Tuesday, 8 September 2026

(10.00 am)

Opening remarks by THE CHAIR

THE CHAIR: Well, good morning, and welcome back to Mary Ward House for the hearing of the final submissions in this Inquiry.

Since 5 June, which was the last day of oral evidence hearings, I've been working on my report reviewing not only the evidence which was given by witnesses or referred to in the hearings, but as I made clear at the outset of the Inquiry, all of the evidence which has been obtained and disclosed to Core Participants.

As Core Participants are aware, this Inquiry has taken a dynamic, rather than static, approach to evidence, and where gaps emerged or particular issues needed further clarification, evidence was sought and obtained during the weeks of oral hearings so as to cause no delay. And that approach has continued since 5 June to address any outstanding issues which have arisen or which arise from reviewing the evidence.

Shortly, Counsel to the Inquiry, Ms Langdale King's Counsel, will provide an update summarising the additional work which has been done by the Inquiry and the results of it.

As with any public inquiry, at this stage I can't say that the evidence is now complete. As I go through the writing process it is possible that some further directed Rule 9 requests may be made where I consider that that is necessary. Updating statements from some individuals or organisations may also be required in due course, in order that the report is as up-to-date as possible when published.

It is, however, disappointing that over the break since we were last here, some evidence has emerged which ought to have been identified by Core Participants and disclosed earlier. With that in mind, having taken into the current state of the evidence, developments since June and the submissions made by counsel, I have circulated in advance some directions made under the current provisions of the Inquiries Act 2005, which reflect the spirit of the Hillsborough Duty of Candour. I've made these directions now because the Public Office (Accountability) Bill, the Hillsborough Bill as it's properly called, is anticipated to complete its passage through Parliament at some point in the future and we are at an advanced stage in the life of this Inquiry with limited time between this hearing and the publication of the report.

So I make clear that the direction does not seek to

pre-empt the passing of the Bill or to assume its final wording if passed. The passage of the Bill and its content is a matter for both Houses of Parliament. The aim of the direction is twofold and is grounded in fairness and proportionality in the conduct of this Inquiry: Firstly, to give all concerned a fair opportunity and sufficient time to reflect on the evidence which has been given, and time to provide further assistance to the Inquiry by way of additional documents or other evidence to correct any errors or omissions which require correction. And secondly, to provide that assistance within a timeframe which enables me to take it into account in my report without unnecessary additional public expense or delay.

Core Participants are aware, for example, that there are warning letter processes which must be undertaken prior to publication of a report, and having to undertake those twice because of revisions required to be made at a later stage would not be in the public interest.

I therefore make the following direction. Can we have INQY0000035 up, please.

Prior to the passing of the Public Office (Accountability) Bill, (a):

"All Core Participants who are public authorities

and public officials must as soon as reasonably practicable, and in any event no later than 31 December 2026, review with candour, transparency and frankness the assistance given to the Inquiry to date and provide such further assistance as they can reasonably give to assist the Inquiry to meet its objectives in the following respects:

"(i): if any errors or omissions are discovered in information previously provided, whether in disclosure of documents or in witness evidence provided to the Inquiry, correct those errors or omissions; and

"(ii): In the case of public authorities, provide a position statement that they have complied with this [direction].

"(b): All Core Participants which/who are not a public authority or public official but had a relevant public responsibility, in that they carried out activities as a service provider to a public authority which had a significant impact on members of the public in connection with the events, acts and omissions which are the subject matter of this Inquiry and set out in the Terms of Reference, must also comply with (a) above as soon as reasonably practicable, and in any event no later than 31 December 2026.

"2: Upon the enactment of the Public Office

(Accountability) Bill, if the same occurs before the delivery of [the Chair's] report, no later than 7 days after the enactment of the new Act, Core Participants included in 1(a) and (b) above must provide a written confirmation to the Inquiry that they have complied with any obligations imposed upon them by the new Act, whether the subject of this Direction or not."

So before we start, thank you for all your helpful written closing submissions. When you come to make your oral submissions over the next two days, please be assured that I have read them in full and therefore you may wish to emphasise those points which are most important in the time available.

I may ask about aspects of the submissions as I do leave some time for questions.

So in a moment I'm going to hand over to Ms Langdale, thank you.

SUBMISSIONS BY MS LANGDALE KC

MS LANGDALE: Thank you, Chair.

At the end of the oral hearings, statement requests were made by the Inquiry Legal Team to various individuals and organisations in respect of a number of matters. Core Participants are aware of the issues arising and have received further information over the summer. I will highlight some of the issues at this

point and by way of update.

Burford Road. On 16 June 2023 Nottinghamshire Police recovered a holdall belonging to VC from 165 Burford Road, Nottingham. You will remember, Chair, that VC lived at this address from 19 October 2022 until 11 June 2023. On 11 June, VC was evicted by his landlord owing to rent arrears and he travelled to London to stay with a friend. VC returned to Nottingham shortly before midnight on 12 June 2023. CCTV that you have seen demonstrates he arrived at Nottingham station carrying a rucksack and a large Slazenger bag.

In a recent statement, Retired Detective Superintendent Sanders tells us that detailed examination of the holdall retrieved from 165 Burford Road was not prioritised in June 2023 because investigative efforts were focused on recovering the Slazenger bag VC had with him on the evening of the attacks.

You may consider, Chair, that the searching of or for bags was not mutually inclusive and both should have been done shortly after 13 June 2023. However, the holdall found at Burford Road was assessed as not containing time-critical evidence and its contents remained unchecked until 13 September 2023.

When they were checked, the contents of the holdall,

including further notebooks belonging to VC, were not considered to be of evidential value to the homicide investigation. The notebooks were not, therefore, seen by Detective Superintendent Sanders, nor were they provided to the CPS for consideration by the psychiatric experts.

The notebooks were not disclosed to the Inquiry until June 2026. This was an oversight by Nottinghamshire Police corrected after a prompt from counsel for the bereaved who noticed a reference in a police statement dated 14 September 2023 to a sketchbook and two notebooks.

It will have been clear to everyone that the Inquiry would be interested in this material. Indeed, one of the first documents created by the Inquiry Legal Team and shared with all Core Participants, was an analysis of VC's writings and messages and this document was referred to on a number of occasions when questioning witnesses.

That Inquiry Legal Team document has been updated, Chair, with this new information for your use when writing your reports.

The notebooks in the holdall included two Pukka Pads, one A4 Oxford notebook and one Claire Fontaine sketchbook. The first Pukka Pad was mainly

filled with maths and physics equations, one page is dated 3 October 2019 and another contains the date 11 April 2020. There is a note on one page where VC wrote the words "mea culpa", followed by two bullet points: "Illegal actions 2013/2014" and "defied lockdown".

The writing in the second Pukka Pad covers various apparently random topics. Some pages are filled with various line drawings and patterns. VC wrote that he must die, that he had died, that he was the tree that guards the key between heaven and hell, and that he was a god.

In the Oxford notebook, VC wrote about the incidents at Brook Court on 24 May 2020. He provides an account of what happened including references to the police having mind reading software and him having the power to resurrect people. He also wrote how he'd knocked down the door of the next flat and the female occupier jumped out of the window and broke her spine.

On another page, VC seemingly wrote a further account of May 2020 and wrote that "This was when the AI system that monitors me first came out of the background."

VC wrote a list which he headed "To do list when interviewing Gail". This is likely a reference to

PC Gail Collins, who interviewed VC on 24 May 2020 and from whom, Chair, you heard evidence. You will remember VC agreed to meet PC Collins on 29 July to discuss repair costs for a door he had damaged.

VC wrote a lengthy list of questions, including who the officers involved in the case were, querying why he was not provided with an appropriate adult -- in fact he was -- if he had committed a serious crime, why it was not recorded in the PNC; whether or not the case had been passed to the CPS; whether or not he was classed as mentally vulnerable, and why.

Interestingly, and in accordance with legal knowledge demonstrated in other material, the list included a number of detailed references to the Police and Criminal Evidence Codes of Practice as well.

Mobile phone and battery also found in the holdall. Also in the holdall recovered from Burford Road was a mobile phone and a battery although this was not flagged until July 2026 when officers were asked to photograph the contents of the bag at the request of the Inquiry legal team.

Chair, the mobile phone and battery remained unchecked within the bag until July 2026, notwithstanding that it had been in police possession following its recovery in June 2023.

DC Rowbottom undertook a review of the phone and SIM card, and her report is dated 11 July 2026. The device and SIM card contains nothing of relevance to the Inquiry's terms of reference. In fact, there is no data at all on the SIM card apart from pre-installed network numbers and the phone appears to be a new, unused device.

Professional opinion on the notebook contents.

Having received and read the notebooks, the Inquiry sought further witness statements from relevant individuals including Detective Superintendent Leigh Sanders, Specialist Prosecutor Alan Murphy, and Professor Nigel Blackwood.

Detective Superintendent Sanders' view, in short, is that nothing in the notebooks would have changed his policy decisions, nor, in his opinion, would the contents have affected the investigation or prosecution.

Mr Murphy considers the material to be largely irrelevant. To the extent that he does consider any of the material in the notebooks to be relevant, he says it might have been capable of assisting the defence in respect of VC's mental health issues. As such, two of the notebooks would have been disclosed to the defence as unused material.

Professor Blackwood -- significantly, you may

think -- said that any material which would help him inform a psychiatric understanding of VC's mental state would be of interest. He says he would have used the notebooks to inform his interviews with VC, and may have asked questions about particular references. For instance, he would have asked what VC was referring to when he wrote "mea culpa, illegal actions, 2013/2014, defied lockdown."

In Professor Blackwood's view, the notes VC made about previous incidents and questions he wanted to ask the police are not atypical in intelligent but insightless psychotic individuals. He states that a psychotic individual can have apparently rational concerns sitting alongside profoundly psychotic beliefs and experiences.

Professor Blackwood opined that there is nothing in the notebooks which fundamentally changes his understanding of VC, calls in question the nature of his mental disorder or cause him to question the psychotic underpinnings of the index offences. In particular, in relation to the sections of the notebooks which appear more rational, he warns that it would be a profound mistake to consider that the fatal assaults also derived from some similar island of retained rationality, distinct from his severe and repeatedly described and

demonstrated psychosis.

The more rational content in the notebooks was not explored in oral evidence with Professor Blackwood or any other witness because the Inquiry was not in possession of this material. This is regrettable. However, we do not consider that further questioning of the psychiatrist by any advocate is necessary or proportionate at this point. The fact is that these documents were not provided to Senior Investigating Officer Sanders, who in turn did not provide them to the CPS, who therefore did not provide them to Professor Blackwood. Hence, the more important omission, and one which simply cannot be remedied, is that Professor Blackwood was unable to question VC about the contents of these notebooks at the time of interviewing him and he cannot possibly know what VC's responses would have been.

The same is true of the video footage of the attack on PC Pritchard in September 2021, and the assault on Christopher in January 2022, as well as the contents of VC's Mental Health Tribunal records, particularly what VC was saying at that time. None of this material was provided to Professor Blackwood. Furthermore, VC was not asked about extremist material he viewed or a note I'll refer to shortly and found in a bin at Burford

Road.

It is a matter for you to determine, Chair, whether, on all of the evidence you have received and heard, neither expert psychiatrists nor, ultimately, the court were furnished with all of the material relevant to VC's functioning and retained rationality and if not, why not.

We urge caution towards the suggestion that given VC's mental illness, nothing VC might have been asked about would have made a difference to psychiatric assessment of him. We submit that this suggestion underestimates both the dynamic nature of the psychiatric interview, the complexity of VC, and also undermines the independent role of the judge viewing the totality of the evidence as a whole.

You may also consider, Chair, that the basis of the expert psychiatric evidence was undermined by the lack of consideration of VC's resistance to taking medication and his culpability for the same. The Inquiry heard evidence that VC repeatedly failed to take the medication he was prescribed and was deceitful in doing so. This is to be contrasted with treatment-resistant illness which necessarily can only be diagnosed when a patient has been concordant with their prescribed medication.

Finally, in terms of the psychiatric evidence used in VC's case, Chair, we invite you to comment in your report upon the role of experts as distinct from the judge when determining the issue of culpability. The Royal College of Psychiatrists has given some guidance on this and there is relevant case law. Is the existing professional guidance sufficient?

Documents found in a bin at 165 Burford Road.

Nottinghamshire Police also found a variety of documents relating to or created by VC in a green bin at 165 Burford Road. The material is described as documentation in a green bin located in the rear yard of the property and ripped paper.

The underlying material was disclosed to the Inquiry on 14 July 2026. Many of the documents are bank statements, receipts and documents relating to VC's employment. However, there were also pieces of paper on which VC had written. VC's writing is not dated and bank statements taken from the bin go back more than a decade.

The content of much of the writing is similar to that contained in VC's notebooks. For instance, there are pages containing various diagrams and mathematical equations. The writing on other pages relates to matters such as AI and popular culture, the economy,

nutrition, statistical and mechanical modelling, a proposed fitness app, and predicting football results.

On one page, however, VC wrote the following bullet points about explosives under the heading "Thoughts". The bullet points were:

"TNT, ammonium nitrate fertiliser sugar, booster tube, Semtex high explosives, PETN RDX, and acetone peroxide."

This piece of paper, listing thoughts about a number of different explosives, was not identified or taken into account by the police at the time. It was not available to the CPS, the psychiatric experts nor the judge. At no point was VC asked about the viewing of extremist content or why he was thinking about explosives.

VC's background.

Since the conclusion of the oral evidence and at the request of the legal team of the survivors, the Inquiry Legal Team has further investigated VC's history in Wales.

In 2018, Sir Thomas Picton's School merged with a local school to form Haverfordwest High School. Statements were obtained from the following: Julie Foss, Business Manager of Haverfordwest High, who held the same role previously as Sir Thomas Picton; Rebecca

Pritchard, Head of Sixth Form at the school from 2004 to 2013, who continues to teach there; Nigel Thomas, a teaching assistant who worked with VC and also continues to work at Haverfordwest High; and Sylvia Allen, former Headteacher at Sir Thomas Picton.

Ms Foss states that all of VC's school records have been destroyed in line with retention of school records policies. Therefore, the evidence of school witnesses necessarily depends upon a recollection of events occurring approximately 18 years ago. The school confirmed that VC was one of a small number of black children at the school. Mr Thomas states a decision was made to admit VC to Year 10 in order to give him the best opportunity to achieve a sufficient number of GCSE examination passes. When VC was 16 years of age he was therefore in a class with 14-year olds. Ms Foss comments that although she does not have access to any records that could answer the query regarding the frequency of children being placed in younger year groups at Sir Thomas Picton, she would say that it was rare.

Mr Thomas, the teaching assistant who spoke Portuguese, was assigned to work with VC. Mr Thomas states:

"VC was in many ways a model student. He was

extremely focused on succeeding and attaining high levels of achievements in all his subjects. He was unfailingly polite and kept himself to himself."

Mr Thomas had never heard of VC either being a victim of bullying or being the perpetrator of such behaviour towards others.

Ms Pritchard states she recalls reaching some of VC's work for the English literature course and being extremely impressed with the quality of his writing. Ms Pritchard does not comment on any issues with VC's behaviour other that to describe VC as suffering from anxiety. At her first meeting with VC she noted perspiration was visible on his face. The learning assistant later told her that VC's presentation was because he was speaking to someone he did not know.

Mr Thomas, meanwhile, does not recall such anxiety on VC's part although he does state that he was initially hesitant when speaking in English.

VC's former headteacher Ms Allen describes VC finding it difficult to settle into school life and to maintain a positive pattern of study. VC achieved a Grade B in GCSE mathematics in 2008, and the following summer he obtained a further number of GCSEs.

Move to sixth form. There was not an automatic right of entry from the school into the sixth form and

VC achieved the necessary examination grades to enrol for A-level studies. Initially he seemed to have transitioned into sixth form well. However, Mr Thomas states that a few months later he was asked to attend a meeting with VC and the headteacher because VC had spoken about not completing his studies.

At the meeting it was decided that Mr Thomas should meet with VC on a weekly basis in order to keep an eye on his progress and he was asked to reflect before deciding whether to leave. Mr Thomas states VC co-operated with him and his understanding was that he intended to continue with, and complete, his A levels in the sixth form.

Ms Allen recollects that whilst in the sixth form VC fell into a pattern of non-attendance. Ms Allen had a direct conversation with VC and learnt that, without the knowledge of his parents, he had been spending his days at the local library. The local library offered a quiet area for private study and reading. Ms Allen details a meeting at which she, VC's parents and Mr Thomas were present. The outcome of the meeting, so far as she recalls, was that VC was to be encouraged to attend school regularly and could turn to Mr Thomas for support when required. However, the pattern of non-attendance continued.

In June 2010, VC passed three AS levels. However, at some point in 2011 he made the decision to leave the sixth form without sitting his A levels.

Mr Thomas recalls that he attended another meeting with the headteacher and VC's parents. Mr Thomas said VC's parents were clearly relieved to have someone at the meeting to whom they could speak in their own language and in many ways it served to allow them to express their concern at his decisions but also to thank the headteacher and the school for all the care shown to VC. At this meeting, Mr Thomas was told VC had left the family home, was living in a bedsit and was not pursuing his studies. He was not told the reasons for VC leaving the sixth form or the family home although a colleague told him that he'd taken a cleaning job at a local college and had begun to study A-level maths there.

Ms Pritchard, head of sixth form, provided to the Inquiry an extract from the Leavers' Yearbook 2011. It contains a short description of VC written by his peers and included the following:

"Always charming, has a good taste in films, very hard working and friendly, someone that will always say hello to you. Remembered for: insane footballing and brilliant compositions". [As read]

In summary, Chair, from the extensive evidence the

Inquiry has obtained, there is no suggestion that in childhood or adolescence, VC was violent or had a conduct disorder.

VC's working life in Wales.

As the Inquiry heard, in 2009, VC started working with his mother in the evenings as a cleaner at Pembrokeshire College. Since the oral hearings concluded, the ILT has received further evidence that VC was employed by two local cleaning companies and that VC undertook contract work at the local oil refinery during shutdown periods. There is no evidence of concerns expressed by his employers during this period.

This contrasts with the position from 2021 onwards during which period the Inquiry is aware of three work-related incidents involving violence. In May 2021, VC is recorded to have been banned from premises in Eastwood for fighting with a permanent staff member. There was an incident of fighting in another warehouse job in Nottinghamshire in February 2023 and in May 2023 there was the violent assault at Arvato. These three episodes at work followed VC's involvement with mental health services.

Nottingham City Council and CCTV.

The Inquiry heard evidence during the public hearings from CCTV operators and staff employed by

Nottinghamshire City Council, Colin Wilderspin, Brian Bussey and Jayne Harvey. They were asked in particular about issues with camera functionality on and around 13 June 2023 and whether disclosure carried out by the council had been thorough.

Since the conclusions of hearings and in response to concerns about disclosure, the ILT has requested further evidence from Nottingham City Council. Much of that has now been received. Witness statements have been received from James Pykett, a CCTV operator who was working with Jayne Harvey on 13 June; Gregory Hague a CCTV operator who had been working until 7.00 pm on 12 June; and Kenneth Cromwell, CCTV Control Room Manager.

Those statements provide further detail as to the experience of the CCTV operators on the day and how the camera functionality issues and recent system changes affected their ability to look for and track VC on the 13 June.

The Inquiry has also obtained information from, and relating to, the company which operated the CCTV management software, under a contract with Nottingham City Council, Total Integrated Solutions. This included information about FollowMe data. FollowMe is the tool allowing the police to view the council's CCTV in realtime. Council have now informed the Inquiry via

further statements that they no longer have access to the FollowMe data from June 2023 due to system upgrades in '23 and '25 and because the relevant data from 2023 was not specifically marked for retention prior to those upgrades.

The council have therefore told us they cannot identify precisely who was viewing which CCTV cameras on 13 June, nor which cameras were patched through to the police control room.

The Inquiry is awaiting further evidence still from the council to address a number of remaining issues including confirmation as to who were the supervising staff members in the CCTV room on 12 and 13 June and whether they were aware of any issues with camera functionality. It is not anticipated that we will seek further information relating to CCTV once this information has been received.

It is uncontroversial to state that VC was not located or arrested by the police between his attacks on his first victims and Ian, and between the killing of Ian and the driving attack on Wayne. There are a number of failings which contributed to this, not least, you may think, Chair, an erroneous and unjustified belief that the perpetrator of the attacks on Barney and Grace would be long gone following those first attacks.

You will also remember, Chair, that there's a very clear image of VC walking along Gregory Boulevard towards Mansfield Road between 4.38 and 4.41 before VC killed Ian and stole Ian's van to use as a weapon. This image, clear as it is, did not lead to VC being stopped in his tracks.

Separately, Nottingham City Council have also been asked to provide further information regarding a social care referral which appears to have been sent to them about VC in October 2021 by the ward team at the Priory. This referral did not form part of the council's disclosure. The Inquiry have been informed that after discussion with the Priory team in October 2021 the referral appears to have been withdrawn and no Section 117 needs assessment was ever completed.

However, we have also been told that Nottingham City Council are unable to search for any items on their system which date from prior to September '23. We are obviously concerned by this and we are asking the council to explain why this is the case so we can understand their disclosure process and whether it has been thorough enough.

Dr Park's report.

The Inquiry's term of reference require it to examine the response of the police and emergency

services to the attacks. In order to fulfil this requirement, the Inquiry instructed a medical expert, Dr Claire Park, MBE, to consider whether Barney, Grace or Ian could have survived the injuries inflicted on them by VC on 13 June 2023.

THE CHAIR: Just before you go on, if anybody would like to leave during this section, Mr Moloney --

MR MOLONEY: [Off microphone].

THE CHAIR: Thank you.

MS LANGDALE: Dr Park is a consultant in pre-hospital emergency medicine at London's Air Ambulance charity and in anaesthesia and critical care medicine at King's College Hospital, London.

In May 2026, Dr Park provided a report relating to each of the deceased to the Inquiry and the bereaved families. In August 2026, she provided a supplementary report clarifying a number of matters arising from her initial reports. The Inquiry does not intend to disclose these reports more widely than to the bereaved families. The information contained within them is personal, confidential, sensitive, and distressing.

It is important, however, to inform Core Participants and the wider public of the conclusions reached and the basis for them. With the agreement of each bereaved family, I do so as follows: Dr Park was

provided with the deceaseds' medical records as well as key witness statements, bodyworn video and CCTV footage. She was asked the following questions: whether it is likely that Barney, Grace or Ian would have survived had treatment been commenced earlier; whether she considered that any medical interventions which would have affected the outcome and which were not provided could have been provided; whether she considered, in respect of the medical care provided, that anything should have been done differently.

Recognising that the emergency response on 13 June 2023 involved input from a wide range of professionals, before finalising her conclusions and reports, Dr Park chaired an expert multidisciplinary panel bringing together expertise from across the medical profession in order to assess the question of survivability as effectively as possible.

The expert panel consisted of seven experienced clinicians from a range of relevant fields. Mr Duncan Bew, consultant trauma surgeon, Dr Sam Hutchings, consultant in critical care and anaesthetics, Dr Gareth Grier, consultant in emergency medicine and pre-hospital care, Dr Ben Swift, forensic pathologist, Dr David Gay and Dr Ian Gibb, clinical radiologists, and Ms Alice Kershberg, patient and family liaison clinician.

Dr Park and her colleagues approached the question of survivability with reference to three possible conclusions: non-preventable, injuries that were non-survivable, even with optimal management; potentially preventable, injuries that may have been survivable with optimal management; and preventable, injuries that were survivable where the care provided was sub-optimal.

Barney Webber. The first police officer reached Barney at around 4.08. As to the care they provided, Dr Park commented:

"From the arrival of the first officer at Barnaby's side, they are all clearly working hard in their attempts to save his life and continued to do so alongside the paramedics and doctors who subsequently arrived to help. The panel would like to note that they were impressed by the composed and dynamic nature of the police officers' first aid response along with their continued efforts to assist the healthcare response."

At around 4.12 the first paramedics arrived and began directing Barney's care with the ongoing assistance of police responders. Prior to his transfer to hospital, those treating Barney included a specialist paramedic crew, an enhanced care team, and an emergency pre-hospital doctor.

Barney received extensive treatment at the scene and Dr Park and the panel noted the appropriateness of the interventions, the clarity of handovers given, and the rapid and effective decision making and actions of the enhanced care doctor from their arrival at around 04.20.

Dr Park and the panel noted that the severity of his injury was recognised by all involved in treating him and it was clear that all responders worked together to deliver both compassionate and efficient care to Barnaby. It was recorded that many steps were performed that contributed to his chances of survival.

Barney entered cardiac arrest on at least one occasion whilst in receipt of care at the scene though his heart continued to show pulseless electrical activity. His heartbeat returned in response to the provision of fluids along with aortic compression at which point a decision was taken to transfer him to the Queens Medical Centre Major Trauma Centre where he arrived at 0453. During transfer, however, his cardiac output ceased and he could not be resuscitated in the ambulance or the emergency department in order to enable him to reach the operating theatre.

Here, Dr Park and the panel identified one area in which care could have been improved by those treating Barney at the scene. If more aggressive volume

resuscitation had taken place at the scene following the initial arrival of the ambulance, namely the earlier and more rapid administration of blood products and crystalloid, then Barney might have arrived at hospital with sustained spontaneous cardiac output, thus allowing for a decision to immediately operate.

It was the view of Dr Park and the panel that these steps should have been taken by those treating Barney at the scene. However, the panel acknowledged that even if such steps had been taken, multiple rapid and meticulous steps would have been required in order for Barnaby to survive to intensive care.

Dr Park and the panel concluded that there was a small chance, being far less than 50%, that Barney could have survived his injuries. In terms of survivability, his death was therefore categorised as "potentially preventable".

Grace O'Malley Kumar. The first police responders arrived at Grace's side at around 4.10, around one to two minutes after they arrived with Barney. Paramedics and specialist paramedics arrived with Grace at around 0412 and 0416 respectively. Further input was provided by an enhanced care team from 0421. On her discovery, Grace was already in cardio respiratory arrest. She was not breathing and had no heart function. She could not

be resuscitated.

Dr Park noted the following in respect of the care Grace received: the clinical interventions provided were carried out by police, ambulance and enhanced care team responders who attended the scene in that order, and all worked together as a team to the best of their ability to provide immediate care and medical interventions for Grace.

The report noted that the officers continued to provide good quality chest compressions and to work hard with the ambulance team that is split across both patients to delivering continuing resuscitation to Grace whilst also providing their policing role of securing the scene and finding out further information regarding the attack on Grace and Barnaby. From arrival of the first officer at Grace's side, they are all clearly working hard in their attempts to save her life and continued to do so, alongside the paramedics who subsequently arrived to help.

The panel would like to express a view to the Inquiry that was held by all members that they were impressed by the efficient, dynamic, well-coordinated and compassionate nature of the police officers' first aid response along with their continued efforts to assist the healthcare response.

It was the opinion of Dr Park and the expert panel that Grace's injuries were unsurvivable and that it is unlikely that resuscitative treatment would have been successful if she'd been discovered at the same time as Barney. Accordingly, in terms of survivability, Grace's death was categorised as "not preventable".

Ian Coates. When police arrived at Ian's side at around 0539 he was identified to be in cardio respiratory arrest, i.e. he was not breathing and had no heart function. Dr Park and the panel considered that the officers worked hard to resuscitate him for 12 minutes prior to an enhanced care team from the Air Ambulance Service arriving on scene who stopped the resuscitation at 0552. Due to the severity of his injuries, Dr Park and the panel were of the opinion that even if an enhanced care team had been present immediately after the attack on Ian, the injuries would not have been survivable.

Accordingly, in terms of survivability, Ian's death was categorised as "not preventable".

Additional evidence received from healthcare providers.

Chair, I turn now to the additional evidence relating to the issues concerning the healthcare received by VC.

Disclosure. The inquiry has continued to seek and to receive documents following the conclusion of the oral evidence. A further 1,685 documents relevant to the healthcare issues have been disclosed to Core Participants. That disclosure includes documents from the Trust, NHS England, and the CQC. Amongst the additional documents, a number from the Trust are relevant to issues surrounding the EIP service in respect of which additional statements have also been provided and which I'll turn to shortly.

Amongst the documents from the Trust there was an updated Social Circumstances Report prepared by Claudia Birtles, VC's then care coordinator, and sent to the Priory for VC's Section 3 appeal. Although the report was not used, as VC's Section 3 detention was rescinded, it and the documents relating to it ought to have been disclosed sooner, but were not, due to the Trust informers either human or technical error.

The Trust was asked to provide records of the supervision meetings between Dr Lloyd and Dr Burri, but have confirmed that despite further searches and save for a document relating to supervision generally, which has been identified, they have been unable to locate any documents recording supervision of Dr Burri by Dr Lloyd. Separately, Dr Lloyd has confirmed in her statement that

she didn't make any notes of her supervision. NHS England have provided additional documents relating to the improvement, oversight and assurance group for the Trust as well as the national recovery support programme. It has also provided documents relating to its guidance, recent publications on NHS data breaches, and the NHS leadership framework.

The Inquiry continues to take steps to ensure all full disclosure is provided. Where anomalies have been identified, such as a document being provided by one material provider that ought to have also been provided by another, Rule 9 requests have been sent seeking an explanation of the admission. By way of example, Rule 9 requests have recently been sent to the Priory and members of staff at the Priory, and Nottingham City Council, seeking clarification and an explanation of a notification of assessment from social care provided to the Inquiry by the Trust. In a similar vein, the Inquiry sought an explanation from the Trust as to minutes of its Quality Committee meetings provided to the Inquiry by Theemis.

Early intervention in psychosis statements.

As indicated at the conclusion of the oral evidence, in light of the evidence given by Dr Adamson, the inquiry sought evidence from the Clinical Directors and

Adult Mental Health managers at the Trust relating to knowledge of escalation of concerns in respect of the EIP resourcing and services.

In response, the Inquiry has obtained a statement from Ann Wright. She was a General Manager in Adult Mental Health between February 2019 and February 2021. She was aware from the start of her tenure that the EIP team was not performing to national standards, that was widely known at the Trust. Ms Wright understood the failures to be attributable to the merger of the EIP and other teams into a single Local Mental Health Team in 2018. Funding was an issue as well as a national deficiency in available cognitive behavioural therapy trained clinicians.

Her statement describes the attempts made to recruit staff and discussions she had as to the difficulties the EIP team faced. The separation of the EIP team to a standalone service was ongoing at the time she ceased to be General Manager.

The Inquiry has also obtained a statement from Andrew Latham who was a General Manager in Adult Mental Health, replacing Ms Wright, from November 2020 until September 2024.

He explains that he was operationally responsible for a number of teams including EIP.

He had a limited understanding of the EIP service and its challenges but quickly became aware of the high level of pressure the EIP leaders were under during the decoupling process. He explained that transformation funding was received to recruit additional staff, albeit cognitive behavioural therapy remained a difficult role to recruit, due to a lack of national training places.

The separation process he describes as being viewed positively with a reduction in caseload sizes.

A statement has been obtained from Michelle Malone who was a Co-clinical Director for Adult Mental Health alongside Dr Seedat from March 2019 to May 2022. Unlike Dr Seedat, she did not have clinical duties and so had a wider set of responsibilities in the director role. She had a greater focus on community transformation. Similarly to Ms Wright, she recalls that difficulties with staffing numbers and concerns around functioning led to the decoupling of EIP from the Local Mental Health Team.

She was aware of general difficulties across healthcare in recruiting psychologists and recalls specific issues relating to the provision of CBT and EIP. Having reviewed her emails, she did not find specific issues were raised with her about psychology input to EIP but she did find an email from a consultant

in the City North team raising concerns about care coordinator caseloads.

That was an issue that other consultants had raised with her and one that she corresponded with Dr Adamson about. Ms Malone explains that caseload pressure with resources stretched to meet demand existed within all services within her Directorate.

Dr Seedat provided a second statement to the Inquiry, one that focuses on his role as Clinical Director for adult mental health and as lead consultant. He was clinical director from 2016 to 2022, and after that he was lead consultant. His statement sets out the challenges of the role, which was balanced alongside his consultant duties, particularly in light of the pandemic. He describes it being a constant issue raised by EIP consultants that there were insufficient care coordinators in the face of increasing demand, and that additional funding was obtained to address that.

He does not recall it as being raised with him about a lack of senior consultant input within the EIP service or insufficient medical time to meet the needs of the service. He also has no recollection of psychology provision being raised with him but he was not involved in psychology recruitment. As lead consultant he was involved in annual job planning for Dr Lloyd. He

believes she raised increased demand in caseloads with him but he describes this as being raised as something which did not require immediate action but as a matter to be acknowledged and monitored.

Dr Thangavelu, who the Inquiry heard oral evidence from, was lead consultant from 2019 to 2022, and then replaced Dr Seedat as Clinical Director between August 2022 and June 2025. He was aware that EIP was being restructured due to concerns it was not meeting relevant performance indicators, though he was not involved in the decision making and work for restructuring. In his job planning for Dr Lloyd, she raised issues as to lack of capacity in EIP and a specific issue about medical secretaries not arranging appointments and sending letters.

Dr Lloyd's statement and consequential statements.

Of particular note, Dr Thangavelu exhibits an email exchange that includes an email from Dr Lloyd dated 30 April 2019 in which she states:

"We are currently under pressure from our team leaders to discharge high risk Assertive Outreach clients on the grounds that they are not engaging! There seems to be a lack of understanding about the nature and ethos of AO model." [As read]

A request for a further statement explaining these

comments was made to Dr Lloyd in response to which she has prepared a second statement. She explains that her team leader was Helen Taff and the deputy team leader was Sarah Hayler. Her understanding is that the team leader and deputy team leader put care coordinators under pressure to discharge patients to make space for new referrals. Pressure to discharge higher risk Assertive Outreach patients continued from 2019, the time of her email, until VC's attacks in 2023. This pressure was being applied in respect of Assertive Outreach patients not EIP patients. That pressure was, in her opinion, inappropriate and unsafe. Her email requested a meeting as she was seeking support and advice on this issue. No meeting occurred so far as she can recall.

The lack of understanding of Assertive Outreach she described in her email was that the Local Mental Health Team was not a specialist Assertive Outreach Team and had no specific training or expertise in the Assertive Outreach Model of Care.

In the light of Dr Lloyd's further evidence, the Inquiry sought evidence from Helen Taff and Sarah Hayler. Ms Hayler states that some staff were unhappy about an Assertive Outreach service premised upon a 9.00 to 5.00 pm provision and concerns were raised that

patients were likely to disengage or not receive an appropriate level of care. She says she was not aware of any members of her team applying pressure to discharge higher-risk Assertive Outreach patients.

Helen Taff's statement explains she was a team manager in Adult Mental Health from 2016 to 2024. She was one of Dr Lloyd's team leaders. She exhibits a number of emails referencing concerns raised about the EIP team, with EIP staff struggling to manage the number of referrals being made. She recalls, amongst those raising concerns, were Claudia Birtles and Abigail Parsonage who the Inquiry heard evidence from. She states she did not pressure or guide colleagues to discharge Assertive Outreach clients on the grounds of non-engagement.

Dr Lloyd's email, to which I have referred, had been in response to an earlier email dated 26 April 2019 from Dr Eileen O'Regan, a consultant at the Trust who worked with both EIP and Assertive Outreach patients, but in a different team from that which treated VC.

Dr O'Regan's email said that her Assertive Outreach numbers were going up and she was not sure if she should be gatekeeping more or not. In a statement to the Inquiry, Dr O'Regan explains that patients on the Assertive Outreach pathway were generally considered to

be the most clinically complex and difficult to engage, and patients often remained under the service for prolonged periods. The capacity of the Assertive Outreach pathway at the Trust was limited and her email querying gatekeeping, a process of reviewing whether patients met the inclusion criteria for Assertive Outreach, was querying whether some patients would be more appropriately managed on a different pathway of care.

Dr O'Regan also states she has never felt under pressure to discharge higher-risk Assertive Outreach patients due to non-engagement and she thinks non-engagement alone should not determine discharge for either EIP or Assertive Outreach patients. It would be exceptional to do so and it would require careful oversight and monitoring.

Assertive Outreach reintroduction.

Glen Owen is the current Nurse Director of the Trust's Mental Healthcare Group. His statement addresses how an Assertive Outreach service was provided by the Trust. Until 2017/2018, there was a specific team specialising in working with patients who had difficulty engaging but this, like the EIP team, was integrated into the Local Mental Health Team. On reading the statement, it does not appear that there was

a specified Assertive Outreach pathway but Mr Owen explains there was an intervention available across a number of pathways and was an important part of the pathways for support and engagement for enduring psychosis.

The Trust is now preparing to have a standalone Assertive Outreach Team by next month. However, the delivery of a standalone team is at risk. An application to the Integrated Care Board for funding was not responded to and the Trust has been informed there's no additional funding to develop an Assertive Outreach Team.

Overview.

The additional evidence in relation to the EIP team reveals prolonged issues in relation to staffing, particularly those with the necessary training to provide CBT for psychosis which is suggested to have been a national problem and with care coordinator caseloads. The merging of the EIP into a broader Local Mental Health Team with mixed caseloads appears very quickly to have failed, it becoming apparent that national standards were not being met. This appears to have been common knowledge amongst the leaders in the Trust. The solution appears to have been a decoupling of the service.

Chair, you may query whether the merging of Assertive Outreach, which does not appear to have a dedicated pathway in the Local Mental Health Team, and according to the Trust's own consultants, appear to have been poorly understood, had also failed following its absorption into the Local Mental Health Team and should have undergone a similar kind of decoupling process to the EIP. Furthermore, did the absence of national standards, as with the EIP model, result in any shortcomings in the Assertive Outreach being overlooked?

The evidence of Mr Owen that the reintroduction of a standalone Assertive Outreach Team may be in jeopardy due to uncertainties as to funding, you may consider troubling, Chair, in light of both the oral evidence and what has emerged subsequently.

The pressure it is suggested was being applied to staff, right up until VC's attacks, to discharge non-engaging patients was, Dr Lloyd clarifies, in respect of Assertive Outreach patients rather than EIP patients. The question that nevertheless arises is whether such an approach, which would reflect a lack of understanding of Assertive Outreach principles for the reasons that she gives, reflects a concerning culture at the Trust in respect of complex, non-engaging patients such as VC.

More broadly, the additional evidence obtained by the Inquiry provides further support for that which was explored in oral evidence. The problems in respect of the care provided to VC were from a team that was, and had been for some time, experiencing significant problems in failing to meet national standards, with high caseloads and insufficient CBT for psychosis provision.

Audit witness evidence.

In her oral evidence to the Inquiry, Diane Hull, Chief Nurse at the Trust, had agreed that the Trust did have the capability interrogate Rio to determine who accessed VC's records when and for what period of time.

The Inquiry asked the Trust to undertake an audit of the Rio records and to set out the members of staff both at the Trust and at Priory or Cygnet who accessed VC's records prior to 13 June 2023, and set out when the records were accessed, the parts of the records that were accessed, and how long they were accessed for.

That audit was carried out by the Trust's Digital Data Technology Service and is set out in a spreadsheet that is exhibited to a statement from Dr Jeenkeri, a consultant psychiatrist and Associate Medical Director at the Trust. The spreadsheet illustrates who accessed VC's records and when and which screen was accessed.

Dr Jeenkeri explains the methodology of the audit and its limitations. The audit cannot accurately determine how long the user accessed the records for although inferences may be drawn from the time at which different screens were accessed.

The audit confirms that there was access of VC's Rio records by consultants from the Priory who had read-only access, but not by Cygnet whose evidence, you will recall, was that they did not have access to the Trust's Rio system. As Dr Jeenkeri explains, the audit would tend to corroborate that.

Further statements.

Further statements have come from staff who had interactions with VC. Neil Watson was a support worker at Cygnet, Sylvia Levy was a mental health nurse at the Priory. Neither add anything to what is covered in the medical records as to their interactions with VC. Ms Levy does describe an environment of constant pressure and understaffing at the Priory.

Rosie Draper, a nurse employed by Mitie, who had carried out an assessment of VC in a police cell following the attacks, in respect of which she has already provided evidence, has now provided a second statement addressing an earlier custody record relating to VC's detention on 24 May 2020 which indicates she

assessed him then. Ms Draper has no recollection of that assessment and can add nothing to what is contained in the notes.

Amber O'Brien, the professional lead for mental health at the Royal College of Nursing, has provided a further statement setting out the RCN's response to the NMC's consultation on proposed changes to nursing education standards. The Royal College of Nursing opposes a proposed reduction from 4,600 hours to 3,600 hours in the nursing programme on the basis that there's a lack of credible evidence that reducing hours would maintain or improve outcomes for students, nurses or patients. The RCN does, however, support the proposal for community placements for all nursing students and strengthening equality, diversity inclusion standards.

Professor Appleby.

Professor Appleby, Director of the National Confidential Inquiry into Suicide, Homicide and Safety in Mental Health, provided a further statement to the Inquiry dated 14 July 2026. Within it he provides further detail about the methodology and breadth of the NCI's data collection and learning, particularly in respect of the issue of schizophrenia and violence. It states that the NCI has consistently reported the number of victims- of mental health-related homicides in its

reports and academic publications.

Professor Appleby also touches upon the future work of the NCI. He notes that there will be a number of differences going forward, many of these arising from the Nottingham attacks. There will be a focus on severe mental illness particularly schizophrenia. The NCI will update homicide figures for different definitions of mental illness and show how these are related. It will investigate early notification by Mental Health Trusts and examine previous episodes of violence in more detail. There will be a greater emphasis on victims, it will work with victims' families and aim to address their questions.

Features of other high-profile incidents will also be reflected in its work plan, for example, autism, child victims, terrorist motives, domestic violence, ethnicity.

Professor Appleby notes that these sensitive areas are already part of the public discourse on mental health homicides and reliable evidence is needed.

The NCI also considers there will be benefits in extending data collection to serious non-fatal violence with a focus on perpetrators with schizophrenia. It would also like to investigate the use of linkage studies connecting criminal justice and NHS databases to

identify mental health-related homicides. The new homicide study will also identify mental health contacts in A&E departments. It will also seek to explore, subject to feasibility, contact between perpetrators and other health settings such as primary care.

Other serious incidents prior to the Nottingham attacks.

You will remember, Chair, that the Inquiry received evidence in relation to three other serious incidents that occurred in the year prior to the Nottingham attacks. Incident 1, a homicide in August 2022. This was reported to the Nottinghamshire Trust via the Blue Light incident reporting system on 10 August 2022. It was discussed by the Trust board on 6 September. The Patient Safety Incident Investigation was delayed to await a police investigation and approved on 2 May 2025.

Incident 2, a non-fatal attack. The perpetrator had been under the Trust's care at the time of the incident. This was briefed to executives at the Trust on 16 February 2023. An initial management review was completed on 24 February 2023 which concluded non-currently as regards lessons to be learned.

A Comprehensive Investigation Report, undertaken by an independent chair, was completed in July 2024 and approved in November 2024.

Incident 3: a non-fatal attack resulting in a charge of grievous bodily harm, discussed at the Trust on 18 April 2023, a concise investigation was completed in June 2023.

These previous incidents were explored in oral evidence with a number of witnesses. The Chair of the Nottinghamshire Healthcare NHS Trust Board, Paul Devlin, stated that the Trust received information about these serious incidents at or around the time of the incidents, and more should have been done as a result of this information. His evidence was that actions that should have been taken may have prevented the attacks on 13 June.

On behalf of the Trust, Mr Beer King's Counsel states in his closing submissions at paragraph 346, that in each of these cases the most Comprehensive Investigation Report was not concluded and available to the Trust until after VC had been discharged from the Trust. Further, that none of the cases raised a potential systemic issue regarding discharge such that would have triggered an audit of EIP discharges in the proximate period.

In oral evidence to the Inquiry on 4 June 2026, Amanda Sullivan, Chief Executive and Accountable Officer at the Nottingham and Nottinghamshire Integrated Care

Board stated she was aware of these incidents before June 2023 and was concerned at the time taken to investigate them by the Trust. Further, she stated the ICB was very challenging about the timescales of the investigations, that the ICB escalated its concerns to the Care Quality Commission before June 2023. She also said these sorts of things would have been on the agendas at regular forums as they were emerging.

In oral evidence to the Inquiry on 3 June 2026, NHS England's Dr Sokolov was asked to what extent NHS England was aware of these previous incidents. Dr Sokolov stated this was at a time before she was in post "but I had assumed through the normal process at that time that we would have had sight of those attacks."

Following the conclusion of the oral evidence, Rule 9(2) requests for documents were made to the Nottinghamshire Trust, the ICB, NHSE, and the CQC, to understand if these serious incidents were in fact discussed between relevant agencies prior to 13 June 2023. Documents created prior to that date were therefore requested.

In response, the Nottinghamshire Trust did not provide any documents created before 13 June 2023; the CQC have explained by letter dated 19 June 2026 that

they have in relation to the three incidents been unable to identify any evidence that they were made aware of the three incidents by the Trust or the ICB in the relevant period. Disclosure provided by NHS England indicates that it was made aware of the first incident in around August of 2022. Its disclosure does not, however, provide any material produced before 13 June 2023 that indicates it was made aware of the other two incidents or that it took any action or provided any oversight in relation to any of the relevant previous incidents.

The ICB provided documents and a further explanatory statement from Amanda Sullivan dated 27 August. In the statement Ms Sullivan explained that when giving oral evidence, she was attempting to explain that the ICB's escalations of concerns in relation to the Trust took place through both NHS England and CQC regulatory routes and that these escalations were general and thematic in nature, reflecting wider and developing concerns about the Trust, including serious incident investigation timelines and backlog rather than being framed as separate instance-specific escalations in relation to each of the three serious incidents.

She clarifies she was personally aware of incident one being the subject of a homicide review process but

does not recall having specific knowledge of the other two incidents prior to the Nottingham attacks.

Ms Sullivan explains that the ICB was made aware of the three incidents at or around the time the Trust was informed of them and that the ICB were also aware of the timescales of the various investigations taking place. The ICB, she says, did not raise concerns with the Trust about investigation delay nor make formal escalations to NHS England or the CQC. Ms Sullivan explains that this was because incidents 1 and 2 remain subject to ongoing police investigations, with incident 1 also progressing through a homicide review process and the investigation for incident 3 was being managed within its agreed timeframe.

She also states that whilst no concerns were raised as regard the timescales of the investigations of the three incidents, specifically general concerns regarding serious incident management, investigation timelines, and backlogs were raised in a broader sense and were discussed and escalated through routine oversight, quality and regulatory forums as part of a wider quality governance and patient safety arrangements.

Documents from the System Quality Group, which was attended by the NHS regional team and the CQC and the quality assurance and improvement group have been

disclosed. These demonstrate that concerns regarding serious incident investigation backlogs in general were raised at a number of meetings.

Insofar as further evidence is required on the extent of information communicated between the ICB and NHS England, the Inquiry Legal Team considers this can be achieved through a further Rule 9 Request to NHS England for a witness statement on this issue.

Coroner.

The Inquiry has received a statement from Maureen Casey the Senior Coroner for Nottingham and Nottinghamshire. She makes clear that as a judicial officeholder she cannot express views or opinions on evidence given to the Inquiry by others or matters within the Inquiry's terms of Reference and cannot give her view on the adequacy of the actions taken by the Trust in response to concerns raised by her and assistant coroners in Prevention of Future Death reports.

Ms Casey said in her statement that the efficient running of the coronial service requires collaborative working arrangements with a number of public bodies, including NHS Trusts, and that she has held meetings with executives from all the NHS Trusts in her jurisdiction, the Nottinghamshire Police, and others.

Having considered the Trust reports on learning from inquests, she has no reason to think the reference to a meeting with her and two assistant coroners on 8 July 2021, which we induced in evidence, Chair, does not accurately capture the matters raised or identify the key themes raised in the Prevention of Future Death reports.

The Coroner's statement explains the process by which a Prevention of Future Death report will be issued, namely where there is a concern that circumstances creating a risk of death will occur or will continue to exist. She explains that in the past 10 years, 33 Prevention of Future Death reports have been issued to the Trust, all but one of which are appended to the statement. It is to be observed that one of those 33 was in fact issued to various local commissioning groups rather than the Trust.

The Inquiry Legal Team have examined the Prevention of Future Death reports in the context of the issues being considered by the Inquiry. We note, in particular, in June 2023, an area Coroner's criticism of the Trust to implement the Triangle of Care. The Triangle of Care refers to a programme which supports health and social care organisations to improve safety, recovery and wellbeing by ensuring carers are recognised

as partners in care. That coroner observed in 2023 that "despite the Trust adopting the Triangle of Care initiative many years ago, I continue to hear evidence of missed opportunities for carers to be involved in the patient's care. Sadly, often appreciated at inquest."

In the piece of work undertaken by the Inquiry Legal Team on the wider canvas of mental health-related homicides, concerns in respect of communication with carers and families were identified in 345 of 528 cases, 65%. In 241 cases, 46%, family members had raised concerns about risk prior to the incident.

Chair, you, will doubtless be interested in the failure of psychiatric services and individuals to recognise the important role of VC's family, particularly his mother, in VC's treatment and care. The ILT agrees the schedule of recorded contacts attached to VC's family submissions which set out Celeste Calocane's involvement and attempts at involvement with health services, the failure to share with Celeste Calocane the diagnosis of schizophrenia, and, to be clear, about the level of risk VC posed, as described by Dr Seedat in his earlier discussions with VC, is highly significant and served only to undermine the essential role that a carer/family has in mental health treatment.

You may think, Chair, the risk VC posed was understated to his family.

Chair, you will also remember in the context of the involvement of family members that when VC told Ms Birtles in December 2021 that he did not consent to sharing information with his mother, that was accepted by the Trust. There was no capacity assessment, risk formulation or safety plan undertaken.

When VC was discharged to a GP pool in September 2022, there was no attempt to inform the family of what you may conclude, Chair, was an appalling decision. In all the circumstances, you may consider that VC's family, in particular Celeste Calocane as the nearest relative, were also let down by psychiatric services.

Publication of evidence.

As you are aware, Chair, the Inquiry followed a protocol in respect of the publication of evidence given during the hearings. Live-streamed video evidence was ordinarily published the following day and a transcript of the oral evidence likewise, subject to any restriction order or other limitation on disclosure.

Witness statements were uploaded to the Inquiry website within seven days of a witness giving evidence, save for those witnesses who gave evidence over live

link, for whom a transcript of their evidence was published instead. Exhibits to statements have not been published.

Some of the statements referred to in this update will be uploaded onto the website within the next seven days. When your report is published, Chair, consideration will be given to the publication of further documents on the website. The Inquiry is mindful of the costs of preparing material for uploading onto the website and will use its discretion in doing so.

Requests for further statements pending publication of the report.

Chair, you intend to publish a report containing findings and recommendations in the early summer of 2027. In order to ensure that your report remains current, particularly in respect of recommendations, the Inquiry Legal Team will request updates from some organisations in the early New Year. Evidence obtained will be served on Core Participants. Some organisations will update the Inquiry with their progress, as a matter of course, including the IOPC.

The Inquiry Legal Team understands that work on the updated Mental Health Act Code of Practice is taking place this year. William Vineall, director of NHS

Quality, Safety and Investigations at the Department of Health and Social Care confirmed in his oral evidence that the Department is committed to awaiting the report of this Inquiry before the revised Code is finalised. We will ask to be kept abreast of the timetable. If the position were to change from that stated in Mr Vinyl's evidence, we agree with the submissions made on behalf of the bereaved families that you should consider making interim recommendations before publication of your final report.

The Inquiry heard oral evidence about neighbourhood mental health pilot projects from Dr James and Professor Tim Kendall. The date for the final report to evaluate those projects was pushed back to September 2026. You will doubtless wish to see the final report, Chair, when it is available.

The Inquiry is aware that examples of unauthorised access to records of the deceased continue to be discovered. Each new instance of unauthorised access is highly distressing and an affront to the bereaved families. The bereaved families were particularly concerned to have this issue included in the Terms of Reference, and in doing so, they have drawn public attention to something which is both plainly wrong and seemingly prevalent.

Chair, even with the number of instance of unauthorised access to victims' records in this case to date, we say that you have sufficient evidence to cover this issue in the report and to make recommendations. We will, however, and in any event, request further statements from the bereaved families in March 2027 by way of update.

Warning letters.

Chair, as you continue to consider all of the written and oral evidence, you are drafting your report. Where any individual or organisation falls to be criticised, in accordance with the Inquiry Rules, a warning letter will be sent to that individual or organisation setting out the nature of the proposed criticism. Warning letters will likely be sent out by the Inquiry Legal Team between December 2026 and February 2027. You will, of course, consider responses to warning letters in the process of finalising your report.

Recommendation.

Chair, it may be that early next year when considering what recommendations to make, you will wish to visit or contact existing mental health services, not those under investigation by the Inquiry, of course. In the event you do so, the Solicitor to the Inquiry,

Ms Farhana Rahman-Cook will update Core Participants about any visits you undertake and the purpose of them.

Closing remarks.

As former Parliamentary Ombudsman, Sir Rob Behrens said in evidence, too often the successful resolution of these cases has depended upon bereaved families campaigning at a time when they are least prepared to do that and it is an outstanding public service that they perform.

Although Sir Rob was talking generally about bereaved families, his words could have been written as a description of the bereaved families and their legal team in this Inquiry. Indeed, without their efforts, there would not have been a public inquiry at all.

As you made clear at the end of the oral hearings, Chair, the Inquiry has proceeded at a pace. The content of the written and oral evidence has been emotional and intense.

On behalf of your Inquiry Legal Team, I would like to express our thanks to all of the Core Participant legal teams who have worked hard with us to meet the exacting deadlines necessary to present the evidence and to achieve the aims of the Nottingham Inquiry.

The momentum and timetable of this Inquiry has not been at the expense of accuracy. The evidence we have

obtained has revealed one failure after another. There is a suggestion in some submissions that further oral evidence should be called. We submit that there's no need for further oral evidence from any source.

Barney, Grace and Ian should be alive. And the survivors uninjured.

Chair, you have sufficient material to fulfil the Terms of Reference and to write your report.

THE CHAIR: Thank you, Ms Langdale.

Mr Moloney, we will take a break now. I think we originally scheduled the break a little bit earlier for 20 minutes, but we will take that 20-minute break in any event. Thank you. 11.35.

(11.25 am)

(A short break)

(11.37 am)

CLOSING SUBMISSIONS ON BEHALF OF BEREAVED GROUP BY MR MOLONEY KC

THE CHAIR: Just before we start, Mr Moloney, just to test whether everyone can hear you because I know you're going to be slightly more addressing me than we've had in the past because the witnesses were sitting there last time.

MR MOLONEY: Indeed.

THE CHAIR: So if you say something, I just want to make

sure everyone can hear you in the hall.

MR MOLONEY: I'll simply say, Chair, that the bereaved families are very grateful to you for allowing us to make oral submissions.

THE CHAIR: Thank you.

Can everybody hear at the back?

MR MOLONEY: Thank you Chair.

MS CAREY: There are indications from those sitting behind me that they can't hear. If Mr Moloney can adjust the microphone a little bit.

MR MOLONEY: I'm very grateful to Ms Carey for her guidance in acoustics. It appears to have worked.

THE CHAIR: Is that working? Yes, thank you. It's worth the test anyway, thank you.

MR MOLONEY: Chair, we have already served 100 pages of detailed written submissions and you've said this morning essentially to focus on the main points and we will do that. In addressing you, we will attempt to distill that material to fit the available time.

THE CHAIR: Yes.

MR MOLONEY: And what we'll do, Chair, if we may, is we'll touch only briefly on some of the Terms of Reference and rely on our written submissions, but spend more time in relation to some of the topics which are more important and those for our purposes will be the timeline, the

prosecution of VC, and we will spend a little time, Chair, although it's not a specific Term of Reference, on the new Mental Health Act and the Code of Practice in the hope that that will be of some assistance to you, Chair.

THE CHAIR: Yes, well, I hope you got a message in advance also that I would like to understand if you're making any submissions in relation to intimate samples under the Police and Criminal Evidence Act.

MR MOLONEY: Chair, shall I deal with that now?

THE CHAIR: Yes.

MR MOLONEY: Essentially, no. We do not feel it would be appropriate for intimate samples and especially blood and urine, to be taken without consent.

We understand also that it is important that adverse inferences under the Act should only be drawn when it's reasonable in all the circumstances and so, Chair, we would feel that in circumstances where an issue such as that arises, then there should be an assessment of capacity by the mental health practitioners in the police station in order that the courts can take a fair approach to any refusal of consent from a person who is suffering from mental illness when the case comes to court in due course.

THE CHAIR: Yes, the point is that, of course, there are two

aspects of it in relation to cases where there may be mental health issues. There's firstly the trial itself, or the -- and any inferences that can be drawn, but then there's also the issue of culpability which is a matter for the judge at the end.

MR MOLONEY: Absolutely, yes.

THE CHAIR: And at present that's not on the list, is it, in that section?

MR MOLONEY: It isn't, Chair, and of course that, we would say, would not prevent a sentencing judge from considering that in the overall context of the case. It would not be, as it were, an adverse inference that would be drawn in a process of proof but could be taken into account, if the judge thought it appropriate within the confines of the existing legislation.

THE CHAIR: Thank you. That's very helpful, thank you.

Yes, I put that at the beginning but do carry on in your submissions, thank you.

MR MOLONEY: Thank you, Chair.

We'll turn firstly to the timeline, then.

THE CHAIR: Yes.

MR MOLONEY: And this necessarily demands significant attention relative to the other Terms of Reference because we say it contains a litany of unnoticed red flags, missed opportunities and individual and systemic

failures.

Ms Langdale was kind enough to make a remark at the end of her submissions, which I'll echo now, which is that the bereaved families firmly believe that if opportunities had been taken to effectively deal with the behaviour of VC, if there'd not been so many failures by so many people in institutions between 24 May 2020 and 13 June 2023, then their loved ones would still be here today.

And they have good reason to believe that because VC's history of contact with public agencies is one of repeated individual and systemic failures in the face of a clear and growing risk that he presented a deteriorating level of risk throughout that time from 2020 through to 2023.

But before turning to that, Chair, may I just briefly spend a short time on what we would say are gaps in what is known about VC prior to 2020, especially from 2015 to 2020, and I hasten to say, through no fault of the Inquiry legal team, and the fact --

THE CHAIR: The question, really, I have is given my Terms of Reference are from 2019 onwards --

MR MOLONEY: Indeed, Chair.

THE CHAIR: -- except where there are instances of violence, obviously there is a bit of background that we have

obtained, but so far, there is no evidence of violence before 2020.

MR MOLONEY: Absolutely, Chair. And we only make this point because essentially it is relevant only to your Terms of Reference by consideration of the prosecution of VC and whether or not there was sufficient information to go before the sentencing judge to make the appropriate disposal when he came to do so in early 2024.

That's why we highlight, as it were, particular gaps, but as I say, we don't, we hasten to say that it's despite the considerable efforts of the Inquiry Legal Team and through no fault of the Inquiry that there remain those gaps. We have records from schools and so on but we have other information which we say is suggestive that VC was not a completely untroubled character prior to 2020, and it may be that the more important accounts of how VC was between 2015 and 2020 in particular, perhaps going back to 2013 and 2014, given what Ms Page Harris says, would be most important and useful, would be more likely to come from VC's peers. It's not the case that schools know everything about somebody when they're in that school, and we have the recent statement from the headteacher who says: well, he wasn't coming, when he was in the library, he said he was in the library, the local library, and then

he left school really quite shortly thereafter.

That's all we say about those gaps, Chair.

And if we can now, we'll move on to the first stage of the chronology which is relevant to your Terms of Reference --

THE CHAIR: Thank you.

MR MOLONEY: -- essentially 2020, Feven, Liam and his partner, and the first and second Mental Health Act admissions.

On 23 May 2020, VC told ambulance staff taking him to hospital after he had called them, that he had a history of mental ill health. The EMAS form that we've all seen during the course of this Inquiry, Chair, VC is never asked about it but he admits to having mental health problems in the past but would not say what. That was not seen by the police and Professor Blackwood and so VC could not be asked about it.

Another example of that which Ms Langdale alighted upon during the course of her address to you: look, these things can't be asked if people don't know about them.

The following day there were two violent attacks by VC, and that led to life-changing injuries for Feven, to VC's arrest, and the section 2 Mental Health Act

detention, but then, after his first release, he was again, there was another instance of violent trespass on 13 July 2023 and there was his second Mental Health Act detention, and that was pursuant to Section 3 on that occasion when later admissions to hospital continued to be Section 2.

The response by Nottingham City Council was inadequate through its AMHP service, by Nottingham Police, and the mental health services, the Trust, NHFT. And we say that set a pattern which continued in VC's contact with agencies between 2020 and his killing of Barney, Grace and Ian in 2023. With every incident between 2020 and 2023, there were failures to follow existing follows and procedures, and adequately consider his harm which was growing and growing and growing, his risk of harm, and police were too quick to let things go in the teeth of really quite serious incidents, and clinicians were too quick to adopt a least restrictive practice which ignored the rights of his victims, we say ultimately, and the rights of the public.

Together, these practices diverted VC away from the criminal justice system or forensic psychiatry and he should have been going down that pathway.

And together, these practices failed VC, and the people he affected who sit in this room, and are

elsewhere.

His first admission proceeded on the basis that bloods had been taken from him for toxicology and drugs-related behaviour, and those -- that toxicology had ruled drugs-related behaviour out, but the Accident and Emergency records show that wasn't right. He was detained, but not -- but community treatment was -- so he wasn't detained, he was to pursuit community treatment but he was essentially sent home where he had no support to the same place from which he'd just been arrested and then he -- inevitably Feven was attacked within hours.

The first important observation is that the assessors of VC concluded that community care was appropriate following the least restrictive principle.

And problems in the interpretation of that principle extend throughout the relevant period and we say with respect, Chair, that a critical issue for the Inquiry must be how risk to the patient or others is considered in reaching that view on least-restrictive options for treatment. It must not ever be simplistically interpreted as avoiding restriction and that least-restrictive option must be essentially -- must essentially involve an understanding of the risk posed by a patient to others and themselves.

Secondly, the failures by the police in these 1 May incidents and the later July incident lost sight of what was learned in the Clunis Inquiry. Following the offences on 24 May and 13 July, there was a failure to accurately record relevant information and facts about the incident and a failure to adequately investigate VC's actions and his presentation. There were no statements taken in relation to the first incident and information taken from Feven appears to have been taken without a translator. And she was recovering in hospital from major spinal surgery --

THE CHAIR: Can I just stop you on that point because I think statements were taken in relation to the first incident. They were taken from Connor, and also from, obviously there was Inspector Eustace's statement and those were available to PC Collins when she was doing her --

MR MOLONEY: Indeed, and, I apologise for that inaccuracy in relation to that, but importantly, and I think more generally in terms of the first incident is what I'm referring on, that there was no record of VC having tried to attack Feven again when he was escorted from the property, for example.

THE CHAIR: That is correct.

MR MOLONEY: And that meant he could never be asked about

that after the killings.

Additionally, the offences were inappropriately categorised and wrongly treated in isolation. The attack on Feven was never re-categorised as grievous bodily harm, and that had an effect on the forensic referral. And both offences were inappropriately closed with no further action.

There was very little regard for the rights of victims in each of the offences and a failure to act in accordance with the Victims' Code and there was no statement, for example, taken from Liam, despite concern that VC would return, and he did return and threatened to rape Liam's partner, and Liam chased him down the road and he never bothered them again.

There was a failure of supervision and a failure to comply with local policies throughout.

And thirdly and significantly, in 2020, the actions taken by NHFT, in community and inpatient care, with the first and second admissions, failed to adequately consider the risk posed by VC to public safety.

Importantly, 3 June 2020 Dr Seedat received the journal of Elias Calocane. The Trust was therefore aware, or ought to have been aware, that in that journal, VC demonstrates a potential for him seriously harming others. VC had already been violent to

strangers and these actions had resulted in serious injury. And that degree of risk was not reflected in the approach to diagnosis, care planning, and risk assessment.

Dr Seedat accepted that the full contents of that journal should have been shared. He accepted that what was said was really dangerous and very chilling. And he accepted that the messages indicated VC was very volatile, he was thinking about murder, feeling anger and hatred, and feeling the darkest thoughts you could imagine.

Dr Seedat accepted that the summary of those messages he produced on 3 June was not adequate and he said there were parts of the notes he did not understand including "red rum".

In not sharing the notes with others -- if he'd shared them, he may have come to understand what "red rum" meant because Dr Ludvigsen did know what it went and he accepted that he did not tell VC that he knew about those messages. He accepted that he ought to have asked VC about each of those messages to understand his insights.

Dr Ludvigsen had not seen the journal but she said that even the information recorded in Dr Seedat's note on 3 June was enough for them to consider VC high risk.

She said that had she seen the underlying materials it would have further informed her existing concerns and she knew "red rum" was "murder" spelt backwards.

By contrast, his contemporary risk assessment was there had been no incidents of violence yet.

Relevant history and triggers for VC were indicated in clinical notes but they do not appear to have been explored directly with VC or incorporated effectively or at all into care and risk planning for VC.

Pride and sensitivity was there in that journal, but it played no part in any treatment for VC. The reference to pride spiking, which we're familiar with, was not in Dr Seedat's note. And indeed, there was little or no evidence of any therapeutic input for VC beyond medication, whether in inpatient care or while he was in the community.

Whilst there was some evidence of some insight, VC's non-accordance and his intention not to comply with treatment was communicated with the Trust from an early stage and evidence of masking or manipulation was readily apparent from those early admissions but there was little evidence of this being actively considered, challenged and countered.

And shortly after, 3 July 2020, VC had no medication. When he was questioned, he said that he'd

read that the medication could slow his mind. The clinicians knew that studying exam stress may be a trigger for VC but there's little or no evidence of this being challenged or otherwise informing the care plan. By July there was clear evidence of deliberate non-concordance and limited evidence of efforts being made to deal with that.

Depot was considered during VC's second admission and clinicians appear, as happened many times in the future following his first and second admissions, they appear to have been inappropriately guided by VC's preferences without regard to the risk to public safety VC posed when unwell.

And that guidance from VC's preference extended not just to whether he was prepared to undergo depot medication. You'll remember, Chair, that in his final admission it was: "Well, he wanted to move from one drug to another, and I was content to do that."

VC was discharged on both occasions in 2020 after a brief admission and without adequate coordination within the EIP or others engaged in supporting him in the community.

And importantly, we say, Chair, a feature of the evidence of this Inquiry which was consistent, whilst VC's deliberate non-concordance and risk of violence

were well known, there was no dedicated Assertive Outreach Team in Nottingham, and no adequate replacement, we say, for the Assertive Outreach Model in the alternative.

THE CHAIR: I think it was accepted that not only was there no dedicated team but there was nobody who really was trying to put those principles into place at the end.

MR MOLONEY: With respect, Chair, I agree, obviously.

And after his second release, it was clear beyond peradventure that he was non-concordant, but the practitioners who dealt with him in the community were happy to accept what he was saying, that he was essentially taking his medication, and allowing him to continue in that way.

We draw attention to our written submissions, Chair, to the Good Practice Guide issued by the Royal College of Psychiatrists where it advises "Be curious and look beyond face value", and we say that was a constant failure in VC's care both when an inpatient and in the community.

May I just try and summarise those individual and systemic failures around the time of the first and second admissions. Because VC was diverted from the criminal justice system, despite repeated reports of violence, and he was not directed down the forensic

pathway in terms of psychiatry care. Each failure which masked or diminished the degree of risk VC posed undermined the narrative on risk, considered the next crisis by the next individual officer or clinician who bothered -- and I say that, Chair, with respect to those who were involved, but who bothered -- to check VC's contemporary records.

There was an inappropriate deference to VC which allowed him the benefit of the doubt on every occasion and there was a lack of professional curiosity or clinical rigour in each assessment of his risk, despite there being material which pointed directly to his being really dangerous.

The next section, 2021, visiting MI5, attacks on Sebastian and PC Pritchard and his third Mental Health Act admission.

Between the second and third Mental Health Act admissions of VC, there were numerous red flags and missed opportunities again, Chair, which individually and collectively highlight the lost opportunity to create a picture of VC's instability and the significant risk he continued to pose for others. For example, VC's attendance at MI5 on 31 May 2021.

Now, we don't seek to criticise the process around that, but it was flagged and that flag was missed, and

it should have been noted as essentially him in crisis. Or him experiencing turmoil, which would lead him to go all the way to London to the headquarters of MI5 to essentially ask to be arrested.

And when Sebastian --

THE CHAIR: I don't think the officer asked him why he should be arrested.

MR MOLONEY: No, he didn't, did he? No.

And that, of course, in terms of what we've received over the past week, illegal acts 2013, 2014, and a breach of lockdown, obviously that raises questions for us about what it was he was going to ask to be arrested for, and that question, as you rightly say, Chair, was not asked.

And when Sebastian reported that he'd been attacked by VC on 5 July and made his later report in July, we say overall, Chair, and we won't dwell on the evidence but the response by Nottingham Police was again inadequate. Sebastian told PC Purnell that VC had visits from healthcare but there was no follow-up in that regard when the crime had been reported, and when he rang later on the phone was switched off.

We make no specific criticism of her for that but the reality is her phone was switched off and there was no arrangement for the phone to be picked up by anybody

else while she was on holiday.

Then the circumstances leading to VC's third Mental Health Act admission on 3 September which culminated in VC's attack on PC Pritchard demonstrated conclusively, we say, that VC was capable of extreme, unprovoked violence. And it ought to have been clear that he required more assertive care and a longer period of compulsory treatment to support him, and secure his concordance with medication.

But the narrative of that third admission, and I'll include within that narrative what actually happened to him during that third admission when he was an inpatient, is replete with evidence of individual and systemic failure.

That attack on PC Pritchard, the Inquiry has graphic and powerful footage of it, he calmly said he wasn't going anywhere. When the officers refused to go away, he took off his glasses and said, "I don't have a history of mistreating women. Gentlemen, if you want to take me out." And after an incredibly violent attack on PC Pritchard, VC commended him. He said, "You did good, you didn't go down." And the CPS reviewing lawyer noted that there was an element of planning involved and VC's actions indicated he wanted to hurt PC Pritchard to the extent that he couldn't fight back.

Dr Lomas, who was the consultant psychiatrist present at the attack, gave evidence that what happened looked like a serious assault to him, and just because somebody is psychotic doesn't mean that any criminal act they commit is caused by their psychosis.

And in that regard, he further observed that the assault on Christopher in January 2022 had none of the hallmarks of psychotically driven violence, and in contrast to other psychiatrists who gave opinion evidence to the court and have given opinion evidence before you, Chair, during the course of these proceedings, then he examined VC at the time and saw no overt signs of psychosis.

THE CHAIR: I think Dr Lomas and Dr Manzar were present, weren't they, at this incident?

MR MOLONEY: Yes, absolutely, yes.

And Dr Lomas, if you remember, Chair, he described, as it were, the first interaction with VC outside the flat, which was a cordial interaction. There appeared to be no difficulty, he said, "Well, I'll wait for the police if the police are going to come." And then he went to his flat and then they went, they asked him to come with them, he said no, and that's when the trouble started.

But once again, the police failed to follow its own

policy by initially diverting VC away from criminal investigation, and you know, Chair, that when the decision was taken to proceed with the prosecution of VC, the process was inordinately delayed.

VC's time in detention at Cygnet, Darlington PICU, provided yet further evidence of his masking, lack of insight, and intended non-compliance with medication. Of all the clinicians, we say, Dr Shoilekova appears to be the one who was least taken in by him. She expressed serious concerns to VC's Mental Health Tribunal and the tribunal recorded unequivocal evidence that when VC was well, his risk to others was high, relapse occurred rapidly and his risk was difficult to managed.

Dr Shoilekova's evidence was that VC had not fully recovered since the onset of his illness and his history of swift discharge and consequent medication non-compliance was expressly highlighted. She was concerned about the risk of harm both to VC and others, if he were discharged. And she confirmed that when unwell, the risks were serious. And we would say, with respect, that she got it right.

THE CHAIR: I think she didn't have access to all the Rio notes either.

MR MOLONEY: No, she didn't.

THE CHAIR: And she was out of area.

MR MOLONEY: Absolutely, Chair.

THE CHAIR: So those sorts of things which are considered to be bad in the sense of being out of area but she made the decisions that she did.

MR MOLONEY: She did, Chair, and we respectfully say that she worked hard to make those decisions as well and was very -- gave great consideration to the position, perhaps, we say, in contrast to others who dealt with VC.

THE CHAIR: Yes.

MR MOLONEY: One of the reasons the tribunal refused VC's application to be discharged was the fact that he minimised his violence to others. By that stage, and Ms Langdale has already alighted upon this this morning, VC had angrily refused in July 2021 to accept a conditional discharge, conditional caution for his actions in respect of damage on the first incident of 24 May. But on the very night of the tribunal decision, he wrote to PC Gail Collins to ask if he could accept the conditional caution.

When she didn't reply, he wrote on 4 October to remind her of his offer. That demonstrated, we say, if more proof were needed, a capacity to manipulate. We don't say he's a master manipulator, we've never said that, but we say there's a capacity to manipulate.

Then he was transferred, Chair, to Priory Arnold, after the work that had been done by Dr Shoilekova, he was transferred to Priory Arnold, and that transfer was approved at a time when it had been placed -- Priory Arnold, that is -- into special measures. The evidence and conclusions in the tribunal judgment ought to have been impossible to miss for the staff at Priory Arnold and Dr Shoilekova gave evidence in response to a question from you, Chair, that ideally, those tribunal records, ordinarily they would have gone with the records to the Priory.

Those records said that maintaining and optimising VC's medication was essential. And unless things changed dramatically in his presentation, VC required depot medication and a CTO. Or at least it should be considered before his release. But no, the Priory entirely failed to engage with his known risks of masking and non-concordance. When VC told the MDT that the assault on PC Pritchard was because "he got too stressed and overreacted", he was not challenged.

When VC failed to engage fully with his medication regime and therapy, he was not challenged. When VC brought a hammer back to the ward following Section 17 leave, there's no record he was challenged and we say with respect to Dr Gurusinghe, his explanation that

essentially VC had been hanging things on the wall essentially was implausible, in the circumstances.

And most significantly, Dr Gurusinghe did not have any conversation with VC about depot medication or a CTO. To the contrary, to go back to what I said earlier, Chair, he took VC's request to switch from haloperidol to aripiprazole as a significant turning point in his recovery. And he released him back to the public.

VC emerged again and on 22 October 2021, VC left the Priory having been admitted there for just 17 days of formal detention and four days of informal detention after the tribunal finding that you have heard about, Chair. It's clear that the Priory's approach to assessing and managing VC's risk failed throughout his admission, and it wasn't just a failure at the margins; it was a wholesale failure.

2022, the attack on Christopher and his final Mental Health Act admission.

Not surprisingly, VC was clearly non-concordant almost immediately after he was discharged from the Priory. How anybody could expect anything else in these circumstances. His approach to things changed again. On 5 November 2021, VC expressed that his admission to hospital following the assault on PC Pritchard had been

"awful and unnecessary". He did not agree with medical professionals that he'd been unwell. He was taking one 10-milligram tablet rather than two and had just taken just two weeks of VC's apparent insight which Dr Gurusinghe had so steadfastly relied upon to disappear, and to be renounced.

At that time not one of EIP spoke to him for a period of four weeks and in mid-December 2022 when contact was resumed, VC was described as angry and confrontational. Now, the reaction to that is important, Chair. The reaction to that was to consider discharge at that stage, and that was on 15 January 2022.

At that time, VC assaulted Christopher and held his flatmates hostage and the Inquiry may conclude that the police response again was wholly inadequate. They discouraged pursuit of the case and Christopher agreed to endorse a police notebook recording that he did not wish to pursue his complaint.

The EIP team were informed of the assault on 18 January 2022. And the one -- their response was one of immediate concern for the staff going to visit him in his home. The Inquiry may question whether the EIP team were concerned for their own safety and the crisis team would only see VC in pairs, but it was safe for students

to live with him and members of the public to face that same risk without warning.

And he was finally admitted for the fourth time on 28 January 2022. He should have been detained pursuant to Section 3 rather than Section 2 for assessment. Everything was there for him to be detained under Section 3 but he was detained under Section 2. And you have that which Mr Ruck Keene succinctly said:

"An ethos which says I should always try and steer myself towards using Section 2 because it feels less restrictive is a problematic challenge."

Defending his decision to discharge from this fourth admission without depot, Dr Thangavelu relied on VC's assurances that he would continue taking oral medication. He said he did not have any reason to believe that VC was not being true in his statements when he said he would continue to take his medication.

Then non-concordance, stalking, and responsibility for discharge from care, the final months leading to VC's inappropriate discharge shows a lack of care and patent signs of deterioration in VC's presentation, and the failure to address VC's continuing risk by the police was the same.

Sebastian's concerns about VC's return to stalking him, a known indicator of risk, were dismissed. VC was

never asked about repeated stalking of Sebastian at any time.

After months and months of delay, VC was charged with the assault on PC Pritchard but nobody bothered to go and see him to inform him of proceedings. Instead, a letter was sent to an address he was no longer living at. And the last time VC was seen by EIP staff was on 4 July 2022. They didn't know where he was. An address provided by VC at 209 Ilkeston Road was visited by Mr Carter. Police intelligence was that it was a trap house, a place to take drugs, but Mr Carter was unaware of that. Police were not contacted.

The records of VC's discharge from EIP in September 2022 when Mr Carter nor Ms Birtles were present, the evidence around that you have, Chair. I won't dwell on it.

The claims of Dr Lloyd don't stand up, and the failure by Dr Lloyd to accept any responsibility for the care of VC is deeply troubling for the bereaved families. She held professional responsibility for VC's care. The Inquiry heard confirmation from the Senior Leadership Team that the consultant retained responsibility for clinical decisions within the EIP team. It was the consultant leading the MDT that leads the decision to discharge, and this was the consistent

evidence before the Inquiry.

Then the final missed opportunities. The failure to attend and the warrant that was issued in September of 2023 but was not executed almost nine months -- for almost nine months between the issuance of the warrant and 13 June 2023, during which time Nottingham Police, especially PC Myers, simply failed to take any steps to locate and arrest VC.

Temporary Deputy Chief Constable Rob Griffin accepted that the failure to act on the warrant was a systemic operational failure on the part of Nottinghamshire Police. It should never have happened and it was a genuine missed opportunity. Then in February 2023, VC violently attacked a male colleague whilst working in a warehouse in Nottinghamshire. It was a sustained attack with multiple punches thrown. There appears to be no evidence of overt psychosis nor any record of unusual behaviour by VC in any of the contemporary records disclosed.

And the footage of this was uncovered by the Inquiry. Not Nottingham Police. Needless to say, therefore, to echo that which Ms Langdale said, neither Professor Blackwood nor any of the other psychiatrists, nor the sentencing judge, crucially, were able to see it but we ask that it is played now, if we may.

Whilst that is coming up, if PC Myers had taken the steps he said he would and had sought to locate VC and enforced the warrant in the week of 27 January, this would likely not have happened.

We see VC leaning against the wall there, with the yellow high-vis jacket on it and then a work colleague next to him. There appears to be a discussion between them.

Continuing discussion. Appears to get more heated; and then they're separated, things calm down quite quickly. You see VC there after the incident.

On 5 May 2023, the bereaved families believe that the failures in the Leicestershire Police response to the further attack at Arvato on 5 May proved significant and devastating. You have the evidence in relation to that, Chair. You've heard evidence about mistake upon mistake by the officers concerned, and in the systems operating at Leicestershire Police.

If Leicester police had acted as it should following 5 May, VC would have been arrested shortly after the attacks at that warehouse. At a minimum, even if not remanded in custody for failing to appear, to answer a charge of serious violence against a police officer, as well as committing another violent offence whilst unlawfully at large, as well as not having a fixed

address -- even in those circumstances he wasn't remanded, it's likely, on the evidence of previous events, that VC would have been subject to a further Mental Health Act Assessment with the equally likely prospect of further detention, whether for assessment or treatment, and an opportunity to implement the CTO and depot that the evidence overwhelmingly suggests was warranted. Instead he remained at large, and the Chair may consider the failure to intervene at this stage was a critical and obvious missed opportunity to divert VC away from the attacks on Ilkeston Road.

Chair, the timeline is replete with missed opportunities and individual and systemic failures.

Turning to the events of 13 June, 91 minutes from call to cuffs, all we say about this is that Nottinghamshire Police had no reason to congratulate themselves on that 91 minutes from call to cuffs.

We know that Ms Cartwright King's Counsel will focus on this within her oral submissions to you, Chair. She has done within her written submissions, and so we say no more about it.

Next, the invasion of personal privilege at the time of tragedy. If I may say, we've set out in our written submissions what the bereaved families have had to endure at the hands of a number of employees of public

authorities breaching data regulations with apparently voyeuristic motivation, and the survivors have experienced similar. We adopt but don't repeat our written submissions and indeed we don't repeat what Ms Langdale has said before the first break, Chair, where she identified the issues.

THE CHAIR: In fact, as Ms Langdale says, the Inquiry will be wanting an update as to whether there are any further instances just so it is as up-to-date at point at the time of -- (overspeaking) --

MR MOLONEY: Thank you, Chair, because if I may say, it has been something of an unfolding picture over the time that it was first raised, there's been, as it were, I won't say drip, drip, but there have been incremental developments around data breaches, from 2023 onwards.

THE CHAIR: Well, certainly when it was first raised as an issue, the extent of it was not known.

MR MOLONEY: Absolutely, Chair.

THE CHAIR: And that it wasn't just this case, either.

MR MOLONEY: Yeah, absolutely.

Next, Chair, the understanding and management at risk. It follows from what was said about the timeline that the bereaved families submit that there were repeated and basic failures by different organisations, and individuals to appropriately assess and manage the

risk posed by VC to public safety.

Police minimised his offending on each occasion he came into contact with them. They didn't use their own intelligence systems to create a longitudinal assessment of risk. And those failures can't be explained away by insufficient resourcing or inexperience; they were basic tasks.

So far as the health services were concerned, NHFT, Chair, Ms Langdale has drawn to your attention the number of incidents that there have been, and if I may say with respect, Chair, the study that's been carried out by the Inquiry Legal Team during the course of this Inquiry shines a very good light on what has been going on in that area and beyond.

Everything pointed to VC being a high risk individual who needed careful management and risk reduction to keep the public safe, but, we say, Chair, that the principle of keeping the public safe had all but disappeared from the NHFT EIP service. Risk assessments weren't updated or failed to include key information, so often.

And time and time again, reliance was placed on the information that VC was telling professionals, despite it being glaringly obvious, that he was entirely capable of saying what he thought they wanted to hear to achieve

the result he wanted. They were basic failures, but the clinicians were regulated by the GMC or NMC. They were bound by regulatory standards of professionalism in care, and the Inquiry may consider that the role played by lead consultants in VC's care, whether the responsible clinicians as an inpatient or in the community with Dr Lloyd, was inappropriately perfunctory and superficial.

Just on the future plans around risk management, essentially, Chair, we respectfully suggest that the Inquiry urge a clear central mandate from the Department of Health recognising true Assertive Outreach teams as essential. They mustn't be optional; they mustn't be left to local discretion, they must be a priority approach for patients like VC and they must be funded to succeed.

Also, Chair, future risk management requires careful scrutiny of the Mental Health Act 2005 and its revised Code of Practice. The Inquiry has heard evidence about the new detention criteria. The test is now whether serious harm may be caused to the health or safety of a patient or another person, unless the patient receives medical treatment or is detained. With the Inquiry, we ask you, Chair, to recommend the statutory wording, either that it not be gone ahead with or that it

essentially be amended to ask whether there is a risk of harm and to remove the requirement that clinicians conduct an analysis of the likelihood of harm. In the alternative, at a minimum, the risk should necessarily be amended to ensure the threshold is a risk of serious harm.

THE CHAIR: But there are a number of instances which the practitioners gave evidence about, some very cogent evidence about how they'd wrestled with the test as it currently exists. And I think what you're saying in your submissions is that when you're dealing with likelihood, you know, does it mean more than 50%? Does it mean something different? And meaning when?

MR MOLONEY: Absolutely.

THE CHAIR: So it has an additional, you say, aspect to it.

MR MOLONEY: And Simon Wessely, the architect of the Act, in evidence before you, Chair, he said: look. It's all about risk, it's not about causation. Well, if it's about risk, why can't we have those words, and therefore maintain that important concept which enables practitioners to assess a situation and not analyse likelihood?

THE CHAIR: Yes.

MR MOLONEY: We're grateful to Ms Langdale for her indication in respect of the progress of the formulation

of the Code of Practice and we respectfully agree with that which Ms Langdale has said.

Working together, Chair, countless times with individuals and organisations working with VC ought to have shared what they knew about his growing risk and ought to have been more curious as to what others knew about him, and ought to have recognised when a multi-agency approach was critical.

Clinicians taking decisions about VC's care were acting without a full understanding of the nature and extent of VC's offending behaviour. And the most stark example of this and perhaps the most stark example there ever could be, is that VC was discharged from the care of NHFT, in ignorance of his being charged with the assault on PC Pritchard and in ignorance of how he was due to appear in court the next day.

Similarly, critical decisions about VC's offending behaviour were taken without a full appreciation of his mental health history and associated risks, often because officers didn't check the records.

There were clear failures to share information even within organisations. So PC Collins didn't know about the details of the second attack on 24 May when she began her investigation, as she believed data protection prevented her from considering it.

The true risk of VC would have been more fully appreciated if organisations were working effectively together.

Actions in the police station, Chair. You have our written submissions on this. Just very briefly, the bereaved families have concerns about what happened during this time. Psychiatric assessment, contemporary to VC's crimes of 13 June 2023, should have taken place.

After examining VC many months after the offences, when he'd been detained in a high-security prison or a high-security hospital setting, throughout the intervening time, psychiatrists ultimately gave opinion evidence that on 13 June 2023, VC had diminished responsibility for his actions.

There was no assessment in the police station at the time when he was deemed fit for detention, interview, interviewed on six occasions, answered the questions appropriately without any concerns raised by a solicitor or appropriate adult and deemed to have capacity to be fit to refuse to provide samples.

And the evidence you have, Chair, is that a detailed mental state examination by a psychiatrist would only have been available if there'd been an assessment for admission under the Mental Health Act which wasn't going to happen so they didn't do it.

There's now no provision, really, for that to take place. Dr Kumar highlighted that 30 years ago that would have -- that type of assessment would very likely have been carried out.

Dr Latham, emphasising the importance of this, says there's a legitimate question about the extent to which it's possible to reconstruct someone's mental state when considering diminished responsibility or insanity, and ideally a psychiatric assessment would be carried out as soon as possible after someone is arrested.

We urge you, Chair, to consider in serious cases like this, where there is a mental health issue in the police station, and there's a recognition that it will be a reconstruction of mental state when it comes to any criminal proceedings months down the line, then there could be this type of analysis.

THE CHAIR: What would be the status of that, in the sense that -- who would commission that? Thinking about it in terms of any prosecution that would follow, in the past it would have been the police, wouldn't it, and that would have been done not simply for welfare reasons whilst he was in custody, but also to get a sense of the state at the time as we heard from, I think, Dr Latham and also there were other -- there was other evidence to that effect, that that used to happen.

MR MOLONEY: Yes.

THE CHAIR: But if one was thinking about instituting that as a new, standalone report within the police station, where would the responsibility for that lie?

MR MOLONEY: My first idea, Chair, would be that it could come under the auspices of the Liaison and Diversion Services because they would be people who would be attuned to that type of situation and then they could refer the position to a local Consultant Psychiatrist.

THE CHAIR: So they have an involvement up to a point, don't they?

MR MOLONEY: Yes.

THE CHAIR: But when it's quite clear that someone isn't going to be diverted because of the seriousness of the allegation, as happened here, there was some concern about whether they should be involved further, and at that point you would say that they should be -- they should bring in an independent consultant -- psychiatrist -- (overspeaking) --

MR MOLONEY: -- in order to maintain an independence from the police.

THE CHAIR: Yes.

MR MOLONEY: Chair, you have our submissions on toxicology.

THE CHAIR: Yes.

MR MOLONEY: And we make this point: that a blood sample was

asked for in order to be able to either confirm or rule out VC's presence at the scene, but no urine sample was asked for, and toxicology was not part of the investigative strategy.

And obviously, we have raised the points with our written submissions about the absence of candour by the police, for example, going to charge without CPS authority because of the concerns around the reporting that was to become over the warrant.

Investigating and prosecuting VC, Chair. We say that it must be a given that families of people who are brutally killed are entitled to expect that police lawyers and expert witnesses will do all that they reasonably can to assure a just outcome to the case, whatever that outcome may be, and they're entitled to expect rigour.

The evidence heard in the Inquiry, we say, confirms the concerns of the bereaved families there was conspicuous absence of rigour when it came to certain aspects of the prosecution of VC.

May I just build in upon something that Ms Langdale said earlier, Chair. It's important, when considering this question, to recognise that diminished responsibility is a partial defence to murder, as you know, Chair. It was introduced by Section 2 of the

Homicide Act 1957.

It's a legal issue which is susceptible to medical evidence. It's not a medical concept. And thus, when somebody is judged to have diminished responsibility, whether by acceptance of guilt or by a finding by the jury, the question of just how diminished their responsibility is for the crimes they've committed is fundamental to the disposal of the case by the court, not by the doctors.

So the degree of retained responsibility of an offender for his actions is vitally important, because as you know, Chair, a disposal following a finding of diminished responsibility need not have any treatment element to it. An offender may be sentenced to determinant or indeterminant custodial sentence and nothing else. What is important in that consideration is how a person was at the time of the killing or the killings. And VC is not alone in having a psychotic disorder which centres on thought interference. But not every person with such a disorder goes on to kill three innocent human beings who he doesn't know, and try to murder three others he doesn't know.

And moreover, whilst there are differences of medical opinion on whether VC experienced relapse and remission in his condition, there can be no reasonable

dispute that the intensity of his symptoms waxed and waned between 2020 and 2023.

Nobody saw any overt symptoms of psychosis when VC assaulted Christopher, for example. And the same applies to the February 2023 warehouse incident, and we don't know the full circumstances of the 2021 warehouse incident.

In that context, Chair, this is why we spent time on it: it is important that as much as possible was known about VC when the judge came to pass sentence. He was -- VC -- and I don't want to be trite or simplistic, but he was not charged with shoplifting or a routine assault in a factory in Leicestershire or Nottinghamshire. He'd committed horrendous crimes and the proportionate approach to understanding who he was and how he was when he committed those crimes was required.

And we say that there were a number of significant failures which would be relevant to the decision of the court when determining the disposal, when determining the retained responsibility of VC.

There was a failure to test for illicit drugs. I've dealt with that. But also, for some reason, the connections with Bill Monteiro and 209 Ilkeston Road were not rigorously researched. There was a failure to

investigate the incident with Bill Monteiro's neighbour. You know about that Chair, I won't repeat it. He gave one account to Professor Blackwood. It appears that in a voice note, Bill Monteiro understood something different.

There was a failure to effectively search for the Slazenger bag and his laptop has never been found, Chair. And there was a failure to consider VC's own notebooks. I won't repeat that which Ms Langdale has said this morning. We alight upon the illegal actions, mea culpa, 2013, 2014. The commission of illegal acts in 2013 very, very important to the disposal of sentence, and the notebooks also revealed relevant information, including what we say was a deep seated misogyny and we put in our written submissions why we say that and we won't repeat it, and it's material relevant to insight.

Professor Blackwood now says in his second statement that he would have asked VC about these notebooks if he'd seen them but it would have made no difference to his ultimate opinion. That begs the obvious question of how he can know that without asking but also, we say, fails to recognise the importance of such matters to the ultimate disposal of his case, not necessarily diminished responsibility or not, but what actually

happens in terms of disposal of the case.

THE CHAIR: There are two routes, really, for this evidence, aren't there? One is the psychiatrist and one is before the court.

MR MOLONEY: Absolutely, Chair.

THE CHAIR: Who have different functions.

MR MOLONEY: Indeed.

THE CHAIR: But obviously the psychiatric evidence is part of the judge's assessment.

MR MOLONEY: It is, Chair, and of course you'll be conscious, Chair, that psychiatric evidence in such cases is almost an exception to the rule of having expert evidence as to the ultimate issue, and it is important evidence, but the decisions are for the court, not for the psychiatrists.

And the court can take into account information that's relevant to disposal.

THE CHAIR: There is guidance, obviously, from the Royal College of Psychiatrists as Ms Langdale referred to, and there's also case law --

MR MOLONEY: Yeah.

THE CHAIR: -- on that issue.

MR MOLONEY: Absolutely, Chair.

THE CHAIR: So as I understand it, you're saying more needs to be done.

MR MOLONEY: There needs to be rigour. When you're dealing with an offence of this nature, or offences of these nature, the courts have to get it right because -- well, they have to be given the material to get it right. We make no criticism whatsoever on the basis of the material that is before the sentencing judge, but they have to be given the material. They're entitled to demand that they are provided with sufficient information because the court can't make its own investigations.

But it gets worse, Chair, because last week, in terms of further notes, we -- Ms Langdale has briefly mentioned these but could we please see NGPF0014206.

Now, these are the notes which bear the familiar manuscripts of VC predicting football results, analyses of how to maximise muscle growth, and letters relating to his interest in coding at work document.

If we could go to page 209, please.

At the top, Chair, "Thoughts: "TNT, ammonium nitrate fertiliser sugar."

Ammonium nitrate fertiliser sugar is a recipe for creating secondary explosives at home, or it's the basic ingredients for it. RDX, Semtex, PETN, and acetone peroxide are primary explosives.

Acetone peroxide, Chair, is the highly unstable

primary explosive otherwise known as TATP that can be made at home and was used in the 7/7 tube and bus bombings, the 21 July tube and bus bombings, the airline bombing plot, and the Manchester Arena bombings, to name but a few. And the primary explosive detonates the secondary explosive and the booster tube mentioned there -- the booster tube connects them.

He must have researched this information.

And then if we could go, please, to page 172. There's a whole lot of important matters mentioned on there including, just above where the first hole punch might be, "Manchester arena". Rwanda, Watergate, Manchester arena, Iraq, and so on.

And this gives new relevance to the fact, Chair, and not previously included in our submissions, that VC researched large venues in Nottingham and when his phone was analysed, two of the nine web bookmarks in that NGPF009008, I don't ask for it to be shown, two of the web bookmarks were, for some reason, Albert Hall Conference Centre, Nottingham, and Theatre Royal and Royal Concert Hall, Nottingham.

In the light of other information, those bookmarks might just have been worth asking about.

And then, on Friday afternoon, we had disclosed to us NGPF0014204, and this is something of a tangent but

it comes in terms of the disclosure and if we could go to page 28, thank you, page 28, there we see, Chair, on the top row of cards second from the right his Covid vaccination card, confirming, if necessary, deception as to problems with needles.

Nobody has ever asked VC why he was researching explosives and large venues because they couldn't. There was a failure to investigate VC's historical behaviour and actions. The failure regarding the notebooks, we say, is compounded by the police failure to investigate VC's life as a young adult and then failure to investigate VC's recent history.

The Inquiry has done this. The Inquiry has uncovered the 2021 incident and has uncovered the February 2023 incident. Professor Blackwood was not aware of either of those incidents and, indeed, it appears that those incidents were also not known to VC's family.

On the face of it, that footage is quite disturbing. But also, banal.

The failure to provide material which was in police possession to the forensic psychiatrists for their consideration. Professor Blackwood was not provided with CCTV footage of VC's previous assaults, including the video footage of the attack on Christopher, or the

body-worn video of the assault on PC Pritchard. Professor Blackwood conceded that this material may have been helpful and you, Chair, may consider this was a significant failure, because it meant that there couldn't be a fully informed and rigorous explanation of the extent to which VC's violence was solely attributable to his psychiatric disorder.

We know what Dr Lomas felt about it when he was there, and surely, if this potential issue as to whether violence is connected with the events of 13 June, and a close connection to his psychotic illness, then a psychiatrist would need to look at all the evidence especially a video recording of an assault.

The documentary evidence of the assault on PC Pritchard is nothing compared to what is seen on camera of VC. And VC's Mental Health Tribunal records were also never examined by Professor Blackwood. He conceded that they should have been scrutinised because they contained VC's own previous inconsistent accounts of his previous violence and the motivation behind it. Dr Shoilekova thought these would have ideally gone to the Priory and so they should have been in the Priory records.

And the prosecution failure to critically assess the psychiatrist's report. We say there was too readily an

acceptance of Dr McSweeney's report. On the very day following it, Mr Murphy reported that he'd spoken to Dr Blackwood that afternoon, he had seen Dr McSweeney's report, his initial impression was that "This is a clear case of untreated psychosis and we are most likely heading towards diminished responsibility and a Section 37(41) disposal."

And he was able to make that sort of quick assessment following his seeing VC on 14 November 2023 when he was on the train at 17:22.

We do note that Professor Blackwood's fitness to plead assessment during his meeting with VC was solely based on VC's understanding of what would happen if he pleaded guilty or not guilty to manslaughter. And we say that further indicates an element of putting the cart before the horse. He was not asked about pleading guilty to murder or being tried by the jury for murder, despite that being the main charge that he faced. And that begs the question why not.

And there appears to be no challenge to the inconsistencies between the account that VC gave to the respective psychiatrists and the known evidence. His account was unquestionably accepted and not triangulated with the other evidence, and strikingly, leading counsel was required to rewrite his advice on acceptance of

pleas, such was the perfunctory nature of it. Andrew Baxter, the Deputy Chief Crown Prosecutor, said red light, there wasn't enough time to do a proper advice.

And then failure to consider the inconsistencies in VC's account with the evidence.

He claimed insanity, Chair, in his account to Professor Blackwood and Dr Shoilekova. He said, "I did not know the nature" -- essentially, "I didn't know right from wrong, I did not know the nature and quality of my actions". That was dismissed by Professor Blackwood but that does not feature in Professor Blackwood's -- he was able to dismiss it quite easily because he said, "Look, if he's said I've done something stupid, that shows that he does know what he's done."

There was also something else, though, which he suggested to Elias Calocane, that Elias get the family out of the country. That's not been -- received much attention but we say that is very significant in him understanding the implications of what was about to come down on that family, what media attention there was going to be on that family, what police attention there was going to be on that family.

But Professor Blackwood accepted he relied on VC's account triangulated against other sources of evidence.

And then the failures of psychiatrists to ask VC about important material. We rely on the fact, Chair, that VC was -- they had the downloads, counterterrorism police had carried out -- been responsible for the downloads, they had them, but he was never asked about why it was he had the material that he had in a context where VC had admitted the brutal killings of three innocent people unconnected with him and the attempted murder of three others unconnected with him, and seemingly had only ceased his murderous actions because he was intercepted by the police.

Nobody sought to ask VC what first attracted him to videos of mass killings of innocent people unconnected with the killer. It's inexplicable and the list of documents Professor Blackwood recounted in his report as having been considered in preparation of the report contained neither the summary views nor the phone download itself and there was no reference in the body of the report to the material and nor, crucially, was the existence of the material drawn to the attention of the sentencing judge.

It's clear from the evidence of Dr Mirvis that nobody has ever asked VC about this material.

And then, finally, in this regard, the failure to consider whether VC could be properly diagnosed with

treatment-resistant schizophrenia. You have our submissions on this, Chair. There's reason to doubt the medical and the opinion of the -- the opinion that was given by Dr Mirvis at the sentencing hearing on 14 January 2024, and similarly, Professor Blackwood stated to the court that VC's failure to comply with the prescribed oral antipsychotic medication was not a culpable admission, it was determined by his lack of insight into his illness.

The Inquiry has heard evidence, however, that in the early stages of his illness, VC actively resisted taking medication because he felt that it caused issues with his studies and he felt as though they were slowing down his thinking. It seems to be accepted by all that as his illness continued, it was compounded by his consistent failure to take medication. Well, Professor Blackwood was asked in terms of about VC resisting medication because of his studies, and Professor Blackwood said he had not seen that.

Then finally, Chair, what the -- and finally, in all of these submissions, what the families saw as an institutional defensiveness on the part of the prosecution.

And firstly, the review as to material considered by the psychiatrists was not candid. You have our

submissions on that. There was misleading information given on toxicology testing. You have our submissions on that.

But the Beddoe report, if I may, Chair, just for the last -- as the last matter to raise, that on 23 November 2022, as you know, Mr Khalil King's Counsel asked DC Beddoe for a list of observations of seemingly rational behaviour by VC, and that was completed and circulated on 15 December. Mr Murphy was disparaging, but -- and Mr Murphy at the conclusion of his email said:

"Can I ask that this document is placed on the sensitive schedule of unused material MG6D; it is plainly sensitive, in my view. It will not be disclosable to the defence as it doesn't meet the CPiA test and will plainly not be disclosable to anyone else." [As read]

That "anyone else" is readily identifiable from the follow-up email that it's all about the families and sent by junior prosecution counsel, which you have in our submissions, Chair.

And Mr Khalil agreed he was concerned that the views of DC Beddoe might be shared with the family, and we say to place the document on the sensitive unused schedule was wrong.

Mr Murphy said this was an internal police CPS communication and that they don't go on an MG6C, but Mr Murphy knew that the test for its entry on the MG6D was that disclosure of it would give rise to a real risk of serious prejudice to important public interest.

Ms Shallow said it needn't have gone on the sensitive schedule, but it could have not been scheduled at all. And the -- and Mr Khalil said it could have been put on the non-sensitive schedule and marked clearly "not disclosable" but it invites a Section 8 process to which it shouldn't have been vulnerable and then, ultimately, he said that this type of material could go on the MG6D.

Can I just look at that, just to take you, Chair, to the MG6D which is NGPF0003194.

Chair, it's very unusual, as you know, for an MG6D to be seen in public. It is usually only ever seen by the police and the prosecution, the defence never see it. This is the -- there's only five items on it, Chair, or six items, rather.

The first is the Index Police Guide. "Code 8" means that it reveals techniques and investigative methods relied on by the police, and one can expect that with that type of document.

Similarly, the briefing document. One could expect

that that would contain material which would come under 8. And 15 is confidential information.

The Crime Stoppers Intelligence Report, confidential information, 15, completely understandable. If we go over the page, and then again, because that's -- that one's blank but then to the next one if we could, please. This is the statement of PC 3191. The reason for sensitivity is 8, that's material relating to police and investigative techniques. If we -- and so understandable. If we then go -- it's about the drones.

If we then go back one page to the -- we see Officer's Report by DC Beddoe, extensive review of mental health records of Valdo Calocane, document D61 Rio patient records, and then the Beddoe report.

Now, the reason for sensitivity for that first report is 4, which is information given in confidence, and 10, which is internal police communication.

We see, though, Chair, that actually this report was disclosed on 20 November 2023 which just goes to show that internal police communications aren't incapable of disclosure. We then see that it's 4 and 10: information given in confidence, and internal police communication for the Beddoe report.

All on the face of it, legitimately on the sensitive schedule. Second one stayed there, though.

Now could we please go to CPSE0001729, and just to page 6 of that, if we could.

We see there, this is an MG6C. We see "Officer's Report by DC Beddoe explains partial system failure within the NICHE telephony recording system and not all lines were recording that day."

So there's one officer's report.

And then if we go to CPSE0000046, please, and to page 46 of this, please. Classic internal communication. Officer's Report by DC Grayson detailing updates for a number of allocated actions. Actions will show details. DC Grace also reports," et cetera, et cetera.

But if we now go back just two pages to 44, having seen that internal police communication, we then see at page 44 "Officer's Report by DC Robertson. Officer's Report by DS Cooper."

Over the page, please, to 45. Officer's Report, Officer's Report, Officer's Report. all of these clearly not disclosable, rightly. They're on the C schedule, they are on the non-sensitive but clearly not disclosable. Then on to 46. Officer's Report, Officer's Report, Officer's Report, all clearly not disclosable.

And then I believe on 47, as well, yes, Officer's

Report, Officer's Report, and so on.

There was absolutely no legitimate reason for the Beddoe report to go on the MG6D internal communications. There was -- nothing in it met the test to go on the D schedule. And things -- internal communications can go on the sensitive schedule if they're sensitive. And if it was routine for internal police communications to go on the sensitive schedule, there would have been no reason for Mr Murphy to say in his email, to ask in his email "Can you please put this on the sensitive schedule? It's my view that it's sensitive."

The disclosure regime is under the CPIA is not simply about disclosure to the offence, it is crucial to the integrity of investigations and prosecutions, and the point about the MG6D is that ordinarily it's only ever seen by the police and prosecutions.

To conclude, Chair, respect for the rights of people with mental ill health who are known to be violent can only truly be ensured with treatment and care which considers action necessary to protect public safety and nothing in these submissions is or was intended to seek to stigmatise mental illness or people living with serious mental illness.

Clearly not all people who live with serious mental illness are violent but the Inquiry has heard important

statistical evidence on the numbers of homicides connected to mental illness. The bereaved -- and we won't go through it Chair, but you know it. The bereaved families believe that this Inquiry has shone a light on all of that.

And the bereaved families are very, very grateful to the Chair and the Inquiry team for all their work on this Inquiry. It's been a very difficult process for the families to endure, but it would have been much worse for them if this Inquiry had not taken place. Their sincere hope is that what they have had to go through will mean that others do not have to go through the same in the future, and in that vein, Chair, we entirely agree with that which Ms Langdale has said this morning to you: about the potential for ensuring that there is monitoring of the implementation of your recommendations, Chair, as Sir Robert Behrens said: it's a very difficult time for these people and they need support to ensure it shouldn't be left to them.

Thank you, Chair.

THE CHAIR: Thank you, Mr Moloney.

Just before we -- I think we're going to break for lunch now, we'll take a break rather earlier, maybe take three-quarters of an hour for lunch.

But I just wanted to say that I wasn't aware that it

was, I think, Charlie Webber's birthday. And had we known that, I think the submissions would have been listed on a different day, but there's been too much disruption already. Thank you.

MR MOLONEY: I know the Webber family will really appreciate that, Chair. Thank you.

THE CHAIR: Thank you. Well, we'll start again, yes, at 1.45. Thank you.

(12.57 pm)

(The Short Adjournment)

I N D E X