

Wednesday, 6 May 2026

1
 2 (9.59 am)
 3 **THE CHAIR:** Thank you.
 4 **MR BLAKE:** Good morning, Chair. Can I please call Anthony
 5 Rogers?
 6 **ANTHONY ROGERS (sworn)**
 7 **Questioned by MR BLAKE**
 8 **THE CHAIR:** Yes.
 9 **MR BLAKE:** Mr Rogers, you are His Majesty's Chief Inspector
 10 of the CPS Inspectorate; is that correct?
 11 **A.** That is correct.
 12 **Q.** You were officially appointed I think in February 2025.
 13 **A.** Yes.
 14 **Q.** Although you held the role on a temporary basis in 2024;
 15 is that right?
 16 **A.** That is right.
 17 **Q.** You previously held roles in the Civil Service and since
 18 2003 at HMCPSI.
 19 **A.** Yes, but I left HMCPSI in 2012; went to become the first
 20 Head of Compliance in the Crown Prosecution Service.
 21 I then was Area Business Manager in the Crown
 22 Prosecution Service for the London area. I then left
 23 the Civil Service in 2016, took up some consultancy work
 24 and then returned back to HMCPSI in 2018.
 25 **Q.** Thank you. Could I ask you perhaps to come slightly

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1 **A.** That's right.
 2 **Q.** And the request is that:
 3 "Following the sentencing of [VC], [she] would like
 4 the Inspectorate to undertake a thorough and rapid
 5 inspection of the CPS actions in [that] ... case."
 6 And the report was due by Easter time; is that
 7 right?
 8 **A.** That's right, yeah.
 9 **Q.** How long do your inspections usually take?
 10 **A.** A normal inspection would, depending on whether there is
 11 a file examination, could take anything up to, from
 12 beginning to end, six months.
 13 **Q.** Six months. So this is considerably quicker than your
 14 ordinary inspection.
 15 **A.** Yes, I conducted two Covid inspections after the
 16 pandemic, when I was Deputy Chief Inspector, and
 17 I managed to deliver those in 12 weeks, from beginning
 18 to end.
 19 **Q.** And here it's envisaged approximately two months, so
 20 approximately eight weeks.
 21 **A.** Eight weeks, yes.
 22 **Q.** So quicker than the Covid ones, considerably quicker
 23 than an ordinary inspection.
 24 **A.** (*The witness nodded*).
 25 **Q.** "Thorough and rapid" are not necessarily good friends

3

1 closer to the microphone, if possible. Thank you.
 2 You're giving evidence today in respect of the
 3 HMCPSI report into the CPS's actions in the prosecution
 4 of VC. Your evidence is taken slightly out of order in
 5 respect of our overall timetable.
 6 I just make it clear at the very beginning that the
 7 Inquiry has obviously been gathering evidence for over
 8 a year now, and there's nothing in our Terms of
 9 Reference that would prevent the Chair from reaching
 10 conclusions that are different to those set out in your
 11 report, and it's for that reason that I'm not going to
 12 take you to a particular document and ask you if that
 13 will have changed your opinion, and I'm not going to ask
 14 you to give evidence as some sort of expert on
 15 prosecution matters. What I want to ask you today
 16 concerns essentially the sufficiency of the inspection
 17 and the report.
 18 Could I please ask you to turn to HMCP0000625.
 19 Thank you. So this is the report. If we could start,
 20 please, on page 99.
 21 **A.** Yes.
 22 **Q.** This is the beginning of HMCPSI's involvement and that
 23 is a letter from the Attorney General, the then Attorney
 24 General, to your predecessor, Andrew Cayley King's
 25 Counsel; is that right?

2

1 with one another when it comes to an inspection; is that
 2 something you would agree with?
 3 **A.** Not -- in this case, as it's a single case, I think that
 4 is possible, and I think we did conduct a thorough and
 5 rapid inspection. Obviously I, in my statement, have
 6 some reflections on if we were asked to do it again,
 7 what I would do differently.
 8 **Q.** Because broadly there is a tension between the two.
 9 **A.** There is. Especially when you're trying to engage with
 10 bereaved families in an inspection of this nature.
 11 **Q.** And at this particular time, I think Andrew Cayley
 12 King's Counsel had recently stepped down.
 13 **A.** Yeah, Andrew resigned to go back to the International
 14 Criminal Court. He'd announced that resignation in
 15 January. I was appointed -- you can only have one Chief
 16 Inspector because of the Act, and I was appointed to
 17 take up post on 27th February. Andrew was still Chief
 18 Inspector but he wasn't with the Inspectorate, he'd
 19 actually gone over to the Hague. So I was running
 20 the Inspectorate but I wasn't officially the Chief
 21 Inspector because you can only ever have one.
 22 **Q.** And he had stepped down after a three-year term, so not
 23 serving the full term.
 24 **A.** Yeah.
 25 **Q.** Am I right in saying that there wasn't at that time

4

1 a succession plan prior to his --

2 **A.** No, Andrew's term would have been five years -- sorry,

3 four years, apologies. It was five years with me, it

4 was four with Andrew. So Andrew would have had -- he

5 stepped down actually after about 25 months, I think.

6 He'd got into his third year.

7 **Q.** Thank you. You've also said in your witness statement

8 that HMCPSI was fully committed in respect of the

9 existing inspections that were taking place at that

10 time; is that right?

11 **A.** Yes, absolutely.

12 **Q.** You put together a team, that included Richard Whittam

13 King's Counsel, Former First Treasury Counsel,

14 presumably he had other cases on at the same time?

15 **A.** He was on Horizon, but actually Horizon was stood down

16 at that time, so Richard had time to be with us. So he

17 was counsel on Horizon representing, I think, Fujitsu.

18 **Q.** I think the Inquiry wasn't sitting at that particular

19 time --

20 **A.** It wasn't.

21 **Q.** -- but that was resuming in March/April time?

22 **A.** Yes, that's right.

23 **Q.** Jo Milner is a name we'll come across.

24 **A.** Yeah.

25 **Q.** She's a legal inspector, former prosecutor?

5

1 **A.** Yes, that's what we call those who we bring back on

2 associate terms, yeah.

3 **Q.** I think you personally led the inspection; is that

4 right?

5 **A.** I did.

6 **Q.** Sticking with this document, if we could please turn to

7 page 7, we'll have a look at the remit of your

8 investigation.

9 **A.** Yeah.

10 **Q.** It's set out at 1.3. Halfway through that paragraph, it

11 says:

12 "Our remit was to examine whether the decision not

13 to proceed to trial for murder but to accept pleas to

14 manslaughter was correct and whether the approach taken

15 by the CPS in engaging with the families during the case

16 met the standards and expectations as set out in The

17 Victims' Code and its own Bereaved Family Scheme."

18 This could potentially be quite a wide remit, albeit

19 a single case; do you agree with that?

20 **A.** Yes, which is why I developed a scope, as in all

21 inspections, following our methodology and I outline in

22 my statement at paragraph 21 the inspection question and

23 in paragraph 22 the scope of the inspection.

24 **Q.** Do you see the difference between an inspection and

25 investigation and, if so, what is the difference between

7

1 **A.** Yes.

2 **Q.** I think we've seen on emails or we will see on emails

3 that she was working on a temporary basis, I think

4 Monday to Wednesday; is that right?

5 **A.** No.

6 **Q.** Certainly that's what appears on the emails that --

7 (*overspeaking*) --

8 **A.** Right. Jo was part-time at the time but I think for the

9 VC inspection she came back to be full time.

10 **Q.** Emma Jones, legal inspector, former CPS prosecutor for

11 20 years?

12 **A.** Yes, and she'd worked on the homicide team in London,

13 CPS London, so she obviously did have some experience of

14 dealing with homicide-type cases, murder cases.

15 **Q.** Is she the individual who you've described in your

16 witness statement as coming back from retirement or is

17 that somebody else?

18 **A.** No, that's James Jenkins.

19 **Q.** James Jenkins. Who was James Jenkins?

20 **A.** James Jenkins was an ex-inspector. He'd been with the

21 Inspectorate for six years. He was a legal advisor in

22 the Attorney General's Office and had also previously

23 been a senior manager in the CPS.

24 **Q.** I think we may see him listed somewhere as an associate

25 inspector?

6

1 the two?

2 **A.** We're an Inspectorate, we inspect, so we inspect against

3 the standards there are expected to be had. We don't

4 investigate, so we don't actually go behind the evidence

5 to try to take our own evidence or find our own

6 evidence. We actually look at what is available and

7 what, you know -- in line with our scope. So we're not

8 investigatory, we don't have those powers. We actually

9 inspect against the standards expected.

10 **Q.** So, essentially, you look at existing documents, for

11 example, and assess those against standards, rather than

12 seeking witness statements --

13 **A.** Yes.

14 **Q.** -- or additional information?

15 **A.** Yes, although we do interview as part of evidence

16 gathering but it's not interview as per investigation.

17 **Q.** If we could please turn to WITN0245006, we start on

18 page 3, we can see that, I think, you met with families

19 of the bereaved on 9 February 2024; is that correct?

20 **A.** That is correct, yes.

21 **Q.** Then on the 26 February, you have received, from

22 Dr O'Malley-Kumar some thoughts regarding their

23 interaction with the CPS, which may have affected the

24 acceptance of the plea of diminished responsibility.

25 Can we turn to WITN0245008, and I think this is the

8

1 attached document; is that right?

2 **A.** Yes, we also received, I think, documents similar to
3 this in the meeting. They were handed over in the
4 meeting on 9 February by the families.

5 **Q.** Thank you. I'll just read to you a few sections from
6 this complaint. The heading there is "Discussion with
7 Samantha Shallow at Avon and Somerset police and fire
8 headquarters", and it says as follows, it says:
9 "Myself and my husband specifically requested that
10 the 4th psychiatrist report should focus his assessment
11 of [VC's] state of mind on the day and leading up to the
12 killings. We were aware through previous mental health
13 history that self-reporting by [VC] was unreliable. He
14 is documented as being misleading and duplicitous to
15 clinicians in the past for his own agenda as per the
16 previous reports."
17 I'll just skip down to the penultimate paragraph,
18 please. The third sentence there says:
19 "We told Ms Shallow about advice we had received
20 from a colleague who is a forensic psychiatrist
21 regarding the importance of collateral history from
22 others and irrespective of this she discounted our
23 concerns as unworthy of consideration and said that she
24 flatly refused to instruct or specify a line of enquiry
25 upon them, even an educated and informed line of enquiry

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1 then I'll take you to one further email, that's
2 WITN0245011, 6 March, and this is about the case that we
3 know --

4 **A.** Yeah, the stalking case. Yeah, yeah.

5 **Q.** -- as Sebastian, further information regarding VC's
6 stalking.
7 If I could please now take you back to the report,
8 HMCP0000625, thank you, this is page 1. The report is
9 dated March 2024. We see at the top of the page that
10 it's embargoed until 25 March. I think it was published
11 on 25 March.

12 **A.** It was, yes.

13 **Q.** Can you assist us with how long before the publication
14 it would have been sent to the printers for --

15 **A.** It was sent to the printers on the Saturday.

16 **Q.** Thank you. I --

17 **A.** Sorry, it was printed on the morning; it was sent to the
18 proofreaders on the Saturday.

19 **Q.** Are you able to assess what date that would have --

20 **A.** 23rd. I think, sorry, either the 22nd or 23rd. I can't
21 remember whether the 25th was a Monday or Tuesday.

22 **Q.** Because reports like this -- I mean, it's quite
23 lengthy -- would require --

24 **A.** We have printed in-house at the Ministry of Justice and
25 bound, we have an arrangement with them and we only ever

11

1 that we had specifically requested.

2 "We were adamant we felt a fresh set of eyes should
3 review [VC]."

4 Over the page, please, there's another section,
5 headed "CPS engagement with the Police", if we scroll
6 down, and a section below that regarding a discussion
7 with Mr Karim Khalil KC and the CPS. I'm going to take
8 you back now to that series of emails that we just
9 looked at and that's WITN0245006. If we start on
10 page 2, we can see that Dr O'Malley-Kumar's email is
11 then followed by, if we look at the bottom email, an
12 email from Emma Webber, she says:
13 "We have read and noted all of the comments that
14 Sinead makes here. We were present at the meeting on
15 7 December we confirm and agree with everything that she
16 has said."
17 Then goes on to provide further comment.
18 If we go up, please, we can see that James Coates
19 has also followed on 27 February, and he says:
20 "As a family we fully stand behind the other
21 victims' families with the issues that have been
22 previously raised concerning the way the CPS have dealt
23 with the whole [VC] debacle."
24 Then to the top email, please, on page 1. Emma
25 Webber has sent a further email on 28 February 2024, and

10

1 have now -- because actually we relay electronically --
2 we had enough for the families and enough for the team.
3 So we had, I think, probably no more than a dozen
4 reports printed on that morning in the print room.

5 **Q.** But in respect of the finalisation of this, it is normal
6 to have, for example, proofreading type settings --

7 **A.** Yeah.

8 **Q.** -- and that kind of thing?

9 **A.** Yes.

10 **Q.** What would have taken place on the Friday or earlier?

11 **A.** It took place over the weekend. We worked the weekend
12 to proofread the report.

13 **Q.** If we could please bring on to screen HMCP0000618. This
14 is the letter that was sent to the families of the
15 bereaved.

16 **A.** Yeah.

17 **Q.** "HMCPSI inspection plans for publication and offer of
18 a meeting on 25 March ..."
19 In that second paragraph you say there:
20 "I was clear when we met on 9 February that, given
21 the timescales of the inspection, it would not be
22 possible to provide copies of the final report prior to
23 a meeting on 25 March."
24 Can you assist us: by this date, so 15 March, was
25 the report pretty much there in terms of finalisation?

12

1 A. No, it wasn't.
 2 Q. No?
 3 A. Not at all.
 4 Q. So you were still going with the investigation?
 5 A. Yes. We were still inspecting, we were still drafting,
 6 and we were still working. Now we had assessed the
 7 evidence but we were certainly in the report-writing
 8 stage at this stage. It wasn't complete on the
 9 15th March.
 10 Q. In terms of the timing then, I think you said 23 March
 11 or thereabouts.
 12 A. It was certainly -- if somebody can remind me, if
 13 somebody can remind me if the 25th was a Monday and I'll
 14 be able -- I'm not --
 15 Q. But thereabouts, quite soon before the final
 16 publication, it was completed. It's still under
 17 two months from being asked to conduct the inspection;
 18 is that right?
 19 A. It was very rapid, yes.
 20 Q. And during that time, am I -- is my understanding
 21 correct that you had to assemble that new team from
 22 scratch? You led the inspection --
 23 A. *(The witness nodded)*.
 24 Q. -- presumably alongside your other work at the time?
 25 A. Well, I was Chief Inspector. I don't inspect. So I --

13

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

15

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

14

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

16

1 Q. And are those, I think, witness statements?
 2 A. No, no. They are -- the witness statements we hadn't
 3 seen, obviously, because they were written after the
 4 inspection. They are related to two aspects of probably
 5 a mental health assessment at Rampton I think, or
 6 wherever VC was. And it's two pages within this
 7 document, this bundle, which we may have seen them
 8 because actually, as you may have realised, doing an
 9 inspection like this, not every inspector sees every
 10 document, and the only inspector who is left in the
 11 Inspectorate, Jo Milner, didn't actually look at the
 12 mental health aspect; Richard Whittam looked at the
 13 mental health aspect.
 14 Q. Thank you, so Richard Whittam was charged with looking
 15 particularly at the mental health aspect, you'd say?
 16 A. Yeah. Emma Jones looked -- we all look at all -- sorry,
 17 not all documents, but most documents. But Emma Jones
 18 had specific responsibility to look at the case, the
 19 previous CPS case which is covered in chapter 7 in the
 20 report: the assault on emergency worker.
 21 Richard Whittam was looking at mental health, along
 22 with James Jenkins, because they were the two who were
 23 more experienced in that, of course Richard being First
 24 Senior Treasury and a KC, and Jo formed and looked at,
 25 you know, sort of the handling, the Victims's Code

17

1 the Blackwood, Professor Blackwood's report. But
 2 obviously there was an issue which the families raised
 3 about, it's termed in James Jenkins's interview note, of
 4 the Blackwood interview of the "back calculation" how he
 5 presented on the 13th.
 6 So we decided as a team it was worth putting the
 7 questions the family was so keen to understand to
 8 Blackwood. I felt that was the right thing we needed to
 9 do. I didn't think we needed to do that with Latham.
 10 The report from Latham was on a different basis, and we
 11 outlined that in our report. But I did think it was
 12 probably quite helpful to talk to Professor Blackwood
 13 about some of the family concerns, to actually allow us,
 14 within the report, to set out with clarity, I hope, and
 15 in detail, and try to give the family -- families some
 16 understanding of actually what they said they hadn't
 17 been able to see because people weren't talking to them,
 18 weren't giving them the full picture. That was
 19 mentioned a lot in that meeting of the 9th February, and
 20 I thought it was incumbent on the Inspectorate to set
 21 out, hence why we decided, as a team, to go and see
 22 Professor Blackwood.
 23 Q. Now in terms of the interviews you carried out, if we
 24 could start with the first in time, so that's
 25 HMCP0000551, the interview with Samantha Shallow on

19

1 element, you know.
 2 Q. Was one treated as more senior than the other of those
 3 two?
 4 A. Of Jo --
 5 Q. Richard Whittam and the investigator?
 6 A. Than the Associate Inspector?
 7 Q. Yes.
 8 A. No, it's a team. We all -- you know, we all muck in and
 9 just get on with it, you know.
 10 Q. You say in 1.4 that you have been able to interview the
 11 first prosecution psychiatric expert.
 12 A. Yeah.
 13 Q. Is there a reason why, for example, Dr Latham wasn't
 14 interviewed?
 15 A. Yeah, we made a decision based upon -- and I think it's
 16 worth saying at the outset, it actually mattered to me
 17 in terms of the values that the Inspectorate has and my
 18 own values, that we actually listen to the family. You
 19 know, we met them on 9 February because actually their
 20 experience of the system had let them down. I was aware
 21 of what they were feeling; I'd been told, I'd seen, I'd
 22 heard.
 23 So as part of that, there was a real concern
 24 expressed at that first meeting about some of the issues
 25 around the psychiatrist reports. And obviously we read

18

1 13 February. We then go to HMCP0000552, that's with
 2 Alan Murphy on 14 February.
 3 A. Yeah.
 4 Q. We then go to HMCP0000575, that's an interview with
 5 Michelle Mannion on 14 February.
 6 A. Yeah.
 7 Q. Then HMCP0000576, an interview with both prosecution
 8 counsel.
 9 A. Yeah.
 10 Q. And then HMCP0000629 we get to Dr Blackwood's on
 11 29 February. And then HMCP0000609, an interview with
 12 Janine McKinney on 5 March.
 13 In terms of our timeline, Samantha Shallow,
 14 Alan Murphy, Michelle Mannion, and both prosecution
 15 counsel have been interviewed before the time that we
 16 saw that very first email from Dr O'Malley-Kumar.
 17 I appreciate that you had met them already on the 9th,
 18 but you hadn't yet received those emails, at the time --
 19 A. Well, we had to have papers handed to us in that meeting
 20 by the family.
 21 Q. Yes, but that wasn't the question. The question was you
 22 hadn't received those emails?
 23 A. No, I hadn't received those but we had similar -- we had
 24 similar points being raised in papers that were handed
 25 to us in the meeting.

20

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

21

1 was the view that it is very difficult, I think, for
 2 anybody to accept in the circumstances of this case, and
 3 others that I've been written to since, that their loved
 4 ones have been killed by someone and it is
 5 a manslaughter. You know, that word "murder" is
 6 something that is very important to people, you know,
 7 people -- as I say, since this case, I've been asked by
 8 a number of families to look at the cases of very
 9 similar circumstances but it's a matter for Parliament
 10 whether they adopted this.
 11 But I think what I was pointing out was that,
 12 actually, it's a very difficult legal concept for
 13 ordinary people outside of the system to understand, and
 14 it would have possibly been more understandable and
 15 a little bit more -- "acceptable" is the wrong word but
 16 that's the word I'm going to use -- if it had been
 17 second degree murder, not manslaughter.
 18 Q. The conclusions then address CPS engagement with the
 19 families.
 20 A. Yeah.
 21 Q. The first paragraph there, 1.11, generally you found
 22 that the CPS met their obligations to the bereaved
 23 families --
 24 A. *(The witness nodded)*.
 25 Q. -- under the Victims' Code and the Bereaved Family

23

1 to look at the findings now, HMCP0000625, we start on
 2 page 7. We have at 1.5 "Headline findings", so the
 3 first headline finding relates to "The charge" and
 4 that's essentially that the charging decision was
 5 correct?
 6 A. Yes.
 7 Q. We then get to "The acceptance of pleas to manslaughter"
 8 and, essentially, again, the acceptance of the plea,
 9 your finding was that that was correct?
 10 A. Absolutely.
 11 Q. It says:
 12 "The CPS could not have proceeded on the murder
 13 allegations because of the clear and unambiguous
 14 findings of the prosecution and defence psychiatric
 15 reports that the offender's actions were because of pure
 16 psychosis that substantially impaired his ability to
 17 form rational judgements and to exercise self-control."
 18 If we scroll down to 1.10, you set out there,
 19 essentially, that it would have been a different
 20 position if the law had been different.
 21 A. Yes.
 22 Q. Do we read into that final sentence there, in 1.10, that
 23 you consider, or HMCPSI considers, that the law should
 24 change?
 25 A. It's not a matter for HMCPSI. What I was setting out

22

1 Scheme; is that right?
 2 A. That's right.
 3 Q. Then you address some things that you consider could
 4 have been handled better?
 5 A. Yes.
 6 Q. I'll just take you through those. So the first one, the
 7 first bullet point there:
 8 "[The] Introductory letters included standard
 9 paragraphs about the legal proceedings which may not
 10 have been understood or well received by grieving
 11 families."
 12 Over the page, please:
 13 "The Family Liaison Officer is the conduit through
 14 which all CPS engagement is handled. In this case, the
 15 first CPS letter to the families was dated before the
 16 first hearing date but was delivered after it to each
 17 family by the FLO and thus was out of date when
 18 received."
 19 Then:
 20 "Where FLOs are being asked to explain legal
 21 concepts to bereaved families, it would be good practice
 22 for the CPS to provide them with case specific written
 23 guidance. In this case the families' understanding of
 24 diminished responsibility may have been aided at an
 25 earlier stage had the CPS provided a form of words for

24

1 the FLOs to use."

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

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

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

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

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

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

25 **Q.** Thank you.

25

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

2 **A.** Inform and explain, yeah.

3 **Q.** Then we see below that the recommendation.

4 **A.** Yeah.

5 **Q.** The recommendation is:

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

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

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

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

27

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

10 **Q.** We then have two further conclusions:

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

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

20 **A.** Yes.

21 **Q.** Then the entry below:

22 "The CPS used the word 'consult' on a number of
23 occasions when referring to engagement with the families
24 ..."

25 And, essentially, there is no obligation to consult

26

1 a recommendation?

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

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

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

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

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

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

28

1 complaint we got in the psychiatric reports.

2 **A.** Yes.

3 **Q.** If we stick with the report that's currently on screen,
4 please, and if we turn to page 17. This section is
5 headed as follows, "Concerns relating to the CPS
6 decision to accept guilty pleas to manslaughter", and it
7 says:

8 "Whilst the bereaved families acknowledged that the
9 four psychiatric experts found that the offender was
10 suffering from a recognised mental illness at the time
11 of the commission of the offences, which afforded him
12 the partial defence of diminished responsibility, they
13 had concerns that this was not a properly reached
14 conclusion based on the following ..."

15 Then there's a series of bullet points. The first
16 is:

17 "The psychiatric experts did not adequately consider
18 and assess the offender's presentation at the time of
19 the commission of the offences, but placed too much
20 weight and emphasis on the offender's presentation when
21 they interviewed him some months later and at a time
22 when his mental state may have deteriorated due to his
23 incarceration."

24 The second relates to:

25 "The fact that a mental health assessment was not

29

1 yes.

2 **Q.** The interview with Dr Blackwood then was presumably
3 quite important in the overall context of determining
4 that issue?

5 **A.** Yes, which is what I said earlier.

6 **Q.** Because, I mean, his methods were being called into
7 question?

8 **A.** Yes, they were.

9 **Q.** Could we please return then to HMCP0000551.

10 This is the interview with Samantha Shallow and we
11 see there, in terms of who is present, we see Richard
12 Whittam, Samantha Shallow and then you have your
13 investigator, I think --

14 **A.** Inspector.

15 **Q.** Your inspector, thank you very much. Is that --

16 **A.** So we have three inspectors in there: Richard Whittam,
17 Jo Milner and Emma Jones. Scarlet Johnstone is a CPS
18 note taker.

19 **Q.** If we go to the next interview, HMCP0000552, the Alan
20 Murphy interview, similar cast list. You have Richard
21 Whittam, Jo Milner, James Jenkins --

22 **A.** Jo Milner -- actually, we have all four inspectors in
23 that one.

24 **Q.** Yes. HMCP0000575 again, Michelle Mannion, again Richard
25 Whittam, Jo Milner, Emma Jones --

31

1 deemed necessary whilst [he] was in police custody ..."

2 In particular, that first bullet point, is that
3 something, following the conversation with the bereaved
4 families, you were aware was a significant concern of
5 theirs?

6 **A.** Absolutely, which is why it's in the report.

7 **Q.** That criticism isn't actually just of the CPS, is it?
8 That's a criticism also of the experts that carried out
9 the assessment?

10 **A.** Yes, it is, yes.

11 **Q.** Who did you interview to determine that issue?

12 **A.** Well, we interviewed Professor Blackwood on that very
13 issue and obviously saw the papers from the CPS, which
14 then asked the question in November, after it was raised
15 again, about how he had -- why he didn't interview
16 witnesses, how he'd made and whether he'd considered the
17 presentation at the commission of the offences.

18 **Q.** As we've already discussed, you didn't interview
19 Dr Latham?

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

21 **Q.** You didn't interview, for example, any independent
22 psychiatrists --

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

24 **Q.** -- because that's not the way you go about it.

25 **A.** That's not inspection. That would be an investigation,

30

1 **A.** No Emma Jones on that one.

2 **Q.** Oh, thank you. Jo Milner and James Jenkins.

3 **A.** Yes.

4 **Q.** HMCP0000576, the interview with prosecution counsel:
5 Richard Whittam, James Jenkins, Emma Jones. So three
6 members of your team?

7 **A.** Yeah, one taking notes.

8 **Q.** Then HMCP0000629, this is the interview with
9 Dr Blackwood?

10 **A.** Yeah.

11 **Q.** It's described as a conversation with Dr Blackwood. Can
12 you assist us with why it's described as a conversation?

13 **A.** I presume the note taker, Jo Milner, has called it that,
14 rather than an interview.

15 **Q.** Was it over the phone or in person, as far as you can
16 recall?

17 **A.** I think it was over the phone.

18 **Q.** Over the phone. We have there James Jenkins, Jo Milner
19 taking notes. Richard Whittam is not present at this
20 one?

21 **A.** No, he's not.

22 **Q.** I think you had previously said that Richard Whittam --

23 **A.** And James Jenkins were leading on mental aspects --

24 **Q.** Yes, but Richard Whittam was involved in the psychiatric
25 side of the complaint?

32

1 A. He was, of the report, yeah.

2 Q. Can you assist us, then, in respect of such

3 a significant witness, in fact the only psychiatric

4 witness that is being interviewed, why Richard Whittam

5 isn't there, and why it's a smaller cast list?

6 A. It's availability of Dr -- Professor Blackwood and

7 Richard Whittam. There was a clash. It didn't work.

8 Richard actually was on holiday at that point and it

9 couldn't be changed. We had obviously the pressure of

10 time, and actually all inspections, the reason for

11 a note and the reason, actually, for the interview, we

12 come together and we discuss the evidence together as

13 a team, so actually Richard would be fully appraised as

14 part of the inspection process.

15 Q. Yeah --

16 A. And he will have helped, I know James and Richard

17 prepared the questions together and actually they were

18 provided to Professor Blackwood before the -- as

19 Professor Blackwood's statement said to the Inquiry --

20 before the interview.

21 Q. As Former First Treasury Counsel, it would have been

22 helpful to --

23 A. It would, but he was, as I say, on holiday.

24 Q. Then I'll just read to you a couple of the questions.

25 Mr Jenkins starts:

33

1 "Regarding the materials -- you were given a lot of

2 material from the CPS. Do you essentially make your own

3 judgement of what to read or do you read it all?"

4 Then Professor Blackwood says:

5 "No I look at everything I am given. You are not

6 immune to error so you may miss the odd line etc but

7 that would be pointed out by barristers or further

8 questions posed from the CPS. As here, the families pay

9 particular focus to the defendant speaking to the

10 security guard outside Seely House. I had obviously

11 been aware of this interaction but I was further

12 prompted to consider this by the CPS. I was asked if

13 the security guard should be further interviewed by the

14 police or should I myself interview him? So this is an

15 example of where I was prompted by the CPS to look at

16 the materials again. I responded that I did not seek to

17 interview him. I have never done so in the past, and

18 cannot think of colleagues who would speak further to

19 such a witness like this."

20 Then the interviewer says as follows, he says:

21 "Is it fair to say that you were quite satisfied

22 from all the material you had plus speaking to the

23 offender that you were in a position to make a rational

24 and reasoned assessment to his mental state at the time

25 he committed the offence?"

35

1 "Before we start with the specific questions I have

2 previously sent you, is there anything you want to

3 mention you think is important and not covered in what

4 I sent to you?"

5 Can you assist us with that? Are interviewees

6 provided with the questions in advance?

7 A. Sometimes; sometimes not.

8 Q. Is it usual in your investigations for --

9 A. Inspections. -- (*overspeaking*) --

10 Q. Inspections -- for a significant witness to be provided

11 with the questions in advance?

12 A. Depends. Sometimes -- it's not unusual.

13 Q. Professor Blackwood then responds and he says:

14 "Just that the families concern also seemed to be

15 the delay between me being instructed and me seeing and

16 assessing the offender".

17 So he raises a further issue that wasn't addressed

18 in the questions that had been sent.

19 Did you obtain any independent evidence in respect

20 of whether it would have been beneficial for

21 Professor Blackwood to have seen VC earlier?

22 A. No.

23 Q. And if we go over to page 2, please, I'll just read to

24 you an exchange between the interviewer and

25 Professor Blackwood. He says:

34

1 Is this typical of the kind of question that might

2 be posed by HMCPSI in an interview?

3 A. Yes, it is.

4 Q. It may be suggested, that's not a particularly probing

5 question.

6 A. It may be. That's why -- you know sort of, we find from

7 all our interviews that actually conversation, as this

8 note is actually titled, is much more able to actually

9 get to the nub of the issue, because not only does it

10 put the person at ease but it also allows you to follow

11 hooks as the evidence comes out. That's how -- that's

12 the approach. If you came on our interview training

13 course within the Inspectorate you would -- that is one

14 of the techniques we use. So we don't -- we try not to

15 cross-examine and we don't purposely cross-examine, and

16 we don't try also to trip up.

17 Now if the person being interviewed becomes

18 difficult we obviously change our technique, but

19 generally this is the sort of question, and you'll have

20 seen it in the other interview notes, that actually

21 these are the general -- it's a general approach in

22 HMCPSI when we are talking to people to gather evidence,

23 that we do it in a very open and constructive way.

24 Q. So is that again something that distinguishes you from

25 an investigation --

36

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

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- 1 Over the page, please:
- 2 "He [has] ... taken into account the evidence that
- 3 suggested that the offender could exercise some
- 4 self-control ..."
- 5 And there are further bullet points that I think --
- 6 perhaps I'll read to you the very final one:
- 7 "The first prosecution psychiatric expert had taken
- 8 into account previous assaults including the assaults
- 9 [of his] ... co-workers, police and housemates. These
- 10 all occurred when the offender was under the influence
- 11 of untreated psychosis."
- 12 What seems to have occurred here is that
- 13 Dr Blackwood has -- it says here "the expert confirms to
- 14 us", he has essentially been asked to provide his
- 15 account.
- 16 Am I right in understanding that HMCPSP are, perhaps
- 17 because of your role, perhaps because of your resources
- 18 or some other reason -- please do tell me -- don't set
- 19 out to test the account that is given to them by what is
- 20 identified there as the psychiatric expert?
- 21 **A.** Yes, I think the point is, he is the psychiatric expert;
- 22 we are not. We're inspectors, lawyers. And, you know,
- 23 in a way, it's very difficult, I think in any sphere of
- 24 life, to be saying, "I've now become an expert in
- 25 psychiatry so I'm going to test you on your findings."

39

- 1 please, so that's HMCP0000625, page 52. Page 52, you
- 2 have findings in respect of the psychiatric expert.
- 3 **A.** Yes.
- 4 **Q.** It says as follows, it says:
- 5 "In relation to the first prosecution psychiatric
- 6 expert's report and finding that the partial defence was
- 7 available to the offender, the expert confirmed to us:
- 8 "[1] He had been retained at an early stage of
- 9 proceedings ...
- 10 "[2] His approach was guided by the material that
- 11 was made available to him."
- 12 If we scroll down please, thank you:
- 13 "[3] He's considered whether the offender had either
- 14 fabricated his mental illness or that his illness had
- 15 deteriorated whilst he'd been in custody ...
- 16 "[4] Even if the offender's condition deteriorated
- 17 later, his psychosis persisted at the time of the
- 18 offences.
- 19 "[5] There was no inconsistency with the offender
- 20 being assessed as fit to be detained and ... later
- 21 diagnosis of diminished responsibility."
- 22 The next one:
- 23 "Three of the expert psychiatrists, including
- 24 himself, had concluded that the offender was not
- 25 insane."

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- 1 And so we challenged Professor Blackwood on the
- 2 basis of the family's concerns, some of those concerns
- 3 which are outlined in chapter 3 of the report in detail,
- 4 to try to understand whether he had considered some of
- 5 the things that the families said to us they were
- 6 concerned hadn't been considered.
- 7 We are not psychiatric experts. None of my
- 8 inspection team who spoke to Professor Blackwood, and
- 9 none of us are psychiatrists.
- 10 And it's the same for any expert, I think, in any
- 11 walk of life. You know, we are doing a job trying to
- 12 test the evidence the CPS had. We've seen all the
- 13 evidence the CPS had, and we have come to the point --
- 14 and again, I take you back to the fact that I wanted the
- 15 families, it was at the heart of this inspection for me,
- 16 to know what had been said. Because they said on
- 17 numerous occasions they were in the dark. We tried to
- 18 outline what Professor Blackwood had done and what he
- 19 thought, and that is why this is in this report.
- 20 This report could have been probably a lot shorter.
- 21 I purposely made the decision to actually do a very full
- 22 report to try to set out what happened in this whole
- 23 case, so that the families could understand.
- 24 **Q.** What you're essentially doing, though, you're putting
- 25 the families' case to the expert, but what you don't

40

1 have is the sufficient material to test the expert's own
 2 response, do you?
 3 **A.** No, I don't.
 4 **Q.** And if we look at page 54, paragraph 6.35, the finding
 5 there is:
 6 "The first prosecution expert was an eminent
 7 forensic psychiatrist. His conclusion was clear and
 8 unambiguous. A plea of guilty to manslaughter by virtue
 9 of diminished responsibility was appropriate. That
 10 report considered countervailing arguments. It is clear
 11 to us, as a result of our meeting with this expert, that
 12 he had taken into account the concerns that had been
 13 raised by the bereaved families about the assessment of
 14 the offender's mental state on the day of the attacks."
 15 Are we really to read into that the caveat we've
 16 just discussed?
 17 **A.** We asked about that, James Jenkins's interview note, as
 18 you see, talks about a back calculation. You know, I am
 19 not going to get behind and I don't think anybody
 20 should, you know, saying that Dr Blackwood wasn't the
 21 expert in his field. He told us he'd done it. We're
 22 not experts. We don't -- you know, we don't
 23 investigate. We didn't ask an independent psychiatrist.
 24 So what, you know, that is our judgement. That is
 25 the judgement that actually he'd thought about it, he

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1 and bereaved families".
 2 **A.** Yeah.
 3 **Q.** If we go to page 65, we see at the bottom of that page
 4 "The role of the family liaison officer ..."
 5 **A.** Yeah.
 6 **Q.** At page 67, please, this the beginning of the section of
 7 the "Crown Prosecution Service engagement with the
 8 bereaved families before the decision to accept pleas to
 9 manslaughter". And if we have a look, please, at
 10 page 69, paragraph 9.10, you say:
 11 "We have considered the contact that the CPS had
 12 with the bereaved families, both directly and
 13 indirectly, including via the family liaison officers
 14 ... from 13 June, the date of the offences until
 15 24 November."
 16 Now it's right to say that you didn't speak to the
 17 FLOs themselves.
 18 **A.** We didn't.
 19 **Q.** You were working simply from their logs; is that right?
 20 **A.** That is right.
 21 **Q.** If we continue down section 9, over the page please,
 22 there are repeated references throughout this section to
 23 the FLOs. If we look at 9.21, for example, it says:
 24 "In the aftermath of losing a loved one in horrific
 25 circumstances, bereaved families will understandably be

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1 said he'd done it, and we therefore made that finding.
 2 **Q.** As we discussed towards the beginning of your evidence,
 3 though, part of the complaint wasn't just about the
 4 CPS's handling of the complaint; it was also actually
 5 about how the expert reached his own opinion.
 6 Realistically, that's not something that --
 7 **A.** That's out of the scope of this inspection.
 8 Realistically, you know, that would, I presume there
 9 will be some governance of psychiatry, you know.
 10 I don't know who does it, but if that's the issue that
 11 somebody is saying that Blackwood has got it wrong then
 12 actually they should be investigating through the line,
 13 through -- and it is not nature -- that is not the scope
 14 of this inspection.
 15 **Q.** Thank you. And then moving on to a second topic,
 16 briefly, and that's the Family Liaison Officers. If we
 17 could go -- sticking with this report, if you could go
 18 to page 9, please. We saw there that those first two
 19 bullet points in the headline findings relate to the
 20 FLOs.
 21 **A.** Yeah.
 22 **Q.** And I think you've said really it's not actually
 23 a criticism of the FLOs themselves. Could we please
 24 turn to page 61. We have here the section relating to
 25 the "Crown Prosecution Service obligations to victims

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1 in a high state of shock, disbelief, and grief. This is
 2 where the FLOs are vital in being the conduit and can
 3 reinforce to bereaved families, as the days and weeks
 4 move on, that the offer made in the CPS introductory
 5 letter to meet with the prosecution team remains an
 6 ongoing offer. The CPS cannot force bereaved families
 7 to meet with them and are heavily reliant on the FLOs,
 8 who are in regular contact with the bereaved relatives,
 9 to keep them updated about the family's position and
 10 views on if, and when, they are ready to meet the
 11 prosecution team."
 12 We can see there, below that, plenty of mentions of
 13 the FLOs and their role, and their involvement. If we
 14 keep on scrolling down, please. Just to give some more
 15 examples. Perhaps if we go to page 73, 9.39. It says
 16 there:
 17 "Following the request for a meeting that was made
 18 by [Barney's] ... mother to her FLO on 7 November, the
 19 FLO informed the reviewing lawyer of this on
 20 13 November. The FLO informed the reviewing lawyer that
 21 the request was for a meeting with the CPS and counsel,
 22 preferably before the PTPH, as [Barney's] ... parents
 23 wished to understand fully the partial defence of
 24 diminished responsibility and the possible outcome of
 25 the PTPH on 28 November. The FLO said that she and her

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

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

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

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

45

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

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

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

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

20 9.58:

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

25 And 9.60:

47

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

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

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

16 If we keep on scrolling and go perhaps to 9.54 and
17 9.55:

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

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

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

9 **A.** No, I don't.

10 **Q.** Why is that?

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

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

21 **A.** Yes, we have -- sorry?

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

23 **A.** No, I haven't --

24 **Q.** We have obtained statements that --

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

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

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

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

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

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1 Prentis but I was made aware that Easter was the hard
2 cut.
3 **Q.** Page 68, paragraph 9.2, this addresses Elaine Newton, it
4 says:
5 "Ian's partner declined to meet with us but
6 confirmed in a telephone call that she had no concerns
7 regarding the CPS's engagement with her and was
8 complimentary about the service she had received."
9 Again, could you have done more to have engaged her?
10 I mean, she wouldn't have known the concerns that
11 perhaps you shared?
12 **A.** I had that -- I had the telephone call with Elaine and
13 she was very clear in that telephone call. She was very
14 grateful for the call, she was very grateful for what we
15 were doing but she was very clear she didn't want any
16 contact about this in that telephone call to me.
17 **Q.** In none of your inspections do you inform those who were
18 affected in advance of a summary of your findings?
19 **A.** We don't do inspections like this. This is a unique
20 inspection. There has only ever been, in the history of
21 the Inspectorate, two specific-case inspections: one was
22 on the Jubilee Line Inquiry, and this one. This is
23 a very, very unique inspection. We do not look, and
24 have not looked, bar this and Jubilee Line, at
25 individual cases.

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1 **Q.** You read the transcripts of all of them.
2 **A.** I have.
3 **Q.** Thank you very much. You were aware, from your
4 inspection of the events, during the course of the
5 investigation and prosecution that you were concerned
6 with, and having written your report, that the family
7 raised numerous concerns to the effect that insufficient
8 regard had been paid to the apparently rational actions
9 of VC on 12 and 13 June. Did you -- and I think you've
10 already said you knew about Mr Beddoe's report in answer
11 to the question from Mr Blake --
12 **A.** *(The witness nodded).*
13 **Q.** -- during the course of your -- the formulation of your
14 report?
15 **A.** Yes, we saw the evidence, we saw the Beddoe report, we
16 saw Alan Murphy's response on that and we saw the
17 correspondence that followed that report and where it
18 came and, you know, whether it was requested or not. We
19 saw all of that evidence.
20 **Q.** So you saw all of that and, indeed, having read the
21 transcripts, you've seen that some of that
22 correspondence has been gone through with Mr Murphy and
23 various others?
24 **A.** Yeah.
25 **Q.** Now, that report of Mr Beddoe was placed on the schedule

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1 **Q.** Looking back at this, just as a criticism may be made of
2 the CPS and their engagement, do you think that HMCPSI
3 could have spent a bit longer and have engaged a bit
4 more?
5 **A.** Yes, I do, which is why I said it at the end of my
6 statement.
7 **MR BLAKE:** Chair, I don't have any further questions. There
8 are questions from Core Participants.
9 **THE CHAIR:** Yes, thank you.
10 Mr Moloney.
11 **Questioned by MR MOLONEY**
12 **MR MOLONEY:** Morning, Mr Rogers.
13 **A.** Morning.
14 **Q.** Just three topics, if I could, please. First of all,
15 the report of DC Beddoe; secondly, Dr Latham's
16 instruction; and, thirdly, the publication of the
17 reports.
18 If I could take each of those in turn, you've
19 already set out what the remit of your report was at
20 paragraph 1.3, Mr Blake having asked you questions about
21 that. I'll ask you about Mr Beddoe's report, if I may.
22 Have you watched any of the evidence, did you watch any
23 of the evidence, of Mr Murphy, Ms Shallow, Ms Mannion or
24 Mr Khalil, King's Counsel?
25 **A.** I have read the transcripts of all of those.

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1 of sensitive unused material?
2 **A.** Yeah.
3 **Q.** As the head of HMCPSI, did -- is it your view that the
4 Neil Beddoe report should have been on this schedule of
5 sensitive unused material?
6 **A.** It is. Communication between the police and CPS and, as
7 a natural course, that's where it would live. It would
8 live on a schedule of unused material.
9 **Q.** So I just want to explore that with you. The disclosure
10 of Mr Beddoe's report. How would that give rise to
11 a real risk of serious prejudice to important public
12 interest, so as to justify it being placed on the
13 schedule of sensitive unused material?
14 **A.** I think Alan Murphy actually answered that question, as
15 did Sam Shallow, and, you know, sort of in a way, we
16 were inspecting -- this was -- we did not get into the
17 management of disclosure as part of this inspection.
18 What we thought about was actually what was in that
19 report and actually the issue that related to that, and
20 whether, obviously, the psychiatrists had considered
21 some of the issues which I think we all realised that
22 they did understand the issues that was raised in that
23 Beddoe report. We were not doing an inspection of
24 disclosure on this inspection.
25 **Q.** You said Alan Murphy answered that question --

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

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1 It doesn't appear we did.
 2 **MR MOLONEY:** No. But does that email not -- did that email
 3 not concern you, that counsel was concerned about the
 4 police sharing this view with the family?
 5 A. I think, given the concern that was expressed where that
 6 report had come from, nobody was clear why the report
 7 had been produced and, actually, it was contrary to what
 8 the issues in the case were. I think it probably would
 9 have caused more disquiet, confusion and upset. So
 10 I actually think it was inappropriate not to share that
 11 with the families because I'm not sure the report
 12 actually --
 13 Q. I didn't ask you that, Mr Rogers. I asked you whether
 14 or not it concerned you, whether or not you thought at
 15 the time, "Actually, this might reveal a little bit of
 16 tension about the families and part of my remit", if
 17 I can just read, is that to:
 18 "... whether the approach taken by the CPS in
 19 engaging with the families during the case met the
 20 standards and expectations as set out in the Victims'
 21 Code and it's own Bereaved Family Scheme."
 22 Were you not concerned by this, that there might be
 23 an apparent tension as perceived by junior counsel, in
 24 terms of the -- firstly, what the police were trying to
 25 do; and, secondly, revealing information to the family?

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1 "Hi, Alan
 2 "I entirely agree with the below. I am also far
 3 from convinced with Leigh's response. If it wasn't to
 4 set out the police view as to the acceptability of the
 5 pleas then I don't understand the point of it, and
 6 specifically the 'it is not possible to say with any
 7 certainty' opinion aspect.
 8 "I hope that your last sentence got the message
 9 across to the police about sharing this view with the
 10 families. I am very concerned that this may have been
 11 or will be done -- whether in the form of the 'report'
 12 or in discussion."
 13 Did you ask junior counsel about that email?
 14 A. I'd have to look at the notes of the interview. I'm
 15 sorry, I don't -- can you bring up the notes of the
 16 interview that we did with junior counsel and Mr Khalil,
 17 please?
 18 Q. We can check that. Do you recollect asking?
 19 A. I recognise this email. I can -- let me have a look at
 20 the notes, sorry. I don't know if we did.
 21 **MR BLAKE:** The URN is HMCP0000576.
 22 **THE CHAIR:** Mr Rogers, it's going to come up on the screen.
 23 A. Thank you. Can you scroll up, please, or down.
 24 Whichever way it goes, sorry. Keep going, sorry. Keep
 25 going.

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

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

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1 **THE CHAIR:** Yes, Ms Cartwright.
2 **Questioned by MS CARTWRIGHT**
3 **MS CARTWRIGHT:** Good morning, Mr Rogers.
4 A. Good morning.
5 Q. I ask questions on behalf of the survivors.
6 Could I go first of all, please, essentially, to the
7 request for the inspection that you undertook. So it's
8 in HMCP0000625, at page 99, please, which is the
9 commissioning and the inspection, thank you. Now,
10 you've indicated that the remit was only for the
11 bereaved families, not for the survivors. Looking at
12 this request from the Attorney General, why do you say
13 it did not apply to the survivors, bearing in mind this
14 was a rapid inspection of CPS actions in the VC case,
15 the survivors were part of that VC case --
16 A. *(The witness nodded).*
17 Q. -- and you see it says:
18 "This inspection should address the concerns raised
19 by the victims' families about the charging decision and
20 the approach taken by the CPS in engaging with the
21 families."
22 A. Yeah, I said that because, actually, the commission and
23 the conversations had related to the conversation that
24 the bereaved families had with the Prime Minister, and
25 the Attorney General and others at the time. But

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

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

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

4 Q. No. Well, again it doesn't require hindsight. And
 5 perhaps whilst we're looking at that, just to
 6 contextualise what you've said in your witness
 7 statement, please, if we could just disclose your
 8 paragraph 52, I think it is, in the witness statement
 9 where you effectively -- thank you, could we move to,
 10 I think it's paragraph 52, you say:
 11 "I consider that the ... inspection report fully
 12 addressed the concerns raised by the bereaved families
 13 in respect of both the CPS decision-making and the CPS
 14 communication with them. There is nothing further that
 15 I consider we could or should have done. This is in
 16 respect of responding to the remit of the commission
 17 received from the Attorney General, addressing the
 18 families' concerns, and in reaching the clear findings
 19 that we did."
 20 Would you agree or would you now, therefore, amend
 21 your paragraph 52 that essentially there is more that
 22 the Inspectorate should have done in respect of the
 23 remit of the commission?
 24 A. Yes, I would.
 25 Q. And I think even leaving aside the complete failure to

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1 who have traumatic brain injuries, post-traumatic stress
 2 disorder and physical disabilities as a result of the
 3 attacks on them, that there was a real opportunity for
 4 improvement more broadly as to how CPS engaged with
 5 victims if this Inspectorate had undertaken what we say
 6 should have been done, the views and specific look at
 7 the perspective of the survivors; would you agree?
 8 A. Yes, I would.
 9 Q. If we can just go down please. Again, in terms of
 10 an inspection, what is key is the "user perspective",
 11 principle 3:
 12 "Inspection should be delivered with a clear focus
 13 on the experience of those for whom the service
 14 I proved, as well as on internal management
 15 arrangements. Inspection should encourage innovation
 16 and diversity and not be solely compliance-based".
 17 I think you've already accepted that this inspection
 18 completely fails to have the perspective of the
 19 survivor-victims as to how the CPS engaged with them;
 20 would you agree?
 21 A. I do, but these principles are actually about what
 22 I would call usual inspection. As I've said already,
 23 this is a unique inspection looking at one case.
 24 Inspection actually is very unusual of this nature. We
 25 normally focus on the experience of a cohort. So be it,

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

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

16 Q. Well, then can we then perhaps just look at the purpose
 17 of inspections. It's document WITN0245002. Thank you.
 18 Certainly in terms of the principles for the inspection,
 19 if we look at principle 1, "The purpose of improvement".
 20 A. Yeah.
 21 Q. I'm going to suggest to you that a rushed inspection or
 22 inspection where there plainly were significant issues
 23 from those that I represent, in respect of
 24 communication, that are not just fact specific, that
 25 will assist more broadly the CPS engagement with victims

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1 you know, we've just published an inspection on the CPS
 2 performance of those involved in knife crime, or crimes
 3 against older people.
 4 So the user perspective is a much wider -- and these
 5 principles, these 2003 principles, what you're saying
 6 I agree with from the point that I could have engaged
 7 with the survivors, but that user perspective I think is
 8 not as you've just set it out, because of the unique
 9 nature of this inspection.
 10 Q. Well, what I'm going to suggest to you is not just
 11 fact-specific matters but one of the matters you've
 12 robustly said in questioning today: there would have
 13 been no purpose in speaking to the FLOs.
 14 A. Yeah.
 15 Q. Essentially they are police individuals in any event, so
 16 they may not need to cooperate with our Inspectorate.
 17 A. No, I don't have a remit to inspect them. I didn't say
 18 not cooperate. They may -- they could have refused.
 19 I can't make them talk to me.
 20 Q. Because what I'm going to suggest is, it was a real
 21 opportunity for the Inspectorate to look at how the CPS
 22 rely or absolve their responsibilities by saying, "Well,
 23 that was for the FLO to sort". Because perhaps if
 24 I give you a context, the -- those that I represent were
 25 asking for meetings, along the way, to understand, and

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

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

8 **A.** There is.

9 **Q.** -- that affects nationally --

10 **A.** It does.

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

14 **A.** Yeah.

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

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

23 So I don't agree -- we did miss an opportunity here,
24 I agree, from the survivors, we missed an opportunity.

25 But actually I don't think, because of the work that we

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1 allocation of the FLO.

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

9 **A.** Right, okay.

10 **MS CARTWRIGHT:** Thank you.

11 **THE CHAIR:** Thank you.

12 Ms Carey?

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

14 **Questioned by THE CHAIR**

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

18 **A.** No, it wasn't.

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

22 **A.** It was, yes.

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

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

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

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

6 **A.** I agree.

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

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

11 **Q.** There was one FLO for three cohorts --

12 **A.** Yes.

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

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

17 **Q.** And particularly victims who sustain cognitive
18 injuries --

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

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

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

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

3 **A.** Yes.

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

8 And you make one recommendation.

9 **A.** Yes.

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

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

21 **A.** Of the sentence, yes, yes.

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

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

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

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

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

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

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1 **A.** I will check.

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

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

5 **THE CHAIR:** Thank you, well --

6 **A.** But I will check again.

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

9 **THE WITNESS:** Sure, no problem.

10 **THE CHAIR:** Thank you.

11 (11.33 am)

12 (A short break)

13 (11.51 am)

14 **THE CHAIR:** Yes?

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

16 **DR TUHINA LLOYD (affirmed)**
 17 **Questioned by MS LANGDALE**

18 **THE CHAIR:** Yes, Ms Langdale?

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

23 **A.** There are two small areas of inaccuracy, paragraph 342
 24 there's a date inaccuracy, a date that reads 4 July
 25 2022, which should be 4 August, when Mr Carter and Paul

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

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

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

12 **THE CHAIR:** Yes. All right. Thank you.

13 **A.** Thank you.

14 **MR BLAKE:** Thank you, Chair.

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

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

21 **A.** It is, thank you.

22 **MR BLAKE:** Thank you very much.

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

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1 Robinson did their visit and there is a further
 2 inaccuracy in paragraph 346 when I mentioned that Gary
 3 Carter was present at the meeting on 22 September
 4 2022 --

5 **Q.** The discharge meeting?

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

8 **Q.** How have you come to learn that?

9 **A.** It was through reading his witness statement.

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

12 **A.** Yes.

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

16 **A.** Yes. So I qualified as a medical practitioner, gaining
 17 my Bachelor of Medicine and Bachelor of Surgery in 1995
 18 from the University of Nottingham. I have also got
 19 a Bachelor of Medical Sciences and Master of Medical
 20 Sciences Degree, in addition to that, and my membership
 21 exams, Membership of the Royal College of Psychiatrists,
 22 was obtained in 1995 -- sorry, that's incorrect. In
 23 1999, I do apologise.

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

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

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

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

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

20 **A.** I heard most of his evidence.

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

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

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1 later than that?

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

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

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

13 **Q.** So did you do it?

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

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

21 **A.** That's right.

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

24 **A.** That is right.

25 **Q.** Was there nobody that you discussed it with?

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1 prevented this."

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

4 **A.** Not at all.

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

9 **A.** As a team?

10 **Q.** Mm.

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

17 **Q.** Who did that message come from and when?

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

21 **Q.** Who's that?

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

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

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1 **A.** There was nobody.

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

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

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

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

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

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

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

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1 It's important, isn't it, so people know what their
 2 responsibility is going forward and they can't shake it
 3 off?
 4 A. Sure.
 5 Q. Can I ask you to look first of all at documents you will
 6 not have seen at the time relating to VC.
 7 A. Of course.
 8 Q. If we can have INQY0000003. This is a complaint that VC
 9 brought to the Investigatory Powers Tribunal, which is
 10 concerned and deals with complaints about the conduct of
 11 the intelligence service and whether there's been any
 12 infringement in his case. He was arguing for human
 13 rights.
 14 Have you seen this document? It was sent with a
 15 number of documents and you may not have looked at it
 16 properly, but we can go, please, to page 2 and we see at
 17 paragraph 6, if we can enlarge that:
 18 "He complained ... organisations ... had carried out
 19 'continuous intrusive surveillance and harassment and
 20 recorded information about all aspects of [his] ...
 21 life'. ... said to have taken place 'primarily in
 22 Nottingham'."
 23 Paragraph 9:
 24 "'The conduct began around September 2019 at the
 25 accommodation on Salisbury Street.'"

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

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1 information is another piece of that bigger picture. So
 2 I think it is important.
 3 **Q.** And we know that he'd -- I don't take you to them all --
 4 written many times about communication requiring
 5 technology, a system communicating in his mind.
 6 The significance of what's on the screen, if I can
 7 take you to it again in the italics at the top:
 8 "... so as to drain him mentally to coerce him to
 9 commit criminal activities ..."
 10 Would you have to pick that up as high risk? Can
 11 you see at the top?
 12 It's actually the second paragraph.
 13 **A.** Oh sorry, the second paragraph, yes.
 14 **Q.** Yes, move down, sorry. So he says:
 15 "... and misinform him, so as to drain him mentally
 16 to coerce him and commit criminal activities ..."
 17 So he's describing that's the effect.
 18 **A.** Okay that's --
 19 **Q.** Would you have picked that up? I mean I'm drawing it to
 20 your attention. Tell us if you wouldn't. But that's
 21 what is being stated. Would you have read that and what
 22 would you think about that?
 23 **A.** He's essentially saying that there are these systems in
 24 place that are forcing him to commit a criminal activity
 25 or criminal activities. He doesn't specify what that

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1 that could 'plausibly' be dismissed as a sudden mental
 2 illness. The objective of the activity as far as the
 3 complainant can ascertain is to harass and misinform
 4 him, so as to drain him mentally to coerce him to commit
 5 criminal activities that retroactively justify the
 6 illegal surveillance that the agencies committed. The
 7 complainant asserts that the local police department is
 8 aware and involved in the illegal activity and as such
 9 that avenue for resolution is non-viable."
 10 This was May 2022 that he sent it, at a time he was
 11 a community patient under your care. It wasn't sent to
 12 you by the Investigatory Powers Tribunal. Would it have
 13 been helpful to see this document?
 14 **A.** Yes, it would, yes.
 15 **Q.** Why is that?
 16 **A.** I think one of the things that I've realised in sort of
 17 watching all the Inquiry hearings is that each
 18 organisation seemed to have small pieces of a jigsaw
 19 puzzle, and none of us really had the full picture at
 20 all, and so much information is now being revealed that
 21 us as a Community Team would have absolutely no idea
 22 existed. And I think it's so important that when we
 23 make judgements, when we, you know, make really
 24 important decisions, that we should have all of that
 25 information available. So yes, every piece of

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1 is. But he's suggesting that there is -- there's
 2 a process in place that is somehow having some kind of
 3 control over him. So yes, that is concerning.
 4 **Q.** And when we go to the notes you know as early as
 5 May 2020 is when he is going into properties, smashing
 6 doors down, causing a woman to jump out of a first-floor
 7 window. That's what he's doing: committing criminal
 8 activities. You know that.
 9 **A.** (*The witness nodded*). And that was very much in
 10 response to auditory hallucinations, I understand,
 11 rather than some sort of mental coercion, as he
 12 describes here.
 13 **Q.** Is there a difference if the activity is the same,
 14 whether it's an auditory hallucination from the victim's
 15 perspective or a coercion through mind control? It's
 16 the impact, isn't it, of whatever it is?
 17 **A.** But it's also something about intent, isn't it? So in
 18 the incidents where he kicked down a door, my
 19 understanding, having read the notes in a lot of detail,
 20 was that he did not actually have any intent to harm
 21 anyone. He was responding to auditory hallucinations.
 22 He could hear his mother screaming on the other side of
 23 the door and he wanted to go and help. So there was no
 24 actual violent intent there. There was no intent to
 25 harm anyone. The kicking of the door was an action that

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

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

11 **A.** To the victim, yes.

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

16 **A.** Yes.

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

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

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1 the document there?

2 **A.** In terms of risk to --

3 **Q.** To others.

4 **A.** To others?

5 **Q.** Yeah, what would that tell you, if anything, about VC?

6 So assuming you're always interested in your patients'
7 thought processes --

8 **A.** Sure.

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

11 **A.** No, absolutely.

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

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

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

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

4 **A.** No, that's right.

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

8 **A.** That's right.

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

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

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

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

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

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1 as such.

2 **Q.** A bit more generic?

3 **A.** Absolutely.

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

6 **A.** Yes.

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

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

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

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

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

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1 VC making reference:
 2 "Because I know that they are watching. I know that
 3 I can break their heads with my hands."
 4 That's a particularly graphic phrase. Would that
 5 concern you, that description?
 6 **A.** It sounds violent. So, yes, again, if we start to add
 7 together all of the little bits and statements and get
 8 a sense of a bigger picture, then, yes, you know, it's
 9 more concerning --
 10 **Q.** Page 17, please, 14:52 and 14:54.
 11 "That previous night I felt immense anguish,
 12 paranoia, anger, hatred, couldn't sleep ... darkest
 13 thoughts could imagine wanted to hurt ... permanently
 14 ..."
 15 What about that?
 16 **A.** It's more of the same, isn't it, of what we've seen.
 17 **Q.** Page 18, please, 15:19:
 18 "... why do I feel like this now? I know I didn't
 19 work myself into this state of mind. I was thinking
 20 about red rum not 120 minutes ago."
 21 Would you know what "red rum" suggests?
 22 **A.** Yes.
 23 **Q.** What does that suggest to you?
 24 **A.** "Murder" backwards.
 25 **Q.** So if you saw that text, what do you think about that?

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1 obligation, don't you, to share information relevant to
 2 risk. If you consider these were relevant and you
 3 identified someone saying, "I was thinking about murder
 4 not 120 minutes ago", would you share that information,
 5 whether it's actually uploading the whole document or
 6 making a more vivid summary in the notes?
 7 **A.** Because I understood the meaning of "red rum" as being
 8 "murder", yes, I probably would have. But I'm not sure
 9 that everyone would necessarily understand. You would
 10 have to have watched the film *The Shining* or seen it in
 11 some other -- you know, some other meme or context,
 12 whereas, you know, if you hadn't, it could mean
 13 anything, really.
 14 **Q.** But your evidence is, despite the fact you didn't have
 15 admin support for Multi-Disciplinary Team meetings,
 16 there would be support for a task like that --
 17 **A.** Yes, there would be --
 18 **Q.** -- if a doctor wanted assistance, a consultant in having
 19 material made available --
 20 **A.** Yes.
 21 **Q.** -- for the rest of the team; and it's perfectly
 22 feasible, isn't it, that some people if they can't read
 23 all the notes might just use a control function and
 24 search for what you've said, for example, as the
 25 consultant? It's possible, isn't it?

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1 **A.** Again, it's another piece of information that adds to
 2 all the others in terms of informing risk.
 3 **Q.** Do you think the summary I took you to earlier,
 4 adequately conveyed those messages, the risk element of
 5 those messages?
 6 **A.** No.
 7 **Q.** Dr Seedat, of course, uploading all of these documents
 8 to RiO, no doubt if he'd wanted to do that, that's quite
 9 a difficult task, is it, or time-consuming task, or not?
 10 **A.** It's usually the medical secretaries that do the
 11 uploading.
 12 **Q.** So you can ask a medical secretary to upload something
 13 like that?
 14 **A.** Yes, you normally would.
 15 **Q.** If you were given something like that from a patient's
 16 family member who wanted to assist and were quite happy
 17 for you to use it as you saw fit, in terms of sharing
 18 the information, what would you do with it?
 19 **A.** It's very difficult for me to comment on that. I don't
 20 know the circumstances of the situation at the time,
 21 what Dr Seedat had been told by family, if they were
 22 worried or concerned that releasing that information
 23 might have impact for them. It's not a question I could
 24 answer without being actually in that situation myself.
 25 **Q.** Well, even if they were, either way, you still have an

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1 **A.** (*The witness nodded*).
 2 **Q.** If someone thinks: I can't read everything, I'll just
 3 see what the consultant thinks, or the Consultant
 4 Psychiatrist.
 5 **A.** It is possible to do that, yes.
 6 **Q.** And probably quite useful for trainees and others to see
 7 what you do think on occasion, yes?
 8 **A.** Yes. That's right.
 9 **Q.** So you do say you have the right support in the event
 10 you want to do that.
 11 Thank you. That can go down and can we have please
 12 WITN0428001, and this is a statement from a woman who
 13 lived in the same premises as VC between 2014 to 2015.
 14 I think we've sent you this as well, have we,
 15 Dr Lloyd? Have you seen this statement? If we go,
 16 please, to page 2. Her impression:
 17 "... he was quiet, unfriendly ... did not appear to
 18 want to socialise with other people living in the house.
 19 ... sometimes try to start conversations ... usually met
 20 with one word answers and [so] he would often leave the
 21 conversation as soon as possible."
 22 Paragraph 5, if you read that, she refers to:
 23 "... frequently [waking] ... up to the sound of
 24 someone in the kitchen, which turned out to be him [at
 25 night] ... I remember wondering how he was able to sleep

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1 if he was often so up during the night and during the
2 day.
3 "On other occasions, during the early hours of the
4 morning, I heard repetitive noises and what I can
5 describe as screaming coming from his room. A friend
6 who was staying with me also heard these noises."
7 Then if we go to paragraph 8, page 3, an incident
8 where food had gone missing, her housemate asked
9 everyone about it:
10 "When she asked [VC] ... raised his voice ... asked
11 why she was accusing him, which [she] ... found
12 intimidating. He ... walked away and the issue was not
13 discussed further."
14 And then we see, please, paragraph 14, page 4.
15 "... I gave them a factual account of my time living
16 in shared accommodation with [VC]. I described
17 behaviours I had observed, including unusual patterns of
18 activity during the night, loud noises ... and ...
19 interactions with housemates."
20 So she was concerned about his mental health then,
21 when she saw he was in the news, and had concerns back
22 to 2014 to 2015. Were you aware of any earlier concerns
23 about his mental health?

24 A. No.

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

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1 A. Yes, yes, sorry.
2 Q. Can you see that?
3 A. I'm just reading, I do apologise.
4 Q. No, take your time. It needs to go further up, so you
5 can read it:
6 "[VC] has been speaking to his brother ..."
7 Under "Family/Carers involvement".
8 A. Yes, I can see that, yes.
9 Q. And then further down a few lines in the same paragraph
10 if it can be scrolled further up, please, again just a
11 little bit:
12 "Dr Seedat explained ... the real test for [VC] is
13 when he is back in the community where he will be
14 followed up by a Community Team. Dr Seedat says that
15 based on what Mrs Calocane has said, it would appear
16 that [VC] may be suffering from some sort of mental
17 illness. However, only time will tell."
18 His mother offers to send a journal to Dr Seedat.
19 When you read the notes, I know you read the notes,
20 you tell us, did you spot that a journal had been sent
21 or was available that might assist you?

22 Can you see it?

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

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

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1 assessing him at the time that you did?

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

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

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

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

19 So in terms of the duration and nature of VC's
20 illness, whilst nobody was saying anything about 2014 to
21 2015, it was a matter of months, wasn't it, right from
22 the off, that Dr Seedat was alerted to the fact that
23 he's been heard voices.

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

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1 it?

2 A. Yes, potentially.

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

5 A. Yes.

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

8 A. *(The witness nodded)* Yes.

9 Q. Likely to give you some insight.

10 A. Yes, yes. It would be helpful.

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

13 A. No, I didn't.

14 Q. Did you have any conversation with him?

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

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

18 A. Yes.

19 Q. -- but no conversation?

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

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

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

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1 was doing the initial assessments, and the diagnosis,
 2 and so in actual fact, it was Dr Burri that had the sort
 3 of more of the lead medical role and responsibility at
 4 that stage, and --
 5 **Q.** He might have been more reluctant about phoning another
 6 consultant though, mightn't he, than you could have been
 7 as a consultant --
 8 **A.** Possibly.
 9 **Q.** -- to say, "Is there anything I need to know about this
 10 patient? What was your experience of him?"
 11 **A.** Yes. No, I can appreciate that, but at the end of the
 12 day, we have really clear systems in place, in terms of
 13 ward liaison, and it's our care coordinators that have
 14 that really important role of liaising with the wards
 15 when we have patients who are inpatients --
 16 **Q.** I'm sure Claudia Birtles will liaise with the ward and
 17 attend ward reviews et cetera, but she's not going to
 18 phone Dr Seedat. And I'm really asking why two
 19 consultants at your respective levels of experience,
 20 where we know we speak to others at the same levels of
 21 experience, in a different way, a more effective way, in
 22 terms of having to explain our reasoning and having
 23 shared experience of many, many cases over years,
 24 wouldn't that have been wise, prudent and indeed should
 25 have happened at some point in the duration of VC's time

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1 **Q.** So at the time, this is 2020, 2021, would you have
 2 written emails about this kind of thing?
 3 **A.** It wouldn't necessarily be emails, but if you look
 4 through the minutes of consultant forum meetings you'll
 5 see that all of my colleagues are constantly raising
 6 concerns about the time that we have, the allocated
 7 caseloads that we have, what we're expected to do. It's
 8 a continuous and repeated issue which we bring up pretty
 9 much in every single meeting. And we're all in the same
 10 boat. It's not just me on my own. You know, some of my
 11 colleagues have got in excess of 300 people on their
 12 caseloads.
 13 **Q.** In terms of reading these notes, we're going to go
 14 through them in some detail, did you read them at the
 15 time?
 16 **A.** Yes.
 17 **Q.** So it's fair for me to ask you about them because you've
 18 read them?
 19 **A.** Absolutely.
 20 **Q.** So in terms of the journal, you haven't picked that
 21 journal up but here we see VC in the next paragraph,
 22 "MDT discussion", Dr Ludvigsen asked him what he was
 23 thinking about, he said "capital punishment", and didn't
 24 say what the "solution" was, and her evidence to the
 25 Inquiry was that was concerning, it was worrying.

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1 in the community?
 2 **A.** Yes, I agree it would have been helpful, yes.
 3 **Q.** Does that mean you agree you should have done it?
 4 Phoned him?
 5 **A.** I think ideally, if there had been time, I would have
 6 done that, but there are so many patients who are in
 7 a similar position coming into the EIP team from
 8 inpatient wards, and we have really clear processes in
 9 place which involve the care coordinators doing that
 10 liaison work, mainly because, as the consultant, there
 11 often isn't time to do everything, as much as I'd like
 12 to, and I've already made it very clear in my statement,
 13 that I had one and a half days allocated to the EIP
 14 team, that's 12 hours per week.
 15 **Q.** Did you ever say, "I can't do justice to these cases?
 16 You need to get someone else in. I can't look at the
 17 detail, can't make calls to find out the information
 18 I need"?
 19 Did you raise that with anyone?
 20 **A.** Absolutely.
 21 **Q.** Who did you raise that with?
 22 **A.** It's been raised over and over again to clinical lead,
 23 clinical directors, and this happens regularly at
 24 monthly forums, and it's not just me, it's all of my
 25 colleagues.

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1 Were you worried when you saw that?
 2 **A.** I don't believe I was particularly worried by that.
 3 **Q.** Did it raise any questions in your mind, in what context
 4 is he thinking about it?
 5 **A.** I can't remember.
 6 **Q.** Sounds like --
 7 **A.** This is such a long time ago, I honestly can't remember.
 8 But I do recall reading the notes and particularly the
 9 medical entries.
 10 **Q.** If we go to page 12, this is a continuation of this
 11 entry at the very top, Dr Seedat is explaining to VC:
 12 "... the most likely cause of the psychotic
 13 breakdown is sleep deprivation/[and]stress. [VC]
 14 explained ... he would want to seek a period of being
 15 medication ['free', that should be] so that he could
 16 better understand [where] ... he is."
 17 So we see at the bottom, under "MDT plan", a bit
 18 further down from where we've cut off at the moment,
 19 please. "MDT plan", we see "Stop regular medication".
 20 So Dr Seedat agrees to a medication-free period, but
 21 we see from the ward review on 2 June, page 17 in the
 22 notes, page 17 under "Patient comments":
 23 "Thinks people have been following him/watching him
 24 probably since last October".
 25 And we see at this stage he says:

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1 "[He] Believes it is a matter of control ..."
 2 Under "Patient comments":
 3 "... never wants to experience anything similar
 4 again or cause distress to others".
 5 And the effect of it is, if we go to page 28,
 6 9 June, VC is back on medication and he's disappointed
 7 about that. So if we go to 9 June, page 28, under
 8 "Patient comments", please. We see:
 9 "[VC] is disappointed ... he is going to have to be
 10 on the ward for longer. He is disappointed ... he will
 11 need to take medication."
 12 So very early on, he doesn't want to see that he is
 13 ill and he's disappointed to be taking medication, isn't
 14 he?
 15 **A.** Yes.
 16 **Q.** "He denies feeling depressed about his illness. He
 17 [hadn't thought] ... about hurting himself or others."
 18 But he appears at this early point, five lines down:
 19 "He believes ... it has been helping him."
 20 The aripiprazole. "He believes ... it has been
 21 helping him."
 22 The Inquiry has received evidence that the earlier
 23 the treatment is provided, the better for outcome.
 24 **A.** That's correct.
 25 **Q.** And at this stage, this admission was really important,

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

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

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1 **A.** Yes, so I knew about that.
 2 **Q.** He is discharged from the second admission, 31 July
 3 2020. He told Professor Blackwood he'd never had any
 4 medication or he'd stopped medication by October 2020?
 5 **A.** And I didn't know that.
 6 **Q.** But by knowing that the rapid readmission was required,
 7 didn't that tell you all that you needed to know about
 8 likelihood of not taking further medication? He doesn't
 9 take it after the first admission, goes back on the
 10 second admission.
 11 **A.** Yes.
 12 **Q.** So your starting point should have been he's not taking
 13 medication, in other words he needed to actively
 14 demonstrate he was. Seeing him take that medication,
 15 whether it was a depot or swallowing a tablet, seeing
 16 him take medication was essential, not just to rely on
 17 what he said, given he hadn't done it before, even when
 18 he appeared to recognise some benefit, from the notes in
 19 2020?
 20 **A.** With oral medication it's just not possible. You know,
 21 the Community Team would have been seeing him weekly at
 22 most, or fortnightly, and it would be for a brief
 23 period. They would get a snapshot. But what we didn't
 24 have was the ability to see him every day and watch him
 25 take his medication, which was something that, for

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

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

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

20 **Q.** During that Mental Health Act Assessment in September
 21 2021, Amie Staples, making a note on the day of the
 22 assessment, recorded that there was seven months' of
 23 medication that was found in his premises?

24 **A.** That's right.

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

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

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

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

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

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

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

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

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

25 **Q.** Could you ask a medical secretary to communicate that

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1 would depend on the side effects.

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

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

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

10 **A.** In the community --

11 **Q.** Yes.

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

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

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

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

7 Top of the next paragraph:

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

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

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

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

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

8 **Q.** Mm-hm.

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

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

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

23 **Q.** More typically represented?

24 **A.** Absolutely.

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

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

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

10 **A.** Assess him on the ward?

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

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

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

25 **A.** It can, yes. It can.

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

7 She said in evidence:

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

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

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

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

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

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

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

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

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

9 **A.** That's correct.

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

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

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

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

3 **Q.** It still happens.

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

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

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

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

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

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

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

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

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

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

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

23 **A.** That's right. So this is the -- essentially that period
24 of two weeks, where he's out but then he's in again.

25 And in actual fact, for the majority of that two weeks,

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

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

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

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

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

25 **A.** Yes.

120

1 Q. Doesn't appear in his care plan, doesn't look like VC is
 2 told about it. We'll hear in due course if his family
 3 are. What's the issue about protecting patients from
 4 a reality, if they have a functional illness?
 5 A. I don't think there is an issue about protecting
 6 a patient from reality if they have a functional
 7 illness. I think what we have to remember is that
 8 psychosis is a broad umbrella term, and under psychosis
 9 comes a whole series of different, specific diagnoses,
 10 one of which is paranoid schizophrenia. You may have
 11 delusional disorder, you may have schizoaffective
 12 disorder, it may be a bipolar disorder with psychosis or
 13 depression or mania with psychosis.
 14 They are all specific diagnoses that fall under the
 15 umbrella term of psychosis. And the reason why, in
 16 Early Intervention, we don't give specific diagnoses is
 17 because we know that in the first three years, diagnoses
 18 change a lot, a concept called diagnostic stability.
 19 The illness is going through a slow, evolutionary
 20 process, and what we see right at the outset isn't
 21 necessarily what we find at the end. And that's part of
 22 the assessment. So --
 23 Q. So the illness is likely to be the same, or one that's
 24 developing, but you may not detect it earlier on, the
 25 diagnosis --

1 suicide in young people.
 2 Q. Recovery-based communication can be positive but only if
 3 it's backed with an ability to require the treatment
 4 that brings about recovery; do you agree?
 5 A. Absolutely, yes.
 6 Q. And what we don't see here is that part of it.
 7 A. Yes, and it's not that we didn't try.
 8 MS LANGDALE: Well, we'll come to that later. It's probably
 9 a good time to stop, thanks.

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

12 (1.02 pm)

(The short adjournment)

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1 A. Yes, it might present in very, very different ways so
 2 that you might, right at the beginning, think: okay,
 3 this is more of an affective picture, but later on down
 4 the line you start to realise no, it's not, it's
 5 starting to look more like a schizophrenic picture.
 6 So that's why we keep that much more broad
 7 terminology of "psychosis". Psychosis doesn't mean that
 8 it's necessarily short term or temporary or
 9 non-functional. All it means is that we're not pinning
 10 it down to a very specific ICD-10 diagnosis.
 11 Q. But you do say something in your statement about why, in
 12 the EIP service, you're careful not to label early on.
 13 A. That's another secondary reason and I think that's
 14 something which, right from the outset of EIP services
 15 being developed, it was a -- it's a very strong sort of
 16 ethos of the service that we focused very much on
 17 reducing stigma, that it was -- it's a recovery-focused
 18 service, so it's very much about instilling hope that
 19 people could get better, rather than right from the
 20 outset giving the message that, you know, this is
 21 a lifelong condition that, you know, you will never get
 22 better.
 23 One of the things that we, you know, the literature
 24 found was that that lack of hope, that lack of sort of
 25 recovery-based thinking could lead to high rates of

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