Tuesday, 8 September 2026

(1.45 pm)

CLOSING SUBMISSIONS ON BEHALF OF SURVIVORS GROUP BY MS CARTWRIGHT KC

THE CHAIR: Ms Cartwright. You have until three o'clock. That's the hard stop.

MS CARTWRIGHT: Thank you.

THE CHAIR: Thank you. And as with Mr Moloney, you can assume that I've read all your submissions. We haven't put up the timeline that you've provided but I've also read that.

MS CARTWRIGHT: I'm very grateful.

THE CHAIR: Thank you.

MS CARTWRIGHT: Madam Chair, as you've just identified, these are the oral submissions on behalf of the survivor Core Participants, Wayne Birkett and Sharon Miller and their respective partners, Tracey Hodgson and Martin Reed. I'm grateful, Madam Chair, for confirming that you have read the 99 pages of written submissions but also the detailed appendix 1 that addresses essentially Terms of Reference 1 and 4.

THE CHAIR: Yes.

MS CARTWRIGHT: Madam Chair, the structure of our slot this afternoon will be principally to address four matters. Some general opening remarks. The second topic to be

point 2 there are now some identified conflicts of evidence that I'd like to draw to your attention.

THE CHAIR: But I can resolve those, can't I?

MS CARTWRIGHT: Well, you can but, Madam Chair, essentially that is the context, in any event, my item 2.

THE CHAIR: Yes.

MS CARTWRIGHT: If it's considered as a candour issue, but also again, it flags the diligence of the Inquiry but in particular some further disclosure even received last night that raises significant matters.

THE CHAIR: Right. Thank you.

MS CARTWRIGHT: Thank you.

Then my item 3 is to touch upon, as headlined by Mr Moloney KC, the issue of the events of 13 June. But in saying that, Madam Chair, there is extensive detail within the written submissions that address the matters that the survivors maintain were the failures in the response that meant that there was a preventability issue that applied to the attacks upon those that I represent.

And then the final area where I'll focus my submissions will be the issue of, really, recommendations linked to the forgotten victim and experience of the survivors. It's a theme that has come up throughout the evidence, and the -- on behalf of the

addressed, as has already been headlined, both by your observations and Ms Langdale KC, it is within our submissions where we have made a request for additional days of evidence.

Madam Chair, we've noted what you said this morning. I will deal with that still as my item 2, but do so really in the context of flagging relevant new evidence but also to speak to the candour point and the matter you raised as to disclosure on behalf of the survivors, we would submit, should have been disclosed well in advance of the oral hearings, so it would have enabled proper exploration of some significant evidence.

THE CHAIR: Well, I think that really goes without saying, doesn't it --

MS CARTWRIGHT: Yes.

THE CHAIR: -- in view of what's been disclosed but perhaps we can just deal quickly with that point about further evidence. Now you've seen what has been provided and the order that I've made or the direction that I've given, it's obviously something that I would keep under review but it seems to me that the way forward is written evidence, bearing in mind what we have heard this morning from Ms Langdale.

MS CARTWRIGHT: Madam Chair, I completely take on board what you and Ms Langdale have said, but in dealing with my

survivors I'll expand upon matters touched upon within the submissions that deal with the impact of their life-changing physical injuries, the brain injury, the PTSD, but also their experience as victims of the attempted murder and how that -- they've been engaged with as victims because you will see, in the recommendations, it is the fervent desire of Wayne and Sharon, in particular, that there are changes that come in for victims, and particularly victims of serious, grave injuries at the hands of those with mental health issues.

Before dealing, then, with those topics can I echo the thanks that's been indicated by Mr Moloney KC. You and your team have worked tirelessly since the Inquiry was announced. This has continued since the oral hearings finished in June. We are grateful to you and your team for your considerable efforts for the volume of disclosure that has been made and continues to be made.

We also thank you and the wider team, including the Secretariat, the Solicitor to the Inquiry, but also the usher and Hestia support. As was made clear in the opening, those that I represent are a long way from home, from Nottingham. They have essentially put their lives on hold to participate in this Inquiry. And we

are incredibly grateful for the support that's been provided to those that I represent, for the comfort that's been provided as they participated in this Inquiry.

I've already indicated in the written submissions our concerns were such as to make a request for further oral hearings. Essentially, that concern has continued as the more recent disclosure has been made, including disclosure made on Friday and the disclosure made in tranches 215 and 216 that will be addressed.

We are grateful to you, Madam Chair. In our submissions we asked for compliance directions to be issued in accordance with the Public Office (Accountability) Bill that's likely to come in in the spring of next year, and we're incredibly grateful to you for the directions that you have made clear for those relevant organisations and individuals to comply with the direction that you have set for compliance by December.

In our opening submissions we detailed that it would be for this Inquiry to find out what did and didn't happen, persons who fell short of their duties and responsibility, and sought the requirement of all those to engage to do so with candour, transparency, and frankness to seek the truth. We recorded our thanks to

the bereaved families and do so again today, for their tireless and selfless campaign, seeking the establishment of this Inquiry, and in the pursuit of truth, accountability, and to achieve justice for Grace, Barney and Ian.

We are grateful to Ms Langdale KC for referencing the comments made by Sir Rob Behrens, but in due course, on recommendations, we are going to reference the work of the Independent Public Advocate, Cindy Butts, and I wish to use a quote that she has herself adopted as to the importance of the principle of candour.

She has made clear that the burden of seeking truth and justice must rest with the system, and never on the shoulder of victims and families, who themselves are experiencing unimaginable difficulties.

We commend that recommendation as to the principle for all of those organisations and agencies as they look again at their disclosure to this Inquiry, and provide all required information.

We are also grateful to Ms Langdale for the observations she made this morning linked to the issue of preventability. We submit, as has already been indicated by Ms Langdale, that the evidence heard at this Inquiry has revealed widespread and devastating multi-agency failures, both systemic across the state

agencies and individual failings, such that we also maintain that you can find as a fact that the killings by VC of Grace, Barney and Ian, and the attempted murders of Wayne, Sharon and Marcin were entirely preventable.

The scale of the multiple and repeated missed opportunities and failures revealed in the evidence each day in the hearings of the Inquiry has been stark.

It has been difficult for the survivors to listen to, and has left them in no doubt that VC could and should have been stopped before inflicting on them their devastating and life-changing injuries on 13 June of 2023.

The survivors would urge you, Madam Chair, to recommend that the National Confidential Inquiry into Suicide, Homicide and Safety and Mental Health, is expanded to include data collection for serious non-fatal violence with a focus on perpetrators with schizophrenia, to ensure robust consideration by the National Confidential Inquiry, and to assist in lesson learning and prevention of attacks. And that's one of the recommendations that we've detailed at the end of our submission.

THE CHAIR: I think it's a suggestion that's also made by Professor Appleby, isn't it?

MS CARTWRIGHT: Yes, it is. But you'll have seen that there are different ways of expressing it but again we submit that --

THE CHAIR: Yes, it's the principle.

MS CARTWRIGHT: The principle, yes.

As residents of Nottingham, the survivors have been shocked by the scale of the failings and the issues revealed by the Inquiry. In particular, in respect of the state agencies in Nottingham, namely the police, mental health services, both inpatient and the community services operated by Nottingham Foundation Trust, and Nottingham Council.

The scale of the failings at Nottingham University Hospital's NHS Trust, linked to data breaches, and unauthorised access to their private and confidential records is alarmingly still to be determined, and has caused great upset and anxiety to the survivors.

Madam Chair, you will see that we reference that as to how little progress has been made since the hearings concluded in June in respect of the cohorts of individuals who access the data of the survivors, and we reference the updated letters from Browne Jacobson.

As you heard in evidence, Madam Chair, it was only when Mr Almond, the solicitor, raised the concerns as to whether there had been data breaches, that that

commenced the investigation and to essentially be three years on and there still not being clarity as to the scale of the data access is highly regrettable and causes continued stress and anxiety.

The survivors want to see meaningful change so that public services for the people of Nottingham are made fit for purpose, and operate always to keep the public safe. The ministerial and government oversight of the failing state agencies in Nottingham also to be monitored. Further support for the issues you've identified in this Inquiry have also been revealed by the recent Ockenden Review, and now the live corporate manslaughter and gross negligence investigation into Nottingham Foundation Trust being undertaken by Northumbria Police.

Building on that, we return to a matter we raised in our opening, and it relates to Nottingham Police. Within the recommendations, the survivors ask you to request that the paused College of Policing independent review into Nottinghamshire Police's policing response regarding the events of 13 June, which was said would constitute an exhaustive examination of police powers, actions and policy, is urgently undertaken, for the issues identified in our submissions as to what we say were the failings and the discharge of the obligations

and the investigation on 13 June.

THE CHAIR: Just pausing there a moment, Ms Cartwright. We've had quite a lot of investigation in this Inquiry. What do you think the College of Policing will achieve, bearing in mind what was said by the Chair of the College of Policing?

MS CARTWRIGHT: So there's been no independent expert report with subject matter experts who are policing experts that understand JESIP, M/ETHANE, Plato, the National Decision Model, intelligence, and how police systems operate. We've heard the evidence from the police themselves, but as the College of Policing are the subject matter experts, an independent review with the ability to ensure that services and actions, policies, procedures and training are fit for purpose, we would submit is required, notwithstanding the exploration that's taken place within this Inquiry.

But Madam Chair, it will be a point I return to when one looks at the approach Nottingham Police have suggested to you in their closing submission about where you should pause your inquiry in respect of the events of 13 June.

They rely upon Terms of Reference 2 to say you should not look at the failings that go beyond the arrest of VC, to which I'll turn to shortly.

For the reasons expanded within the submissions, we submit there were multiple missed opportunities on each and every occasion VC was involved in incidents of violence and aggression, with multiple victims from May of 2020 to June of 2023, which brought VC into contact with police and mental health services which, if properly handled, would have altered the outcome for the victims on 13 June.

I don't intend to rehearse the Feven incident -- it's addressed in detail in our submission -- but we submit it is most stark when consideration given is to the Feven incident. Had the Feven incident been properly dealt with by the Trust and Nottingham Police and the index offence of grievous bodily harm properly investigated, as the victim herself has made clear she was requesting, we submit that VC's need for long-term treatment would have been escalated.

Further still, on the issue of the violence and aggression to VC, the suggestion being that it was not direct violence to towards Feven herself, Madam Chair you will recall her evidence as to her belief when she was in the back of the ambulance receiving treatment for her back that as VC was removed from the block of flats, she believed he was trying to get towards her. So we would submit there is further evidence from Feven

herself as to VC's behaviour towards her as he was removed from Brook Court by the police.

Time and time again, the inquiry has heard evidence from frontline police officers who did not know, understand or apply Nottingham Police's own policy for the appropriate criminal investigation of offences of those with mental health issues.

We submit that the adverse consequences that would follow premature and inappropriate discharges from detention in hospital and from community teams were clear and obvious before the June 2023 attacks.

VC had paranoid schizophrenia, a relapsing and remitting disorder, that required his mental disorder to be treated with effective antipsychotic medication, a secure environment, monitoring and supervision, but also essential psychological therapies to ensure that VC had and developed insight. Insight goes directly to the nature and degree of VC's mental disorder. As it was, VC clearly showed on each admission and engagement with others that he completely lacked insight into his mental disorder.

There was also evidence that VC was highly manipulative and had essentially an enduring mental illness that required long-term commitment to care and appropriate medical treatment.

Further still, first episode psychosis needs early intervention to prevent worsening. Each relapse worsens the position and it is well known that reducing the duration of untreated psychosis is essential. It is therefore the failings that have been identified even more so since the Inquiry concluded its oral evidence that raise the real issue as to the systemic failures in the EIP service at Nottingham.

We submit that it was clear even from May of 2020 that if VC's mental disorder relapsed, he would pose a very high risk to safety of other members of the public by psychotically driven violence and so each aspect of the requirements for consideration of detention were engaged, including the need for consideration of VC's physical health and safety. His repeated physical aggression left him at risk, not just of arrest and incarceration, but of retaliation by others.

We submit on behalf of the survivors that the failures to ensure VC's schizophrenia was treated with medication is a culpable failure. It was abundantly clear on each occasion of violence and aggression that VC was not taking his medication and that detention was required for a sufficient period to ensure he was concordant with his antipsychotic medication and until

he developed insight.

Dr Mona Ahmed, expert psychiatrist, accepted that the offences were probably preventable if VC's paranoid psychosis had been properly treated. The need for a Community Treatment Order with the power of recall was abundantly clear on each discharge from Section 3 of the Mental Health Act but never addressed.

We address in our submissions, and I'm not going to repeat the matters I've detailed because Ms Langdale has set out this morning aspects of the additional disclosure from the EIP that has now been disclosed but the Inquiry has revealed a systemic failure of the Trust to have a functioning or effective EIP service at any point when VC needed such interventions between 2020 and June of 2023, noting, of course, that his discharge occurred in the September of 2022.

I deal with, in the submissions, the various factors that have been revealed by the subsequent emails that have been disclosed and have been touched upon by Ms Langdale so don't repeat those as to the catalogue of issues identified in many emails passing between Dr Lloyd and Dr Elaine O'Reagan. But I just wish to draw attention to emails disclosed yesterday in tranche 215.

These have not been uploaded but I'll give you the

reference, Madam Chair, for your consideration.

In WITN0491034, in 2019, Eileen O'Regan was flagging the state of the service and detailing "I really cannot take on any more work" and detailing the very complex situation, and that she was pretty sure she had more patients already than she should have and these are the most complex in the team, and also identifying missing patients who would require safe and well checks with the police.

Further still, in July of 2020, Dr Lloyd in WITN0491029 revealed the scale of the issues, again in an email of 14 July 2020, very shortly after VC had been referred to the EIP. She says the following:

"Dear Eileen, I would appreciate a meeting as, like you, we are significantly above capacity. CPNs and medic for caseload numbers and the situation is no longer sustainable. The Local Mental Health Team (PNs) are now holding new cases for us as we have no other choice." [As read]

And in January of 2022, in WITN0491039, Dr Lloyd to Dr O'Regan:

"I think I'm wondering if we should try and set up Doctors' EIP meeting every three months to discuss how we feel EIP is going and to share thoughts on it. I feel it is getting quite diluted and it's not the same

service as before. It would be interesting to know if this is just me or others feeling it too." [As read]

Ms Langdale dealt with this morning the issue identified as to risk and the pressure of discharge.

Madam Chair, the areas where we had submitted additional evidence should be considered, bearing in mind there was not the opportunity to question Dr Seedat, Dr Thangavelu, Dr Lloyd and Susan Elcock in light of all the additional disclosure is detailed in our submissions. Since that time there have been further statements from Andrew Latham, Michelle Malone and Ann Wright and just yesterday Helen Taff and Sarah Hayler, Sarah Hayler herself critical of aspects of Dr Lloyd's evidence and emails.

This is significant evidence as to systemic and individual failings and is relevant to earlier attacks of those discharged from the EIP before 13 June, and again, noting the significance of the email from Dr Lloyd:

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

The Trust's closing submissions provide a frank

assessment as to the issues of the discharge that took place from the EIP in September of 2022, including Dr Lloyd's oral evidence that the decision to discharge was made sometime earlier in August. In the submissions it's made clear it's not corroborated by any other witness or documentary evidence, and the submissions go further. Indeed, is contradicted by the RiO notes which showed that Mr Carter was taking further steps in respect of VC in late August of 2022.

Last night in tranche 216, the audit, as was referenced by Ms Langdale, WITN0483002, and 3003R, were disclosed. That evidence provides further context to the evidence given by Dr Lloyd. We've not had time to analyse the wider issues revealed by that disclosure, but certainly it shows that Dr Lloyd made no entry in the clinical notes for VC after 1 August 2022, which we submit casts further light on the failings of Dr Lloyd in respect of VC's management and discharge.

The second topic which was in our submissions in respect of the need for further evidence relates to CCTV issues.

We've had additional disclosure from James Pykett, Colin Wilderspin, Kenneth Cromwell, and Brian Bussey. All of these witnesses deal with the updated evidence relating to the significant issues relating to CCTV and

monitoring.

Further disclosure was provided more recently in respect of Kenneth Cromwell and camera 138, as was, which again was not openly disclosed by Nottingham Council as to the issues that have been occurring with camera 138, a camera cited on Lower Parliament Street.

And we submit, Madam Chair, that even the statements that have been provided as recently as last week still don't give the full candour. There is now reference to the repair to that camera having taken place, but again, no underpinning evidence to support the asserted repair on 8 June 2023. And we ask that further evidence is provided to support what is now said about repairs to that significant camera.

Within the closing submissions of Nottingham Council, they provide an account that challenges Officer Mather's evidence, and this is one of the conflicts of evidence that now exist in respect of between Nottingham City Council and Mr Mather. They essentially invite you to reject the evidence of Officer Mather where there is a dispute of evidence.

We submit that it is significant that the council themselves identify the failings linked to the camera monitoring and the lack of knowledge they had with not having access to the firearm channel. They detail that

after-the-fact evidence from the police and a frame-by-frame analysis of the CCTV reveal that there were sightings of VC as he emerged from Radford Road into the forest area of Nottingham and made his way north towards Mapperley where he killed Ian.

It is a tragedy that he was not seen and apprehended. CCTV staff did not have access to the firearms channel so the crucial bit of intelligence that VC might have headed north on Hopedale Close never was identified, utilised. So again, Madam Chair, we say that this is further evidence that, had the multi-agency cooperation and collaboration taken place, there was a very real opportunity to identify VC before his attack on Ian if the relevant intelligence was shared with those who were tasked to observe the CCTV.

We are concerned by the disclosure made yesterday in tranche 215, the seventh statement of Colin Wilderspin, WITN0224043, where again new issues are raised as to the functionality of the FollowMe unit, but also, as referenced by Ms Langdale, the data logs, the data storage, but also the deletion of records. And again, it's highly regrettable that this significant evidence is only being disclosed yesterday.

We are highly concerned as to the lack of candour on behalf of Nottingham City Council. Nottingham City

Council has only provided, save for witness statements and exhibits, 198 disclosed documents on relativity. A recently disclosed document, namely the notification of assessment from social care, made clear that there was relevant contact and again, last night, a statement was uploaded from the Priory from Amelia Parton, but also from Christopher Atherton, WITN0225002. That statement reveals that there were entries on Liquidlogic. It is astounding, bearing in mind the issues in relation to Section 117 obligations and duties, that that was not disclosed before yesterday.

But further still, that statement identifies a systemic issue in respect of NCC has recognised over time that its system in relation to the receipt of notices of assessments needed reform, and therefore has implemented changes to ensure that proper records are kept of notices of assessment. It is staggering that that was only provided yesterday.

The Amelia Parton statement, which again flags the relevant contact from a social worker is WITN0134002.

The third area where we say we'd ask for consideration of further hearings relates to the incompetent search of 165 Burford Road. Mr Moloney has already touched on an aspect of that disclosure, but we had submitted that PC Martin Tombs, PC Dalton,

PC Mosely, PC Aspers, Geoffrey Julias, Adam Cooper, Leigh Sanders and Alan Murphy should also answer questions in respect of the significant disclosure found in the bag and the bin at 165 Burford Road.

Madam Chair, it is significant that the statement of Vasper(?) was disclosed in tranche 2 to the Inquiry in September last year. That statement identified the exhibits that were disclosed last week.

I'm not going to take you to the matters already raised by Mr Moloney linked to the entries of thoughts linked to the composition and creation of explosives, but say this in relation to that matter: it has not been referenced at all in the SIO Sanders statements that have been provided, and further still, even if not relevant to the assessment and the significant issue for the bereaved, plainly, that entry as displayed on the screen, is of the most important significant to risk of harm to the public, and it is staggering that it was only disclosed last Friday.

That additional risk information about VC's plans and thoughts linked to making explosives raises significant concerns about public protection. That document should be immediately brought to the attention of VC's responsible clinician, social worker, the Ministry of Justice, the Secretary of State, and the

Parole Board, so that the assessments of risk that are taking place of VC consider the highly relevant and significant information as to risk.

Mr Moloney KC dealt with the sites where VC was researching and the reference to the Manchester Arena Inquiry. Madam Chair, you may have noted that the Theatre Royal, one of the venues where VC was researching, was exactly opposite where Sharon and Marcin were hit. We have submitted throughout this Inquiry that the addresses that VC visited on 13 June are highly significant. I won't repeat what has been said before about the note in the backpack, the attack being within the eyesight of Raleigh Park, visiting Middleton Road where a further attack was carried out, and then going to Brook Court.

But I ask also that you consider this additional information as part of the chronology, and please could it be disclosed -- sorry, displayed on the screen. WITN-- sorry, NGPF0014206, and page 120.

Again, on the timeline, this document appears to suggest that VC may be using an alternative name and receiving dental treatment in February of 2023, another aspect of the timeline that should have been investigated linked to that document.

I'd also ask that is displayed, please, NGPF0014204,

pages 39 to 45. Thank you.

Madam Chair, we have the original documents within the rucksack which show the disqualification of VC in April of 2022, and if the documents could be moved through, please.

They include the offences and if we continue, the -- what would happen in respect of if there was non-payment of the fine alongside the disqualification -- and if you could just go back one, please -- Madam Chair, you will see in the bulletpoints as well as seizure of assets there is reference to, if non-payment, a warrant for his arrest, as well as an increase in the fine.

And if we continue through those documents -- thank you -- Madam Chair, you will also see also the date of the April 2022, the 19th, is significant also on the timeline because it was two days later when VC went back to Raleigh Park looking for post and so again we ask, when you are considering the timeline, to consider this issue but also the fact that VC did not pay his fine, and there was the further issue as to the potential for a further warrant of arrest for non-payment of his fine. As of June 2023, VC had still not discharged the fine, payments, and we submit this is further relevant when you consider the Arvato incident, the checks that could have been made but also the warrant of arrest from

September of 2022 linked to PC Pritchard.

If we could just continue going through those documents, please.

But we also have evidence of the fact that VC, if we continue, did not return his licence either to DVLA. If you go to the next one, essentially we see the slip that was not returned. So again, further relevant documentation only just disclosed that were relevant to timeline.

Turning then briefly to data investigations, I've already touched upon that, but it is of concern to the survivors that they are no further forward in respect of that matter.

Last night, the statement of the Custody Sergeant Hennessy was disclosed, WITN0493002. Again, this statement raises further factual disputes between Sergeant Hennessy and Sergeant Swift in respect of VC's detention and discharge and release in April -- sorry, May 2020, and again, the further factual dispute that exists between Sergeant Hennessy as to -- and PC Swift. Essentially that statement highlights now:

"I disagree with PC Swift's evidence to the Inquiry in which he stated this was failing on my part and also suggest that the responsibility for VC's ultimate release was that of PC Swift." [As read]

A further conflict of evidence that exists now between two officers at Nottingham Police of central importance to the Feven incident that happened subsequently.

Turning then to the next topic, please, Madam Chair, namely the issue of Nottingham Police's involvement on the 13 June. I have already referenced in the submissions that we ask that you consider with care the examination of the events of 13 June, and in particular, the body-worn footage that exists of what greeted the officers as they arrived at the scene. It is only on viewing what VC did to Grace and Barney that the true extent of the seriousness, the brutality and sadistic nature of the attack, is highly relevant.

THE CHAIR: Well, I've seen that footage.

MS CARTWRIGHT: I'm very grateful.

Madam Chair, that's helpful because we submit that if you look at it through that lens, we would say it's clear that Officer Mather did not have full situational awareness of the significance of that incident and we ask you to consider with care the four pieces of top desk footage alongside the audio.

I've already highlighted that in the Nottingham Police's submission they submit that whilst there was much criticism of Nottingham Police concerning the

events of 13 June after VC's arrest, particularly of Chief Inspector Mather, those matters do not come within the Terms of Reference, it is said by Nottingham Police.

We submit that that is not the answer to how to explore the events of 13 June, because what took place subsequent to VC's arrest a little after 5.30 in the morning shows just how little Officer Mather knew or understood about the events that had occurred that morning. And I would ask you to consider that point alongside also the significance of this evidence, bearing in mind Operation Plato had been declared before the arrest, to two short pieces of footage, and I'd ask, please, for NGPF0008562R, to be played.

THE CHAIR: Have we seen these two? Because I think we saw some footage.

MS CARTWRIGHT: We did and, in fact, I actually think this piece of footage was played and so perhaps then just to remind you rather than taking time. This is footage a little after 6.30 in the morning, and is Officer Mather giving his understanding as to what happened, had happened that morning.

THE CHAIR: Yes.

MS CARTWRIGHT: And bearing in mind now this is several hours after the attack on Barney and Grace, and Ian, but also Sharon and Wayne, it gives a real understanding

about the lack of detail he is providing to the officers in his briefing to the firearms officers.

Madam Chair, if it won't assist you to play this point -- play it again, but again, we say that's highly relevant to the suggestion that when you look and analyse the events of 13 June you should stop at 5.30 in the morning after VC was arrested because we say the limited information that is detailed by Officer Mather reveals that when he gives the briefing to the officers, he does not reference Ian and Ian's location. He only refers to very brief information about the attack on Grace and Barney and adds no real clarity as to the incident on Milton Street.

Perhaps -- it's short, it could be played, please.

(Video footage was played)

MS CARTWRIGHT: Then that continues in the next piece of --

THE CHAIR: Can I just say, Ms Cartwright, that we've got some transcripts of this, haven't we?

MS CARTWRIGHT: I don't think we've formally got transcripts --

THE CHAIR: You've provided transcripts of it and I've seen it and I'm not sure we can really gain much in this kind of room rather than my watching that again when I -- (overspeaking) --

MS CARTWRIGHT: -- (overspeaking) -- then the reference to

VC as a 50-year old male. There is no reference to the incident with Ian. We say the footage that morning shows no real situational awareness about what had happened to Ian which may itself contribute to why Ian remained where he was for so long when one looks at this but also the later footage and again for your note, Madam Chair, it is then the later footage where there is an assessment from 28:23 onwards as to the number of fatalities and we would urge and ask you to watch the body language of Officer Mather, who shrugs his shoulders. There's a discussion then that the word two, maybe three, but back to two, but four road traffic collision injured, and we submit that shows plainly that the M/ETHANE messaging process, the situational awareness, was completely lacking even at 7.00 in the morning which we say is highly relevant to information and behaviour that happened after VC's arrest that cast light on the inadequacies of the command and control by Nottingham Police that morning.

THE CHAIR: Thank you.

MS CARTWRIGHT: So Madam Chair, can I then just take you forward, please, and I'm not going to take time essentially reading what is within the submissions, from page 23 onwards, we set out there our summary of the failings we submit occurred on that morning which are

failings to be seen in the context also of the recommendations that were made by the Manchester Arena Inquiry, how JESIP should work, M/ETHANE, and we've set out there that we submit there was an inadequate threat and risk assessment by Officer Mather. For actions which could and should have been taken, we submit there was a failure to grant a firearms authority in a timely manner, and again, Madam Chair, we refer you to the purpose of an ETHANE or a M/ETHANE message, that is for those in command to assess the exact location, the type of incident, the hazard, the access, the number of casualties, how many and in what condition they are in. But also in respect of the E for emergency service, it's how and how many emergency responder assets and personnel are required or are already at the scene.

And we would submit when you look at this incident from 4.00 in the morning from an ETHANE perspective, and in particular in light of the issue now of preventability that applies for Barney, we would submit that the decisions that were made that morning were sadly lacking but also the decision to utilise the armed response officers in the way they did, because in our submissions, we submit that there was no proper consideration given to how that exposed the city centre that day.

And you know, Madam Chair, from the Armed Response Vehicle Patrol Strategy, and the Armed Policing Strategic Threat and Risk Assessment, and again, we commend you to consider the unredacted versions of those documents, NGPF0007968 and 7970, Madam Chair, you know the exact location in the city centre where it was anticipated an armed response vehicle would be, it is in close proximity to where the attacks on Wayne and Sharon took place, and noting the gap between those attacks, we submit, had the assets been properly deployed that day, there was an opportunity to prevent the attacks upon Wayne and Sharon.

We reference the flawed working assumption that Officer Mather saw it as a robbery that had gone wrong, and we ask you, in considering that, Madam Chair, to review the recent disclosure that has been made in tranche 214 of relevant policies in respect of Operation Plato, namely NGPF0007437, and we would submit that the description there of "a marauding attack", much better fits what greeted the officers and those attending the scene, and that guidance both at paragraph 2.4 and 2.8 makes clear the definition of a marauding attack.

Thank you. Perhaps we can move to page 5.

And so we say when conducting the consideration of that attack, Officer Mather, if he'd had the appropriate

information about the sadistic and brutal nature of the attack, all of which was captured on CCTV and door camera footage, that within the range of considerations about what that attack was, it should have included, as detailed at 2.4:

"a marauding terror attack may take many forms ranging from a low sophistication attack, for example, a single suspect using a bladed article or vehicle to injure or kill." [As read]

And this policy also explains, as you can see at 2.8:

"It is also recognised that not all marauding attacks may be motivated by terrorism. The motivation may also include personal dissatisfaction with an employer, family, school." [As read]

So again, Madam Chair, we say within the range of factors considered, it was wholly erroneous to consider that it was a robbery gone wrong or a domestic incident, whereas even as early as shortly after 4.00 in the morning within the range of what could have happened at Ilkeston Road, it should have been within the threat and risk management as a potential when spinning the wheel of the national decision modelling, that this could be a marauding terror attack.

Madam Chair, we've also had disclosed in tranche 214

the M/ETHANE documentation but also the action cards that applied to the Ground Commander, and Madam Chair we say when you look at all of these documentation alongside also the criticisms we make as to the failure to coordinate the search for the suspect, the failure to properly utilise the armed response officers, the absence of a coordinated search strategy, the failure to update threat and risk assessments as the events unfolded, the inadequate and inaccurate ETHANE and M/ETHANE messages that are throughout the documentation, the inadequate briefing provided to the armed officers, the early ones, but the one just played, the failure to communicate Operation Plato declaration to the ground bronze commander, the lack of situational awareness and the failure to convey the nature of the attack, and the failure to ensure that information was shared across radio channels, Madam Chair, you will know that the monitoring of the airways that morning, we submit, failed badly, including in a significant way as to the self-deployment of PC Reynolds but his difficulty on the radio, because there was not proper airway control.

We submit also that the failure to maintain an armed response vehicle in the city centre had a direct causative effect for Wayne and Sharon. We raise the issues, as we've already highlighted, as to the

effective use and the failure to monitor CCTV, but also no proper analysis is in any of the threat and risk assessments as to the seven-minute gap between the two van attacks and the fact that during that seven minutes' time, VC drove his van passed Nottingham Police Station on two occasions and was captured performing manoeuvres going the wrong way down the streets, and we say you should analyse with care now the dispute between Nottingham City Council and Officer Mather which we submit essentially shows that both failed significantly that morning in the monitoring of CCTV.

We further raise the communication failures across talkgroups but significantly, the lack of preparedness for a Plato marauding terror attack incident.

Madam Chair, I won't repeat what we say at Terms of Reference 5, linked to the recommendations from the Manchester Arena Inquiry report, where we submit all of the learning as to issues that eventuated on 13 June are addressed within that report and we submit that is evidence of a wider failing to properly implement the learning from the Manchester Arena.

So Madam Chair, we commend to you all of the references and the submissions made in respect of the events of 13 June, but in respect of the recommendation building from what we say are the failures that took

place in Nottingham Police in training, and also in the operation of Operation Plato, we submit that you should make a recommendation that the Home Office should undertake or direct an audit to ensure that all police forces have undertaken training and have in place effective procedures that are fit for purpose to ensure that forces are able to respond to a spontaneous attack, a Plato incident, because we would submit that the evidence that is shown as to what occurred on 13 June 2023 show that Nottingham Police sadly failed in respect of their implementation of an Operation Plato that did not comply with JESIP, M/ETHANE, or the Plato procedures, action cards, declaration of zones, rendezvous point, but significantly, where is the evidence of communication with the Ambulance Service, which we say was relevant even before the major incident was declared, as to how Nottingham Police liaised with the Ambulance Service and the appropriate assets that could have been available to treat and deliver care to Grace and Barney.

But in particular, by utilising the armed response vehicles, all three of them then returned to base on the footage that's included within our submissions to essentially re-stock, leaving the city centre of Nottingham exposed when VC attacked the survivors.

Madam Chair, turning then to the concerns from the perspective of the forgotten victims. They are detailed from page 76 onwards in the submissions.

THE CHAIR: Yes.

MS CARTWRIGHT: But Madam Chair, you've heard all of the evidence as to the many occasions where the Inquiry evidence has shown that the survivors were forgotten. They were not engaged in investigations, they were not updated, or the inadequacies of the support that was provided to them.

Madam Chair, we go through in the submissions from page 76, the various aspects of the failings that occurred that you have explored in evidence, including the breaches of the Victim Code by Nottingham Police, the failures in respect of the allocation of Family Liaison Officers, the failure to include DC Johal in key meetings to provide key information, and Madam Chair, it does not need stating, but the significance of the injuries for both Wayne and Sharon meant that they needed a bespoke victim engagement, and we would submit that it was totally forgotten, the significance and scale of the impact of the attempted murder on them.

And we submit also that the closing submissions of the CPS in particular, essentially detail that their assessment is that there was good engagement with the

survivors. But Madam Chair, that was not the experience and is not the views of the survivors as to how the CPS engaged with them. It is suggested that there was, essentially, bespoke input with the survivors, but Madam Chair, we would submit that the timetable provided in the CPS submissions is simplistic and does not meet with the evidence you heard on those issues as to how HMCPS investigation, Mr Murphy, counsel, engaged with the victims.

We also have detailed the many examples where there was delayed provision of information to the survivors, failures in the communication methods, the failure to make reasonable adjustments for Wayne and Sharon and their particular needs. Many examples of the survivors being treated as secondary victims by the police, the language used describing them as "walking wounded", "road traffic collision victims", the insensitivity of no correspondence from Buckingham Palace, so the lack of thought given to them and the impact of that, but also the thoughtlessness regarding Sharon's property.

In terms of Terms of Reference 7, we give the detail as to the failures we submit in respect of the CPS's engagement with the Victim Code and the engagement with the victims.

We submit strongly that there were failures to

implement reasonable adjustments and special measures for the survivors. The CPS did not accommodate Wayne's brain injury in their communication with him. Mr Murphy did not appreciate how significant the cognitive impairment and impact of the attack was on Wayne. You heard Mr Khalil describing how he spoke slowly and carefully to Wayne in the less-than 15-minute meeting that took place after the hybrid order had been imposed on VC, a failure to ensure that the survivors understood the hybrid order that was imposed at the sentence.

I'm now at page 85, Madam Chair, and holding organisations to account under the Victim Code.

Claire Waxman, the Victims' Commissioner, agreed that Wayne and Sharon's basic rights under the Victims' Code were not delivered by the police or the CPS throughout the proceedings. The evidence has shown that the FLO system is fundamentally flawed. Nottingham Police failed to follow best practice in deploying only a sole FLO to three families, and excluded DC Johal from key updates. As a result from the outset, the surviving victims were forgotten.

The FLO system has been used by the CPS and other agencies to excuse their own failures in communication with the victims. As a result, we submit the CPS has failed to accept accountability for their own failures

in providing key information to the surviving victims at key stages of the investigation, prosecution, and sentencing hearing.

We therefore submit to you and your recommendation that an overhaul of the FLO system is required as recommended by Claire Waxman but in addition, the introduction of independent advocates or victim hubs needed to ensure that victims are properly delivered their rights under the Victim Code.

Claire Waxman detailed the following:

"And again, the frustration with this Victim Code that comes to me time and time again, from speaking to victims, is it feels quite meaningless, because if rights are not delivered and they were not delivered in these cases, what's the accountability? Who do we hold to account for failing to deliver basic victims' rights to victims in this country? Nothing, and that I have to say is an outstanding frustration of mine as Victim Commissioner." [As read]

In her submissions to the Ministry of Justice consultation on the new Victims' Code under recommendation 1, she encourages the Government to enforce a code compliance monitoring framework under the Victims and Prisoners Act.

I've already highlighted the role of Cindy Butts,

the independent public advocate, and Madam Chair, today we've had uploaded RLIT000128, which is essentially Cindy Butts' views about the extension of the IPA scheme but also that could take place alongside increased funding, in terms of exceptionality for cases, we submit, like Wayne's and Sharon's, where they are victims of attempted murder with particular features of exceptionality linked to their injuries where there can be an expansion of the scheme, and Madam Chair, you see there the publication following the review of the UK Government's response to the death of Harry Dunn and the recommendation that was made as to the consultation that should take place for widening the role of the independent public advocate.

And we submit that this should be a recommendation you consider in a way that attributes a Birkett-miller change for victims that allows a bespoke service to enable them to be properly engaged with.

And Madam Chair, I won't take you to the document but separately, INQY00029, there is essentially the current remit of the IPA's role but we submit there is an increased role for the IPA that you can recommend consultation but also funding to expand in exceptional circumstances the role as indicated by this document, for the IPA. And in particular, in the name of

Sharon Miller and Wayne Birkett, they would ask that that change comes in as something proportionate and measurable that they believe would make a real difference, having an Independent Public Advocate that could essentially advocate on their behalf and ensure that state agencies do not forget them and have the appropriate scrutiny in respect of them.

Madam Chair, we would submit, when one looks at the public interest factors contained within the guidance, this is a key area for where victims of attempted murder by mental health patients where public interest factors should be engaged, victims who are not killed but are left with life-changing injuries do not have the scrutiny of an inquest but the IPA can assist in ensuring the scrutiny and accountability of victims such as Wayne and Sharon, who have to live the rest of their life with the life-changing injuries inflicted on them on 13 June.

So Madam Chair, we commend to you consideration of expanding or recommending the expansion of the role of the Independent Public Advocate, but also note the CPS themselves in their submission indicating an expanded role for an equivalent IDVA scheme, you have had reference to the Independent Domestic Violence Advisers or the Independent Advisers for Sexual Offences, or for

stalking.

We would submit, similarly, that there is an enhanced role for an independent advocate for victims of grave injuries caused by mental health defendants, and we would submit that that should be part of the legacy not just for Wayne and Sharon and their loved ones, but also with a look-back as to what happened for Feven herself, a significant victim of a grave injury who has had no accountability for the lack of investigation and accountability for the significant injuries inflicted upon her.

Madam Chair, then finally two final matters on behalf of the survivors. In our recommendation 87, we ask that you give consideration to accountability and enforcement of Inquiry recommendations. We submit that public inquiries should be given the power to monitor their own recommendations to ensure implementation of identified changes. Too many recommendations are accepted but then not implemented following public inquiries and we would submit the failures in respect of the implementation of the Manchester Arena Inquiry's recommendation by Nottingham Police are just one example of the failure for those recommendations to be implemented nationally.

Bereaved families and survivors should not have to

carry the burden of chasing progress of recommendations, and we would submit that there is a clear public interest in recommending a time now for you to be able to monitor and ensure enforceability of your recommendations in due course. And so we commend that recommendation to you also, Madam Chair as something that we believe makes a measurable change.

Finally, in our written recommendations, we also comment upon the matter Mr Moloney KC has touched upon, namely the -- as changes to Section 2 and Section 3 relating to risk of harm. We were grateful for the evidence Mr Vineall gave to the Inquiry, but also the Department of Health and Social Care's submissions, but again, we would submit that there is a role you have to ensure the clearest foot on the ball linked to the changes in respect of risk of harm, and we would submit that it is dependent upon all risk information known about mental health patients being shared, and if ever there was an example that has been typified from Friday of last week as to state agents failing to identify key and significant information as to risk, namely VC's thoughts around creating an explosive, that has been completely missed in an investigation, we would submit there are real concerns about the ability for all relevant risk information to be fed into this heightened

test and we therefore commend to you also our recommendations linked to the Mental Health Act and the Code of Practice as detailed within our submissions.

So Madam Chair, those are the highlights of our submission to you, and we thank you for the opportunity to make those submissions to you, but again, thank you and your Inquiry for the way you've enabled these victims to provide a pen portrait. We thank Ms Langdale for the time and care she took with ensuring that the victim-survivors were able to give their best evidence to this Inquiry, and we thank you for adopting a trauma informed approach which has enabled the survivors to fully participate in your Inquiry.

THE CHAIR: Well, thank you, Ms Cartwright, and obviously the survivors as Nottingham people, have represented the people of Nottingham, along with the Coates family, in their attempts through their legal teams, to improve services in Nottingham. So I'm sure that all those who live there will be very grateful to them for the particular effort they've made, bearing in mind the injuries they've suffered.

Can I just raise one point with you. And it is a small point but it's one which I think you make, which is about Police Constable Dean Reynolds and the pursuit of VC.

MS CARTWRIGHT: Yes.

THE CHAIR: Now, what I'm going to ask you, is, bearing in mind that VC deliberately swerved and hit Wayne, what do you say was any different? Just ignore for the moment the fact that there is a police car behind for the moment. What was different about the way in which he approached Sharon?

MS CARTWRIGHT: So, first of all, he self-deployed and --

THE CHAIR: No, I'm talking about VC.

MS CARTWRIGHT: Oh, VC, in terms of the impact of it. Well, you have the evidence of Sharon Miller herself that as Dean --

THE CHAIR: I can understand why she may think that, obviously, because the car is there.

MS CARTWRIGHT: Yes.

THE CHAIR: But in reality, what is the difference between the way that VC behaved in relation to swerving to hit Wayne, and the way he behaved in swerving to hit Sharon and Marcin?

MS CARTWRIGHT: Because in this scenario he had a police car in pursuit of him and so --

THE CHAIR: The point I'm making is: ignore the police car, what do we look at on the video that we have, which indicates that it made a difference?

MS CARTWRIGHT: Well, I would ask you to consider the

evidence of Sharon Miller herself as to what she saw and heard that day, but also we would submit that when Officer Reynolds continued in pursuit as he turned right on that final bit, that's where he shouldn't have continued. He was not given instructions to pursue. The information in the IOPC report is fundamentally wrong on that.

THE CHAIR: I have all of those points but I'm looking at it adjectively whether in fact there was any difference.

MS CARTWRIGHT: Well, I think if you look how he proceeded along the roads before he went on to Upper Parliament Street, we would say there is evidence of his driving changing when Dean Reynolds went behind his vehicle, particularly as he turned right and went up the first road as he's captured in the glass of the buildings and then particularly how he speeded up and then swerved into Sharon Miller on to the pavement area. So we'd say that is different.

So Wayne wasn't actually on the pavement, he was in the road when he swerved at him, but he's deliberately, essentially, knocked over members of the public to effect an escape away from Officer Reynolds at a time when we say he should not have been in pursuit, he had not that the advanced driving, neither had he been given the authority of anyone in command to continue his

pursuit.

THE CHAIR: Thank you.

MS CARTWRIGHT: Thank you.

THE CHAIR: That was the only point that I wanted to raise other than those that you've already set out in your submissions, but thank you very much.

MS CARTWRIGHT: Thank you. And thank you for giving us the opportunity to make those submissions to you.

THE CHAIR: What we'll do now is have a 10-minute break before we start your submissions, Mr Straw. So we'll start again at 3.05. Thank you.

(2.54 pm)

(A short break)

(3.05 pm)

CLOSING SUBMISSIONS ON BEHALF VC'S FAMILY GROUP BY MR STRAW KC

THE CHAIR: Yes, Mr Straw.

MR STRAW: Good afternoon, Chair.

VC's family would like to pay tribute to the approach taken to this Inquiry by you, Chair, and by the Inquiry Legal Team.

The investigation has been far reaching and thorough. Just one example is the highly informative analysis in the Inquiry Legal Team's homicide review.

The focus of this Inquiry should of course be on the

victims. In order to understand how these horrific attacks could have been prevented and how to avoid similar harm in future, it's essential to properly understand what they were the victim of.

And the underlying cause of these attacks was schizophrenia and the failure to properly treat and manage it. VC's risk to others was exclusively associated with the relapse into acute psychosis. His relapse would probably have been prevented if, from an early stage, he'd received a full and assertive package of NICE-compliant medication, treatment and management. And there was a manifest failure to do that.

Whilst VC's family's written submissions contain criticisms of individuals, their overriding concern is systemic change. Widespread systemic flaws were at the root of this tragedy and as long as they remain in place will be at the root of many future tragedies.

Chair, you have the benefit of many constructive suggestions for recommendations from a very broad range of expertise in both the written submissions and also from many of the witnesses.

THE CHAIR: Yes.

MR STRAW: For VC's family it is of the first importance that with the benefit of that expertise, you set out far-reaching and comprehensive recommendations for

systemic change.

In these submissions I would like to start with the background, then consider the nature of VC's schizophrenia, then the events of 13 June 2023, individual and then systemic failures by the health services and recommendations for change, and finally, multi-agency working and information sharing.

So the background. Before VC suffered schizophrenia he was perfectly ordinarily. During his childhood he was well behaved and well liked. There are a couple of minor incidents such as what might be described as bullying or racism, but nothing unexpected or out of the ordinary.

The Inquiry has obtained extensive evidence about VC's behaviour prior to 2020 from his schools, colleges, jobs, GPs, and others, but other than possible pre-morbid signs of schizophrenia, which I'll come to, the evidence contained nothing to suggest he was violent before he became unwell. To the contrary, as Ms Langdale King's Counsel explained, he was described by teachers as a model student, never sanctioned for poor behaviour. He was described by other students as always charming. VC's employers from 2009 until prior to his illness have given statements and there's no evidence of concerns about him in that period.

His GP's surgery from 2007 to 2017 similarly had no concerns about him and Dr Shoilekova was right to state that:

"Before becoming ill, he was a kind and caring person who would not be physically violent."

There have been suggestions that this comprehensive evidence showing that before this illness he didn't commit misconduct, is undermined by two matters. The first matter is a reference to an animal in the statement of Tessa Paige Smith, a neighbour from 2014 to 2015, but all she says is that another housemate told her that he found that the bath was full of soil and within the soil there appeared to be the spine of an animal. She made clear that she could not say who put the soil or the spine in the bath, there was no witness to it. This was shared accommodation and there were often many people coming and going, including friends and other visitors. It could have been anyone, and there was no evidence it was VC.

Professor Blackwood reviewed the statement of Ms Paige Smith and indicated that, at most, the comments there, for example about VC being awake late at night, raised possible pre-morbid symptoms of the schizophrenia but they didn't point to any other problems of personality or otherwise.

The second matter is a page in one of VC's notebooks. Could we have this on screen, please, it's NGPF0011499. Page 3, please.

So this is undated and it's unclear when it was written, but on page 3 it says at the top there "Mea culpa illegal actions," there's a space and then "2013/2014, defied lockdown".

Then he goes on:

"Often one attributes little value to the moral high ground because it can ... buy anyone power however we respect for two reasons [arrow] (unclear) reverence because of the cost." [As read]

Now, in our submission, Chair, it's difficult to take anything concrete from this. It comes amid the obscure ramblings of a schizophrenic man. He wrote many other pages of notes and made other comments that are equally hard to interpret, for example, in NGPF0011500T, he wrote "Valdo must die."

Does this show he was suicidal?

VC had close contact with his family through his whole childhood, and -- thank you, that can come down now, thank you very much.

VC had close contact with his family through his whole childhood and early adulthood until he moved to Wales, aged 24, in 2015. They too observed him to be

a peaceful and non-violent son or brother. It's not correct to say that VC was effectively missing from his family from 2015 to 2017 or that his contact was extremely limited prior to the Covid pandemic.

As Celeste makes clear in her statement, after VC left Wales and moved to England, she frequently spoke to him on the phone. Although he lived a long way away he still came home for special occasions. Those special occasions included but were not limited to Christmas. He didn't go home for one Christmas in 2015 but that was because he couldn't get time off work.

Reference has been made to Miss Doherty's report of a relatively short call that she had with Celeste about VC's life history on 22 August 2023. There were apparently some communication problems between the two of them, but this is unsurprising, given that this was a hugely distressing time for Celeste, and indeed, Ms Doherty was the first person from any state institution, other than the police, that she'd spoken to since the attacks. Ms Doherty did not obtain a full and accurate account of VC's life history, for example in respect of the detail of his bullying, but there's no criticism of her in those circumstances.

VC's personality and character transformed after he became mentally unwell. The first time VC's family

became alerted to this is summarised in the transcription Elias produced for Dr Seedat of communications between Elias and VC in early 2020. I'll refer to this as Elias's transcription.

Elias was asked what he understood VC to be saying. In considering his answers, we submit that two points are important: firstly, context is critical. Anyone reading the communications in the context of knowing in hindsight about VC's terrible crimes will naturally interpret them as malign, but Elias was reading them in an entirely different context. He was speaking to his brother who he loved, who he had never known to be violent and who he knew, in his words, to be a "very calm and peaceful person".

It's important to stand in Elias's shoes and ask: "What would I think if my own brother started speaking like this?"

Secondly, it's easy now to pick out single lines in the messages, to abstract and isolate them from the context, and to take time and focus on the meaning of those isolated words and what they may be, but Elias was facing a barrage of bizarre, jumbled and complex information. The sudden onset of VC's psychotic breakdown was for Elias highly alarming and caused him real distress.

Elias wasn't a psychiatrist with the expertise and responsibility to come up with a diagnosis or to provide treatment to VC. He had no understanding of VC's illness. And in that context, it is understandable that Elias was, I quote "so confused and thrown by it all that I had no idea what was going on."

But Elias explained as best he could what he understood from the messages. I'll pick just two examples. First, there are a series of messages from 12 April 2020 in which VC said, "Wanted to hurt ... permanently ... it was so overwhelming so at some point something in me begged take it away, nothing else, just take it away."

Elias explained that he thought VC wanted to hurt himself. Elias's reasons for thinking that included the words themselves, such as "something in me begged take it away, nothing else, just take it away." But Elias's reasons also included that up until this point he'd never known VC to be a violent person, only an ordinary, peaceful brother.

The second example is the "red rum" comment. It's really important to take this in its full context. It fell within a barrage of ostensibly bizarre and incoherent thoughts. It fell within VC's response to a comment made by Elias about Jesus. The "red rum"

sentence was immediately followed by "not only do I not care, I feel appreciation. I want people to know I love them and I want them -- to be there for them."

Elias thought the conversation may have been about the experience of praying. He wasn't sure if he noticed the "red rum" at the time but did not associate it with murder. It's notable that a number of people who read the transcript did not initially ascribe any significance to those words, including Nottingham Police, the CPS, and all of the Core Participants in their opening submissions.

Of course, the question of what the psychiatrists, who are experts in schizophrenia, and were fully aware of VC's recent acts, should that have taken from those messages is different from what Elias understood VC to be saying.

VC has been definitively diagnosed with schizophrenia by a number of experts who collectively have had a great deal of time and information to assess him. It's important to note that schizophrenia is, once established, a lifelong condition. It doesn't just go away. The family were not aware of the schizophrenia diagnosis until after 13 June 2023. They've never claimed that they didn't know VC suffered from a serious mental illness; their complaint is that they were not

told that VC had been diagnosed with schizophrenia. Knowing about schizophrenia was of real importance because of the particular symptoms and features of that illness. For example, one important feature of schizophrenia is that if it's not properly treated and managed, it's associated with an increased risk of violence.

A summary of the contact between VC and his family from May 2020 onwards is in our written submissions, but just in short overview, after VC went into hospital in May 2020, Celeste visited him a number of times. She spoke to him roughly daily until October 2020. He then cut off contact with her for a month or so but they resumed speaking by phone in November.

A Covid lockdown intervened but they then saw each other a few times in the first half of 2021, lastly on 11 July 2021.

Celeste was away from the country when VC was taken into hospital. Around this time VC began to disengage from his family. He refused consent for medical staff to tell Celeste anything about his contact with mental health services, Celeste tried to visit him but nobody at the hospital enabled her to do so. VC also himself began to refuse to disclose any information about his condition or whereabouts to his family. He declined to

tell Celeste his address. This was the main reason she didn't visit him after that.

She did travel to Nottingham to try to seek him in out but he refused to let her see him. When she asked how he was, he would just say, "I'm fine." And by 2022, he stopped telling her anything about his condition. He completely shut her out.

In hindsight, it appears that this maybe because he was suffering paranoid delusions that if he did have contact with his family, they would be at risk.

Clearly after VC was struck down with schizophrenia, then when he was relapsing into acute psychosis, he was a serious risk of violence to others. After he was effectively abandoned by the mental health services in early 2022, unmedicated in the community, he evidently spiralled into a highly disturbed and dangerous state. This included assaults on his co-workers, purchasing knives, looking up violent information online, as evidenced in his notes and writings from that time, and then ultimately the horrific attacks on 13 June 2023.

But as explained above, there's no evidence that he was violent or said words which might be interpreted as misogynist or he was otherwise badly behaved before becoming ill. There's extensive evidence that he was not.

VC exhibited classic symptoms of schizophrenia from an early stage of his illness. They included persistent delusions and hallucinations, which, when he was relapsing, led him to commit those aggressive and violent acts.

It's clear he genuinely believe those experiences were real. For example, he became tearful when told on 24 May 2020 that his mother was okay and was perplexed on 5 June 2020 when shown there was no one in the cupboard from which he heard a woman screaming. His delusions were severe and distressing. The Mental Health Review Tribunal on 24 September 2021 concluded that VC's delusions were sufficiently severe and distressing so as to cause him to seriously assault PC Pritchard.

His lack of insight, that is the genuine belief that his delusions were real, was described by Dr Shoilekova and Professor Blackwood as an integral feature of his illness. His belief that he was perfectly well, was itself a symptom of schizophrenia.

Another integral feature was his delusion that medical professionals were conspiring against him to use psychotronic harassments to insert voice experiences into his brain. He believed he was at risk from them and would be at risk if he engaged with them.

Those two symptoms of VC's schizophrenia drove him to stop taking medication, to disengage from medical staff and to try to mask his symptoms from them. This is common in people suffering from this illness. Thus, as Professor Blackwood and Dr Ahmed explained, VC's non-compliance with medication, his disengagement and his lying about his symptoms and medication weren't culpable decisions by a mentally capacitous individual. Rather, they were determined by the integral features of the schizophrenia.

In coming to that conclusion -- I'm sorry. Although VC was intelligent, and so his masking was sophisticated and ostensibly devious, this does not get away from the fact that, as the experts concluded, the masking was driven by his illness.

Chair, it appears that VC's schizophrenia changed as time went on. For example, at the beginning, he at times exhibited some insight and he reported that his decision to stop medication after the first admission, June 2020, was because he felt it interfered with his studies. But as time went on, his insight decreased. He became more and more convinced that the hallucinations were real and increasingly paranoid that medical staff were part of the conspiracy against him. His refusal of medication became ever more driven by his

illness.

Another aspect of VC's schizophrenia, which was critically important, was that he was only at risk of violence to other people when he relapsed. As the Trust's submissions note, this was the consensus view of the treating clinicians. It was the conclusion, among others, of the CPTC experts, Dr Ahmed, Professor Blackwood, Dr Seedat, the Mental Health Review Tribunal, and Dr Shoilekova.

But when he relapsed, the risk of harm was serious and this meant that assertive treatment and management of his psychosis was of great importance in order to protect the public from serious injury.

The key experts, so Professor Blackwood, Dr Latham, and Dr Mirvis, decided that VC's offending was attributable to schizophrenia and that he was mentally unwell at the time of the offences. The evidence to support that conclusion was compelling. What VC told the psychiatrists in late 2023 was only one element of that evidence. It was triangulated by a wide range of other sources, and those include the following: Elias's transcript of the communications he had with VC in early 2020; the numerous reports in the extensive medical records between May 2020 and August 2022 by a wide range of clinicians and by the tribunal. This wealth of

information was consistent with the account VC gave in May 2023, and we submit demonstrated VC suffered from a typical case of schizophrenia for years.

Although during 2022, VC sought to disguise his symptoms from medics, to a competent psychiatrist taking a longitudinal view, there remained a considerable number of indications that he continued to suffer psychotic symptoms. We set these out in our written submissions but just three examples are as follows: first, the incident on 15 January 2022 when, after assaulting Christopher, VC was described as "acting strangely" and he refused to allow students to leave the flat.

This was preceded by him entering a flatmate's bedroom in the middle of the night in response to hallucinations that he suffered that someone was screaming. This is a clear warning sign of psychotic relapse, given that VC had done a similar thing several times before in the midst of relapses.

A second example is the IPT complaints VC made on 21 and 22 May 2022; and a third example is the zip file that he sent to his parents at Christmas 2022. These all make clear that he remained psychotic.

Further triangulation for the experts' views came from the content of VC's call to Elias at 7.09 pm on

12 June 2023. This demonstrated that VC continued to experience the same sort of schizophrenic delusions that he'd been suffering consistently since early 2020. After being taken into police custody on 13 June, VC sought to mask his symptoms from police officers, but there were still a number of signs that, to a trained psychiatrist, would demonstrate that he was psychotic.

Indeed, several professionals described him as appearing as mentally unwell, even in the first couple of days of detention.

Then finally, Dr Mirvis has had the opportunity to closely observe and assess VC for an extended period and on the basis of VC's behaviour and presentation, he is confident in his opinion that VC's offending was due to his schizophrenia.

Thus, as Professor Blackwood and Dr Latham explained, their opinions were founded on comprehensive evidence, fortified by years of psychiatric investigations pre-dating and then post-dating the offence.

There have been suggestions that the experts did not consider certain information, for example, at the time of writing his original opinion, Professor Blackwood had not seen the Mental Health Review Tribunal's notes or the videos pertaining to mass shooting events. He

should, of course, have received all relevant information at the time but it would have made no difference to his opinions.

Professor Blackwood's attention was drawn to missing pieces of information, both in oral evidence and in written correspondence subsequently. He said the information supported his view that VC's schizophrenia caused him to try to mask his symptoms in compliance and that his illness latterly led him to entertain murderous intentions. And Professor Blackwood accepted he could have asked further questions of VC, but he said none of this would have made any difference to his ultimate opinions. This did not undermine or alter his conclusions that VC's offending was entirely attributable to his schizophrenia.

Professor Blackwood was first contacted about VC's case on 14 June 2023, when he accepted instructions to provide a psychiatric report. He was provided with extensive records and videos, he made various separate requests for further information, and was provided with it, as he describes in his witness statement at paragraphs 7 to 21. He plainly studied this mass of information with conspicuous care. He finally interviewed VC on 14 November 2023 for no less than five hours and by then he had had a long time, months,

to digest the extensive records and to reflect on what his opinion would be.

We respectfully suggest that there can be no suggestion that when he came to give his view of diminished responsibility to Mr Murphy on the evening of 14 November, he had not had enough time to give the case careful thought.

Turning to the horrific events of 13 June 2023. The survivors suggest that there was a failure by VC's family to contact the police or mental health services after the 4.52 am call between VC and Elias, and they suggest that this is because the family were aware of VC's dark thoughts from Elias's May 2020 transcription. We assume the survivors aren't here referring to Celeste, given that she didn't read that transcription and did not herself speak to VC on 12 to 13 June 2023.

As to Elias, I've touched upon his understanding of the communications in his transcription. He found the barrage of bizarre, jumbled and complex information VC presented him with confusing and unclear. He did not interpret this as demonstrating that VC was at risk of violently attacking someone, in part because of the contents and in part because of the context, as I've already explained.

On 12 June Elias spoke to VC by phone. What VC

said, his delusional beliefs about Government monitoring, mirrored what he had been saying to Elias many, many times over the previous three and a quarter years. The family had repeatedly reported to mental health services similar things that VC had said about his delusions of Government monitoring, but the message they got back from those mental health professionals was that VC was fine, there's nothing to worry about.

Over time, this discouraged the family from reporting their concerns.

On 12 June, VC's manner was also significant to Elias. He sounded calm and coherent. He did not exhibit the sort of disordered or agitated behaviour that Elias had associated with previous relapses.

Then on 13 June, at 4.52 am, in the phone call between the two brothers for about a minute, Elias was asleep and had been woken up. He was concerned but confused by what VC said. His interpretation at this time, and I quote was:

"I was a little bit confused after a while in terms of, you know, him saying it's already done, and me thinking maybe he took something. Maybe. Maybe it's something else, and not really knowing how to square that. But yeah, I was just worried in general and trying to figure out what happened."

Elias did take action in response which reflected his concerns. So he sent a series of messages to VC, he tried to open the zip file but it was corrupted. He called VC a number of times but got no response. He called Celeste. He Googled Coventry police station and considered filling in a missing person form but it said it shouldn't be used where, as here, there was contact with the missing person within the last 24 hours. Also, Elias didn't know where VC was so he couldn't ask the police to go and look for him.

The survivors suggest that the clinical records do not support Elias's suggestion that he feared VC may have harmed himself. If by this, the survivors mean that Elias could have been expected to tell the clinical team about his fear, then we respectfully submit that that's misplaced. Firstly, Elias felt they should have recognised that VC may have suicidal ideation since the transcript, Elias's transcript, contained words to that effect. For example, VC's comment "Something in me begged take it away."

But more importantly, Elias barely spoke to the clinical team. Celeste was the family's main point of contact. The clinical team never asked Elias for his views on VC's mental state. When he provided his transcript in May 2020 he gave them the raw, underlying

communications without the interpretation because he wanted to see what the expert psychiatrists thought about it.

He heard nothing back from them so he assumed that his input wasn't helpful.

If the survivors rely on the fact that the clinicians themselves did not conclude VC was suicidal, again, in our respectful submission, that's of little relevance to Elias's perspective. Elias had little understanding of VC's clinical history because he was provided with very little information from the clinicians. A central complaint that we have is that the clinical services failed to give Elias or the family adequate information about VC's condition, clinical history, and risk. Elias had to make his own uninformed non-professional judgement of VC's behaviour, and to decide what action to take, based on the ambiguous and brief words that VC uttered on 13 June 2023.

Those words didn't leave Elias to conclude that VC had just violently attacked someone and we submit that he shouldn't be criticised for his interpretation and the action that he took.

Chair, it has been suggested in the written submissions that Celeste said that the family did not understand that VC presented a risk of serious violence

to members of the public. That's not what Celeste said. Rather, her evidence was that she understood, from the incidents in 2020 and 2021, that VC posed a risk to others, but in the context of him reacting to voices or paranoid delusions.

She thought he was a risk when responding to his delusions rather than a risk of randomly attacking someone. But it is important to remember that Celeste was not made aware of key information about the extent or seriousness of that risk. No one from the clinical team ever explained to Celeste what VC's risk was assessed to be. Further, from autumn 2021 when he withdrew consent to share information with his family, no one told VC's family anything substantive about his illness.

By June 2023, nearly two years later, VC's family had no basis for knowing what his illness entailed or what risk he posed to members of the public.

Our written submissions identify a number of failings by individuals involved in the health services. At this point I will just summarise a few key points. First, there were a number of failures to communicate with VC's family. VC's family were not told important information about his condition, the risks he was said to pose, and his treatment and discharge.

There were repeated failures to involve VC's family properly in his care. For example, there were a number of occasions when Celeste raised her concerns about VC but these weren't properly responded to. In response to her concerns, Celeste was given the repeated impression that there was nothing to worry about.

An example of this is the 29 May 2021 call that Celeste made to the health services when she said she believed VC was becoming unwell. The response, again, was that he is fine. She communicated again about this with Ms Birtles on 14 and 17 June 2021 and, again, was told VC has been assessed and they thought he was okay.

In fact he was far from fine. We know now that, on 31 May 2021, he had attended Thames House and on 5 July 2021, he assaulted Sebastian. A proper assessment or a second opinion may well have recognised that he was relapsing.

The failure to respond to VC's family properly had two consequences. First, it meant that VC was not provided with assessment, care and treatment that he needed. Second, the fact that when they raised their concerns, the family were repeatedly given the message that nothing was wrong, discouraged them from telling the services about VC's presentation as time went on.

An example of that is VC's trip to his family home

on 11 July 2021, shortly after the assault on Sebastian on 5 July. He reiterated the same sort of paranoid delusions that he'd been expressing repeatedly to his family since spring 2020 and which Celeste had repeatedly raised with the Trust. As she explained in her evidence, she didn't tell the Trust about this on that occasion, 11 July 2021, and that was in part because she had repeatedly told them about similar things he had said in the past and the Trust had said he was well. Indeed, that had happened only a few weeks before, on 17 June, as I've just mentioned.

In that context, it's, we submit, completely understandable that she felt there was no point in doing it yet again. VC's family had no psychiatric expertise, they cannot be expected to gainsay the advice they got from medical professionals.

Another reason Celeste didn't contact the Trust on this occasion was that there was something that had particularly concerned her about VC's mental state previously was when his speech and thoughts were disordered. That was the case on 29 May, for example. But on 11 July 2021, when VC visited her, his speech and thoughts weren't disordered and he sounded calm and coherent.

There were also failures to consult VC's family in

respect of significant decisions such as the discharge from the third and fourth admission to hospital and discharge to his GP. This sort of support was provided to VC's family to help them cope with their loved one being struck down with this severe condition. The Triangle of Care principles weren't respected.

The second area of individual failings is that there was a failure to properly assess VC's capacity to accept oral or depot medication. There was also a failure to properly assess his capacity to refuse consent to his medical information being shared with his family. This was important. Had the health services kept Celeste better informed after September 2021 this would have enabled her to continue to play a central role in VC's care, but instead she was left in the dark about his illness and risk.

The third area of individual failings is during his third admission when he was detained under Section 3 of the Mental Health Act, VC should have been placed on a Community Treatment Order with a condition that he take depot antipsychotic medication. He should have been detained under Section 3MHA during his fourth admission and then placed on a Community Treatment Order with the condition that he take depot.

If necessary, the depot should have commenced whilst

he was in hospital.

Dr Ahmed was right to conclude in this context that inappropriate emphasis was placed on VC's autonomy. By those third and fourth admissions it was evident that the reassurances that he was giving to inpatient teams that he was going to adhere to medication in the community, that those weren't reliable, based on a more longitudinal view of his presentation.

Had depot been administered to VC, he would have been properly medicated. This was therefore a really important failing because there's cogent evidence that antipsychotics are effective in preventing violence. They have around a 63% reduction in violent outcomes. Similarly, a CTO has obvious benefits. If VC failed to comply with the depot condition, he could have been recalled to hospital, pursuant to Section 17(e) of the Mental Health Act, and there's every reason to think this would have motivated him to accept the depot, since it was clear that he would take medication to avoid being in hospital.

Fourth area, there was a failure to provide a robust and assertive package of care and monitoring in the community. This should have included the appropriate care and treatment for first-episode psychosis as required by NICE Guidelines, beginning within two weeks

of discharge from his first admission, June 2020.

That package was never properly implemented. No CBT was provided to VC in the community at all, yet he was open to it for most of 2020. Psychoeducation was provided only once. It should have been much more frequent. Monitoring by Mr Carter was pretty hopeless.

Had a robust and assertive package of care been provided from an early stage, together with proper medication, that had every chance of stabilising VC and removing his risk to others. Professor Appleby explained that, for patients with schizophrenia it's exceptionally rare for patient homicide to occur without comorbidity or problems in delivering standard care.

Fifth area, Chair, we submit that VC should have been detained in hospital for longer and should have been provided with assertive psychotherapeutic interventions to improve his insights. The Priory was particularly inadequate, largely leaving him to his own devices.

Sixth, risk assessment was flawed in a number of respects. There was a failure to take a longitudinal view, to identify VC's relapse warning signs.

The history of his relapses demonstrated that those signs included not taking medication, disengagement, being especially guarded and suspicious, trespass, and

other strange or unusual behaviour. But those simply weren't listed and set out in his records.

Seventh, there was a failure to recognise signs of relapse and respond appropriately in 2022. By August 2022, all of the relapse warning signs that I've just mentioned were present. A competent psychiatrist, taking a longitudinal view, should have recognised that there was every reason to think that VC was relapsing into acute psychosis at that point. He should have been assessed with consideration of detention in hospital.

Instead, the opposite occurred: he was discharged to his GP. This was inexplicable and disastrous. The team led by Dr Lloyd took a slapdash and reckless approach to the discharge of a schizophrenic patient who was highly likely to be relapsing and therefore to pose a serious risk to members of the public.

The evidence that management put pressure on staff to discharge high risk patients like VC on the ground of non-engagement is of huge concern.

There were a number of potential means of finding VC as set out in the Do Not Attend policy and one of them was just to ask the police. There's every reason to think the police would have helped, not least because on 24 August 2022 they obtained a summons for VC to appear before a court for the assault on PC Pritchard.

Turning, Chair, to the systems. Many of the problems brought to light by this case are founded on inadequate resources. It was clear from many of the witnesses at every level that resources for mental health services are far too low. This has an adverse impact on the care and management of potentially high-risk patients like VC. It's dangerous, it increases the risk that those patients will kill or cause serious harm to the public and themselves.

The lack of resources has caused dangerous workforce shortages. There's a huge deficit in mental health nurses, particularly experienced nurses. EIP staff, including CCOs had caseloads well above the safe level, causing a serious risk to patient safety. Mr Carter said his high caseload undermined his management of VC and was a reason why he did not take more steps to try to find VC in August 2022.

From July 2021, the only psychiatrist for the EIP team was Dr Lloyd. She had 12 hours per week for 150 patients. Other psychiatrists had an even worse ratio.

Hospitals did not have appropriate psychological staff which was one reason why psychoeducation and CBT was not provided to VC in hospital. Similarly, in the community, there was no clinical psychologist and only one CBT therapist for the whole of the city and county

teams. There should have been sufficient therapists in place well before 2019 when the NICE Guidelines on EIP were established, but all psychology posts remained vacant at the time of the 2024 CQC review.

And then lastly on this topic, there were insufficient inpatient beds in psychiatric hospitals. This can obstruct access to hospital for patients who need it, increasing the risk of harm to public and patients.

Chair, we submit that to tackle this there should be an increase in resources for Mental Health Services generally, it should be ring-fenced. There should be national guidelines on minimum staffing levels for relevant roles, including in EIP and Assertive Outreach teams, for psychiatrists, nurses, CCOs and psychologists. The minimum staffing levels should be resource linked, that is ringfenced resources should be provided, funded by the Department of Health and Social Care, to ensure those staff can be employed.

Measures such as those recommended by Ms O'Brien should be implemented to aid recruitment.

A fundamental reason to increase resources for mental health care is that this will reduce harm, harm to the public from patients who are dangerous and harm to the patients themselves because their illness is

poorly treated, or because they harm themselves.

But there's also good evidence, including from Professor Fazel, that it's cost effective to properly fund mental health care, costs are fully offset by savings elsewhere. And it would have a positive impact on productivity in the economy.

Other systemic problems included the following: there's systemic failures to properly assess capacity. The family agree with Mr Ruck Keene KC that there should be a legal duty on professionals to consider capacity where there's reason to do so. Ms Hull accepted that the failure to involve families and carers properly was a systemic and chronic problem. It's a national issue. For example, Professor Lade Smith said that the number of families who had not been told what illness their relative suffered from was striking.

We welcome the fact that the Trust now provides mandatory training on the Triangle of Care but we submit this should be a national requirement. There should also be mandatory national training and guidelines for mental health services requiring the following: first, relevant information such as diagnosis, to be passed on to the family and carer where lawful; second, the family or carer should be involved in the patient's care and formulation of care and crisis plans where appropriate,

and third, staff must properly respond to concerns raised by the family or carer.

We submit that there should be a mandatory requirement in cases of schizophrenia and similar illnesses to offer the families -- sorry, the patient's family or carer or a support worker. That is someone who would provide support, advice, and assistance in liaising with the services.

Martha's Rule should be introduced in mental health care. This is a right for the family of a patient to seek a second opinion. Professor Appleby and Mr Hendy supported it.

There are number of systemic problems linked to risk assessment. There was no dedicated NHFT policy or national guidance which nurses were expected to follow and trained in, on the assessment of risk to others.

There appears to have been no formal training on the CCO role or supervision to ensure a CCO was competent. This is a concern given the importance and specialist knowledge required of the CCO role.

There should also be mandatory national training and guidance for CCOs and other mental health nurses which includes the following: firstly, how to assess the risk of relapse, including the need to take a longitudinal approach and take account of non-overt signs of illness.

Second, clear and simple guidelines and information sharing.

Third, the assessment of mental capacity.

And then fourth, for those involved in an EIP service or equivalent services, there should be training and guidance on patients who disengage or are non-concordant, information sharing and communication with the patient's family, and discharge of this type of patient, including the need to take all available steps to re-engage the patient before discharge.

Chair, we submit there should be minimum national standards for supervision to ensure CCO's and other staff are competent. There should be a national policy on the assessment of risk to others, applicable at a local level, which is clear, simple, and meets best practice.

Full, standalone Assertive Outreach services should be reinstated nationally to cater for patients in VC's cohort, that is schizophrenic patients who are high risk when unwell, and whose illness leads them to disengage from medical services. As Dr Dissayanaka explained, there's "a wealth of evidence that a properly resourced Assertive Outreach approach works and indeed is enormously successfully".

It's of real concern that there is no specific

funding earmarked for Assertive Outreach since history demonstrates that without proper funding, the service will be ineffective.

Sufficient resources should be provided and ringfenced. The overriding reason for this is the clear evidence that a fully resourced AO service reduces killings and violent attacks but as Dr Dissayanaka explains, an effective service will reduce costs elsewhere in the system, for example, costs of criminal justice, physical health care, homelessness, drug use, lost employment and so on.

There was a wholesale failure of senior management oversight and response in this case. The problems that are relevant to VC's case had been repeatedly identified in reviews going back to at least 2018, for example by the CQC, by inquests, by the Royal College of Psychiatrists, and others, yet for several years the problems weren't addressed.

To remedy that, one solution is a more effective oversight mechanism, to ensure that appropriate changes are made in response to public inquiries, inquests, and other authoritative and respected investigations. Professor Appleby, Minister Jones and Baroness Merron also supported that.

There also needs to be effective oversight at a

national level. There should be someone in each ICB who is responsible for mental health care delivery and who has mental health care and nursing expertise.

Another means of ensuring that managers do their job properly is outside scrutiny. So trusts should be obliged to collect and publish data to show whether they are complying with NICE EIP requirements. And further, serious incident investigations and other investigations into deaths or near deaths, including mental health homicide investigations, should be independent, published, and the bereaved families of the deceased victims, or the survivors, should be able to effectively participate.

Those changes are likely to improve the quality of those investigations and help ensure that lessons are learned.

Chair, I'd like to now turn to multi-agency working and information sharing which I will deal with relatively briefly.

THE CHAIR: Yes, thank you.

MR STRAW: There were deficiencies in information sharing within the health services, for example, between inpatient and community settings and also with the Approved Mental Health Professionals. There was poor communications between the health services and the

police. It's of particular concern that the Trust did not become aware that VC was found ringing the doorbell at MI5 on 31 May 2021, that he apparently assaulted, followed, or stalked his former flatmate, Sebastian, on four separate occasions in 2021, 2022, that on 24 August 2022, the police had obtained a summons for VC to appear in respect of the assault on PC Pritchard, or that VC seriously assaulted a colleague at work in May 2023.

It's of great concern that as a consequence there was so psychiatric assessment, response or input whatsoever in respect of the May 2023 assault. Nor was there in respect of the February 2023 incident.

Those incidents were of obvious significance to the mental health services and the system should have ensured that they were fed back to the Trust.

The police also failed to pass on important information to the University. There was poor communication between health services and the University. For example, when VC first became unwell in May 2020, the university did not become aware that he had been detained in hospital until they were told about it by Celeste. The Trust should have taken responsibility for informing the University about VC's recent mental health history. It wasn't Celeste's job

to be doing that.

Further, the University weren't told that the triggers for VC's psychosis included stress from university work. Given that the university were in the best position to manage and limit that stress, this clearly should have been passed on. If they'd known about it, they could have been expected to monitor the stress VC suffered and take steps to reduce it. As it was, the University placed him under considerable pressure.

There was no contact between the University's Mental Health Advisory Service and the Trust after -- about VC after 30 July 2020 until 18 January 2022. In an astonishing failure of information sharing the University was not made aware of the 3 September 2021 assault on PC Pritchard, or of VC's subsequent detention in hospital until 2022.

The University was not told that a decision had been taken on 28 February 2022 that professionals should only see VC in pairs for their own safety.

Although miscommunication was primarily the fault of the Trust, the University ought to have done more to seek information from the Trust. Ms Turner knew that in 2020 VC had suffered a serious psychotic episode and a relapse which had resulted in two detentions under the

Mental Health Act, and threatening conduct towards members of the public.

This should have warranted the Mental Health Advisory Service taking a more proactive approach with VC but this didn't happen, and there was no contact whatsoever after the first week of term in autumn 2020 until Ms Turner became involved again in early 2022.

There's no documented evidence or evidence in Ms Turner's witness statement, that she contacted the Trust after VC had interrupted his studies in 2021 to check whether there was information she needed to be aware of.

Chair, there was also poor information sharing internally within the University, which left VC's tutors largely in the dark about his illness and his risk.

An overriding problem for all the services is that the legal rules as to when information can and cannot be shared are wide only misunderstood. This is a national systemic problem. The ILT Homicide Review concluded the communication and information sharing failures were an overwhelming feature of the cases it had analysed, arising in 92% of those cases.

There's an obvious need for better guidelines for all sectors. Because this guidance is for busy and hard pressed staff, it should be as clear, concise as

possible. But we submit that's readily achievable, since the rules on data sharing are, at their base, relatively straightforward, as we set out in our written submissions.

Clear mandatory guidelines, which all relevant staff should be familiar with, will help demystifying data sharing. They will help find a balance between two competing imperatives which arose in this case. On the one hand, there were widespread failures to share important information about VC's condition and risk, but on the other, confidential information was shared when it shouldn't have been, particularly information about the survivors and the bereaved.

There was no information-sharing agreement between the University and the Trust. The agreement between the University and the police was inadequate. Many officers weren't even aware of it. This may, in part, explain why it simply never occurred to many frontline officers that information about VC could or should be shared with the University. There need to be clearer information-sharing agreements in place which are drawn to the attention of all staff.

There should be a simple system which ensures that a mental health marker is placed on police records so that any officer dealing with someone like VC is aware

that they need to report back any incident involving the patient to the Trust.

Information technology needs to be streamlined. So for health services, a single electronic patient record should be available to all relevant clinicians.

Digital patient records should be interoperable. This was supported by Professor Smith and Baroness Merron.

Police computer systems are fragmented, technologically inept, and siloed. They ought to be simplified to ensure that hard-pressed officers know exactly where to look for mental health markers and other information that they may need. There should be joined-up digital services to ensure appropriate and lawful information between police, health services and public institutions such as universities.

Finally, Approved Mental Health Professionals do not have full access to Rio, and the Trust had no access to information to from local social care, and that should be remedied.

Chair, the family agree with the submissions made by the survivors that there was a failure by the local authority to undertake a Care Act assessment, and there was a failure to discharge the duty under Section 117 of the Mental Health Act. VC was entitled to a Section 117

aftercare, given that he'd been detained in hospital under Section 3, and the recently disclosed Notification of Assessment from Social Care document accepted this, noting that VC would be needing social care and support on discharge in October 2021. But that support was completely absent, and we say that removed a potentially vital component in VC's treatment and care.

Chair, in conclusion, the cause of VC's crimes on 13 June 2023 was schizophrenia. Had VC received full and proper treatment and management of his schizophrenia, beginning in earnest during his first admission in May 2020, there is every reason to think that this tragedy would have been prevented.

The same is true of many other schizophrenia-related homicides up and down the country. Many of these homicides are preventable, but for that to happen, the authorities need to face up to the lessons of the Clunis Inquiry. They need to recognise that robust and assertive mental health support is essential. It has to be properly resourced and supplied by properly trained professionals who have the benefit of full information about the patient. For public and patient safety, it's imperative that this occurs.

This Inquiry has had the benefit of a mass of expertise and analysis. We respectfully invite you,

Chair, to employ that learning by making far reaching and detailed recommendations in relation to mental health services and to the information-sharing procedures on which those services rely.

Those are my submissions.

THE CHAIR: Thank you.

There's just a couple of points that I'd like to ask you about, Mr Straw. Firstly, the Inquiry has accepted the schedule that you prepared, and in fact I think added a couple of other instances to it, of the contact which Celeste Calocane had with the health services to try and get appropriate care.

I just wanted to ask you about diversion, because obviously, right at the very beginning, the Liaison and Diversion Services, the idea was to divert someone with a mental health problem away from the criminal justice system. What do you say about that, in this case? It was obviously something which concerned Celeste Calocane because she asked Dr Seedat about the effects of what had happened, as to whether that would be on his record in some way. But what do you say about the diversion of those with serious mental illness away from the criminal justice system?

MR STRAW: So we say the starting point should be that proper, robust and assertive care is available under

ordinary mental health services, and so that it's not necessary for someone to go to the criminal justice system. It's most unfortunate that, at the moment, the reason given by a lot of people as to why someone should be diverted to the criminal justice system is the resources and the support there is better, and our primary submission is that's not sufficient. There should be adequate and full resources available under ordinary mental health services.

That said, we accept the points made by some witnesses that there can be value in a criminal justice response in certain situations. I think it was said, for example, that can demonstrate the seriousness of the incident.

THE CHAIR: It was quite clear on a couple of occasions that VC took the fact that he'd not been arrested, or it hadn't gone any further, as significant.

MR STRAW: Yes, and we accept that.

THE CHAIR: Yes. So, in essence, what you say is that there is an appropriate time and opportunity for diversion, but not always?

MR STRAW: Yes.

THE CHAIR: All right. Thank you.

Just in relation to one further matter, just the question of the belief that this was a suicide risk,

that he was a suicide risk. And I think you would accept that there's nothing that one can see in the Rio notes that suggest that that was the main focus, although "risk to self" was always ticked, but nobody actually set out what those risks to self would be. Do you agree?

MR STRAW: We do agree with that, yes.

THE CHAIR: Yes. It was not actually identified as him being a suicide risk?

MR STRAW: Yes. And as I'd said earlier, the question as to what Elias or the family understood about his risk is very different from what the clinical team should --

THE CHAIR: No, I understand, yes.

MR STRAW: But yes, we absolutely accept that point.

THE CHAIR: So their understanding came from their own experience of him and what they knew about him rather than anything that was said to them about him being a suicide risk?

MR STRAW: Yes, exactly. It comes from their own understanding and experience of him, in the context of a near vacuum of any information coming to them from the mental health services -- to Elias, in particular -- about the condition.

THE CHAIR: Yes. Just one final matter. There was quite a period when I think that the family were not aware of

where he was when he went to Birmingham. There's a suggestion he might have gone to Newcastle or somewhere else. Were they still in contact with him at that point, even though obviously not at an address or in person?

MR STRAW: So Celeste continued to have telephone contact with him, yes. And I think -- yes, so her evidence about that period is she continued to have telephone contact with him and saw him on special occasions. So that covers the period as well when they were initially unaware of exactly where he was based.

THE CHAIR: And that was something which Elias Calocane referred to in the very late stages on 13th June: that he thought he was in Coventry? So it's a different occasion but a similar ...

MR STRAW: Precisely, yes. On 13th June they understood he was in Coventry when he wasn't. He wasn't living there at the time. But by that stage I think things were very, very different to how they'd been back in 2016/2017 in terms of the relationship with them. The family explain in their statements that the early stage, they understood it to be Valdo being independent and feeling a bit uncomfortable about what he was doing, so initially didn't tell them about it. Whereas the picture, come to 2023, he's completely vacant from them,

really. He's almost -- other than occasional phone contact with Celeste, he's almost completely separated from the family.

THE CHAIR: Just finally in relation to the new Mental Health Act and the requirement of rather than nearest relative, it's a nominated person, isn't it? On a number of occasions when he provided employment details, VC put in names other than his mother, obviously, as his next of kin, and those people have not been identified and it's not clear whether they're real people at all. But in terms of the change, is there anything you want to say about that as to the removal, as it were, of the family from that central role?

MR STRAW: I think this is another area which will be important to be spelled out in the Code of Practice, the significance of the family, that everyone recognises the importance that a family can have in care. So we say that it will be important that a Code of Practice recognises that and gives them the appropriate priority as the nominated person.

THE CHAIR: Yes. Thank you.

Right. Mr Beer, I know that you are keen to be on today rather than tomorrow, so if we just take a five-minute break to give everybody an opportunity of to stretching their legs if they want to do so and we'll

start again at ten past. Thank you.

(4.04 pm)

(A short break)

(4.10 pm)

THE CHAIR: Yes.

SUBMISSIONS ON BEHALF OF NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST BY MR BEER KC

MR BEER: Thank you. These are the submissions on behalf of Nottinghamshire Healthcare NHS Foundation Trust.

Before I make them, can I emphasise I wasn't particularly keen to make them today. My only keenness was to ensure that the Inquiry's timetable was not disrupted and that you didn't dribble into a third day if I added 45 minutes on to tomorrow morning.

THE CHAIR: Well, I think we're here now, so shall we just carry on?

MR BEER: Thank you.

THE CHAIR: I know it's a bit of a difficult slot but I'm certainly listening and I'm sure everybody else is.

MR BEER: Thank you.

We have listened carefully to all of the closing submissions that have now been made on behalf of the bereaved families, the survivors, and Celeste and Elias Calocane. There is, in fact, much in them with which the Trust agrees.

There are also points, however, where the Trust submits that the evidence requires greater qualification. But our purpose today is not to answer those submissions line by line. The proper starting point remains the Trust's own analysis of the evidence, the concessions made by its witnesses, and in its written closing, the improvements already undertaken, and the recommendations which the Trust respectfully invites you to make, and that's the order in which I'll take matters.

There are, we respectfully suggest, four broad propositions. Firstly, that VC suffered from a serious and complex psychiatric -- psychotic illness. The psychiatric evidence was that he could mask his symptoms, that he lacked insight, and that he could therefore be difficult to assess. His episodes of violence and aggression were associated with his psychosis.

Secondly, aspects of his care fell below the standard which should have been achieved. In particular, the Trust accepts that there were deficiencies in risk formulation and recordkeeping, that the longitudinal picture was not always sufficiently brought together, that family information and medical non-concordance were not always given their proper

significance, that there were missed opportunities for greater forensic involvement, and that the final period of EIP care and the September 22 discharge were deficient.

Third, that those conclusions do not mean that every earlier decision to provide community treatment rather than compulsory admission was unreasonable. Decisions under the Act must be assessed by reference to the statutory criteria, the information reasonably available to clinicians, and the patient's presentation at the time. The catastrophic outcome cannot itself provide the test for whether every earlier clinical judgement was correct or incorrect.

And fourth, this case exposes problems which no individual Trust can solve alone. Rising demand for services exceeding funding across the country; fragmented information; uncertainty in information sharing; and the near national loss of Assertive Outreach capacity; pressures upon EIP services and the absence of sufficiently consistent national approaches to risk assessment outside of forensic practice.

It's against those propositions that I turn to the chronology. The first presentation: May 2020. VC first came to the attention of mental health services in May 2020. This was his first known presentation with

serious mental illness. There was no established psychiatric history and no known history of violence or of aggression. He was experiencing psychotic symptoms. Sleep deprivation and examination stress were thought, at that stage, to be relevant factors.

On 24th May, he underwent a Mental Health Act Assessment. The Statutory Framework is important. Admission under Section 2 required the relevant criteria to be met and the Code of Practice also required consideration of whether treatment could appropriately be provided by less restrictive means.

Two doctors assessed VC in person and AMHP was also involved. The Crisis Team was available to provide intensive support. VC was psychotic but he was not aggressive during the assessment. He did not express thoughts of harming himself or of harming others. He had no known previous mental health history and his mother reported no previous history of violence or of aggression. He was willing, he said, to accept oral medication and twice daily Crisis Team involvement.

The unanimous contemporaneous clinical judgement was that the criteria for compulsory hospital admission were not met. The Trust maintains that the Inquiry should assess that decision on the information which is available to those clinicians at that time.

There was, however, an important deficiency. The clinicians did not have the full circumstances of the incident which had led to VC's arrest: namely, the force used against the door; the attempts to gain entry elsewhere; and the need for police restraint, and the concerns of the residents. That information was relevant to risk.

But the evidence also indicates that that information was sought from the police. The AHMP record states that the assessing team spoke to the custody sergeant and were told that there had been no violence when VC had entered the property, and that distinction is important.

Here we say the lesson is not simply that clinicians failed to ask for information about risk; it is also that effective assessment depends upon accurate and complete information moving between the agencies. The CQC subsequently raised questions about the quality of this first risk assessment, but the CQC witnesses themselves recognise the limitations of their retrospective assessment. They had not examined VC at the time. One reviewer expressly recognised that this was a first presentation and that the decision could properly have been more risk-informed without necessarily requiring detention.

The AMHP who assessed VC the following day did not consider that a higher rating of risk would itself necessarily have required hospital admission. That is the proper context in which the first admission should be judged.

Within the following 24 hours, circumstances changed. There was the significant incident involving Feven.

THE CHAIR: Can I just stop you for a moment.

MR BEER: Yes.

THE CHAIR: Even if it's right that, under the Act, there was some, you know, it may be either way, if you like, as to whether he should have been detained or not and therefore it's a question of whether the decision was a reasonable one or not, but the fact that his mother was on the way and he was being discharged to the same place where he had broken into the flats without any medication as yet, without any support as yet, would it not have been prudent to wait? I know there may be no legal requirement but as the following day they managed to keep him for 6 hours because of some mix-up with an ambulance, would it not have been better to wait for the mother to attend?

MR BEER: I would respectfully invite you to frame the question slightly differently: would it have been lawful

to have detained somebody to wait for their mother to have arrived, which was explored in the evidence and the witnesses who gave evidence about it said that they couldn't see a means by which they could contrive that situation to occur.

THE CHAIR: There's no suggestion that he was asked whether he would be prepared to just sit and wait until that happened.

MR BEER: That's correct. I think that question was explored with the witnesses as well and they said that they didn't consider that.

THE CHAIR: No. And that's the point, isn't it? Having shown that, according to them, he was very compliant at that stage, that would have given an extra security, wouldn't it?

MR BEER: Potentially, it may have done, yes.

THE CHAIR: Yes.

MR BEER: But the point --

THE CHAIR: You're making the point that it wasn't lawful, as it were, to insist?

MR BEER: Yes. And obviously I don't want to spend too much time on this but there's quite a fine distinction between people who were in the process of potentially exercising compulsory powers asking somebody to wait.

THE CHAIR: But it's more about actually looking in

a curious and holistic way at the situation, isn't it?

MR BEER: Yes, maybe thinking more broadly. That's a fair point.

The Trust accepts that an incident report should have been raised in relation to the events but was not and that deprived the Trust the one mechanism by which information could be preserved and organisational learning prompted.

The absence of that report was not itself adequately identified after June 2023, including by the external agencies independently investigating the Trust.

The first admission and early community care. During VC's first admission, there were positive aspects of care but also deficiencies. In this admission, his family were engaged, the University was involved, and medication was initiated. Crisis services did participate in discharge planning. But record-keeping and risk formulation were not consistently at the required standard. Information about the circumstances leading to the admission was not captured with sufficient clarity. The document provided to VC's family should have been uploaded to Rio so that future clinicians had access to the underlying material, rather than a simple summary of it, and VC was not provided with the full psychological package which would

ordinarily be expected for first-time psychosis.

THE CHAIR: There's also the issue of any therapeutic intervention, isn't there? I think there are various therapeutic interventions referred to, and at various stages, things like sleeping and eating are considered to be therapeutic interventions rather than anything more substantial.

MR BEER: Yes, I'd intended that to be included within my phrase "full psychological package".

THE CHAIR: Yes.

MR BEER: I think they're subsets of it, I think, Chair.

We do not seek to disguise staffing difficulties which existed, particularly during Covid. There were standing shortages of psychology provision but resource pressure does not alter the fact that an opportunity for fuller intervention was here missed.

The period after the first discharge also demonstrated what would become a recurring issue: medication concordance. VC improved with antipsychotic treatment. Concern then developed as to whether he was taking it reliably. His mother contacted services on 11th July with concerns about his mental state and medication. There was no recorded visit to VC as a result. The Trust accepts that this was not the response which should have occurred. That episode is

important not merely because of the missed contact; as VC's history demonstrated, non-concordance became increasingly relevant to risk.

It was not simply a question of whether treatment would be maximally effective. In this patient, deterioration following non-concordance became part of the pattern which later clinicians needed to recognise.

On 14th July, there was a further incident and police detention. The Street Triage Team became involved and VC was detained under section 136. A further Mental Health Act Assessment was undertaken promptly. The Trust regards that episode as an example of effective police and mental health partnership working. There's an important future lesson in that as well. The evidence in the Inquiry has not simply demonstrated failure; it has shown that where systems enable police and clinicians to work together in real time with a ready flow of information, the result can be effective.

2020 into 2021.

Following the second admission, VC continued to receive EIP care. There were home visits, medication monitoring, psychiatric reviews and attempts to engage him in some psychological work. We say the Inquiry should not lose sight of that evidence. But neither

should the deficiencies be understated. In particular, documentation did not always provide the clear longitudinal account which a complex patient such this required. Diagnosis was not communicated as clearly as it should have been. Family involvement became more difficult, and VC's engagement with medication and services became increasingly uncertain.

The submissions of the other Core Participants rightly emphasised the importance of information provided by VC's family, and the Trust accepts that point.

Celeste Calocane was not simply an observer of her son's illness; she was repeatedly providing information about medication, mental state, and engagement. And when VC later withdrew consent for staff to disclose information to her, that did not prevent staff from receiving information from her. That distinction as it seems to us, was not always sufficiently understood in practice.

Confidentiality is an important protection for patients but it is not an absolute barrier either to listening to families or, where serious harm creates a proper legal basis, to appropriate sharing. A Triangle of Care must therefore operate as a practical clinical principle and not merely as a policy.

There's a related point upon which the Trust accepts the substance of the criticism made in some of the other closings. By 2021, clinicians could not safely assess VC simply by accepting his account at face value. He could mask symptoms, he could be guarded, and could appear relatively settled whilst retaining persecutory and psychotic beliefs.

That made the collateral information and the longitudinal clinical record particularly important. The issue was not that clinicals knew nothing of these matters; it was that the different pieces of information were not always brought together into a sufficiently strong and accessible formulation of risk.

Information which the Trust did not possess.

This leads to a distinct point which should have remained clear: there was relevant information which the Trust did not possess and was only received or revealed as part of this inquiry. It was not informed contemporaneously of VC's attendance at MI5. It did not have the full picture of the behaviour involving Sebastian. There was police information which did not reach his treating clinicians. That information, viewed with the Trust's clinical records, would have added materially to the longitudinal picture.

That is not said to transfer responsibility

elsewhere. Where the Trust held information and did not use it adequately, the Trust accepts its responsibility. Where there was an obvious reason to seek further information and that was not done, that too may be a failing. But no clinician can act upon information which another organisation holds and which never reaches them.

The wider lesson is therefore about system design. A family may hold part of the picture, the police one other part of it, the University another, primary care another. A system which leaves each organisation looking through only its own window will inevitably make risk harder to understand.

There's considerable common ground between the Trust and the three sets of submissions that you've heard on that proposition.

The third admission. By the third admission, in September 2021, VC's history was becoming materially different from that seen at his first presentation. There had been repeated psychotic deterioration, there had been aggression when unwell. There were concerns about medication adherence and community engagement was becoming difficult. VC was initially detained under Section 2 and subsequently under Section 3.

The Inquiry has examined closely whether more

restrictive treatment should have been adopted earlier and whether different medication arrangements should have been imposed. The Trust position remains that there were matters requiring the statutory criteria to be applied at the relevant time. The Mental Health Act cannot lawfully be used simply because compulsory treatment may appear retrospectively to offer greater control, but the developing pattern was becoming increasingly important. That history should have been carried forward into future decision making and so I turn to the events of January and February 2022, which are of particular significance.

On 19 January, VC underwent another Mental Health Act Assessment. The clinicians did not simply ignore the possibility of hospital admission. There was discussion of previous non-concordance, increased risk and instability. The incident which had prompted police attendance was taken into account. The clinicians also considered the possibility that VC might be misleading them about medication and engagement. His presentation during the assessment was nevertheless more stable than anticipated. He was cooperative, displayed more insight and agreed to resume medication, and the decision was made to attempt crisis team treatment.

Here, the Trust accepts that more collateral

information should have been gathered and that too much weight may have been given to VC's autonomy and to avoiding interference with his studies. Within days, however, further deterioration led to his fourth admission. I now turn to that. It's the principal missed opportunity.

It's here that the Trust makes one of its most significant concessions. This was VC's fourth admission, and his seventh Mental Health Act Assessment in less than two years. Each admission followed violence or aggression although the full seriousness of each event was not always understood at the time. Concerns about medication had repeatedly arisen after discharge. The treatment plan following the third admission had not succeeded in preventing a further admission only months later, and immediately before the fourth admission there had been increasing concern about disengagement and lack of insight.

In these circumstances, the question was not simply how VC appeared on the ward after treatment. The nature of his illness over time had to be brought into the decision. There was discussion about Section 3. There was discussion about depot medication. There was discussion about the possibility of a Community Treatment Order, and different clinicians expressed

different views.

We say that's important. These were not possibilities which were wholly invisible to the treating team. But Dr Gibson ultimately reflected in evidence that the wrong balance had been struck and that too much weight had been given to pursuing the least restrictive course, and the Trust accepts that reflection.

The Trust also accepts that this admission represented a missed opportunity for a more explicitly longitudinal assessment of the nature of VC's illness and the risks associated with treatment in the community.

Some of the other Core Participants go further in some respects, and invite you to conclude that Section 3, depot medication, and a CTO, were necessarily required. There is a strong evidential basis for concluding that these options required fuller consideration and certainly documented, and that longitudinal history should have carried more weight, and that too much emphasis was placed on the least-restrictive measure principle.

That does not necessarily mean that there was only one lawful clinical decision available. Nor does it establish that a CTO or depot medication would have

prevented events 17 months later. Those measures were potentially important risk-management opportunities, and that's why the failure to give them sufficient weight matters.

But we respectfully say that a missed opportunity should not be converted into confidence about the counterfactual. I have to say that there were other deficiencies during this admission. The chronic relationship between psychosis, persecutory beliefs and previous aggression could have been articulated more clearly in the risk formulation. Information concerning the incident with Christopher was not fully recorded or followed up with the police.

A breach of the Section 17 leave should have resulted in an updated risk assessment. The University should have been kept better informed, and events seen through the prism of safeguarding. More should have been done to establish that the address provided for discharge represented a genuine address and a safe tenancy, and there should have been greater shared decision making between the teams involved. There was also a missed opportunity for forensic involvement.

The evidence has demonstrated that forensic services do not have to assume complete responsibility for a patient before they can assist. Advice, consultation

and joint working can be provided. Given VC's complexity by this stage, the Trust accepts that forensic advice should have been sought, and that is an important point for future practice.

February to September 2022.

I turn, then, to the final period in which VC remained under the Trust's care. There were some important appropriate interventions after VC's discharge in February. He was seen by his care coordinator, he attended appointments, risk information was updated, and there was discussion with the University. But as 2022 progressed, VC's engagement became increasingly poor. The fundamental criticism of this period is accepted by the Trust. VC's disengagement should have led to a more assertive response. For a patient with his history, disengagement could not be treated simply as a failure to attend appointments.

A written care plan and risk assessment should have been reviewed following discharge, and should have addressed what was to happen in the event of further information non-concordance, disengagement, or deterioration. The EIP policy explicitly required that.

By the final months, a number of things went wrong. The Rio record was not properly maintained. There wasn't an adequate risk assessment plan. The core

assessment care plan and risk assessment were not updated as they should have been. More should have been done to locate VC. A further visit should have been made to the address held for him. Police assistance should have been sought. VC should have been seen in person before discharge so that his mental state could be assessed. An updated risk assessment should then have been completed, and supervision of the care coordinator caseload should have been more robust.

Additionally, the MDT process was itself deficient. The Trust accepts that the decision should not have been made -- that's the decision to discharge -- without the input of those professionals who held important knowledge about recent attempts to engage VC. Attendance and discussion were inadequately recorded and the decision did not adequately consider or mitigate the risks of relapse, violence, or non-engagement.

The discharge letter to the GP was insufficiently detailed and did not contain the key risk material. VC's family were not informed. The GP, police, and University were not consulted about the appropriateness of discharge, and the Trust's own 'did not attend' procedures, which were clear in writing, were not properly followed.

The Trust's written submissions here put the matter

rather directly: the decision did not follow the right processes and should not have been made in the circumstances. That remains the Trust's position.

This was not merely an administrative defect; it was representative of a culmination of shortcomings in risk assessment, engagement, recordkeeping and clinical oversight. The submissions of the bereaved families, the survivors and the Calocanes are right to emphasise that patients with severe mental illness who disengage may require more assertive intervention rather than withdrawal of services. That proposition should inform future practice. But again, the Inquiry should distinguish such a finding of failure with confidence as to the outcome.

Had VC not been discharged, more should have been done to locate and assess him. That may have resulted in renewed engagement. It may have led to a Mental Health Act Assessment. It may have resulted in further treatment. These possibilities are sufficiently important to make the lost opportunity a significant one.

But still, the evidence cannot establish what then would have occurred. After September 2022, after his discharge from the Trust, VC did not re-enter its clinical care before 13 June 2023. Primary care

attempted to engage him but he did not respond to later contacts and declined a later appointment.

In May 2023 there was a further violent incident at his workplace about which the Trust was again not informed. Had it been informed, it could have provided relevant psychiatric history and advice that may have assisted in consideration of whether a further mental health assessment was required, which is another example of why information sharing is central to your future recommendations.

Organisational learning.

The Inquiry has examined whether these failings were confined to VC's case or reflected wider organisational problems. The Trust accepts that its patient safety arrangements during the relevant period were not as effective as they should have been. Concerns about risk assessment had previously been raised. Some improvement measures had been introduced, but they had not produced sufficiently consistent or sustainable change.

The Ellen Collins review identified deficiencies in incident investigation, learning, family liaison and quality government. Those findings required serious attention.

Three other closing submissions invite you to characterise a number of these matters as systemic.

However, here, precision remains important. This was not an organisation in which no one recognised problems and there was nothing being done. There were a number of audits. There was service redesign. Additional posts were created. Risk assessment work was undertaken, and EIP services received attention. The difficulty was that improvements were not always embedded, sustained or translated consistently into practice. That, in the Trust's submission, would be a fair finding.

It avoids suggesting that another policy document by itself provides the answer. The real question is whether identified learning reaches clinical practice, is supervised, tested, and sustained.

In terms of improvements since 2023. Substantial further work continues to take place. The Trust has strengthened governance, incident learning, clinical leadership, inter-agency working, family engagement and risk processes. The SafeNow dashboard is particularly relevant in this regard, and significant, because it allows the Trust to triangulate metrics which were previously held separately across Rio, AMAT, Ulysses, and other systems. Patient safety capacity has been expanded. Safety managers and clinical reviewers have been appointed. Family liaison arrangements have been

strengthened. The PITA framework has been implemented. The Trust has worked with NHS England and the ICB in developing and implementing measures.

We do not say that the journey is complete. Indeed, the CQC's September 2025 report itself demonstrates that it is not. But there continues to be progress in quality and safety systems, while more remains to be done in areas including culture, staff experience, and equality and diversity.

The Trust also recognises the importance of individual accountability and has commenced a comprehensive review of the professional practice of relevant staff who gave evidence before the Inquiry.

Recommendations.

The Trust's proposed recommendations are deliberately targeted. They're not intending to reproduce every conceivable improvement suggested during this Inquiry. They are directed at points which, in the Trust's assessment, are most likely to make a clinical and practical difference.

Firstly, risk assessment. There should be timely national best practice guidance for risk assessment outside of forensic settings. That guidance should support structured professional judgement, not simply form completion. It should make clear the importance of

longitudinal formation, previous violence, relapse, medication adherence, treatment response, disengagement, family information and relevant information held by partner agencies. It should encourage clinicians to seek forensic advice in complex cases.

That recommendation is reinforced, rather than being displaced, by the submissions of the other Core Participants.

Second, Assertive Outreach. There should be ring-fenced funding sufficient to make properly resourced Assertive Outreach available across England. This Inquiry has repeatedly returned to the problem of patients with serious mental illnesses who disengage from ordinary services. A model which depends upon the patient attending appointments will not meet the needs of every patient, nor protect the public.

The other Core Participants propose versions of the same solution, some in more prescriptive terms than others. The Trust's essential point is that any national requirement must be accompanied by the workforce and recruitment funding necessary to deliver it. You will have seen, in our written submissions, that we made a bid to the ICB for such funding and it was rejected.

Third, police and NHS working. The Trust supports

a renewed formal commitment to partnership working, including a Potentially Dangerous Persons Pathway, and joint training modelled upon the positive experience from Street Triage.

Fourthly, there should be clearer arrangements between the NHS, police, and higher education sector. This case vividly demonstrates why. Universities hold information which may be relevant to welfare and safeguarding. Police may hold intelligence about offending. Mental health services may understand the clinical history. Each part is less useful if it remains in a silo. We propose practical multi-agency arrangements supported by case study guidance. We submit that Nottingham could develop a model which is capable of national application.

Fifthly, there should be a nationally maintained repository of investigations following mental health homicide and attempted homicide, with a mechanism for ensuring that recommendations are disseminated and then implemented. The same lessons should not have to be rediscovered independently in different parts of the country.

Sixthly, national and regional support for EIP should be retained. Strategic national and regional leadership can standardise care, promote consistent

clinical standards, and prevent each local provider having to recreate systems independently.

These are recommendations which the Trust has distilled from the evidence as the measures it considers most likely to be genuinely impactful. There are other issues upon which the evidence of other Core Participants adds useful emphasis, including families being given clear routes for providing information to clinical teams, guidance on confidentiality, and information sharing being practical enough to use in real clinical situations. Discharge standards for complex patients should require an up-to-date risk formulation and appropriate face-to-face risk assessment, and services must treat disengagement as a clinical issue capable of requiring escalation, rather than an administrative fact.

Those propositions are consistent with, and sit within, the Trust's principal recommendations, the balance the Inquiry is asked to strike, concluding there are two broader matters. The first concerns hindsight. By the end of the Inquiry, everyone in the room has access to an extraordinary amount of information about VC. We can now place events in chronological order. We can see reports which the clinicians did not see. We can connect police incidents with family concerns,

University information, and clinical records and later offending. Not all of the time did individual practitioners have that view.

Now, that does not excuse failures to seek information which should have been sought, and it does not excuse poor recordkeeping. It does not excuse a failure to read or take into account information already held. But fairness requires decisions to be assessed against the information reasonably available at the time.

A conclusion that a decision was a missed opportunity does not necessarily mean that the later tragedy was predictable or preventable, and a conclusion that a different intervention should have been considered does not establish that it would certainly have prevented the attacks.

The second matter concerns the least restrictive principle, and public safety. The evidence demonstrates that, at important points in VC's care, more weight should have been given to the history of illness, violence, non-concordance and disengagement. As I've said, the Trust accepts that. But the answer is not to abandon the least restrictive principle. People experiencing mental illness retain rights to autonomy and to liberty. The proper lesson is that least

restriction must be applied against the whole clinical history, and must explicitly take into account public protection and the risk to the public.

A patient who appears settled today may nevertheless have a history which changes the assessment of what is safe and appropriate tomorrow.

Conclusion.

As far as the Trust is concerned, things did go wrong. In particular, VC's risk was not always understood or recorded sufficiently longitudinally. The connection between psychosis, previous aggression, medication non-concordance and later deterioration was not consistently brought together. Important family information was not always used as it should have been. And there were occasions when information should have been sought from the police and it was not. The fourth admission was a significant missed opportunity. Forensic input should have been considered, and the final EIP discharge in September 2022 should not have occurred in the circumstances in which it did.

At an organisational level, the Trust did not always translate identified concerns into improvement with sufficient speed and consistency. These are substantial concessions. But the evidence does not establish that every earlier decision to treat VC in the community was

wrong. It does not establish that compulsory detention was required at every point at which it was possible to contemplate it, and it does not establish that a CTO or depot medication would have prevented the attacks.

Those distinctions do not reduce accountability. They make the learning more accurate. The deepest lesson from VC's case is, in the Trust's submission, the importance of seeing the whole patient over time.

The Trust has heard the evidence of the bereaved families and the survivors, and it has also heard the evidence of Celeste and Elias Calocane. It has heard the criticisms made of its services and, importantly, it has heard the reflections and concessions, many of them candid, by its own staff.

The Trust is sorry for the aspects of its care which fell below the standard which should have been provided. It is sorry for the opportunities which were missed, and it is sorry for the failures of communication and partnership working. It's also sorry that after 13 June 2023, its response added to the distress of people who had already suffered profound bereavement, injury, and trauma. It cannot alter what has happened. Its responsibility now is to learn from it, and that requires some local change, much of it having begun.

But the evidence also clearly shows why national

action is required on risk assessment, Assertive Outreach, EIP support, police partnership working, information sharing, and national learning from mental health homicide.

We therefore invite you to make findings which are clear about its failings, fair about the decisions made on the information available at the time, and focused above all on changes which can make a practical and lasting difference. And that's because the enduring measure of the Inquiry will not simply be whether it can describe, with the benefit of hindsight, every point at which something different might have happened, or which went wrong. It will be whether another clinician, faced in the future with a patient who is severely mentally ill, who is difficult to engage, who is intermittently non-concordant with medication, who is moving between different services and agencies, had a better chance of seeing the whole picture, whether that clinician has the right information, whether the service that they work for has the staff, whether the legal and professional guidance is clear, whether specialist advice is available, whether families are heard, and whether agencies are capable of acting together before another opportunity is lost.

That's the change which this Trust supports, and

those are our submissions.

THE CHAIR: Thank you.

Can I just ask, in relation to that list that you just gave at the end there, whether individual responsibility for the execution of your professional duty would include the inclusion that you've talked about systems. Individuals and the care they provide is very important, isn't it?

MR BEER: Yes.

THE CHAIR: It's not just the system.

MR BEER: No. And I think, in this case, you might fairly conclude that both are an issue.

THE CHAIR: Yes.

Just dealing with hindsight, I totally accept, obviously, that you can't apply hindsight and you have to be very careful, but risk assessment and treatment requires an element of foresight, doesn't it?

MR BEER: It does.

THE CHAIR: And looking forward and --

MR BEER: Hence the concessions that I've made.

THE CHAIR: Yes. So it's not just simply on the day, in the moment.

MR BEER: No.

THE CHAIR: It's a question of looking ahead and, as we've said before, looking at the whole picture.

MR BEER: Yes. I mean, the point that I was making, maybe I made it too subtly, it wasn't particularly directed at you drawing conclusions, because of course you'll give yourself a hindsight self-direction, essentially. It was, in part, when judging some of the evidence that you've heard, when some questions on occasions elicited answers that were based on a premise of the outcome.

THE CHAIR: Yes, and obviously things have emerged since that weren't available then. We've had quite a lot of evidence which has come out in this Inquiry which wasn't available to practitioners over an earlier period, and I totally accept that.

Just one further matter, which is in relation to the -- I'm not going to go into the timing of these reports, but the actual content of the investigations that are done. You've listed, I think, in relation to level 2 comprehensive or an initial investigation into incidents which have occurred in the past. Quite a bit of what you've listed there and set out in your submissions relates to what I would think of as KPIs, key performance indicators: how quickly you answer the phone, how often or how quickly you respond to complaints or to emails. But again, the key thing, isn't it, in looking at those, was the quality of the care and decision making, rather than whether you pick

the phone up quickly?

MR BEER: Yes, I would accept that point.

THE CHAIR: Thank you.

Good. Thank you very much.

MR BEER: Thank you.

THE CHAIR: Right. We'll finish there and start again tomorrow at 10.00. Thank you.

(4.55 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X

CLOSING SUBMISSIONS ON BEHALF OF 1
SURVIVORS GROUP BY MS CARTWRIGHT KC
CLOSING SUBMISSIONS ON BEHALF VC'S 46
FAMILY GROUP BY MR STRAW KC
SUBMISSIONS ON BEHALF OF NOTTINGHAMSHIRE ... 92
HEALTHCARE NHS FOUNDATION TRUST
BY MR BEER KC

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MR STRAW: [13] 46/18 47/23 80/21 87/24 88/18 88/22 89/7 89/10 89/14 89/19 90/6 90/16 91/14
MS CARTWRIGHT: [29] 1/7 1/12 1/14 1/23 2/15 2/24 3/4 3/7 3/12 8/1 8/5 10/7 25/16 26/16 26/23 27/16 27/19 27/25 28/21 35/5 44/1 44/8 44/10 44/15 44/20 44/25 45/10 46/3 46/7
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