've always worked in Early Intervention in Psychosis, where we do joint appointments.

Q. Do you think, as a psychiatrist, you are better able than the care coordinators to challenge and explore with a patient why they're not taking medication, for example? Because it doesn't seem, on the records at least, that he's ever really confronted about that, confronted about the impact and how it can't continue, in effect.

A. I don't know. Sometimes, you know, if a patient builds a really good rapport and trust with a clinician, it doesn't matter whether that clinician is a consultant or a nurse. It's that trust and rapport, I think, that is key.

Q. And what's the issue about stigma, worrying about -- we've seen he's got a functional illness, Dr Seedat states that very early on in July.

A. Yes.

Q. Doesn't appear in his care plan, doesn't look like VC is told about it. We'll hear in due course if his family are. What's the issue about protecting patients from a reality, if they have a functional illness?

A. I don't think there is a issue about protecting a patient from reality if they have a functional illness. I think what we have to remember is that psychosis is a broad umbrella term, and under psychosis comes a whole series of different, specific diagnoses, one of which is paranoid schizophrenia. You may have delusional disorder, you may have schizoaffective disorder, it may be a bipolar disorder with psychosis or depression or mania with psychosis.

They are all specific diagnoses that fall under the umbrella term of psychosis. And the reason why, in Early Intervention, we don't give specific diagnoses is because we know that in the first three years, diagnoses change a lot, a concept called diagnostic stability. The illness is going through a slow, evolutionary process, and what we see right at the outset isn't necessarily what we find at the end. And that's part of the assessment. So --

Q. So the illness is likely to be the same, or one that's developing, but you may not detect it earlier on, the diagnosis --

A. Yes, it might present in very, very different ways so that you might, right at the beginning, think: okay, this is more of an affective picture, but later on down the line you start to realise no, it's not, it's starting to look more like a schizophrenic picture.

So that's why we keep that much more broad terminology of "psychosis". Psychosis doesn't mean that it's necessarily short term or temporary or non-functional. All it means is that we're not pinning it down to a very specific ICD-10 diagnosis.

Q. But you do say something in your statement about why, in the EIP service, you're careful not to label early on.

A. That's another secondary reason and I think that's something which, right from the outset of EIP services being developed, it was a -- it's a very strong sort of ethos of the service that we focused very much on reducing stigma, that it was -- it's a recovery-focused service, so it's very much about instilling hope that people could get better, rather than right from the outset giving the message that, you know, this is a lifelong condition that, you know, you will never get better.

One of the things that we, you know, the literature found was that that lack of hope, that lack of sort of recovery-based thinking could lead to high rates of

suicide in young people.

Q. Recovery-based communication can be positive but only if it's backed with an ability to require the treatment that brings about recovery; do you agree?

A. Absolutely, yes.

Q. And what we don't see here is that part of it.

A. Yes, and it's not that we didn't try.

MS LANGDALE: Well, we'll come to that later. It's probably a good time to stop, thanks.

THE CHAIR: Thank you. We'll start again at 2.00, thank you.

(1.02 pm)

(The short adjournment)

I N D E X