Wednesday, 9 September 2026

(10.00 am)

THE CHAIR: Just a moment, Mr Beggs.

Yes, thank you.

CLOSING SUBMISSIONS ON BEHALF OF NOTTINGHAMSHIRE POLICE BY MR BEGGS KC

MR BEGGS: Thank you, Madam.

Madam, prior to 13 June 2023, Nottinghamshire Police dealt with VC on 10 or 11 occasions between 24 May 2020 and 28 July 2022, depending on how you count them.

Any penetrating forensic scrutiny of the kind, rightly performed by this Inquiry, will inevitably reveal things which could have been done better and this is particularly so when a public service -- in my client's case, the police -- has a very high demand which it struggles to meet.

The many Nottinghamshire officers who gave evidence to this Inquiry joined the police to serve the public, often in very challenging circumstances. And as their eclectic previous careers and education reveal, they come from all walks of life. They joined, however, for the best of reasons, and on 13 June, Nottinghamshire officers and staff attended the scenes of the carnage inflicted by VC quickly and they managed the victims and the evidential scenes well.

The crimes were a consequence of VC's paranoid schizophrenia --

THE CHAIR: Well, just a moment there. What about the evidential scene with Ian Coates and what happened there? Would you say that was well managed?

MR BEGGS: Overall it was well managed.

THE CHAIR: The fact that he was there for about 12 to 15 hours?

MR BEGGS: Madam, you have the reasons for that.

THE CHAIR: I've had some reasons, yes.

MR BEGGS: We're not saying things are perfect but we are not-- (overspeaking) --

THE CHAIR: It was the phrase "well managed", Mr Beggs, that I --

MR BEGGS: No evidential degradation was suffered as a result of delay.

THE CHAIR: Well, that's one way of looking at it, isn't it?

MR BEGGS: Madam, I'm hoping that when you come to review it, you'll look at what our clients have said about that and you may disagree with us.

The crimes in question were a consequence of a, not only the individual illness but in the context of a national mental health crisis with longstanding and significant underfunding as the recent past President of the Royal College of Psychiatrists said, 20% of the

disease burden, yet only 8.4% of the funding, and for years, the Police Service has struggled to cope with this crisis, and has been hugely diverted from its primary tasks by the crisis.

And you heard the vignette from PC Severn: when he joined in 1995, he attended a mental health incident once or twice a month, and, by 2016, on a busy day the triage team were dealing with 60 to 100 incidents and that's what prompted the Right Care, Right Person policy by the NPCC in July of 2023.

Madam, when policing as in Nottingham, is running hot all the time, the risk of things going wrong increases and it is too easy, in the calm detachment of this hearing room, to overlook the realities of the very high demand on the service, and whilst the forensic scrutiny of this Inquiry has properly revealed deficiencies, errors, and omissions on the part of my client, many officers acquitted themselves with skill and professionalism.

You heard about that yesterday in relation, if I may name just two people, PC Graham and Sergeant Hallam in their first aid response, see Dr Park, and inevitably forgotten, PC Matthew Bower who arrested VC, who was, see his statement, brandishing the very dagger that he had used to kill three people and was patently very

dangerous, and he did so without the use of lethal force. And we respectfully observe that there is little point this Inquiry making recommendations that create further demand on the service which struggles to cope with existing demand and unless new money is injected into policing and/or mental health services, the current mental health crisis will continue.

Police involvement in those crises must be confined to where there is an imminent risk to life, and even then, the police can only provide an emergency response. It is the healthcare professionals who have to deal with the ongoing treatment.

The care in the community regime consequential upon the '83 Act has plainly not worked in respect of many of the very small subset of dangerous paranoid schizophrenics, see the Hundred Families website.

There is one other factor that may be relevant to your overall considerations. May we invite you, please, to review paragraphs 21 to 60 of the Temporary DCC's third statement as to the impact of the Uplift Programme, just one statistic from it.

The percentage of probationers, that's to say police officers with less than two years' service, in response roles, rose from an already, you might think, somewhat alarming 40.6% in 2019 to almost 52% by 2022.

In other words, more than half of our frontline response officers have less than two years' service.

Equally, and consequentially, by 2022, each response sergeant was supervising 13 constables compared to just under nine in 2019.

Madam Chair, as we've said in our written submissions, we invite you also to have regard to the modern operational realities for frontline officers, including high demand, but also complexity and time criticality in decision makings.

Above all, to assess the police actions prospectively rather than with hindsight wisdom.

And we respectfully invite you to avoid the mindset that a mistake or an omission by an officer necessarily represents a missed opportunity to prevent this tragedy.

The appropriate question might be: missed opportunity to do what, precisely? The police cannot manage dangerous paranoid schizophrenics.

Whilst every effort is made to assess information quickly and accurately to identify and mitigate risk, public protection systems have to remain practical and proportionate. No police force can operate a model that requires immediate escalation or sophisticated intervention in every case simply because information may exist somewhere else in the public sector, or

because this might become an event which, years later, will be said to represent a missed opportunity.

That would engender defensive policing. It would be unworkable and it would undermine prioritisation of the more important and immediate risks.

There is, as may have become apparent, very little time for officers in the frontline to engage in calm reflection in every case in their workload. And that's why we identified for you the dangers of hindsight from as high an authority of Lord Bingham in Van Colle.

THE CHAIR: I'm very well aware of that, Mr Beggs, and I have taken it on board.

MR BEGGS: I'm grateful.

THE CHAIR: What I'm interested in is, and you talk about prioritisation and so on, but it's the basics, isn't it? It's the recording things accurately so that people can see what's happened in the past in an accurate way.

MR BEGGS: Certainly. And inaccuracy is to be deprecated and criticised. All I ask, madam, is that when one looks at it, the inaccuracies that have been identified and largely conceded, that one does so with some understanding of what might be part of the cause at least for those inaccuracies, or those failures to analyse.

The reason we cited Van Colle was to illustrate that

even very senior High Court and Court of Appeal judges can have very different views on precisely the same facts, and the words of Lord Bingham that might be said to be apposite to some of the situations here:

"Any conscientious officer [he said], mindful of the tragedy which ensued, would no doubt have reproached himself for failing to take all the steps which the wisdom of hindsight might suggest. But it is unrealistic to suppose that, at the time, a minor case of theft could have been thought to merit an intensive investigation of the kind which properly follows a murder."

And many of the incidents my clients attended were less serious even than that, objectively.

There is an example of hindsight reasoning to be found in the bereaved's closing submissions at paragraph 3.13, which says of the Cathedral searching, the following:

"There were significant coordinated resources tasked to search in respect of this call."

That was despite there being no victim, no known perpetrator, and in fact no attack.

But, Madam, you know that there were two specific, apparently credible, and separate reports of a woman screaming in the cathedral area, and they were the first

reports of any witness away from Ilkeston Road, and therefore an entirely reasonable lead, some might say compelling without hindsight, not least because from Ilkeston Road to the city centre passes through the Cathedral area.

So prospectively, there was good reason to search that area, and no imagination is required as to the inevitable criticism which would have unfolded if Chief Inspector Mather had not had regard to those leads and they proved to be accurate. It's only afterwards that we know that was an unhappy distraction.

A fair and objective assessment of the evidence prospectively demonstrates, we say, that Nottinghamshire Police couldn't reasonably have foreseen or prevented the 13 June attacks, and we make some observations in support thereof.

First, it's to be borne in mind that all of the interactions with the police and VC and my client's constabulary were borne of his mental illness.

Second, there was no escalation in VC's behaviour. In 2020, all three incidents were of him trying to get through a door, criminal damage, not burglary, with no evidence of his intention to injure anyone.

Prior to 13 June 2023 --

THE CHAIR: Was that not a possibility though?

MR BEGGS: We now know that he was --
THE CHAIR: Was it still not a possibility at the time?
MR BEGGS: Yes.
THE CHAIR: You don't just attack a door, do you?
MR BEGGS: No, he was trying to get through the door, Madam, but I accept the possibility. Of course, we must. There are many possibilities, but that's what happened in '23 the same three things, repetitive behaviour caused by delusions.
THE CHAIR: But are you saying that there is no -- that looking at those, the officers shouldn't have thought or wouldn't have thought prospectively that there was a risk of him breaking through and committing a violent act?
MR BEGGS: I'm not saying that, Madam, no.
THE CHAIR: No.
MR BEGGS: And nor, in case it would be your next question, nor am I saying that Nottinghamshire Police perfectly analysed the fulminating situation. That's perhaps one of the single most important things you're going to give recommendations on, is: how does the public service join the dots between different services so as to better analyse risk, and that's central to this case.

It's worth noting that prior to 13 June there is no evidence, certainly that we had, prior to that date of

VC approaching a stranger with menace. And between July 2020 and July 2021, we had no interactions with him whatsoever. The 5 July incident was a minor, very minor common assault, T-shirt pulling, in the context of emphasising a point, with no injury to Sebastian. I don't dismiss or discount the fear, but no injury.

The most serious incident, in terms of intent, was the assault on PC Pritchard. But even then, it's to be noted that VC was responding to police intervention inside his home. He didn't go out and look for and attack a police officer.

The 15 January headlock on Christopher was a common assault during which, again, for context it's to be noted VC was asking Christopher to say sorry for calling him a dirty bastard.

VC, a strong man, had Christopher under his control and yet didn't escalate beyond the headlock. He allowed Christopher to call the police. He even waited for the police to arrive --
THE CHAIR: Somebody else called the police, didn't they?
MR BEGGS: The police were called, and he waited, and when the police arrived he was entirely compliant and then pursuant to the 'No escalation' point, four days later, on 19 January, VC went quietly with the police, as he did nine days later on 28 January.

The final two incidents scarcely, if at all, involved a crime, and certainly involved no violence to Sebastian. And that's why the Temporary Deputy Chief said there was not an upward trajectory of escalating violence.

Thus, whilst shortcomings by individual Nottinghamshire officers in specific incidents have been identified and largely accepted by those officers, either in their statements or in their live evidence, the June attacks were not reasonably foreseeable or preventable on the information known to Nottinghamshire Police.

The treating clinicians knew, at VC's discharge in October 2021 and February 2022 that he had a well-established record of non-concordance, masking violent behaviour, and I invite your attention in particular to paragraphs 231 and 267(j) of Mr Beer's closing written submissions.

We make one final generic observation. We wonder whether wider society must now be accorded greater protection than dangerous individuals.

So may I turn, then, to 24 May.

PC Eustace, now Inspector, arrested VC for criminal damage and she photographed the damage that he inflicted. The evidence is that VC believed that his

mother was being harmed in the flat that he was trying to enter. He was taken to custody, a detailed occurrence entry was made noting the absence of any drug misuse, and a full mental health assessment was requested by Sergeant Wilde pretty much from the outset. That took place at 2.00 on that afternoon. It wasn't recorded on the custody record, plainly it should have been. The impression was, first-episode psychosis and as was perhaps to become perhaps a theme, the mental health team opted for the least-restrictive option, not to detain him but to let the Crisis Team visit him that evening.

PC Collins, from Prisoner Handling, was assigned to that incident, and Madam, you have the transcript of VC's interview disclaiming any meaningful recollection of the incident, saying he was stressed from his workload and denying any criminal intent, and apologising. He was released at about 20 past 7.00, and taken home by Nottinghamshire officers.

PC Collins' investigation took far too long for reasons, including demand and familial illness, and it was thus not until late September of '21 that then Sergeant Power authorised the closure of that job on the basis of Dr Seedat's email. She wasn't aware of the seriousness on incident 2 and she made many concessions

as to deficiencies in both the investigation and her analysis. But she was clear that she would still have closed incident 1 because she believed there was no realistic prospect of convicting VC for it, and we invite care in dismissing that conclusion, a 29-year old student at university with first-episode psychosis and no police convictions whatsoever.

THE CHAIR: I think you've accepted, and it was accepted, that the two incidents should have been linked right from the start.

MR BEGGS: Of course.

THE CHAIR: And if you deal with them together, do you say the same thing? If they had been dealt with together.

MR BEGGS: They should have been dealt with together, Madam. We've said that from the outset.

THE CHAIR: So treating them separately doesn't quite answer the point, does it?

MR BEGGS: No, it doesn't. Although I again invite caution as to conclude that there would have been a criminal justice outcome even if treated together, but I don't demur from the implication in your question that there might have been a better record, a better audit, created as a result of conjoining the two, which they ought to have done.

THE CHAIR: But when you say a criminal justice outcome,

there are a number of different outcomes that can happen, aren't there?

MR BEGGS: There are.

THE CHAIR: If it gets to court, the court has some powers in relation to mental health orders, which would, in effect, benefit the offender as well as deal with the matter in the criminal justice system. He would have been under the care of the forensic side of things, wouldn't he?

MR BEGGS: That might have happened.

THE CHAIR: If that had been the position, that's one possible outcome, isn't it, if they'd been joined together?

MR BEGGS: Yes, that might have happened, Madam. Whether it would have made any difference is less certain, given that what we know did happen when VC was detained, by whatever route -- whether the criminal justice route would have had a different outcome from the outcomes that did occur on the four detentions would be a matter for you.

THE CHAIR: Thank you.

MR BEGGS: Turning then to the second matter quickly on 24 May. As you know, just over an hour after being released, effectively, VC did the same again, and he so terrified Feven that she jumped from the first floor

window, seriously injuring herself.

VC was arrested at quarter past nine by PC Smith, who took him to the Bridewell, and, again, mental health concerns were inevitably noted. It took until quarter to four on 25 May for the next mental health assessment which resulted, of course, in his first sectioning.

And PC Marsden who was the officer on the second case liaised with Dr Seedat who, on 2 June, sent the email with which you are now very familiar. And it was the next day that Dr Seedat read the notes from Elias about the text messages which were not drawn to the attention of the police, even though Dr Ludvigsen agreed that these messages were another indication of serious violence from the patient whose level of risk, when unwell, was concerning.

PC Marsden took Dr Seedat's 2 June email as determinative of incident 2, and noted that Feven is aware, that the OIC cannot now progress the prosecution. That was a misunderstanding of the position, but one that he honestly believed, in keeping with his sergeant, Katie Sparks, who the next day recorded that, in the light of that 2 June email, the suspect, she thought, had been deemed not to have capacity at the time of the offence, so she filed the matter as undetected.

Like Sergeant Power, she accepted the concessions as

to sub-optimal management of this incident but, as with her colleague, said she didn't think it met the threshold even to refer to the CPS, though, when pressed, she agreed it should have been.

It's important to note that there's no evidence that VC even realised Feven was in the flat, and it -- we say --

THE CHAIR: Why do you say that? According to Feven, they had a conversation through the door.

MR BEGGS: Well, you will have to determine what weight you attach to evidence made after -- many years after the event, with extreme publication in the meantime of facts, but you'll compare that with what Feven told PC Marsden contemporaneously. And that's a matter for you to resolve.

We say in fact, overall, it is unlikely that VC would have been convicted of any kind of assault upon her, given the apparent absence of any malicious intent or recklessness. His motives were entirely delusional.

Sergeant Swift, who is a subject matter expert on NICHE, told you that it would have been easy to conjoin the incidents, and he also told you that NICHE is efficacious, for example the golden nominal principle, you can research everything you have on a particular individual.

Madam, on 17 June, as happened on every of the four occasions of discharge, the police aren't told about that. You may or may not think that is significant. But what is repetitive is that after every release, VC immediately stops cooperating, stops taking medication, starts masking.

13 July, the third incident, is a repetition of attempting to get into a flat.

It was PC Michael Plant who made his way to Brook Court on blue lights, and, in passing, may we invite your consideration of two things he told you. First of all, he gave you an insight into the cacophony of broadcasts that a response officer receives on the way to an incident. The relevance being sometimes officers were impliedly criticised for perhaps not hearing everything on the airwaves. He said, to quote indirectly: everything you can think of coming at you all at once.

He also spoke, you may think with some weight, about the dissonance about what a caller sometimes tells the call handler and what is actually happening at the scene. He said:

"When we get on scene it can be and it is on many occasions, a completely different story."

On his arrival, he apprehended VC, put him in

handcuffs, took him to the van, but noted those on the scene didn't want to make a criminal complaint. His instinct was Section 36 -- 136, forgive me -- and you'll recall that the triage team came to the same conclusion after the Community Psychiatric Nurse examined VC.

We say that PC Severn's decision to 136 VC was reasonable and there was no missed opportunity. The police did their job. It was over to the psychiatrist to manage VC now for the second time.

We observe in passing that it seems unlikely that that incident could ever have resulted or would ever have resulted in criminal prosecution or sanction.

THE CHAIR: What do you think would have happened or what are the possibilities, Mr Beggs, if the first two incidents had been linked, the matter had gone before the court, and then a month later, there we were again?

MR BEGGS: Well, one would like to think that VC would have found his way back into mental health care, and would -- one would like to think that the treatment might have been more sustained.

On 31 July for the second time now, VC is discharged with a diagnosis of paranoid schizophrenia, and you will have noted, Madam, there is then approximately one year where we don't see him.

Then in February '21 there's a succession over the

following two or three months of VC being caught speeding. A contextual factor, but no more.

On 31 May 2021, you have his visit to London, which results, on 2 June, on a report sent to my client's constabulary, but a report not requiring them, objectively or subjectively, to do anything. And for the rest of June and July of 2021 the non-concordance was evident, but, you may think, not tackled. Which takes us to 5 July and Sebastian's first call to the police on 101, reporting the T-shirt pulling and the confused mumblings, but no injuries.

PC Pannell, a probationer with five months' frontline experience, is assigned, and he signs her pocket notebook confirming that he doesn't want to make a complaint or go to court but just to make the police aware, which was a sensible ambition on his part.

The fact that he was moving out, Sebastian, in a couple of months, was a legitimately reassuring factor to PC Pannell, but most reassuring was the objective lack of seriousness of the incident. You'll recall that this probationer knew -- sorry, recent probationer -- knew what a PPN was but said that, because of the non-seriousness and the non-complaint, she didn't submit one, adding, probably incorrectly, that she'd need VC's permission to do so, but also pointing out correctly

that Sebastian didn't want her to contact VC and she had to be victim led.

Exactly the same stance taken by her sergeant, who was herself recently promoted as a temporary sergeant.

That's why PC Pannell closed the case with the authority of her sergeant, who believed that the crime didn't reach the evidential threshold for prosecution, nor even the public interest test.

And for what it's worth, Pannell's tutor, PC Wakefield, felt that the incident was dealt with proportionately and she wouldn't have done anything different, but she added the important rider:

"If Sebastian had said anything more serious or more concerning ... of course we would have followed up on that."

In response to your suggestion, Madam, that PC Pannell could have contacted the Street Triage Team, she doubted whether that team would have attended, and her sergeant told you that it would not have attended since they only deal with incidents where there's imminent threat to life or limb.

What we say is that, in the real world, little if anything, could have been done by PC Pannell to progress that low-level, no-injury assault, where the intelligent and non-vulnerable complainant didn't want the police to

intervene.
THE CHAIR: Just standing back, Mr Beggs, for harassment and stalking cases, you have to have a series of events, don't you? And if there are no records of these earlier incidents, it's rather difficult later on to pick up enough, if you like, incidents to qualify for stalking.
Do you think that there's any room there for those incidents to be noted in rather more detail and not to be dismissed in the way that they are, or no record to be kept?
MR BEGGS: They shouldn't be dismissed. That is obvious, Madam, I agree. And the problem is they're disconnected incidents. The first three and this one --
THE CHAIR: Well, they're always disconnected in these cases, aren't they?
MR BEGGS: Yes, but I'm not sure what criminal offence could emerge from those first four matters.
THE CHAIR: On the PNC or NICHE, should there not be some record of what has happened?
MR BEGGS: Well, there is.
THE CHAIR: A bit more than is here.
MR BEGGS: There is a record. There is actually quite detailed records of the first three incidents. I think, Madam, what your adverting to is what should the police do when you have these fulminating events? And that's

the -- one of the central questions to the Inquiry. The answers aren't straightforward, though.
THE CHAIR: No, but I'm asking you about the importance of noting records.
MR BEGGS: And we agree with that, and accuracy and precision is to be encouraged at all stages.
THE CHAIR: Yes, thank you.
MR BEGGS: Madam, you'll recall in August of '21, VC is summoned for the accumulation of his speeding offences. And then we get to 3 September, and the assault on Pritchard.
It isn't to be overlooked that the professionalism of the officers at the scene ensured that the injuries to their colleague were objectively minor, and that the warrant was executed with no harm to the doctors or the AMHP, and no significant injuries to VC himself, who was very unwell.
PC Pritchard in his inquiry statement said:
"My injuries were not serious ... I did not deem it necessary to seek hospital treatment."
And he said that in his experience, just for context for you, Madam, 16 years of policing by then and having sustained 15 to 20 assaults, he was clear that VC would not have got a custodial sentence for that. Indeed, a much more experienced officer, and senior, Griffin,

said it was highly unlikely that he would have received a custodial for that assault and he said respectfully to this Inquiry: it was inaccurate to describe that incident as serious violence, but it led to -- it was to effect the third inpatient stay, this time for seven weeks, during which, amongst other things, the medics learnt that VC had brought in a hammer to the hospital and was plainly willing to lie. And when released, and VC continued not to cooperate, that takes to us January 15, 2022, the incident with Christopher, as to which you have the detail.
There is a stark, if I may say so, dissonance between the evidence of Zacharia and Christopher, and all we can invite you to do is reflect on whether contemporaneous evidence, prior to the media coverage of this tragedy, might be the more reliable.
The point is this: that both officers, who between them, had over 30 years of law enforcement experience, concluded that arrest was not necessary, things had calmed down, the occupants weren't vulnerable, police advice had been given -- the mere attendance of the police can sometimes be the necessary pivot to change behaviours -- VC was entirely compliant, no weapons were used, and he was warned.
And Sergeant Faulkner told you they wouldn't have

left VC there if they thought there was any further risk to the students and no risk materialised.
And the next day, Christopher complained about VC to the University, and signed PC Zacharia's notebook to the effect that he didn't want to make a statement or complaint or support a prosecution.
Zacharia didn't do nothing with that, because he spoke with VC on the phone, warned him about his conduct, and did try to offer mental health help, but VC hung up on him, and so Zacharia didn't give up then. He left a message on his phone.
The point is, these officers weren't doing nothing; they were doing the best in straightened circumstances and the Sergeant on 23 January, authorised closure of the incident.
We invite you to conclude there was no other sensible disposal of the incident, a low-level student dispute with no known injury to the police at that time.
And if it's suggested it's a missed opportunity, the key question for you then becomes: a missed opportunity by the police to do what?
In any event, within a fortnight, VC was detained yet again, this time, for the fourth time, by the Foundation Trust.
Madam, in passing, we know that 19 January was

uneventful. We know that 28 January again, uneventful, and then we get to Sebastian again in April of '22. And on that occasion, 26 April, it was the Sergeant, Langham who noted on 9 May that the incident had been outstanding, a grade 3 incident, that's the correct grading, outstanding for 13 days. And he observed to you: that meant either that staffing levels were too low or demand too high, or as he said, a combination of the both.

And he told you that morale was rock bottom in neighbourhood policing, in managed incident teams, and in response teams. But nonetheless, he phoned Sebastian to see if he could deal with the matter quickly on the telephone, and he couldn't. So he allocated it to an MIT officer. He didn't change the risk assessment and he was justified in not doing so. There had been no further incident in the previous 12 days. Officers have to take into account the ongoing context. And so it was that PC Beardsmore picked up the case and telephoned Sebastian, who requested the matter be logged, but not that VC be spoken to, and he was told to contact the police should he require further assistance, and Beardsmore decided the incident could be closed.

On 13 May '22, the crime audit team correctly determined that no criminal offence had been disclosed

by the 26 April report. And so, objectively, Beardsmore's decision to close the incident was reasonable and, again, no risk in fact materialised to Sebastian.

Just to keep the flow now, it was on 9 May '22 that the CPS authorised assault on an emergency worker in respect of Pritchard and on 4 June, PC Myers completed the investigation, completed *pro forma*, meaning that the summons, the requisition, would be sent out.

And he pointed out, which everyone in criminal justice knows, it would then depend on how VC pleaded as to whether file upgrades would be required.

Might I observe that it took Constable Myers less than three months from being assigned the case to getting it to a postal requisition, which we respectfully suggest in the demand levels applicable, on his part, was satisfactory.

At the end of July there is the final incident involving Sebastian, a 101 call to report the stalking. Two days later, PC Sarah Barnes of the MIT is assigned. She reads both the incident logs and she speaks to Sebastian. She crimes it as stalking. You may think that was good policing. Sebastian gave her permission to contact VC.

Barnes was five months out of probation. It happens

she was pregnant. She was the only officer on Radford MIT for about two months, with a large work load, two and a half times what it should have been. She was also carrying Beardsmore's workload and she happened to be on a shift pattern that didn't align with her supervisor. All of that is to be regretted. She didn't do nothing. She visited VC's last known address to speak to him on two occasions, and she noted on the latter, despite her inexperience, that there was no post in the letterbox addressed to him. She also went to the relevant gym but there was no available footage.

And thus it was on 11 August she submitted the file to her supervisor, probably Ashley Small, to consider closing the matter, and she concluded that no further police time on the incident could be justified and her sergeant agreed.

THE CHAIR: Can I just stop you there. I think it was PC Barnes who didn't have her password; is that correct?

MR BEGGS: Madam, that particular detail I forget, to be frank with you.

THE CHAIR: And hadn't looked at the PNC before she went to see VC.

MR BEGGS: I think she spoke to him but the point there, Madam, is that she did proportionately what was justified --

THE CHAIR: What I'm asking you, really, is about --

MR BEGGS: -- (overspeaking) --

THE CHAIR: -- is about the importance of the PNC.

MR BEGGS: Madam --

THE CHAIR: -- and checking that because --

MR BEGGS: -- I accept that. I accept that.

THE CHAIR: Yes.

MR BEGGS: But in assessing her efforts, you might conclude that she did a tolerably good job on what she had, and it would not have been realistic or proportionate to deploy dedicated resources to try to locate VC for the matter that had been reported by Sebastian.

24 August '22, the postal requisition is issued. On 22 September, VC fails to appear, which coincides with the same date that the multi-disciplinary team discharged him.

You know that in January '23, the 20th, Myers sent an email to his colleague Pritchard saying, "If he is still wanted next week, we can try and locate him." But as he then explained, the very following week, the Operation Reacher team were deployed to Clifton, and you'll recall this wasn't trivial shoplifting, this was OCG industrial-scale shoplifting, not to be dismissed or scorned, because such shoplifting undermines public confidence in the local Police Service.

So Nottinghamshire Police did progress the prosecution of VC for assaulting Pritchard to the level of a postal requisition. They failed to execute the warrant in a timely manner, which the Temporary Deputy Chief acknowledged was, as has been repeated to you several times, a serious systemic operational failure for which he has already tendered an unreserved apology to the families of the deceased and the survivors.

And you know now that Nottinghamshire's operating practice for outstanding warrants is on the College's good practice bank. That is of some little consolation, I acknowledge, of course.

But we invite you to be very cautious in concluding what might have happened had VC been apprehended on the warrant, and in that regarded, we invite your attention, in much more detail in writing, to the evidence of Alan Murphy, and a fair calibration of the sentencing guidelines, of which you, Madam, of course have a great deal of experience. Low- to high-level community order we suggest is the likely outcome.

So the criticism of our failure to execute that warrant is entirely justified. What is not justified is the assumption that that failure represented a missed opportunity to prevent the attacks, for the reasons we've set out at paragraphs 5.20 to 5.27 of our

closing --

THE CHAIR: Just in relation to that submission which I think you've made on a number of occasions, in effect that the only way that these attacks would have been prevented is if there had been a custodial sentence in relation to all of these offences, or instances.

There are different ways in which these attacks could have been prevented, aren't there?

MR BEGGS: Yes.

THE CHAIR: It wouldn't require a custodial sentence, would it?

MR BEGGS: That's not the only way, but the best way to prevent them would surely have been sustained inpatient treatment.

THE CHAIR: But if he'd come to the attention of the police and the courts on the warrant, that might have happened, mightn't it?

MR BEGGS: It might have done. But in assessing that, Madam, that particular counterfactual, we invite you to be very attentive to what also was happening in the actual chronology as opposed to any counterfactual, in other words, repetitive discharge after relatively short periods of detention. That's the unhappy truth of the chronology.

Before I move to a separate topic, just very

briefly, we invite you not to ignore the demand issue in this case. It's not an inconvenient truth; it is the truth. Relentless excessive demand affects performance, it affects morale, and things will get missed.

And you have the evidence of numerous frontline officers to that effect, including from a different constabulary, Leicestershire, that their evidence in some respects, one of the very young in-service officer's evidence was vivid: having to work on days off just to keep abreast of her caseload. That's not appropriate. And her Temporary Chief said this:

"It's really busy but we're not getting more people. Actually, we've got less police officers, police staff and PCSOs than we had in 2010, but we have far much more demand, calls for service, and complexity." [As read]

And you might note that latter word. It's getting more complex with police because of the panoply of legislation, guidance and obligations.

And at 539 to 545 of our submissions, we've noted that the psychiatrists are saying pretty much the same things.

May I turn very briefly, noting the time, to the response on the day. You have our minute-by-minute analysis in our written submission so I'm not going to it. Might I invite you to reflect on whether

Superintendent Allardice's extremely detailed analysis might not be the fairest and most balanced analysis of the response. And you'll notice he made some clinical criticisms.

However, given what we now know from CCTV coverage of VC's movements, and the resources available, it simply is not realistic to suppose that Nottinghamshire Police could have prevented the killing of Ian Coates, or the running down of Wayne, Sharon or Marcin. I'm not going to repeat the points about the Cathedral area because you have them from my first observation as to hindsight, wisdom.

You will have noted our citation of Robinson v Chief Constable of West Yorkshire and Lord Reed emphasising the importance of not imposing unrealistically demanding standards on police officers acting in the course of their operational duties. And he emphasised that is most obviously the case where critical decisions have to be made in stressful circumstances with little or no time for considered thought.

And on just one point, I wonder whether Ms Langdale was being entirely fair when she said yesterday that the attacks on the three survivors was contributed to by, I quote, "an erroneous and unjustified belief that the perpetrator of the attacks on Barney and Grace would be

long gone following those first attacks."

First, the academic point, it's difficult to see how his belief at 4.32 that the suspect was probably long gone contributed to VC not being located, given the number of officers self-deploying and searching, but more importantly, that "long gone" statement was not erroneous.

May invite your review of 628 and 629 of our written submission and the headline of which is this: by 4.21, we now know that VC was crossing Alfreton Road into Thurman Street, and at 4.30 he was going eastwards towards the Forest Park and Ride, about one mile from the scene, and Allardice gives you that.

Madam, can I turn briefly to unauthorised access and disclosure. For concision, Gell, Skenderaj and Rutherford were dealt with both swiftly and robustly. Two of them are no longer in the force. The first one, Gell, served a final written warning for two years.

Paragraph 4.4 of the bereaved's submissions suggest in respect of PC Gell that:

"Steps were constructed to protect Nottingham Police and to keep those acts of misconduct out of the public eye."

With respect, that is plainly wrong, the LQC directed the hearing to be in public. The media were

alerted to the date and place of the hearing and they attended and they were alerted by Nottinghamshire Police.

The media attended and reported the case that very day. The failure by my client to communicate that hearing to the families was an egregious failure for which we have already (a) acknowledged and (b) apologised. More generically, the failure by my client to communicate the misconduct of the above three personnel consistently, clearly, and in a timely manner, both to the bereaved and the survivors, is a matter of profound regret for which Nottinghamshire Police has already sincerely and unreservedly apologised and I do so now on their behalf again.

Madam, I'm almost finished, if you will indulge me, please.

The SIO admitted that he should have required VC to give head hair samples. However, you have cogent evidence from the very experienced Alan Murphy that he was not concerned by that absence since he considered there to be no evidence of VC taking controlled drugs, and in any event that would not have changed the acceptability of the police of diminished responsibilities.

And just two very short points left, Madam.

The first is to repeat our acknowledgement in opening that the failure by Nottinghamshire Police to deliver three key strands of information to the bereaved and the survivors in a consistent, clear, and timely manner, is deeply to be regretted.

And those three matters are: first, the fact of VC's previously interactions with Nottinghamshire Police from 24 May onwards; second, the failure to execute the FTA warrant; and thirdly, as I've mentioned briefly a moment ago, the management of the misconduct.

But when you are dealing with that matter, if indeed you do in detail, may I remind you from the evidence that it's not a binary position. There were shades of grey. Different people were told different things in the chronology. The mistake was that it wasn't consistent, clear, and coordinated. In other words, it wasn't coherent.

However, fair and objective analysis of the evidence shows that there was no attempt, however much the media may report it, by senior officers to cover up any matters from the bereaved or the survivors, or the public. And you'll recall some of the evidence of DCC Griffin, more importantly his contemporaneous emails to the very opposite effect.

Madam, as to the recommendations, I say nothing

beyond that which is contained in writing.

Thank you for allowing me to overrun shortly.

THE CHAIR: Mr Beggs, I just want to raise one matter and that's the matter of disclosure, which you haven't addressed. Late disclosure, failure to disclose so far.

MR BEGGS: Yes, Madam.

Well, you, have now, I understand, the Rule 9 statements from those responsible for the failures, and there's nothing I can say to either justify or mitigate that.

THE CHAIR: Well, an apology might have been in order, on behalf of the Nottinghamshire Police, don't you think?

MR BEGGS: I had understood that had been made. If it hadn't been made, of course --

THE CHAIR: Well, it seems to me that that is something that should be made in this hearing, because I've made the order that I have in relation to review with frankness and candour, and I expect that to be complied with.

MR BEGGS: Yes, and you're right, Madam. And if an apology hadn't been proffered, which I hadn't appreciated, then I proffer it on behalf of my client, without taking instructions, because an apology is merited.

THE CHAIR: Again, I would have hoped you would have had instructions to do that this morning.

MR BEGGS: Well, I'm sure those are my instructions. If

I've missed them, it's my fault.

THE CHAIR: Yes, thank you.

MR BEGGS: Thank you.

THE CHAIR: Mr Berry.

Yes, thank you.

CLOSING SUBMISSIONS ON BEHALF OF LEICESTERSHIRE POLICE BY MR BERRY KC

MR BERRY: Madam, the central question for this Inquiry is how VC, a man with paranoid schizophrenia and history of violence to others, was in a position to carry out the homicidal acts he did on 13 June 2023.

A similar question has been central to many, many inquests, and NHS homicide reviews, and it was the focus of the Ritchie Inquiry.

In so many of these investigations, the following themes have arisen: risk assessment, the quality of monitoring in the community, concordance with medication, and engagement with treatment, and information sharing, both within and between agencies.

This Inquiry might consider that these themes would have been far less prevalent over the last 30 years had Ms Ritchie's recommendations been implemented in full and without retrenchment.

I'm going to focus my submissions on recommendations, on what the Ritchie Inquiry called the

"Special Supervision Group of patients who need special care", or the SSG; and there can be little doubt that VC fell into that cohort.

In our submission, the SSG should be cared for by the NHS on a mandated and adequately funded pathway, managed by multi-agency partners on a mandated and adequately funded pathway, the subject of enhanced proactive information sharing, and risk assessed based on a common risk assessment tool. And I will deal with each of those in turn.

It is important to emphasise, as others have, that most people with mental illness do not pose a risk to the public, but there is a statistically significant number of homicides attributed to people with serious mental illness. The Inquiry has the figures.

Ms Ritchie concluded that the serious harm that may be inflicted by severely mentally ill people on themselves or on members of the public is a cost of care in the community which no civilised society should tolerate. We agree.

Where the model is care in the community, it must be effective and it must be adequately funded, and the priority must be public safety ahead of patient autonomy.

There is strong support in the closing submissions

from Core Participants for the model of Assertive Outreach teams, properly so-called and not merely an assertive approach.

Assertive Outreach teams achieved national coverage in response to the Ritchie Inquiry, only to wither on the vine due to funding cuts.

To avoid that happening again, in our submission, first, there should be a single care pathway for managing the SSG that NHS bodies are required to apply, and Assertive Outreach teams seem to be the lead contender. And second, the pathway should be separately funded from existing mental health budgets, as Ms Ritchie recommended.

Multi-agency working in respect of the SSG is crucial. It is common ground that the current arrangements are inadequate in design or operation. The existing patchwork quilt of arrangements do not capture all members of the SSG, nor does it promote consistency.

In the Southport Inquiry report, Sir Adrian Fulford was considering multi-agency working with respect to a different cohort of individuals to the SSG, but he recommended this: that there should be a single dedicated agency or structure with responsibility for monitoring and coordinating any necessary information sharing or gathering, and any intervention providing

direction and holding the relevant agencies to account.

In our submission, there should be a new, bespoke multi-agency structure in respect of the SSG, with the responsibilities identified by Sir Adrian.

It should be put on a statutory footing, in other words, a duty for relevant agencies to work together in respect of the SSG, and it should be backed by new, dedicated Government funding for the agencies whose involvement is required.

While this structure could be based on the MAPPA model, it would be inapposite simply to expand the MAPPA criteria. That is because the lead agency with primary responsible for assessing and managing risk and for coordinating multi-agency work with respect to the SSG will be an NHS body, not, as under MAPPA, the police, the Prison Service, and Probation Service.

Information sharing.

There appears to be consensus that information sharing in respect of the SSG is simply not good enough. A solution alighted upon by some witnesses and Core Participants is more guidance. Guidance which is clearer, more concise, or more closely tailored to the circumstances at hand. That would be an easy recommendation for this Inquiry to make but it is hard to be confident that it would make a real difference.

What would, I submit, make a difference is a change in the law that promotes or at least does not stand in the way of proactive data sharing in respect of members of the SSG.

The difficulty with data protection legislation, the UK GDPR and the 2018 Data Protection Act, is that one of its core requirements is data minimisation. Even if all of the other conditions for data sharing are satisfied, the sharing must be proportionate. So each piece of information needs to be examined to ensure that it will be proportionate to share it.

Having an information-sharing agreement in place, or better guidance, would be insufficient to overcome that requirement in law.

I accept that establishing proportionality might not be onerous in emergency scenarios or where there is an obvious overriding public interest. But the same cannot be said in respect of proactive data sharing about the SSG, who pose an enduring risk due to their mental illness, where the ongoing assessment of risk is best done with the richest data, something that numerous of the clinician witnesses attested to.

Our primary submission is that relevant persons in multi-agency partners should be given limited access to police systems in respect of members of the SSG. This

will mean that information sharing from the police is timely and complete. More generally, information sharing between multi-agency partners should be undertaken by means of automated and integrated arrangements.

Now, this approach may require a change in the law to exempt proactive information sharing about the SSG from the proportionality requirement, which is unlikely to be satisfied where information is shared en bloc.

We also submit that relevant NHS bodies should be required to do two things in respect of the SSG. First, to share sufficient information about SSG patients to allow multi-agency partners to contribute meaningfully to the assessment and management of risk to the public.

Second, to specify precisely what information the NHS is interested in, and precisely how, and with whom it should be shared.

The Inquiry heard evidence from clinicians about idiosyncratic early-warning signs of a patient relapsing: something happening to their cat, scratching cars. Unless the police and other multi-agency partners are made aware of these objectively innocuous tells, and that they should be shared, it is highly unlikely that this information will reach the NHS. The mere addition of a mental health marker to police systems will be

insufficient.

In summary, routine proactive information sharing by multi-agency partners should be permitted and promoted by new exemptions to various requirements of the data protection legislation and, most particularly, as to proportionality.

That brings me to risk assessment. The Inquiry has heard evidence about there being different risk assessment tools used within the NHS and different risk assessment tools used among public bodies. This is a recipe for chaos. There must, we submit, be a common tool for assessing the risk posed by the SSG.

In the Southport Inquiry report, Sir Adrian Fulford identified an urgent need for a method of assessing risk which talks across social care, mental health, education, policing and criminal justice.

We agree.

Whatever tool the Inquiry considers is the right one for the SSG, to be effective it must be focused on risk to the public, NHS led, but involve multi-agency partners following the sharing of information, and it must talk across partner agencies so that the nature of the risk and the role those agencies might play in managing it is properly understood.

Turning to Leicestershire Police's actions following

the incident at Arvato. There is, and remains a limit on what I can say on behalf of my client whilst the misconduct process remains under way.

I make three points. First, the Chief Constable has apologised on behalf the force for those things that the three officers have accepted they got wrong. I repeat that apology without reservation. Second, when the Inquiry is considering the discrepancies between the evidence it gathered from the Arvato staff and PCs Taylor and Amos-Perkins, it will no doubt apply the established principles for the assessment of evidence, the Inquiry has contemporaneous documentary evidence from the police and from Arvato and that is the best evidence.

And third, I'm grateful, Madam, for your confirmation that you will avoid hindsight reasoning.

Causation has been addressed by others. So I will be brief. PC Taylor's failure to notice the outstanding warrant for VC's arrest after 24 May 2023 was a missed opportunity. That is acknowledged. But it was a missed opportunity to prompt Nottinghamshire Police to execute the outstanding warrant. Beyond that, in our submission, from the evidence you have, three things are far from clear.

First, it is far from clear that Nottinghamshire

Police would have attempted to execute the warrant, it had gone unexecuted for six months and the force had a massive backlog of outstanding warrants.

Second, it is far from clear that an attempt to execute the warrant would in fact have been successful. The Inquiry has not established exactly where VC was staying after 24 May and even if the officers had identified the right address, he may not have been in when they visited.

And third, it is far --

THE CHAIR: Mr Berry, can I just ask you, the warrant is not back for bail, isn't it?

MR BERRY: It is.

THE CHAIR: So it's a warrant all officers, isn't it, to arrest him?

MR BERRY: Yes.

THE CHAIR: So why do you say had because it was for failure to appear in court for an offence investigated by Nottinghamshire Police then the Leicestershire Police wouldn't have executed that warrant at that point?

MR BERRY: Well, the evidence was that it's likely that the three forces, probably three forces involved because the address, when he was found, was in Derbyshire.

THE CHAIR: But there was an outstanding warrant and they could have executed it, couldn't they? They could have

arrested him, and taken him and then contacted Nottinghamshire?

MR BERRY: Well, they could have done and if they found, if he was standing there in front of them, then they would have had done, but he wasn't.

THE CHAIR: Exactly. If he had been at Arvato, if he had been there, they could have done that, couldn't they?

MR BERRY: If he had been at Arvato, they could.

THE CHAIR: Yes.

MR BERRY: Had they known his name, so that they could have -- (overspeaking) --

THE CHAIR: I'm simply raising with you the fact that you've said because the warrant was a failure to appear at a court in respect of an offence investigated by Nottinghamshire Police, Leicestershire Police should have contacted Nottinghamshire Police rather than themselves being aware that someone in Leicestershire had committed an offence for which he was wanted on warrant in Nottinghamshire.

MR BERRY: Madam, you're absolutely right. My submissions were addressing the circumstance where he'd already left and wasn't in Leicestershire at the time. Plainly, had he been in Leicestershire, had he been at Arvato or had he been picked a some days later on some other offence, plainly that's what should have happened but that's not

the scenario that we're dealing with here.

And third, we submit it's far from clear that even if VC had been located and arrested, that he'd have been remanded in custody and therefore unable to offend on 13 June or, indeed, medicated so that offending would have been unlikely. I accept there are submissions to the contrary. You have heard a number of assertions about what would have happened or what should have happened, but you will no doubt explore the evidence as to what had happened in the past with respect to VC, and what was likely to happen, had any of those counterfactuals come to pass, and reach your conclusion.

Lessons learnt. I have already accepted that the three Leicestershire police officers made a series of errors. Those errors were not fundamentally attributable to failures in policy, procedure or training. And indeed, the officers themselves attributed the errors to human error, demands on their time, and inexperience.

It is nonetheless vital that Leicestershire Police learns from its officers' errors and from the wider policing and multi-agency issues that have been laid bare by this Inquiry. Chief Constable Sandall spoke about the suite of measures that Leicestershire Police has already taken and it should go without saying that

Leicestershire Police will examine the Inquiry's recommendations with the very greatest care.

But I would say this: the Inquiry will no doubt be considering recommendations that involve the deployment of additional police resources. We do not discourage the Inquiry from doing so. But those recommendations will only be effective if they are backed by new Government funding. That is something that Ms Ritchie recognised when she made her recommendation with respect to assertive outreach.

Certainly in Leicestershire, the police already have insufficient resources to meet the demand that they face.

I conclude, Madam, where I began in opening, by repeating Leicestershire Police's deep condolences to the families, and acknowledgement of the terrible impact on all those whose lives have been so profoundly affected by VC's heinous offending. It is hoped that this Inquiry's recommendations will be a catalyst for real change and Leicestershire Police is grateful to you, Madam, for the opportunity to participate in this important inquiry and to contribute to its thinking on how public safety can be improved.

I end by thanking your team, both in this room and behind the scenes, who have administered this Inquiry so

efficiently. Thank you, Madam.

THE CHAIR: Thank you. Yes.

Ms Grey.

CLOSING SUBMISSIONS ON BEHALF OF NHS ENGLAND BY MS GREY KC

MS GREY: Ma'am, I make these oral remarks on behalf of NHS England, and at the very start we'd wish to reiterate our sincere and unreserved apology to all of those who were tragically affected and harmed by the serious failings in the care provided to VC.

NHS England also recognises that an apology alone is not nearly enough. We are committed to learning from the events investigated by the Inquiry and a key part of that is improving how NHS England engages with families in circumstances of profound trauma.

We're also committed to supporting the Inquiry to ensure that its findings lead to tangible and enduring improvements in the care of people with serious mental illness and we will, of course, Madam, fully comply with your directions regarding the review of the disclosure that has been made to date.

We've listened to the evidence given to the Inquiry with care, and we wish to thank both our NHS England corporate witnesses but also all those who have given evidence. We acknowledge that this must often have been a difficult and traumatic process but what has been said

gives the NHS, including NHS England, much to reflect on.

As part of this introduction, we do wish to underline NHSE's position that the single most important measure for reducing the risk of harm both to the public and to patients is to ensure that people experiencing psychosis receive timely, effective, and evidence-based treatment.

In our view, the evidence before the Inquiry has demonstrated the importance of early access to quality mental health care, and we remain committed to supporting improvements in the quality, consistency and accessibility of those services.

We've summarised part of NHS England's evidence to the Inquiry both oral and written in our written submissions, and the Inquiry has heard directly from a number of NHS witnesses, including in their capacity as corporate witnesses, Dr James, the Medical Director for Mental Health and Neurodiversity, and Dr Sokolov as Regional Medical Director.

We've also disclosed relevant material to the Inquiry on a rolling basis in a process that has continued after the oral hearings closed, and so we seek to touch on a few key themes only now.

The first is the mental health landscape in England

and its development over the last 30 years.

We submit that as part of the Inquiry's findings on mental health services now, it should reflect on the profound changes in the delivery of mental health care in the last 30 years or so and the associated challenges. Since the death of Jonathan Zito 1992 and the subsequent Ritchie Report, the mental health system has become larger and more complex, and care once delivered predominantly in institutional settings is now delivered overwhelmingly in the community, reflecting successive policy decisions, advances in treatment, greater recognition of mental illness, and efforts to provide care less restrictive environments.

There has also been a substantial growth in demand and mental health services now support people with greater clinical complexity, often co-existing social physical health and substance misuse issues. Services are expected not only to provide treatment, but also to manage safeguarding concerns and risk across multiple settings.

So against that background, direct comparisons between the risks managed by services in the early 1990s and those managed today are not straightforward, and it may be that the Inquiry will ask whether the expansion of community-based treatment has been accompanied by an

increase in the prevalence of mental health homicides.

If so, conclusions on this will be for the Inquiry, and detailed analysis has not been attempted. But review of the data from the National Confidential Inquiry into Suicide and Homicide, or NCISH, does appear to suggest that the overall prevalence of mental health homicides has not increased over the last 30-plus years.

THE CHAIR: There's a difficulty, isn't there, with that statistic because obviously the treatment and trauma treatment has improved.

MS GREY: Yes.

THE CHAIR: And in fact there are now trauma centres which deal with stabbings and shootings and all sorts of things like that which are far more effective than they were 30 years ago.

MS GREY: Madam, I fully appreciate the complexity of those statistics and I would also like to just add briefly that when we make that assertion, it's not to seek to diminish the tragedy represented by each and every homicide, but they are complex statistics. I think it's right to say there has been a decrease in prevalence of homicides altogether, and so we've made the point that we don't seek to present any kind of detailed analysis which would be for the inquiry and its experts. But we do draw attention to those statistics, because you're

hearing, even in the submissions this morning, submissions about alleged failures on the part of community-based treatment.

And if the Inquiry is to enter into that terrain, it will have to consider the evidence quite broadly, including this data source to which we draw attention.

THE CHAIR: What's very important is that the database is better, and wider, isn't it?

MS GREY: Yes.

THE CHAIR: The National Confidential Inquiry stopped gathering in-depth data about homicides although it registered, as Professor Appleby has pointed out, the number. But I think the point that I'm making is that there's -- is there not an argument for inclusion of serious injury? Because the line between serious injury and death these days is really very fine and depends very much on the efficiency of the trauma services.

MS GREY: Well, we've recognised the evidence that the Inquiry has heard, both from NHS England, but also from Professor Appleby, which, as you rightly just observed, makes the point that statistics on death have continued to be collected even during the point when the more detailed analysis was paused, but there is a case for further extending that, and clearly both as part of consideration of the evidence emerging from this

inquiry, but also, in the course of considering any recommendations that you might be minded to make, those sorts of points would be very carefully considered in the course of commissioning that material.

THE CHAIR: Thank you.

MS GREY: Madam, just to conclude on that point, is that we do also acknowledge, because this is an important aspect of the NCISH data, that it suggests a continuing need to ensure the effective provision of services to people with severe mental illnesses, particularly those with psychotic disorders, and to address associated physical and health and social vulnerabilities, including substance abuse. So these are multifaceted statistics and we don't resile from the need to look at all aspects of them.

More broadly, the Inquiry has heard that pressures on mental health services have been recognised nationally for some time and received sustained policy attention, and again, we recognise that access to timely, high-quality and well-run services, together with the consistent delivery of evidence-based care, is critical to the safety and the effectiveness of mental health services. So sustainable improvement depends on ensuring that all elements of the pathway are sufficiently resourced, coordinated, and able to operate

effectively together.

If I turn briefly to the mental health policy framework, Madam, the Inquiry has heard that there is an established system of legislation policy, clinical guidance, including NICE guidance, and service models, intended to support people experiencing severe mental illness, including patients with psychotic disorders such as schizophrenia. And the evidence has also demonstrated the need for continued focus on the effective implementation of standards and good practice.

We submit that the evidence heard does show that patient safety has always been an essential part of national mental health policy and guidance. Both mental health law and good practice have always focused on both risk to self and risk to others, and those two objectives go hand in hand. And against that background, NHS England has consistently supported investment in services designed to deliver effective evidence-based treatment for people experiencing psychosis.

Now the Inquiry has heard much evidence about Assertive Outreach teams or AOTs, and national policy led to the establishment of AOTs across the country.

The Inquiry has heard that there was subsequently no national policy guidance or change requiring AOTs to be

discontinued, and NICE guidance continued to recommend consideration of intensive case management for patients with psychosis or schizophrenia who were likely to disengage from treatment of services.

Yet, despite this, over time, many local systems, including those of the NHFT, moved away from a high-fidelity AOT model and alternative models were increasingly relied upon for intensive case management of this group of patients in the context of managing finite resources, including of dedicated and expert staff.

Against that background, we suggest that the Inquiry may wish to consider recommending that NICE undertakes a review of its guidance on psychosis and schizophrenia. Consideration could be given to issues such as the maintenance of continuity of care in community mental health services, the management of individuals who disengage from services, and of those who have a history of violence, and when discharge from mental health services is and is not clinically appropriate.

We also invite the Inquiry to consider recommending that NHS England or any successors should work with the relevant Royal Colleges and the NMC to develop further clinical training with a specific focus on meeting the needs of, and managing the risks associated with,

higher-risk patients.

On AOTs, NHS England has been working to strengthen intensive and assertive outreach functions. And, Madam, you've heard how, in July 2024, we published guidance to ICBs on intensive and assertive community mental health care, and the 2024/25 NHS planning guidance required all ICBs to reference their community services to ensure effective provision for people with severe mental illness whose engagement presents challenges.

However, ICBs remain responsible for deciding how services should be configured and delivered within available resources in a way that meets local needs.

THE CHAIR: Is there not a risk that, bearing in mind that there is a limited budget and all ICBs that we've heard about are under pressure in terms of their budget, that if there's a choice between a fidelity model of Assertive Outreach and applying a lesser version of that, Assertive Outreach principles, that that's what's going to happen?

MS GREY: Well, Madam --

THE CHAIR: Because it may seem as if too much resource is being concentrated on what's being seen as a relatively limited number of people.

MS GREY: Well, Madam, firstly we would say that the guidance requires the delivery of the function, but that

there is a legitimate role for local decision making on the manner in which it is delivered.

And you've heard, of course, from experts such as Dr James about the reasons why, in some areas, and rural areas have been outlined as the paradigm, a high-fidelity or dedicated specific AOT team may not be the best use of the expertise that is available.

And so the question is how specific or how focused does the model, the directed model, as opposed to the outcome, need to be? And we would respectfully suggest that the guidance has drawn the right approach or has taken -- struck the right balance, and we have drawn attention in our closing submissions to the fact that this was put together with the support of an expert advisory group which included a wide range of experts, including, of course, Dr Dissayanaka and Dr Shubulade Smith from the Royal College of Psychiatrists from whom the Inquiry has heard.

THE CHAIR: Can I just ask also about groups, these groups, because there is a lot of groups which include lived experience, and representatives, and they're generally on the patient side, not on the carer or the community side. That's the public side. Is there not room in these advisory groups for members of the public, for example, who have an interest? Because they are the

community in which people are operating, aren't they?

MS GREY: Madam, I can't offhand recall the exact membership of that group. I think we appended or have put it in evidence, because it's an appendix to that, but if I might take that back for reflection by my clients, you've heard, I think, of the engagement that we have had with groups including, of course, the advocate from the One Hundred Families of -- for bereaved families in this context of this Inquiry, and there's been no doubt of the value of that experience.

THE CHAIR: Thank you.

MS GREY: But returning, if I may, just briefly, to structures, and it's perhaps an aspect of the question that you did ask me a moment ago. We do say that the improvements to, and the ongoing maintenance of, core community and crisis services must sit alongside strong Assertive Outreach, because, Madam, despite the point you were making, or perhaps in the context of the point you were making, about the availability of resources, each does depend on the other to be effective. Without a strong and effective Community Team, more patients' needs will remain unmet and may reach the tipping point at which escalation to AOT is warranted, which in turn can potentially overwhelm Assertive Outreach teams which operate through providing care to a limited caseload of

patients. So this is a complex landscape and we know that the issues raised by VC's case will not be viewed by the Inquiry in isolation from that complexity.

Madam, if I can move to the topic of improving safety under the NHS Patient Safety Strategy, in 2023 the NHS's response to serious incidents was governed by the Serious Incident Framework, which was the predecessor to the current Patient Safety Incident Response Framework, or PSIRF, which was published in 2022, which trusts began transitioning to in 2023.

In August 2022, the PSIRF guidance was published on engaging and involving patient's family and staff following a patient safety incident. And in the case of a mental health homicide, the expectation is that organisations engage openly both with the patient and their family and the victim's family, and involve a moral obligation to be open, honest, and supportive to all those affected. So we do submit that PSIF does represent a significant development in the NHS's approach to patient safety.

Additionally, the Mental Health Patient Safety Improvement Group was established by NHS England from January 2025 to focus on ensuring that the insights generated from patient safety investigations, or IPSI reports, together with other information on the safety

of mental health services are translated into improvement, and those independent patient safety report investigations are commissioned by NHS England, including following homicides committed by patients being treated for mental illness.

In relation to data about mental health homicides, we acknowledge the need to ensure that the methodology used accurately reflects the nature and impact of those events and enables studies of those causes. And I think, Madam, we have canvassed this already in both the evidence you have heard about the work done by NCISH and the questions that you've asked me about the possible further development of that work.

But we have set out the purpose of IPSIs in our evidence to generate insight to inform safety improvements by looking at systemic factors and failings.

IPSIs don't assign blame or liability, as you're aware, and consistently with that they don't name those involved in a patient's treatment. Individual failings are a matter for other processes, such as disciplinary or regulatory systems, and we do consider this to be the correct approach in order to avoid duplication and to ensure clarity of purpose as well as promoting psychological safety and maximising the potential for

learning.

Now, the IPSI commissioned in VC's case, the Theemis Report, has been studied in care with a number of issues raised, but before turning to those issues, we do invite the Inquiry to find that, overall, the Theemis Report was carefully commissioned from professionals who had appropriate experience and expertise, the CVs of the proposed authors were shared with the bereaved families, following a meeting with Theemis and NHS England met with them about the Terms of Reference. After appropriate quality checks, Theemis delivered an independent and highly useful, we submit, report, which formed the basis for actions by the Trust, as well as NHS England, and the Inquiry's own Terms of Reference has rightly charged the Inquiry to build on its findings.

Now we acknowledge that the establishment of NHS England's Mental Health Patient Safety Improvement Group shows the need to do more to ensure that learning and improvement are embedded after the publication of such reports, but the quality and utility, the IPSIs themselves, have not, it's submitted, been cast into doubt by the evidence heard by the Inquiry.

We recognised the bereaved families' disappointment that the Theemis Report didn't directly hold individuals

to account consistently with the longstanding parameters of such reports. NHS England did, however, communicate with the families involved throughout the process to explain the scope and purpose of the IPSI including through letters and email communications.

In relation to the publication of IPSIs the key concern is the need to uphold the protection given by law to a patient's confidential information, coupled with the difficulty of potential solutions such as trying to anonymise the individual involved. The Inquiry has heard that NHS England adopted new policy from February 2026, aiming to guide report authors to provide a single report capable of publication, rather than two separate, full and summary versions, whilst protecting confidentiality and safeguarding interests.

We acknowledge that tension still exists between this approach and the wishes of members of the public or family members for more information, but we submit that further legislation or action may be required to resolve such tensions, or to --

THE CHAIR: Do you think there's a distinction to be drawn there between family members or those immediately affected by these incidents, and the public at large?

MS GREY: Well, Madam, we understand the distinction, but it may be that it requires careful consideration, not least

in the history and the experience of this case, where we observe that there were attempts made, and genuine and honest attempts, to share the full report with the bereaved families, but that in itself led to further discussions, debate, and entirely understandable concerns on their part that they were then gagged, I think is possibly a loaded term, but prevented from discussing the context in the public domain.

So there's a distinction, but it is a very difficult one to manage in practice.

THE CHAIR: Yes, thank you.

MS GREY: And so we do say that if there are further steps to be taken, those steps have to be balanced against the potential for unintended consequences, including loss of patient trust in the confidentiality of that information.

Madam, in relation to NHS England's engagement with bereaved families, we've set out in our evidence the real efforts made to listen and respond to their concerns, whether through meetings or frequent email correspondence.

Overall, we did seek throughout to be open and transparent about what NHS England could answer and what the Theemis Report would deliver. It's clear however that there remained fundamental difference in

expectations and there was also frustration when, in late '25 or early '26, NHS England took the view that further questions from the bereaved families had to be answered via this Inquiry process.

And so we accept that whilst sustained efforts were made, the engagement didn't meet the needs of the families. We recognise that we didn't get this right, and we are genuinely sorry for that failure.

The Inquiry heard from one of NHS England's corporate witnesses, Dr Sokolov, who was the interim Regional Medical Director from November '22, taking up the substantive post in February '24, and she acknowledged on behalf of the organisation that one of the things that we need to consider going forward is how we do manage to engage with families, because it's not the responsibility of the bereaved or the affected to make this work, and we failed to do this in the way that we wanted to.

We will continue to reflect on the experience gained and what it shows about engagement with families during the IPSI process. We will also reflect on how we can improve communication with bereaved families and adopt trauma-informed approaches across the NHS, building on work already under way in other service areas.

NHS England does, however, submit that the evidence

of its actions demonstrates a proactive and genuine commitment to transparency, and doesn't support a finding of a lack of candour or dishonesty or deliberate obfuscation on the part of those acting on its behalf.

Madam, I'm conscious of the time, but if I can trouble you for a little longer and turn to the topic of learning from previous mental health homicides.

We note that the Inquiry produced a report, the Inquiry Legal Team review of mental health-related homicides, and that the themes identified by this work, including communication and information sharings, shortcomings in engagement with families and carers, deficiencies in risk assessment and care planning, concerns about the effectiveness of post-incident investigations, are serious and longstanding challenges.

And whilst considerable progress has been made across the NHS in response to patient safety concerns over many years, ensuring that effective learning is translated into meaningful and sustainable improvement remains one of the most significant challenges, arising from IPSIs and patient safety incidents across the NHS.

National frameworks, standards, guidance and reporting mechanisms play an important role and the PSIRF and its associated guidance demonstrate, we

submit, that NHS England recognises the need to further strengthen the system through which patient safety events are scrutinised and has sought to do that.

However, even the most robust national framework, cannot of itself deliver improved patient safety outcomes and those outcomes ultimately depend on the extent to which the lessons are translated and embedded, into changes in clinical practice, service delivery, leadership, governance, and organisational culture at a local level.

The steps taken by NHS England following the Nottingham attacks form a part of such efforts to secure change and of course they have been considered in detail by the Inquiry. At the level of the local health system, the Inquiry has heard that formal enhanced surveillance of NHFT started in August 2019, and from 2021 onwards, NHFT was placed in Segment 3 due, in essence, to CQC ratings for two specific services which didn't provide care to VC.

In February '24, the Trust was placed in Segment 4 due to quality, safety and financial concerns across a range of services. One of the reasons was the investigation relating to the care and treatment of VC, but overall, the decision to place the Trust in this enhanced support regime was due to the cumulative impact

of various concerns which had increased in the second half of '23. And the support put in place included the appointment of an Embedded Improvement Director who scrutinises NHFT's performance and improvement activity.

The director doesn't undertake inspection of NHFT's services and that remains the responsibility of the CQC and it was suggested in Inquiry hearings that the system of scrutiny of NHS Trusts was perhaps fragmented. But given the scale of the NHS and the value of local expertise, it is vital that accountability should be, first, to the individual organisational board followed by the local commissioners or ICB, with higher thresholds set by direct involvement by the region.

Furthermore, there must be reliance on the work of a number of expert bodies. For example, the CQC's ratings system requires the CQC to assess the quality of Trust services, NHS England contributes to the assessment of financial and resource governance to that process.

The Inquiry did hear that there was effective information sharing between the CQC and NHS England, and we submit that any other approach would risk duplicating effort and creating confusion.

The Trust remains subject to enhanced regional oversight, including the support from the Embedded Improvement Director for as long as is considered

necessary.

Madam, turning very briefly, in conclusion, to national initiatives, linked to the concerns heard in this Inquiry, but also in other contexts, about unauthorised access to patient data, NHS England has taken steps to strengthen prevention, monitoring, and staff education arrangements to stop unauthorised access to patient data, and the clear message has been that there can be no place in the NHS for those who misuse patient information.

Specifically with regard to mental health services, NHS England published the mental health personalised care framework in July 2026 which establishes a clear and consistent national framework for the planning, coordination and delivery of secondary mental health services for people of all ages, and it does highlight a number of the concerns investigated by this Inquiry. For example, it contains specific guidance on safety assessment, formulation and management planning, linking overall effective care and treatment to the management of risk. It requires the use of outcome measures to assess progress and it makes clear that disengagement from some services should not of itself lead to discharge from care, and reinforces the importance of families and carers in care planning and decision

making.

THE CHAIR: Yes, just looking at that framework, it doesn't really deal with the question of assessing capacity in relation to the central tenet, which is that the patient should be involved in their care.

MS GREY: Their care.

Madam, can I take that back? It's not something that, not having the text in front of me at this very instant, I'd wish to opine on further but we'll hear that comment and obviously --

THE CHAIR: If you want to make a further submission in relation to that, it would be helpful.

MS GREY: Thank you. That's an extremely helpful indication.

We do say that the fundamental elements of good care have not changed, and so the framework reflects the core principles of the Care Programme Approach, but consistent implementation of the principles has not always been achieved and the framework is designed to address this.

In addition, NHS England and the Department of Health and Social Care are developing a modern service framework for severe mental illness as part of the Government's 10-year health plan, and this too will reflect on recent lessons and learning from this

Inquiry, perhaps including the comments you've just made, Chair.

It goes hand in hand with the further development of services, such as the pilot 24/7 Neighbourhood Mental Health Centres, part of the plan for neighbourhood health services.

Ma'am, the Inquiry is aware that on 13 March 2025 the Secretary of State for Health and Social Care announced the government's intention to integrate NHS England into the DHSC and, through legislation, to transfer NHS England's function to a restructured DHSC.

The fact that some future functions are intended to transfer in this manner doesn't alter NHS England's current legal responsibility, and so its role as a Core Participant in the Inquiry reflects that present legal position, as well as its continued commitment to supporting the Inquiry.

Madam, in conclusion, we do wish to restate our sincere condolences to all those affected by this tragedy. We recognise the profound and lasting impact that these events have had on individuals, families, and communities.

We hope that these observations have been useful and look forward to the Inquiry's report.

THE CHAIR: Thank you, Ms Grey.

MS GREY: Thank you for indulging me on the timings, Madam.

THE CHAIR: We'll take a break now. I think if we can start again at 12 o'clock. Thank you.

(11.44 am)

(A short break)

(12.00 pm)

CLOSING SUBMISSIONS ON BEHALF OF DEPARTMENT OF HEALTH AND SOCIAL CARE BY MS SCOLDING KC

THE CHAIR: Yes, Ms Scolding.

MS SCOLDING: Chair, I represent the Department of Health and Social Care which I will refer to as "the Department" during the course of my short submissions.

I wish to start these submissions by thanking the Core Participants for their constructive recommendations directed at improving the system for mental health in England which the Department will carefully reflect upon and consider. We also provide, again, our sincere condolences and sympathies to the victims and survivors of the dreadful attacks of June 2023.

We are determined as a department to both listen and learn from the failures which this Inquiry has exposed. We will fully comply with the directions you made yesterday to ensure we have given all relevant materials to this Inquiry in line with our responsibilities to be frank and candid and commit to updating you with the

relevant policy developments on a regular basis.

Since the tragic events of June 2023 the families have, on a number of occasions, met with the then Secretary of State for Health and Social Care, Wes Streeting, and the then Parliamentary Under-Secretary of State for Mental Health, Baroness Merron. Arrangements have been put in place for further ministerial meetings to take place.

We, once again, thank the victims and survivors for their determination and dedication to make improvements to the system of mental health care in this country. We know it will have come at considerable personal cost. As set out --

THE CHAIR: Just a moment, Ms Scolding, the point was made by the Victims' Commissioner that they shouldn't have to do this, and also by Sir Rob Behrens, wasn't it?

MS SCOLDING: Yes, the reality is for all such tragedies such as this it is be the responsibility of the state and should be the responsibility of the state and state bodies to take effective and proactive steps and to engage with those victims and survivors. We accept that at present, and to date, that has not always happened, both in respect of this tragedy and in others.

One of the reasons why the accountability or the Hillsborough Bill, as it's very well known, has been

introduced is in order to try and encourage or take some steps towards rebalancing the responsibilities of the state towards it proactively engaging and the Department obviously supports that piece of legislation which was not introduced by it, but by other parts of the Government, and wishes to do all that it can to try to prevent the level of personal cost, which we know that having to continuously battle a number of different public organisations can lead to, and the difficulties that that can cause for the families at the times of their greatest grief and tragedy.

THE CHAIR: Thank you.

MS SCOLDING: As was set out during the written and oral evidence of the Department, whilst there has been significant investment in mental health services over the past 20 years, demand has risen and outpaced the services which are available.

The Department recognises that there are problems with the continuity of care in mental health services and that there is not always sufficient capacity in the system for staff to provide the quality of care which they would wish. The Department is trying to take a number of steps to seek to resolve these challenges and to improve service delivery in this area and across the NHS in general.

Firstly, it has introduced a 10-Year Plan to reform the NHS. This has three key aims: firstly, moving care from hospitals into the community; secondly, improving data and patient records through moving from analogue to digital, alongside the introduction of the single patient record, something which Core Participants have welcomed as a necessary change to improve recordkeeping and the interoperability of recordkeeping between different organisations; and changing the focus from sickness to prevention.

Work also continues on the cross-governmental mental health strategy for England. There has been a call for evidence seeking views on how best to deliver the three key aims of the 10-Year Plan in this particular context, which closed in July 2026. The Department will update the Inquiry with its response to this call for evidence once it is finalised.

This strategy will also be informed by the forthcoming findings and recommendations from the independent review into prevalence and support for mental health, ADHD and autism, which is expected in the near future. And will also align with the relevant Modern Service Frameworks, which are currently in development, and the commencement of aspects of the Mental Health Act 2025.

THE CHAIR: Can I just ask, Ms Scolding, in relation to this review and also the, what I'm going to call the Wessely review, the previous review --

MS SCOLDING: Yes.

THE CHAIR: -- they weren't specifically dealing, were they, with severe mental illness, psychosis and schizophrenia? In fact, I think that the Terms of Reference of the Wessely Report were rather different, weren't they?

MS SCOLDING: Well, they were looking at -- the Wessely review or the Independent Review of the Mental Health Act was looking at all aspects of mental health provision. That, by necessity, included people with psychosis and people with severe mental illness.

THE CHAIR: It wasn't the main focus though, was it?

MS SCOLDING: The focus was not on public protection, Chair.

THE CHAIR: No.

MS SCOLDING: The focus was on what was going well and what was going badly.

I think, as Sir Simon Wessely said to you, public protection was in the room, but I think we would recognise it was not the central focus as set out within the Terms of Reference. But plainly, Chair, if you think about the circumstances in which detention takes place under the Mental Health Act 1983, that plainly at the time and will continue to think about detention of

individuals because of their risk to either themselves or to others. That primarily and predominantly involves those in the severe mentally ill category; not exclusively so, but those individuals are the individuals who are most likely to require detention at various points in their lives.

I mean, hopefully the hope of the mental health system as a whole is to seek to minimise the need for detention, even for those who are severely mentally unwell, by providing adequate preventative services so they don't relapse into psychotic or paranoid schizophrenic episodes.

However, recognising that that does not always take place, it's plain, the Department would submit, that the Wessely review had to grapple with issues around psychosis and issues around detention and its effectiveness or otherwise in the context of severe mental illness like that from which VC suffered.

THE CHAIR: And the current review had prevalence and support for mental health, ADHD and autism. Again, the main focus of that is not the severe mental health.

MS SCOLDING: No, the focus of that is firmly upon aspects of ADHD and autism. Now, plainly, there will be people who fall into that category who also have comorbid diagnoses of paranoid schizophrenia or other -- or

bipolar disorder, for example. The diagnoses are not mutually exclusive in this context. However, what that is looking to do is look at a problem, an issue which has caused a significant expansion in the need and the demand for mental health services. So, plainly whilst it may not have a direct impact, the recommendations of it are likely to have an indirect impact, in terms of the way that resources may well be allocated between different aspects of the mental health system.

THE CHAIR: Well, that's the point that I'm making --

MS SCOLDING: Yes.

THE CHAIR: -- and I'm asking you to comment on: the fact that, so far, the issue of severe mental illness, as the Director of Mind acknowledged last week, has really not been at the forefront of debate, because of the risk of stigma.

MS SCOLDING: Yes.

I will obviously -- I am obviously unable to speak on behalf of the Department in that respect --

THE CHAIR: No, but in terms of your submissions.

MS SCOLDING: Yes, I mean, in terms of my submissions I think we would accept that neither the previous review or this review are focused specifically upon public protection in the context of psychosis.

That, Chair, is why your Inquiry is so valuable to

the Department: because it is an opportunity for you to very carefully consider and look at those aspects which may well not have been -- they have not been ignored but they have not necessarily been the central focus, and to consider what recommendations emerge from there.

And we obviously don't seek to identify any particular recommendations you make or don't make, because the role of the Department is to listen and act upon the recommendations that you make.

THE CHAIR: Yes, thank you.

MS SCOLDING: Many of the Core Participants have identified resource constraints within the mental health system as being a rationale or reason for failure in service provision.

There has been a spending increase for 2026/27 to a record sum of 16.1 billion for mental health spending, which is, in real terms, an increase of around 140 million from the previous year. The Department acknowledges, however, that Core Participants may well consider that that is not enough.

As the Inquiry heard, the Department has also made available an additional 473 million in capital funding over four years from 2026/27 to 2029/30, and is encouraging the system to invest in new models of mental health delivery, including community-based mental health

centres, building on findings from six pilot schemes about which the Inquiry heard evidence both from the Department and NHS England.

The Government has recently announced plans for up to 155 new mental health facilities across England, comprising 100 community-based mental health centres and 55 dedicated mental health emergency departments. This is in addition to the significant investment into health reforms more generally, such as the digital transformation of the NHS, that will indirectly improve the care and treatment of those with serious mental ill health.

The Department's written submissions and evidence to this Inquiry have set out in some detail the legislative reforms which have led to the passing of the Mental Health Act 2025 and the rationale for these. There were five key aims behind the amendments to the Mental Health Act 1983, the first of which was improving patient safeguarding and reducing unnecessary restriction. Secondly, strengthening the focus on therapeutic benefit. Thirdly, improving patient choice and autonomy. Fourthly, limiting the detention of people with a learning disability or those who have autism. And lastly, improving advance planning, patient and family involvement, and providing join-up across the

mental health system.

The 2025 reforms do not change the core powers and purpose of the mental health legislation which is fundamentally, as I have already explained during the course of these submissions, to detain and treat people when they are so unwell that they become a risk to themselves or to others.

THE CHAIR: Has the Department considered -- I think the point has been made throughout this Inquiry -- that not having a specific requirement for public protection alongside all of these other aims of the 2025 Act, that that diminishes that, makes it of less obvious status?

MS SCOLDING: The Department does not consider that the fact that the Act was focused on aspects other than public protection means that public protection has been diluted, because principally, the core, as I've just identified, the core powers and purposes of the mental health, the system for detention, remain, and risk to self and others, plainly -- the risk to others plainly encompasses not just close family members but members of the public who could be affected by individuals who are violent and dangerous.

It has carefully, the Department has read with care the written closing submissions that have been provided, as well as reviewing in detail the oral evidence that's

been given, some of which has sought to amend the Mental Health Act, in particular the detention criteria. The Department maintains its position that the appropriate balance has been struck in the amended wording pursuant to sections 2 and 3.

The Department's position is that the wording as drafted does not create greater complexity and is simply a reflection of what good practice should be and does operate on the ground at present.

The Department is of the view that the public protection element of detention can properly be maintained through the detention criteria as amended.

The Mental Health Act is accompanied by the Code of Practice about which you have heard much, and this is the document which in reality explains the legislation and provides practical advice and guidance on how it should operate. As William Vineall, the official who gave evidence on behalf of the Department explained in his oral evidence, the chronology for the enactment of the Mental Health Act 2025 will allow for further changes to be made to the accompanying Code of Practice.

The Department has already begun work on and engagement in respect of the changes needed to the Code of Practice which hasn't been amended since 2015, including engagement with various Core Participants to

this Inquiry, such as the Royal College of Psychiatrists.

Alongside this, it will launch a public consultation on the draft Code, which is anticipated to take place in the summer of 2027. This will enable the views of those with livedexperience, including those who have been the subject of tragic attacks by those who are mentally unwell, to be fully taken into account alongside those of clinicians.

THE CHAIR: Can I just ask in relation to that, that might be the public consultation but, for example, the engagement process which is currently being undertaken with what is referred to as "substantial stakeholder engagement", where is the, as it were, victims' element of that? Apart from the Victims' Commissioner, I would imagine.

MS SCOLDING: Well, I can take that back and provide you with a list of who has been consulted to date --

THE CHAIR: Thank you.

MS SCOLDING: -- and who it is proposed to be consulted for date (sic). And we will obviously seek to ensure that there is a reflection including those who have been the subject -- or who are the victims of those who have been seriously -- who have been injured or have died.

THE CHAIR: And families as well who -- (overspeaking) --

MS SCOLDING: And the families thereof, yes. We will seek to ensure that.

THE CHAIR: Yes.

MS SCOLDING: The Department has ensured that, based on the present timelines, the drafting of the Code of Practice will allow for the recommendations made by this Inquiry to be properly considered and adopted before the Code is commenced. The Department maintains that the appropriate way to provide further guidance, if there are concerns about the way that the detention criteria may operate in practice, is within this Code.

This is the document which is used on a day-to-day basis to provide support and guidance, and this is the document which should clarify issues, if they exist, around the meaning of serious harm or the likelihood of serious harm.

The Department has also considered the submissions which have been made which relate to Community Treatment Orders. It remains satisfied that the amended legislation, together with a redrafted Code of Practice, will ensure that Community Treatment Orders are used appropriately by clinicians. It will, however, carefully consider the proposed recommendations made by other Core Participants during the course of its work on the Act and Code.

The Department agrees with the view expressed by Core Participants that there were clear shortcomings in the care that was delivered to VC. There were errors in respect of his discharge, both from inpatient care and from specialist mental health services back to his general practitioner. This fails to consider or mitigate the risk of in accordance with medication and, as the Trust itself acknowledged, failed to recognise the risk that VC posed to himself and to others. It allowed a seriously mentally unwell person to go without treatment or oversight. These failures should not have happened.

The Department also notes that there was a widespread but, in its opinion, misplaced view that a Section 3 detention should not be used if a Section 2 can be. The Department is clear that this is an incorrect application of the least restrictive principle and will seek to reflect that within any amended Code of Practice.

VC should have been placed under Section 3 and not Section 2 detention. As the Inquiry has heard, this has led to him -- this led to him not being able to have the after-care services which would otherwise have been provided after discharge from Section 3 under Section 117 of the Mental Health Act 1983, which would

or could have provided a degree of oversight.

The Inquiry has heard from the authors of the CQC Review, which was directed by the Secretary of State for Health and Social Care under Section 48 of the Health and Social Care Act, into Nottinghamshire Healthcare NHS Foundation Trust. The Department agrees with the conclusions of this review, which found that the Trust and its clinicians had undertaken inconsistent approaches to risk assessment in respect of VC and had undertaken poor care planning and engagement.

The Department has continued to closely monitor the reviews that have taken place and the recommendations that have followed in respect of the Trust.

The Department last received an update on 24 June 2026 from NHS England, which identified that 37 of the 39 recommendations made in the Section 48 report are now considered to either have been completed by the Trust or by other organisations and bodies.

NHS England has also informed the Department that all recommendations made in the independent homicide review carried out by Theemis are complete or considered to be as complete as possible.

The Department will, however, continue to monitor progress of both the Trust and in respect of NHS England against any recommendations at six-monthly intervals.

In respect of Assertive Outreach, the 10-year Health Plan set an ambition to reach a hundred per cent national coverage of Assertive Outreach models of care by the end of 2035. It is, however, important to note, as was identified in the evidence of NHS England, that that Model of Care is not necessarily limited to a high fidelity Assertive Outreach Team. Whilst such a team will be appropriate in certain areas and for certain patients, it should not be considered a one-size-fits-all approach.

It is ultimately a matter for individual Integrated Care Boards, as is the case for all healthcare provision, to determine how their Assertive Outreach Model of Care will take shape, but as Ms Grey identified just before the break, it must be shaped by guidance, which requires that such coverage must exist.

The local approach allows for resources to be properly allocated and the efficacy of systems to be monitored. This does not mean, however, that in appropriate places there should not be a dedicated Assertive Outreach Team and somewhere like Nottingham would be an obvious place to have had one.

THE CHAIR: Just in relation to that, the point that I put to Ms Grey, which is where you're given an option, where the ICBs are given an option of the fidelity model,

which is clearly a more structured model, and dedicated, and applying Assertive Outreach principles, as it's put, in a tight budgetary situation, is it not likely that that might have an effect on the decision?

MS SCOLDING: Well, the position is it's absolutely clear from the NHS 10-Year Plan that Assertive Outreach is seen to be a model of care which both works and is required to take place. However, as Ms Grey and as the evidence from NHS England has identified, there may be some circumstances and some areas where a high fidelity model is either not needed or would not be appropriate to meet the needs of the community. The best place and the way at present -- and it is envisaged that this will continue to be the case -- for this to be determined is at Integrated Care Board level.

There will always be balances which need to be struck but plainly there is guidance currently from NHS England, also from the Department, because obviously not all particular aspects of health are mentioned in the 10-Year Plan. The fact that Assertive Outreach has been expressly mentioned demonstrates the Department's desire that this be considered very carefully by an Integrated Care Board and plainly, there is oversight currently by NHS England, in future by the Department, and by other regulatory bodies, to make sure that there

is appropriate allocation of resources and services to meet the needs, the mental health needs, of the community.

The personalised -- as Ms Grey has identified, the Personalised Care Framework published by NHS England on 17 July 2026 was drafted in response to recent cases which showed failures in care planning. The national guidance sets out expectations on services around that assessment, planning and management of safety and risk, and plainly, Chair, decisions about development of resources and development of services has to be looked at in the light of the requirement for individual Integrated Care Boards and relevant trusts to meet the expectations on services set out in the Personalised Care Framework, which includes where there is a risk of harm to others or the history of violence.

It provides greater clarity to mental health services on the core elements of care that they should provide to everyone with severe mental health problems and how practitioners are expected to deal with cases like VC.

During the break, Chair, possibly anticipating a question from you about capacity, I had a quick look at the framework but we will obviously come back to you and provide you with chapter and verse to try to manage

and deal with the -- (overspeaking) --

THE CHAIR: Because it is very centralised on the wishes of the patient, isn't it?

MS SCOLDING: Well, yes, however, there is discussion about where services should be provided. I mean, the wishes of a patient are obviously central to all healthcare provision. However, mental health care, unlike other circumstances, are circumstances where the wishes of the patient can be overridden, you know, ultimately by way of detention, because there are some patients, but very many do not wish to be detained, hence why we have the compulsory powers of detention. But we will obviously go away and provide you with a summary and analysis of the way that the framework operates --

THE CHAIR: And also in relation to capacity, I am --

MS SCOLDING: -- to try and provide you --

THE CHAIR: -- particularly interested in that bearing in mind what Mr Ruck Keene said.

MS SCOLDING: Yes, thank you. The Department have sought to take steps to improve the shortages of staff which lead to or can impact the quality of services provided, and also impacts the welfare and health of those who work for mental health services. It has recruited around 8,000 new mental health staff, of which half are mental health nurses, but recognises there is more to be done

in this area.

As Dr Seena Fazel and Dr Lade Smith, in the evidence they gave to this Inquiry stated: the quality of a number of staff are of exceptional importance to provide effective therapeutic care and to be able to undertake adequate risk assessment.

In respect of information sharing, the Department recognises that this can be a key tool in both public protection and the assessment of risk. Following Mr Vineall's oral evidence, the Department has commissioned NHS England to produce guidance on information sharing and public protection, the first stage of which is to be discussed next month.

The Department is also taking steps to seek to produce information-sharing guidance between healthcare services and the education sector, in particular higher education, to manage the risk of harm to self and others, and has engaged recently with the University of Nottingham to begin discussions on that process.

It will also consider whether the representation of mental health specialists at board level within an ICB would assist in ensuring that practitioners' voices are adequately heard.

And that may well, Chair, also feed into the reflections you have about ICB funding.

The Department will also take steps to consider how best to approach oversight of Prevention of Future Deaths reports, in particular by looking very carefully about how Integrated Care Boards, within their present set of powers, make sure that they address such reports, and that concerns are raised to the appropriate level at board.

The Department has also read with care the additional witness statement provided by Professor Appleby and will continue to monitor the data produced by the Inquiry closely. It will also continue to work on the NHS Modernisation Bill, which will improve patient safety and experience through a new single patient record, enabling more joined-up, proactive care.

The Department accepts that it should have done more to meet with the surviving victims and has taken steps to remedy this. Alison McGovern MP, the current minister of state responsible for mental health, as of August 2026, met with the surviving victims on 7 September, last Monday.

It is submitted that, in respect of the bereaved families, the Department has sought to engage proactively and has carefully considered their input in respect of the amendments sought to the Mental Health

Act and other potential legislative changes.

In closing, we end these submissions centred on the bereaved and survivors of the attacks on 13 June 2025 (sic). We again express our thanks to the families of Grace O'Malley-Kumar, Barnaby Webber and Ian Coates, and to the surviving victims, Sharon Miller, Wayne Birkett and Marcin Gawronski, and also to Celeste and Elias Calocane. We are grateful to the victims and their families for engaging with the Department, for urging us to do more, and for their clarity of purpose and commitment.

Finally, we reaffirm our commitment to listen and to act on the findings of this Inquiry and on the experiences of all those who have given evidence to it.

Thank you, Chair.

THE CHAIR: Thank you.

Yes. Ms Patry.

CLOSING SUBMISSIONS ON BEHALF OF NOTTINGHAM UNIVERSITY BY MS PATRY KC

MS PATRY: Chair, University of Nottingham is grateful for the unit to address the Inquiry by way of oral closing submissions.

The Inquiry already has the University's detailed written closing submissions, which set out the University's position more fully, together with detailed

references to the other relevant evidence, and I would commend those submissions to you.

THE CHAIR: Yes. As I've said to other advocates, I've read them in full and I also have your initial timeline.

MS PATRY: Thank you, thank you.

Having now read and heard the closing submissions of other Core Participants, the University is grateful for the concessions made by the police and by the Trust, some of the recommendations made by other parties, which I will come back to, and also, in many instances, the express recognition of the important work done by our staff.

Much of the evidence of the Inquiry has been difficult for all concerned to hear, including our wider staff and student University community, who are still significantly affected by the loss of two of our students.

Fundamentally, insofar as the University's role is concerned, the evidence has suggested that there were significant failures by statutory bodies to share risk information, primarily, we think, as a result of a lack of understanding of when risk information can be shared, as well as inadequate or inconsistent guidance surrounding information sharing and inter-agency working.

VC's family, further, did not proactively share information with the University at any time, or ask for any support for VC, other than informing the University of his first admission in May 2020.

Whether the University acted appropriately within the limits of its powers available is ultimately a matter for the Inquiry. However, having heard all the evidence, the University considers that it did act appropriately within the limits of its powers as an educational organisation.

The closing submissions of other parties, both in writing and orally, often appear to misunderstand the role of the University and its relevant powers so I will come back to this. But in that context, the University considers it important for the Inquiry to recognise, despite their necessarily very limited role, the professionalism, the commitment and dedication demonstrated by many of its staff during VC's time as a student, and particularly Ms Turner.

Staff, we say, worked diligently in difficult circumstances and often through no fault of their own without access to all the relevant information as it was often not made available to the University by relevant statutory services. Often, the University were the only ones sharing crucial risk information at relevant times.

However, I wish to also make this clear: the issue of poor information sharing by the statutory services and others with the University during VC's time as a student is a different question to the question of whether the actions of the University had any bearing on the events of 13 June 2023.

The Inquiry has heard no evidence from any witness, whether factual or expert, which suggests that any different action by the University would or even could have altered the course of events.

The University's position is that VC's trajectory was not shaped by the University's conduct during his time as a student there but by the failure of statutory services to share critical risk information both internally and externally, to provide and/or maintain effective treatment for his illness, and to manage the risks which he posed to the public which they were responsible for.

The tragic events of 13 June occurred over a year after VC had graduated and after he had been discharged entirely from secondary mental health services, a decision which the University played absolutely no part in and was unaware of. It is therefore impossible, we say, to causally link any step which the University could realistically have taken, whether excluding VC

from his course, triggering Fitness to Study policy, or requiring medical disclosure after his voluntary interruption, to ultimately what happened or to find that the failure to take such steps was a contributing factor.

These oral submissions are necessarily limited and I will deal with only two things: One, some of the points made in the oral submissions by other Core Participants; and two, the key points which the University wishes to make in closing.

I'll structure my submissions as follows. I'll begin by setting out the nature and limits of the University's role and powers, as I said I would come back to that, before turning to the role of the Mental Health Advisory Service within the University.

I will then address what the University considers to be the central issue in respect of its part in this Inquiry, the repeated, and as I said, systemic failure by services to share relevant risk information with the University.

I'll then address questions which have been raised around the University's Fitness to Study and disciplinary policies, the decision to move VC's flatmates rather than VC following the January 2022 assault, and VC's voluntary interruption of studies.

I'll then deal briefly with the legal framework for information sharing, the University's own information sharing, and finally I'll set out the recommendations which we would respectfully invite the Inquiry to make.

So starting with the University's role and powers. It is really important for the Inquiry to understand and have firmly in mind the nature and limits of the University's role. The University is a charity whose principal regulator is the Office for Students. Its charitable purpose is to advance education. It is not a statutory service. The University's duties are primarily educational. There is no statutory duty of care towards students and its obligations in relation to those with physical or mental health issues are limited.

To the extent that the University provides health, support and wellbeing-related services, it does so only in the context of an educational setting in order to enable students to maximise their student experience.

The University's Mental Health Advisory Service, which I'll call MHAS, is a specialist referral-only service for students who experience significant mental health difficulties. The MHAS team is very small. It only has four to eight staff at any one time and as its name makes clear, it is an advisory service only.

It does not and cannot provide mental health

diagnosis, assessment, or treatment. It provides advice and it can liaise with relevant statutory mental health services, but importantly, it has no power to compel a student to attend or take advice from MHAS, to prescribe or monitor medication, to require that information be shared with MHAS by a student, or to compel any statutory service to provide information to MHAS.

On that basis, which is in line with the University's role and remit, and particularly where a student is under the care of statutory services and doesn't wish to engage with MHAS, MHAS is obliged to take a reactive rather than a proactive approach, albeit the chronology shows -- and I'll take you to some of this -- that the University, and Ms Turner in particular, were proactive on a number of occasions in this case. Any argument from Core Participants that staff were ill informed and disengaged is both factually wrong and misunderstands that role.

For context, and importantly, while the University does informally assess risk as part of its welfare and support functions, it has neither the expertise nor the power to carry out formal risk assessments. As the evidence of witnesses such as Dr Tully and Dr Faizal made clear, formal risk assessment is a specialist

endeavour carried out by trained professionals using specialist tools such as HCR-20v3 or the Oxford violence tool, and they require appropriate resources, training, and perhaps even more crucially, full sources of information. This is important to understand because in some of the closing submissions it appears to be suggested that the University at various points in the chronology ought to have assessed risk for itself, should have sought information for that purpose, or should have taken a proactive role at every opportunity.

This is to wholly misunderstand its role and purpose, which, as I've said, is primarily to provide education.

The informal assessments that it does make, such as considering whether a student should remain on campus or whether flatmates should be moved, those are welfare judgements made in an educational context and on the basis of necessarily limited information the University has been given. They are not and they cannot be clinical risk assessments.

I'm going to turn to the work of MHAS in this case. Despite that necessarily very limited role, the evidence disclosed that whenever the University was in fact aware or became aware that VC was ill or potentially ill, Ms Turner and her team made every attempt to ensure that

mental health services and, if necessary, the police were aware. They queried decisions around discharge, they challenged decisions not to detain; and in that sense, what Ms Turner and her team did was provide an additional layer of oversight for VC. They facilitated cooperation and escalated concerns, often at times when no one else was doing this.

Staff working for MHAS often went over and beyond their duties because of their concerns for VC and the wider student community.

I'm going to mention some key examples which are important ones. The first example is from May 2020. As soon as Ms Turner became aware of the incidents which had taken place at Brook Court she liaised constantly with VC's mental health team and was very concerned about VC returning to Brook Court. She was the only professional advocating for VC to return to Wales, despite the fact that Brook Court wasn't even University accommodation.

The second example is, as a direct result, in June 2020 the University liaised with the police to let them know that VC was to be imminently discharged from detention and the associated risks. Neither the Inpatient Team nor the Crisis Team took the time to do that. It was thanks solely to the actions of Ms Turner

and Stuart Croy, the then head of security, that the police then became aware that Brook Court was not University accommodation and had the opportunity to warn the relevant victims of VC's discharge.

And also, my third example, in January 2022, as soon as Ms Turner became aware of the assault on Christopher by VC, she contacted mental health services. The police didn't. It was thanks to her actions that the assault even became known to the EIP team. And, even more importantly, that the subsequent Mental Health Act Assessment was arranged which eventually led to VC's fourth admission, Ms Turner having repeatedly informed mental health services that VC could not remain in the University, or the third-party accommodation at Raleigh Park and that she was concerned that the plan to care for him in the community would fail.

I turn to the fundamental issue insofar as the University's part in this Inquiry is concerned: information sharing.

The central issue in this case insofar as it concerns the University is that statutory services didn't, on a number of crucial occasions, share relevant risk information with the University, either in a timely fashion or in some cases at all. I should again make clear that the argument that information should have

been shared is not an argument about causation of the events on 13 June. It is an argument about the protection of the University and community during VC's time as a student and about the systemic changes needed for the future.

I propose to deal first with the relevant duties to share information very briefly.

In understanding the relevant legal duties, it is important to distinguish between, on the one hand, the underlying legal framework which permits the sharing of risk information, and, on the other hand, the professional guidance which assists practitioners in understanding when and how to do so.

As to the law, the University's position is that actually the position is clear: data protection legislation doesn't prevent the sharing of information when there is a risk of serious harm to others.

Paul Arnold, the then interim CEO and deputy Information Commissioner, you will remember, Madam, gave evidence that if there is a genuine policing purpose, for example, and it's necessary to share information with the University, then it can be shared. The law permits it. The difficulty, as the evidence has repeatedly shown, is that many police officers don't understand that the law permits information sharing in

certain circumstances, and there's insufficient guidance to give them the confidence to act on it.

Insofar as the Trust is concerned, and, as an example, Dr Susan Elcock, the Deputy Chief Executive of the Trust, accepted in oral evidence, that the relevant GMC guidance provides that clinicians must share relevant risk information with universities if there is a risk of serious harm. And on the facts of the present case, information about VC's triggers, as well as all the relevant incidents, should have been shared with the University.

Professor Smith explained that medical information can be shared by clinicians in two circumstances, she said: with the consent of the patient and where there is thought to be a risk to others.

The NMC code similarly requires nurses to share necessary information where the interests of patient safety and public protection override the need for confidentiality, as Paul Rees MBE of the NMC accepted. Amber O'Brien of the Royal College of Nurses accepted that this NMC guidance was not sufficiently clear for nurses and, without clear standards from the regulator, it's quite difficult to develop further guidance.

The gap, therefore, is not, we say, within the law, which plainly permits sharing where there is a risk of

serious harm, but in the guidance which translates the law into practical, confident action by frontline professionals.

The University's position is that, in particular, the incidents involving Feven, Sebastian and PC Pritchard, and the surrounding admissions under the Mental Health Act individually and cumulatively created a real risk of serious harm and the legal test for disclosure in relation to both police and clinical staff was plainly met.

The University submits that there was no lawful basis, whether in data protection legislation, duty of confidentiality, or the therapeutic relationship, or any rational basis for the failures to share this information.

What was lacking was not legal permission but professional confidence, clear guidance, and a culture which prioritises the sharing of risk information over a reflective and often misplaced caution.

I turn to the submissions on the police.

The stark fact is that the University was never made proactively aware of any of the incidents involving VC and the police by the police, despite the fact that it became increasingly clear that he posed a risk to the University community. The police failed to inform the

University of all three Brook Court incidents, the September 2021 assault on PC Pritchard, the assault on Christopher on 15 January 2022, and all and each of the incidents involving Sebastian who was himself a student at the University. I'll take them very briefly in turn.

Turning to the Brook Court incidents from May and July 2020. You're well aware that on 24 May 2020, two incidents took place at Brook Court. Despite him being a student at the University and this being known to the police from the time of his first arrest, neither the police, or I should say, in passing, any mental health professional, contemporaneously made the University aware of these incidents. You'll recall the evidence of Inspector Katie Eustace who attended that first instance confirming that she was aware that VC was a student but she didn't pass details on to the University and was unaware of the information-sharing agreement.

PC Gail Collins --

THE CHAIR: I think she recorded the other University, in fact?

MS PATRY: Yes, indeed.

PC Gail Collins who investigated the first incident also acknowledged in oral evidence that she was aware that VC was a student but did not inform the University at any stage. PC Richard Marsden who attended the

second incident, Feven incident, told the Inquiry he didn't inform the University because, I quote "Informing the University is not normally something I would do."

It was not until late on Friday, 29 May 2020 that the University became aware of any issue at all when VC's mother emailed two academics at the University to inform them that VC had been admitted to Highbury Hospital due to a psychotic episode and would be unable to take his forthcoming online exam.

This email made no mention of the two Brook Court incidents but when this information reached MHAS on Monday, 1 June, Ms Turner immediately sprang into action. She called VC's mother. She contacted the Student Support and Wellbeing Officer in Engineering to ensure that VC's academic studies were paused and that he was not caused any additional stress.

She emailed the off-campus affairs manager to find out if he was aware of where VC was living, and whether there were any affected housemates, and she called Highbury Hospital to immediately place MHAS's contact details on VC's file.

It was only on 3 June 2020, when she spoke to Dr Seedat, that she became aware of the second Brook Court incident and that VC was requesting discharge to his Nottingham address. She strongly advocated for VC

to return to Wales where he had family support. She asked for a copy of his discharge plan and risk assessment. This was never provided to her. And Dr Seedat, as you'll recall, confirmed in oral evidence that it was never sent to Ms Turner and was unable to explain why.

Ms Turner was so concerned about the discharge that she took the unusual step of contacting Stuart Croy, the University's Head of Security, to help him liaise with the police -- to request him to liaise with the police. She provided him with a detailed case summary. It was as a result of this and solely as a result of this, as I've said, that the police became aware that Brook Court was not University accommodation, and could warn the relevant victims.

In July 2020, a third Brook Court incident took place and VC was readmitted. Again, the police did not inform the University. PC Michael Plant, who responded to the incident, agreed in oral evidence that the occurrence log referred to VC being a full-time student and he accepted it would have been very easy for him to make inquiries and to inform the University. PC Jamie Severn of the Street Triage Team also accepted he was aware that VC was a student but he considered it was the AMPH's role to inform the University.

Then moving along the line, the AMHP, Geoff Culpin, did not inform the University either, despite the fact that AMPHs are meant to seek information from all relevant sources. He told the Inquiry there were no barriers to sharing information with the University.

I turn to the assault on PC Pritchard, please. During summer 2021, VC -- it's important to remember this, he was on a Voluntary Interruption of Studies but his intention was always to return for the start of the academic year. On 3 September 2021 during the course of a Mental Health Act Assessment, VC, we say, seriously assaulted PC Pritchard.

VC was then detained and shortly thereafter he returned to the University for the new term. The University knew nothing of these incidents, nothing of the diagnosis of paranoid schizophrenia, the assault, the admission, or the decision of the Mental Health Review Tribunal in due course.

Counsel to the Inquiry described as "astonishing" the fact that the University was unaware of all these incidents, and the University entirely agrees.

Chief Constable Kate Meynell confirmed in her evidence that she would have expected this information to have been shared by the police. She also agreed the police needed to get much better at information sharing,

and that there was nervousness about sharing because officers often did not understand what they could and could not share.

Multiple police officers, PS Ellis, PC Johnson, PC Myers, all confirmed that they did not inform the University during this period. Each had different reasons or justifications but each accepted in evidence that this information should have been shared.

I turn very briefly indeed to the Sebastian incidents in summer 2021. Again, VC still on interruption at that stage.

Also unknown to the University, over summer 2021 there had been multiple incidents relating to Sebastian who was, as we know a PhD student who had lived with VC. The University wasn't made aware by the police of any of these at the time. The police officers involved, PC Pannell, Superintendent Price, PS Langham, all failed to share that information despite knowing that Sebastian was a student at the University.

Turning to January 2022 and beyond, when the assault on Christopher took place on Saturday, 15 January, there was a marker on the PNC against VC for serious violence. There was a history of incidents relating to people living in the same accommodation as him and there was an obvious risk to the wider University community. Despite

all of that, the police failed to contact the University to let them know of the assault.

PS Faulkner either didn't ask PS Zacharia to contact the University or PS Zacharia didn't follow his instructions. It doesn't matter. Either way, the University didn't become aware of the assault until Monday morning and even then this was only because the affected students reached out to the University proactively. Those students weren't made aware by the police of the PNC marker either.

VC graduated, as we know, from the University in summer 2022 and his last contact with the University was in August of 2022.

So after dealing with the police, I turn to the Trust. There are also a number of instances where the Trust failed to share relevant information with the University. Risk information, which they could share.

In May 2020 when he was admitted to hospital following the second Brook Court incident we know that the treating team became aware of a number of concerning factors such as text messages containing violent thoughts, VC's references to thinking about capital punishment, having a solution, an emerging risk profile, but none of that, none of that was closed to the University. Dr Seedat did not provide the discharge

plan or risk assessment, as we've touched upon.

Further, at no stage, including post January 2022, was the University informed that academic pressure or stress might be a trigger for VC's psychosis. Dr Seedat accepted that in oral evidence and also said that he may not have explicitly said to Ms Turner that it was important to try to address VC's stresses.

Given Ms Turner's meticulous attention to detail and professional curiosity, there can be no doubt that she would have taken further steps if she'd been aware of that.

Now, the AMHP, obviously employed by the city council, not the Trust, who conducted the May 2020 assessment, Ben Williams, accepted that he would usually speak to the University if a student was involved, but he didn't do so because it was a bank holiday weekend. No explanation was given as to why he couldn't have contacted the University after the weekend.

Dr Ludvigsen, who completed VC's core assessment and was aware that he was thinking about capital punishment and all those other things, did not share any relevant risk information with the University. She appeared in oral evidence not to really fully understand, with respect, the difference between sharing information generally and sharing risk or particular risk

information.

Following the third Brook Court incident, in July 2020, the University wasn't informed of the readmission for nine days, until MHAS received an email from the ward. Ms Turner's colleague, Kath Gent, was told that the discharge was planned. MHAS again expressed concerns about VC being discharged to his Nottingham address. But he was told -- they were told that he'd improve and could manage risk independently.

Ms Turner emailed VC asking him to engage with MHAS. He responded, and they had a telephone call. He explained he felt well and was compliant with medication. She encouraged him to agree to a referral to the University's Disability Support Services but he declined that and then refused any additional MHAS support. It is really difficult to see, in those circumstances, what MHAS could -- what else they could have done at that stage.

Ms Birtles, who became VC's care coordinator from June 2020, accepted that she had not shared the risk which VC posed to his neighbours to the University at any stage.

Then in September 2021, following the assault, which I've been through, and his detention, a range of NHS professionals could have informed the University but

didn't. Dr Manzar, one of the two Section 12 doctors present when PC Pritchard was assaulted, accepted that it would have been very relevant for the University to know and that it was astonishing that the University was not informed.

The AMHP, Amie Staples, accepted she was aware that VC was a student returning to the University but said that once he was admitted, it was for the ward to let the University know.

Dr Shoilekova, VC's Responsible Clinician at Cygnet, told the Inquiry that she wouldn't have told the University anything as VC didn't consent to it.

Dr Lloyd, the Responsible Clinician upon discharge from Priory Arnold, did not inform the University of any of the incidents, the admission, or the involvement of the EIP team.

The lack of information sharing by the EIP team continued after VC's discharge, of course. In October 2021, when he was discharged, no member of the EIP team made contact with the University, despite being plainly aware he was a student and the nature of the risks posed. They didn't contact the University to find out where he may be living, and in December 2021 and January 2022, when VC was plainly disengaging and non-concordant with medication, still no contact was

made with the University.

All such contact, we say, should have proactively come from the Trust. They had the information. The information -- the University is very grateful to Dr Lloyd for accepting personal responsibility for the lack of information sharing in December 2021 and January 2022. The University is also very grateful to Ms Birtles for accepting the difficulties that the team was having with VC should have been shared with the University. And Gary Carter also agreed that the risks posed by VC during this time and after 15 January 2022 should have been shared with the University. We're really grateful for those concessions.

But the consequences of the failure, and that's what's important, are plain. It meant that the University proceeded, entirely understandably, on the basis that VC's psychosis had resolved in summer of 2020, and that he was returning to the University fully recovered. Although its role is not to formally assess risk, as mentioned earlier, it was wholly unable to make any welfare decisions as to the risk to its community.

Following VC's detention in January 2022, the University was not informed when he was granted unescorted Section 17 leave just six days after

admission. Dr Thangavelu accepted that the University hadn't been told and that this denied the University the opportunity to speak to VC about how he might obtain his belongings, to warn students, or to inform them what they should do if VC returned. In fact VC did return to Rayleigh Park on 3 February 2022, unnerving the flatmates that he'd lived with.

Ms Turner telephoned the ward immediately on the same day to voice her concerns. VC was subsequently discharged on 24 February 2022, and, again, the University was not informed.

The University only found out because Ms Turner proactively telephoned VC on 20 February 2022 to check in on him, and Dr Thangavelu accepted responsibility for that failure.

Can I turn to some other matters that have arisen in the context of the University's involvement in this Inquiry. The question of Fitness to Study and exclusion is the first one.

Although -- some, although not all, of the closing submissions raised whether the University ought to have triggered its Fitness to Study or disciplinary policies to either discipline VC or require him to withdraw from the University at some stage.

The University's position is really clear on it, and

its corporate witness statement and written closing submissions set out the relevant policy tests in considerable detail and apply them to all the relevant stages of the chronology. The submissions of other parties, we say, fails to identify and address the correct policy tests and/or the relevant context.

Put shortly, at no stage did the University consider it appropriate to discipline VC for any of the incidents which took place during his time at the University.

This was for several reasons. First, the Code of Discipline requires that actions be shown to be intentional or reckless, which would have been very difficult to establish in the context of VC's illness.

Secondly, such a step would have been destabilising for VC at a time when the Trust was telling the University that stability was important. Keeping VC stable at that point was plainly in the best interests of the University community as a whole.

As to the Fitness to Study policy, Ms Turner explained that she correctly considered it as primarily linked to a student's academic performance, not as a tool to assess or manage risk posed by a student. Professor Linehan explained that in January 2022 it would have been inappropriate to engage the Fitness to Study policy when VC was being assessed for detention

under the Mental Health Act.

But ultimately, and this is a really important point, of course, there is no evidence, and certainly no expert psychiatric or mental health evidence, to suggest that requiring VC to withdraw from the University without completing his degree would have had any positive or safeguarding effect for either himself or others.

Such a decision would not have resulted in his exclusion from private accommodation, for example. That was beyond the University's powers. And the opposite appears to have been true: withdrawal would have entirely removed the additional layer of support and information sharing which the University was actually providing.

In fact the evidence demonstrates that the risks associated with VC did not diminish after he left the University. On the contrary, he continued to disengage from secondary mental health services, he was ultimately discharged from them, he was non-concordant with medication, he remained only intermittently in contact with his family, he went on to assault colleagues at his places of work in February and May 2023, and then ultimately committed the offence of 13 June 2023.

Can I turn then to the decision to move students.

One of the questions also raised by some Core Participants was whether it was sensible to move VC's flatmates out of their third-party accommodation rather than VC after the January 2022 assault. Ms Turner made this decision with her considerable experience and she described it as the "least worst option".

She was concerned that moving VC would have potentially increased the risk to the students, as he could experience delusions around people in accommodation. Moving VC also ran the risk of further disengaging him from NHS support.

This decision was wholly supported by the evidence. Dr Skelton emphasised contemporaneously that it was very important to keep VC stable. Dr Lloyd agreed, in oral answers to the Inquiry. Roseanna Crane, the AMHP, also concluded the same.

Dr Manzar accepted in responses to questions from you, Chair, that this was the only way the risk to the community could be managed. There is simply no evidence from any mental health professional that requiring VC to leave the flat would in fact have been safer for the flatmates, the University, or the wider community.

I turn now to Voluntary Interruption of Studies. It has also been suggested that the University could or should have required VC to disclose medical information

when he returned from his voluntary interruption in September 2021. The University doesn't accept that. And it would be really concerned by any finding that medical evidence should be required in all cases where a student has a history of mental illness. We say such a requirement would be inappropriate.

In assessing whether the University should have required medical information, it's critical to understand actually the whole chronology and context and we deal with this in much more detail in our written closing submissions.

But the bottom line is this. VC did not tell the University in November 2020, when he was seeking to interrupt, that he was interrupting because he was ill. He told his personal tutor that he was finding studying difficult after the summer when he'd been ill, and that he didn't feel prepared for his fourth year. His email to the senior tutor referred to "extenuating circumstances" and being unable to cope with the demands of the course. His interruption form referred to "mental fatigue" but at no stage did he say that he was currently unwell, and when Dr Barney, the senior tutor wrote to him before his return in September 2021 asking him whether he needed any assistance, he replied that he was in good spirits and quite eager to get back into

full-time education.

There was simply no indication, either at the time of interruption, or at the time of return, that he was ill, that he'd been detained during the interruption, or that he'd assaulted a police officer. The University just wasn't told the truth by VC and the evidence makes clear that even if asked, he would not have disclosed it.

Perhaps more fundamentally, requiring VC to disclose medical information at any stage would have placed the onus on a person who repeatedly did not tell the truth to professionals, and who did not wish to disclose such information to the University. The evidence of that is clear and set out in considerable detail in our written submissions.

The key finding which the Inquiry is invited to make on this is that the University was not aware of the incidents which took place in summer of 2021 because statutory services failed to share relevant risk information with the University, as was required, and as I've already alluded to.

I then turn to the University's own information sharing. It's been suggested or it was suggested at one stage that the University had only shared limited information with the police. Well, that's not accepted,

and in written submissions I've set out very carefully the four relevant occasions when information could have been shared and submit that on each it acted appropriately and within the limits of its powers and I say no more about that.

As for internal information sharing, the University applied a need-to-know approach, which again is carefully detailed in the written submissions. This was clearly the right approach and the occasional reference in the closing submissions of other parties to a lack of internal information sharing fails on each occasion to carry out that detailed analysis of precisely who knew what at every stage of the chronology and the context for the University's decisions in each case.

Properly understood, all relevant persons who needed to be aware of VC's medical information were informed at the appropriate time, and all staff knew how to escalate concerns. But this was the case, as is evident from the very start of the chronology, when VC's mother contacted individual academics who then liaised with the relevant colleagues as required to manage the situation.

I turn to recommendations.

As set out already, the evidence discloses this widespread lack of confidence amongst clinicians and police officers to share information in situations where

it was lawful to do so. The University respectfully invites the Inquiry to make recommendations in areas which I shall come to very briefly, but put briefly, the University also respectfully agrees with some of the recommendations of others. So I would ask you to note that we accept the recommendation of the bereaved families at paragraph 6.15, the survivors at paragraph 82 of their closing submissions, the City Council at 121(n), and the Trust at 351.

However, it would not support, as some have suggested, Universities having direct access to Trust or police systems, given the limited duties and powers of universities and that it is the statutory services who hold the responsibility and risk when it comes to individuals who are seriously unwell or a threat to the public.

So turning to the recommendations again, they've been dealt with in closing submissions so I deal with them briefly: A national information sharing framework. Well, first and perhaps most importantly as far as the University is concerned, the University recommends the establishment of a national information-sharing mechanism so that all agencies, the NHS, police, and Universities have standardised information-sharing processes. An agreement with one local NHS Trust or

police force does not address information sharing with other trusts, other forces, or private providers, and bear in mind the student population can be very transient.

The University is pleased to report that the Department of Health and Social Care, as Ms Scolding just alluded to, have been in contact since the evidential hearings to set up a meeting to discuss further information-sharing guidance. We're very grateful for that approach.

Guidance from the ICO. Secondly, we invite you to make a recommendation that the ICO work with the higher education sector to provide detailed guidance covering a wider range of issues than the current 1-page guidance, which only applies in emergency situations. Mr Arnold of the ICO helpfully agreed he would undertake to work with the University and the sector more generally to provided such guidance.

And then guidance on internal information sharing. We've dealt with this briefly in submissions, but the University would welcome a recommendation inviting the ICO to work with the higher education sector to provide detailed guidance on internal information sharing which balances the need for student privacy with the need to share with academics on a need-to-know basis.

So, in conclusion, Madam Chair, in summary, we invite the Inquiry to make the recommendations set out above, which primarily deal with the issue of information sharing between universities and statutory services, as well as the need for guidance relating to internal information sharing.

In the meantime, the University will continue to support its community affected by the tragic events of 13 June 2023, including Wayne Birkett's partner, who works within that community.

It would like to thank the Inquiry for the focused and dedicated way in which it conducted the evidence hearing, Counsel to the Inquiry for the immense work put into these hearings, and everyone involved in the writing of the report for the task ahead.

The University remains committed to understanding and learning from the full context relating to the tragic events of 13 June 2023, and working with all relevant parties, and in particular our partners in the City of Nottingham, as needed, to implement any recommendations from the Inquiry.

Unless I can assist you, those are my submissions.

THE CHAIR: No, thank you very much.

MS PATRY: Thank you very much indeed.

THE CHAIR: Thank you.

Right, we're going to take a break now, and we'll start again at 1.50. Thank you.

(1.08 pm)

(The Short Adjournment)

I N D E X