**Wednesday, 9 September 2026**

**(1.50 pm)**

**(Proceedings delayed)**

**(1.55 pm)**

**CLOSING SUBMISSIONS ON BEHALF OF CROWN PROSECUTION SERVICE BY MS CAREY KC**

**THE CHAIR:** Yes, Ms Carey.

**MS CAREY:** Chair, the Crown Prosecution Service, or CPS as I'll refer to them for short, understands that the decision to accept pleas to manslaughter by reasons of diminished responsibility in respect of the killings of Barney, Grace, and Ian, has gravely disappointed their families. But on behalf of the CPS, for the reasons I'm going to develop, I submit it was the correct legal decision on the facts of this particular case.

I say legal decision because it was one for the CPS and the CPS alone and it was the decision to take impartially, dispassionately and, most importantly of all, independently.

But in saying that, as Michelle Mannion, Deputy Head of the CCU acknowledged to HMCPSI, "The difficulty in this case is reconciling the different views of justice. None of us," she said, "could bring back their loved ones, and that's a frustration, but as prosecutors all we can do is apply the law and our guidance."



And those sentiments were echoed, Chair, by Ms Shallow, who also said to HMCPSI:

"Anyone who works in the system knows that we take decisions independently. I had a statutory obligation to make decision in that way. They had an obligation to their children to do what they needed to do because of what happened." [As read]

And you may think, Chair, that those obligations are very different, but explain why each Core Participant comes to the Inquiry from their very different perspectives, perspectives which may be difficult, if not impossible, to reconcile.

From the CPS perspective, it was the CPS's obligation to apply the Full Code Test and make a decision based on the evidence and that independence, I submit, is vital to the way prosecutions in England and Wales are undertaken.

In summary this afternoon, we submit that the evidence in this case is clear.

At the time of the killings and the attacks on Sharon, Wayne, and Marcin, VC was in the grip of a psychotic state which arose from his paranoid schizophrenia. As Dr Blackwood made clear, his violence emerges in the context of his untreated psychosis, and it is that psychosis that lies at the heart of the



partial defence of diminished responsibility.

That diagnosis of schizophrenia is not challenged and there can be no doubt that, having heard the evidence, VC was not suffering from a personality disorder.

Before I address some of your Terms of Reference, I just want to say this: the CPS assembled in this case an incredibly experienced team of prosecutors to prosecute VC's case. Alan Murphy, the reviewing lawyer, and Specialist Prosecutor, had over 20 years of prosecutorial experience, as did Sam Shallow, the Head of the East Midlands Complex Case Unit.

Leading counsel, Mr Khalil KC, had been in silk for two decades, much of which he spent working on homicide cases, and his junior, Peter Ratliff, was junior Treasury counsel, entrusted to prosecute the most serious and complex cases in the country.

In addition, the CPS took steps to instruct highly experienced experts in Dr Blackwood and Dr Latham, again both of whom have decades of experience as forensic psychiatrists and have been involved in many complicated and high-profile criminal cases.

It's against that background, Chair, and given that the partial defence of diminished responsibility does not apply to the attempted murder charges, the next part



of my submissions will focus on the acceptance of the pleas to manslaughter in respect of Barney, Grace and Ian.

Chair, you may have little difficulty deciding that in VC's case, given his prior history with mental health services, it was immediately apparent that mental health issues may feature in his case, whether that be by way of the partial defence, the defence of insanity or his inability and lack of fitness to plead.

The case law makes clear that a defence of diminished responsibility will only be available if a defendant adduces expert evidence of his or her mental state. Expert evidence is, therefore, an integral part of the evidential picture of cases where the partial defence to murder does or may arise. And so we submit the decision to retain Dr Blackwood on 14 June was not pre-judging the case or the outcome; it was an eminently sensible decision designed to secure one of the country's leading experts in such a serious case.

Once the defence served their expert report from Dr McSweeney, Dr Blackwood was properly and fully instructed. You may recall this email in which he described Mr Murphy's instructions as, I quote, "very helpful", "unusual to receive this helpful degree of instruction".

And those instructions specifically address the legal test for diminished responsibility, and, in particular, ask Dr Blackwood to consider whether there are features of the evidence which appear to demonstrate VC could potentially form a rational judgement or exercise self-control.

That letter of instruction, in my submission, demonstrates the care and thought that was being given to VC's case.

You have from Dr Blackwood a list of materials he considered for his report which shows that the key records and relevant material in the possession of the CPS were provided to him, including VC's phone records.

Contrary to what you heard yesterday, and as Mr Murphy confirmed in evidence, Dr Blackwood was provided with the footage of the incident involving Christopher.

Now, I'm aware that it's been suggested that more material could have been provided to Dr Blackwood, however, in our submission, none of that extra material would have altered his conclusions about the applicability of diminished responsibility, nor realistically could it. Indeed, Dr Blackwood confirmed in his evidence, as did Dr Latham, the additional material he has seen during the Inquiry did not alter



his conclusions as to VC's state of mind at the time of the killings.

**THE CHAIR:** The fact that they've been produced late means that he wasn't able to ask --

**MS CAREY:** Yes --

**THE CHAIR:** -- VC about them, and that's a significant matter, isn't it?

**MS CAREY:** Yes, and I'm going to come on to that, but you're aware, Chair, I think, that a number of those pieces of new material were not, in fact, even in the possession of the CPS and therefore couldn't be provided by those who instruct me to Dr Blackwood.

**THE CHAIR:** I accept that, yes. And that's certainly what's been said anyway.

**MS CAREY:** Can I come back to the material that's been disclosed post the end of the hearings in a moment, please.

But before I do, it is important to remember this evidence. Dr Blackwood described Elias Calocane's evidence of the calls on 12 and 13 June and the zip files as being incredibly important when assessing VC's state of mind at the time of the attacks. He said this:

"It's there before the offences, it's there in the middle of the offences, and both sets of information



speak to his psychotic motivation." [As read]

Now, there may be a separate issue about whether this additional material could or would have affected the court's sentencing exercise. In our submission it's important not to elide the two matters. One is the applicability of the partial defence, and a second matter is the retained responsibility, which is a matter for the judge at sentencing, and they are two separate matters, in our submission.

But, dealing with the applicability of the partial defence, Dr Blackwood's second statement carefully and comprehensively explains why additional material such as the notes found at Burford Road are matters he would have asked VC about but, as he set out:

"I cannot envisage how any discussion thereto would have changed my approach to the essential matters in the case." [As read]

And we would urge, Chair, caution before dismissing or substituting his opinion with non-expert opinion.

Each of the four psychiatrists, Dr McSweeney, Dr Blackwood, Dr Shoilekova and Dr Latham, were, independently of each other, satisfied that the tests for diminished responsibility was met. You know that each psychiatrist has duties as experts to provide the court with objective and unbiased opinions.



But notwithstanding the unanimity of expert evidence I do want to address some of the misunderstandings which still may exist in relation to diminished responsibility and its applicability to the facts of this case.

In VC's case, the statutory test set out in section 52 of the Coroners and Justice Act 2009 was satisfied, because all psychiatrists concluded that VC was suffering from an abnormality of mental functioning, i.e. his psychotic state at the time of the killings, which arose from a medical -- recognised medical condition, namely paranoid schizophrenia, and which substantially impaired his ability to form a rational judgement and exercise self-control, and which was a cause or contributory cause to the killings.

The CPS were alert to the fact that some of VC's behaviour that night might indicate an ability to form rational judgement or exercise self-control which is precisely why Mr Murphy's instructions specifically asked Dr Blackwood to address those matters, and Chair, you know he did in his report where he explained that people in the grip of a psychotic episode do not necessarily lose all aspects of their rationality.

Thus, despite psychosis he remained capable of seemingly rational behaviour such as the slowing down for speed bumps or modifying his breaking and entering

behaviours.

Dr Blackwood expanded on that when he gave evidence before you when he explained that VC's behaviour is not profoundly disorganised. But instead, his psychosis is characterised by what is called a distorted reality, which is why VC does not behave in the way people might ordinarily think.

Some people may have expected VC to have exhibited more florid behaviour whilst in police custody, whereas in fact, as Dr Blackwood explained, in interview, VC displayed what he called a blunted effect: no emotional reaction from him in spite of what he was being shown.

These seemingly rational acts, did not, as Dr Blackwood concluded, undermine the conclusion that VC's psychosis caused the offending.

The fact that VC displayed some signs of rational behaviour does not mean diminished responsibility does not apply. A plea to diminished responsibility does not mean that VC did not intend to kill. Quite the opposite. Partial defence only operates once the CPS is satisfied the defendant intended to kill or cause grievous bodily harm, and in this case the prosecution was entirely satisfied that VC intended to kill.

Chair, in relation to the suggestion that VC may have taken drugs, there was and there continues to be



a complete absence of evidence to suggest that VC's psychosis at the time of the attacks was linked to or exacerbated by voluntarily intoxication with drink or drugs.

You know that once remanded to prison he remained unwell.

I'm sorry, I didn't mean to -- did you want to say something?

**THE CHAIR:** Well, there were some enquiries which could have been carried out into what he had been doing and who he had been with in the period leading up to this incident.

**MS CAREY:** Do you have in mind Bill Monteiro?

**THE CHAIR:** Yes.

**MS CAREY:** A number of things about that. Firstly, the enquiries are a matter for the police. But I accept, of course, the CPS could say, "Have you considered making this enquiry or that enquiry?"

That Bill Monteiro seemingly has a connection with drugs does not ergo establish that VC does. That guilt by association reasoning would not withstand, in our view, the evidential scrutiny.

Contrast that, the absolute absence of any drugs or drugs paraphernalia found on him. Nothing on his phone to suggest he had taken drugs let alone dealt drugs. Nothing found on him at the time of his arrest after the



attacks. Nothing smelt on him.

You have in addition: no prior arrests for drug-related offences. No students from whom statements have been taken say he ever saw or associated with drugs and his family also say that they do not believe he used drugs.

So whilst, of course, that enquiry could have been made, it does not, in my submission, outweigh the preponderance of evidence that this is not drug related or drug exacerbated.

**THE CHAIR:** It would have been -- there could have been more done in relation to the toxicology at the time, couldn't there? And I think that is accepted now.

**MS CAREY:** Chair, there could. Yes, you've heard from, I think, the SIO, Mr Sanders, who accepted that, but in my submission the evidential picture was clear. And one only needs to remind themselves of Dr Blackwood's explanation which was this: the illness was not and is not reducible to a drug-induced psychosis.

He went further with HMCPSI when he said, "It is a case of pure psychosis." That was the position at the time of the sentencing, and as you know, in fact, the sentencing judge was aware of the admission to one-off drug taking as recounted by Dr Mirvis. So the position was clear, we say.



I've referred to Dr Latham. May I just touch on him briefly. I want to explain in the clearest of terms why he was not instructed. He was not instructed because the CPS considered that Dr Blackwood or Dr McSweeney's conclusions were wrong. Nor was he instructed, as has been asserted, to shore up the prosecution approach. Far from it. Dr Latham was instructed to address the families' concerns that the experts had backdated their assessment of VC in custody to his mental state at the time of the offences.

He was also instructed to try to provide reassurance that the decision to accept the pleas was the proper course in this case. And that was in accordance not only with the Bereaved Family Scheme but also with the CPS's utmost wish to try to help the families understand why the acceptance of pleas was appropriate.

May I make this clear. Had Dr Latham disagreed with the other three experts, the case would have been reviewed and as the CPS conference note of 27 November makes abundantly clear, if it meant going to trial on murder, we would.

Dr Latham concluded that the partial defence of diminished responsibility was the proper conclusion of each of the experts. Indeed, he went further by saying it would have been highly unusual for them to come to

any other conclusion.

He told you in evidence this was a classic case of schizophrenia. This is such a clear diminished responsibility case for so many reasons. I think it's very difficult to see how the experts could have reached any other conclusion in this case.

And so drawing those threads together, and as HMCPSI concluded, it was clear from the review notes, the conference notes, counsel's advices, and email exchanges that the CPS and counsel had carefully scrutinised whether it was appropriate to accept pleas. To describe Mr Murphy's review of the psychiatric evidence as "disingenuous" mischaracterises what, in my submission, is a thorough review of the three psychiatric reports on the key issues he was asked to advise about.

To criticise the initial advice provided by counsel ignores the fact that counsel was specifically asked for a short advice and they were asked for a short advice for this reason: from 2 October 2023, when Dr McSweeney's report was served, right the way through to Dr Latham's report on 17 December, the CPS thoroughly and properly considered the evidential picture in a number of conferences, reviews, and written advices.

The decision to accept pleas was not therefore a rash decision. And I can do no better than remind you



of what Mr Khalil King's Counsel stated in evidence where he said he had no concerns, that either he or the CPS that rushed the decision to accept the pleas or had otherwise not considered the matter properly.

He said:

"We individually and collectively have been focused upon potential defences from the very outset, and that never changed. Every time more material came in, I for my part, and I know from emails with Alan Murphy and others, who were individually and collectively reassuring whether any material shed further light on altered, diminished, or changed our views as the overall picture of the case." [As read]

Those advices and reviews properly considered the applicable case law. There would have needed to be a rational basis to invite the jury to reject the expert opinion and there was no such basis in this case.

It is unsurprising, therefore, that HMCPSI concluded that the decision to accept pleas was correct, noting that had the CPS disregarded the Code for Crown Prosecutors and proceeded to trial on the murder charges, it's likely the judge would have stop the trial.

Chair, the CPS is aware how painful and upsetting the decision to accept the pleas would be and continues



to be. But assessing whether the evidential test is met is a purely legal question, and a case which does not pass that evidential stage must not proceed no matter how serious or sensitive.

I submit the CPS properly analysed all the evidence including the expert evidence, applied the relevant law, when determining whether that Full Code Test was met. It was, in our submission, the right decision on the facts of the case.

Chair, may I turn to matters that are said to go to the sentencing exercise, matters that could have been brought to the attention of the sentencing judge.

Now, your Terms of Reference explicitly state that you will not consider any independent judicial decisions.

**THE CHAIR:** I'm stopping at the court door, which still includes what was provided.

**MS CAREY:** Yes, quite. So that's why, in my submission, it's important that I develop some of these submissions, particularly given that it's now asserted that the CPS failed to consider and scrutinise all reasonable lines of inquiry.

And so it is important, though, for everyone listening to understand that at the heart of the High Court judge's decision was consideration of whether



the need for public to be protected from VC was better achieved by the imposition of a hospital order with restrictions or the hybrid order. The sentencing law requires the court to focus on public protection, and that was endorsed by the Lady Chief Justice in the Court of Appeal, who made it clear that had he not suffered from the mental condition he did, the sentencing judge would doubtless have considered a whole life term. But she made clear, the judge, nor indeed her court, could ignore the medical evidence which led to these events or the threat to public safety which he continued to pose.

She went on to state that focusing on the question of public protection was entirely in line with case law, which essentially says the graver the offence and the greater the risk to the public, the greater the emphasis the judge must place on public safety.

It's against that background that we submit that any suggestion that the new matters could or would realistically shift the balance away from public protection to a more punitive sentencing disposal is unrealistic.

Chair, the CPS and prosecution counsel prepared lengthy sentencing notes setting out why the prosecution submitted the judge should impose a hybrid order. And in our submission, the prosecution quite properly put

before the sentencing court the relevant evidence which had -- might have reflected the judge's decision.

It was suggested that no decision was given to VC's culpability for not taking his medication. In fact, both Dr Blackwood's report and his addendum did consider VC's resistance to taking medication, and Dr Blackwood made plain that VC's failure to comply with his prescribed oral antipsychotic medication was not, in his view, a culpable admission, but one determined by VC's lack of insight into his illness, an integral feature of his disorder.

As I'm dealing with sentence, can I deal with the Beddoe report. You know that the Beddoe review was prepared following a request from counsel to highlight the features of evidence that may have strengthened the Crown's submission that VC should receive a hybrid order. That context is important as the report was not designed nor intended to be an attempt to persuade the CPS to reconsider its decision to accept the pleas.

It's also different to the officers' reports on the MG6E, which were not created for the purpose of assisting counsel to prepare his submissions to the sentencing court.

**THE CHAIR:** It appears by the time it was produced that it had been forgotten that somebody had actually asked for



it. It was dismissed, wasn't it, on that basis -- (overspeaking) -- we got this?

**MS CAREY:** Yes, when the Beddoe review came in, Alan Murphy had forgotten that in the conference with the police and CPS when deciding to accept the pleas, Mr Khalil King's Counsel had said that a note setting out potential matters that might suggest a hybrid order was more appropriate would be useful. It was forgotten that that was the reason for the genesis of the note, when the note was itself received by the -- (overspeaking) --

**THE CHAIR:** A bit hard on DC Beddoe who had done that work, wasn't it?

**MS CAREY:** I'm not necessarily going to disagree with that, but it's important not to lose sight of what the Beddoe report was intended for.

**THE CHAIR:** Yes.

**MS CAREY:** And in fact, as you know, it made some good points which were then incorporated into the sentencing. There were other matters that were in error or weren't accurate in terms of the law -- (overspeaking) --

**THE CHAIR:** Not all of the points that he makes were incorporated into the --

**MS CAREY:** Not all of them, no.

**THE CHAIR:** -- opening -- (overspeaking) --

**MS CAREY:** No, not all of them. But I leave that to the



judgement of Mr Khalil King's Counsel.

What is important is that the sentencing note did speak about the planning, the extensive use of weapons that had been bought many years before, the hiding in the shadows, the loss of the bag. A number of features which may have persuaded the judge a different route were properly before the court.

That Beddoe report it has been suggested was in some way covered up or hidden because it appears on the MG6D, the sensitive schedule.

**THE CHAIR:** Do you think that the description of his previous history was adequate?

**MS CAREY:** The description of the -- in the Beddoe report or in the --

**THE CHAIR:** In the presentation that all of the previous incidents -- were they full enough? Were they covered? Because really what the judge was told us was that there was no previous convictions.

**MS CAREY:** Well, he did have no previous convictions, that is right, because VC had never been brought in before the court.

What was before the court? Well, all of the expert reports, which set out extensively the four admissions, and included references to the incidents, albeit that they didn't lead to convictions. So, in our submission,



the sentencing judge had all of the relevant information, whether it was by way of a PNC report, not in this case, but he was fully aware of the harm that VC had done, for example in the Feven incident.

I was just dealing with the suggestion, an erroneous one in our submission, that the Beddoe report was covered up.

In our written submissions, we have sought to correct the misunderstandings and set out fully the disclosure regime as covered by the Criminal Procedure and Investigations Act, and indeed supplemented by the Code of Practice and the AG's guidelines. I'm not going to read it all out but, in summary, investigators are required to record and retain and schedule any unused material which is material relevant to an investigation. It goes on to one of two schedules if it falls into material relevant to an investigation.

The CPS then review those schedules to decide whether there is material that meets the statutory test for disclosure to the defence. I emphasise those words Chair, because that is at the heart of the regime. CPIA does not exist to provide disclosure to any other party apart from to the defence.

You have heard that, ordinarily, internal communications between the police and CPS are not

scheduled at all. If they are to be scheduled, however, it is perfectly proper to schedule them on the MG6D because confidentiality between the CPS and the police obviously an important public interest. You yourself have seen the PII disclosure codes which expressly list internal police communications as a category of sensitive material, and you may think, Chair, that free flow of information between the police and CPS is in itself an important matter of policy, particularly so in the context of privileged discussions and communications between police, CPS, and counsel relating to submissions to be made at sentencing.

The inclusion of that report on an MG6D is therefore part of the established disclosure process. It is not a means of concealing material but rather of highlighting to a prosecutor material that falls into a recognised sensitive category.

That report did not undermine the prosecution case or assist the defence and accordingly was not disclosable.

It's incorrect to assert, therefore, that the Beddoe report was covered up.

Now, I know the bereaved families are still concerned that this was hidden from them. But the suggestion that it was hidden misunderstands the



disclosure regime which governs disclosure to the defendant and to no one else.

No other reports, statements, exhibits, or unused material are provided to anyone other than the court. And so I'd urge you, Chair, not to lose sight of the fact that the Beddoe report does not undermine the decision to accept pleas, and matters in the report that were relevant to sentencing were in fact placed before the court.

Turning to that sentencing exercise and the provision of additional information, the written submissions alight upon a phrase used by the Court of Appeal which stated there was no history of independent offending unrelated to the schizophrenia, and in our submission that statement was and remains accurate.

The assertion that there should have been further investigation of VC's behaviour between 2013 and 2020, notwithstanding that some of that time frame is not within your Terms of Reference, and in particular, the assertion that the line "illegal actions 2013/2014" would have displaced the overall conclusion in 2023 that VC was highly dangerous in our submission is unrealistic.

You'll also bear in mind in Dr Blackwood's second statement he makes plain that even if that phrase was



a reference to an assault, there was insufficient other evidence to lead to an additional personality disorder diagnosis and wouldn't have altered Dr Blackwood's approach to sentencing.

Chair, yesterday you were addressed in relation to the assault on PC Pritchard. And reliance was placed on Dr Lomas's evidence who was present at the scene when the assault took place, that VC was not, and I quote "overtly psychotic."

The reliance was suggested that this potentially indicated that VC's attack on the officer was not linked to his schizophrenia. Can I make two points about that; firstly the phrase "overtly" must not be taken out of context from Dr Lomas's evidence as a whole, which makes plain that the absence of overt symptoms does not rule out psychosis, particularly when you have, as VC did, a history of psychosis.

That accords with Dr Latham's report who told you in terms that severely mentally ill people do not necessarily look or behave in a way that allows determination of whether they are in fact ill, particularly where VC's psychosis is not profoundly disorganised.

And, moreover, you know that that incident resulted in his third admission under the Mental Health Act where



he was placed in seclusion and required antipsychotic medication to be administered intramuscularly. In any event, the court was aware that VC had assaulted a police officer in 2021 and was aware of this aspect of VC's background when determining how best to protect the public.

Criticism is made that Dr Blackwood failed to ask VC about the incident at Barker Ross warehouse on 15 February. That was not an incident that was reported to the police. It was therefore not a matter the police or CPS or Dr Blackwood could have been aware of. In our submission, whether he was psychotic at that time or was simply angry with his co-worker matters not. Given the overwhelming conclusions of the psychiatrist about VC's culpability on 13 June, that incident would not have tipped the balance in favour of a hybrid order.

Chair, in our submission, the CPS was right to ask the court to consider imposing the hybrid order and we appreciate the court's decision not to impose a penal element heaps yet more disappointment on the bereaved families, but given the evidence before the sentencing court and the need to protect the public, none of the new matters could realistically have affected the High Court Judge's view as to the appropriate sentence. He had at the forefront of his mind public protection and

it was his view that the public was best protected by hospital order with restrictions, a decision with which the Court of Appeal agreed.

If, and I do stress if, all the new matters were interpreted by you in a way most adverse to VC, they simply serve to demonstrate how dangerous VC truly is and why the need to protect the public was paramount.

Chair, the Terms of Reference also require you to consider communications with the survivors and the bereaved so may I turn to that, please.

It should be noted at the outset of these submissions that the HMCPSI report found that the CPS had met its obligations to the bereaved families under The Victims' Code and the bereaved families scheme. And HMCPSI found that the prosecution team, and I quote, "were committed to delivering the best possible service to the bereaved families and were disappointed that some of the bereaved families were unhappy with the service they had received from the CPS".

That conclusion accurately summarises the feelings and the views of the CPS lawyers involved in VC's case.

The Family Liaison Officers, the FLOs, are central to the communication between CPS and families and you may think that given their close relationship with families and their understanding of families' particular



circumstances, FLOs are uniquely placed to make those judgements about what information should be communicated and when it should be communicated.

**THE CHAIR:** Well, except that they don't always have the opportunity to make that decision themselves, do they? Where -- because they're directed by the inquiry, by the investigation.

**MS CAREY:** Yes. In part. But if there is an important meeting coming up, the CPS do rely, for example, on the FLO to say, "We're going to impart it a week before because this family needs a longer run-in", or the CPS may say, "Actually, we don't want to overwhelm this family with information until the night before."

That kind of distinction is exactly why the FLOs are central to the provision of communication between the families. Each family has its own needs, desires, wants, and preferences for how things are communicated.

**THE CHAIR:** I mean, in some cases it may be sufficient to have somebody like an FLO who is embedded in the investigation, but also experienced in dealing with families. But in some circumstances, looking at somebody who is independent and who, in a sense, is an advocate and guide for the families, that would work as well, wouldn't it?

**MS CAREY:** It would, and we in our written submissions



haven't argued against that although we do make this point: The Victims' Code specifically states the FLO will normally act as a single point of contact. And there is always a risk, with a multiplicity of either agencies, people or organisations, that either communication gets mis-transferred as it's interpreted down the line or, in fact, information gets missed because one organisation thinks one side is doing it and the others don't.

Equally, there's always a risk, Chair, that the more people who are involved, for some families may be overwhelming. And that's why a single point of contact is not of itself necessarily a bad way of communicating and it's why it's embedded in The Victims' Code. So it's not that we would say, "Please don't have a further independent advocate" but perhaps there may be cases where it's not appropriate and one always wants to bear in mind that a multiplicity of people may not be appropriate for each and every bereaved family.

I refer there to the Victims' Code and the single point of contact for this reason: any suggestion that the CPS is using the FLO system as an excuse for what are said to be failures misunderstands the framework for communicating with bereaved families. The system is designed for FLOs to act as the main conduit for



communications and that's precisely what happened in VC's case.

In VC's case, meetings were offered at the outset to all the bereaved families and the survivors and their families. Offers to meet were repeated at moments of key decision making and, indeed, at the conclusion of the sentencing exercise. Now, some families took those offers up, others did not, and that is entirely to be expected and respected, given the differing ways people react, and had their lives upended by VC's criminality.

The surviving victims were each offered the opportunity to participate in the bereaved families scheme but all declined to do so.

On 8 September, following an indication that Ms Hodgson may wish to meet the CPS, Mr Murphy suggested to the police that Ms Hodgson be offered the opportunity to meet the CPS at the PTPH as counsel would be there that day, and on 24 November Ms Hodgson confirmed that in fact she would like to meet the CPS and SIO but perhaps at sentencing.

That first meeting accordingly took place at the sentencing hearing. In contrast, Marcin Gawronski and Ms Miller had expressed clear views that they did not wish to attend court or meet with the CPS. Ms Miller, in particular, was clear it was because she wanted to

put the matter behind her, understandably you may think, and those views were respected.

Chair, yesterday you were reminded of some of the evidence of Wayne Birkett and Tracey Hodgson, who told you that from their perspective they didn't feel that their particular needs were taken into account when they were spoken to at court by counsel. You may recall Mr Khalil was asked about that. He told you he was conscious that Mr Birkett would find it inevitably difficult to follow what was being said, and so he was careful in the language he used, but he said this: he was reassured that Mr Birkett had family members who would be able to understand what Mr Khalil was saying and speak to him subsequently, and he told you this: that he was asked what he described was perfectly sensible and good questions. You may recall there was a suggestion made post the sentencing exercise that the families were concerned that VC would be sitting in his cell, effectively, playing snooker and it was Mr Khalil who took some time to disabuse them of that, and so that is one of the examples of what Mr Khalil described as perfectly sensible and good questions, which to him conveyed that the family understood and followed what was being said.

And so you have on one hand Mr Khalil's perspective



that he did try and adjust how he explained the sentence to Mr Birkett and his family. You have, equally, Mr Birkett and Ms Hodgson's evidence that that isn't in fact now how they recall it or remember it. It's not a question, Chair, of you deciding who is right or wrong here, but it's another example, in our submission, where parties have different experiences and perspectives, but it doesn't mean the prosecution did not try to ensure that his sentence was understood.

**THE CHAIR:** There's also the possibility of the difficulties of understanding and dealing with brain injury --

**MS CAREY:** Absolutely.

**THE CHAIR:** -- which is not known to everybody.

**MS CAREY:** Yes. But it wasn't for lack of effort, and we are sorry now to hear that notwithstanding the efforts that were made, Mr Birkett and Ms Hodgson feel that their needs were not taken into account.

Chair, a final few matters, if I may. I know you may wish to consider whether a written explanation of diminished responsibility ought to have been provided before December. As I've already addressed you, families react in different ways, and indeed, within this particular case, you know, for example, a one-size-fits-all approach would not have worked.

James Coates told you his preferred method of



communication was via telephone calls as he was concerned that receiving lots of letters, information would get lost.

Dr O'Malley-Kumar told you it was important for her to have information in writing. Equally, Mrs Webber thought information, particularly where it related to institutional failings or potential failings, should be in writing.

Sharon Miller told you she didn't want to receive any information at all.

Her partner Martin said his preferred method of communication was face-to-face.

Tracey Hodgson expressed a concern that emails were sent to Wayne Birkett but his brain injury was such that he was unable to reply to them, and so the reality is that even within this case, each family has its own preferences and needs. Those preferences and needs can change over time. And so whilst we certainly do not argue against a recommendation that written explanation be provided, we would caution you against mandating it in each and every case.

**THE CHAIR:** You say at the beginning of your submissions that it's -- diminished responsibility is a legal concept that's often difficult for those without knowledge and experience of criminal law to understand.



I think it's probably quite difficult, sometimes, for those with experience of criminal law and knowledge to understand, and obviously that's why we have our second review by the Law Commission at the moment.

**MS CAREY:** Quite. It isn't straightforward.

**THE CHAIR:** And presumably the CPS is contributing to that?

**MS CAREY:** That I'm not aware about but I can certainly find out. I'd be surprised if they didn't have a view about it. But what it does show, in our submission, is this: If the law remains in diminished responsibility as it currently stands, there's going to be no argument that it is sometimes not easy to understand. Mandating that information be provided in a particular way at a particular time is something we would urge caution about. Some families, for example, don't want to engage with the CPS at all.

Can I address one other potential recommendation that arose out of the written submissions.

We agree that a prompt evidential or forensic assessment should be undertaken as soon as possible, for defendants plus suspects in this particular category of offending. But it is doubtful that this could always be facilitated whilst a defendant is in police custody. That's not just because of the logistics, Chair, involved in making the arrangements of having the

assessment, but the suspects are subject to PACE clock, the evidence may not be ready, the medical records may not be ready, phone records may not be ready, and proposed recommendation that they be seen in police custody also assumes a defendant would be advised to cooperate with that assessment that could be later used at trial.

The premise itself is a good one, but the logistics and practicalities of it may, in our submission, require some thought and further consideration.

**THE CHAIR:** I think the practice survived the introduction of PACE. We've heard about it in the past --

**MS CAREY:** Dr Latham, I think, recalls it was in his early days.

**THE CHAIR:** Exactly. So it wasn't something that was ruled out --

**MS CAREY:** No.

**THE CHAIR:** -- as a result of PACE, was it?

**MS CAREY:** No, but he was also careful to draw a distinction between a mental health assessment to see where the suspect was best treated or whether they required inpatient treatment immediately and an evidential assessment to be used at court in due course.

So it just highlights -- this is not a bad idea in principle but one needs to be clear about the parameters



of the assessment, where it can be used and cognisant of the fact that it may not always be possible to do so at such an early stage of the case.

Chair, they are all of the submissions that I wanted to make on behalf of the Crown Prosecution Service. Is there any other matter that I can assist you with?

**THE CHAIR:** No, thank you.

**MS CAREY:** Thank you very much.

**THE CHAIR:** Oh yes, there was one matter. I think I raised the question of Section 62 --

**MS CAREY:** Yes.

**THE CHAIR:** -- as to whether you want to make any submission on behalf of the CPS.

**MS CAREY:** No, we don't. We understood that yesterday, in your questioning of Mr Moloney King's Counsel, that there was a query as to whether Section 62(10) should be amended so that there was express provision for a sentencing judge to take account of an adverse inference, and it seemed to us --

**THE CHAIR:** In the appropriate circumstances.

**MS CAREY:** Quite. The words in the Act are, I think, "without good cause", if they refused the consent without good cause. I think what we would say is this: the Sentencing Guidelines Council guideline in relation to manslaughter already allows the court to take



account, as an aggravating factor, the use of drink or drugs, and it seems to us, much in accordance with what Mr Moloney was saying yesterday, that if in an appropriate case there was a refusal to consent, a sentencing court has probably already got the ability to take account of that, if appropriate, and we don't therefore submit that there needs to be an express amendment to the statute.

**THE CHAIR:** Thank you.

**MS CAREY:** Thank you very much.

**THE CHAIR:** Thank you.

Yes, Mr McNamara.

## CLOSING SUBMISSIONS ON BEHALF NOTTINGHAM CITY COUNCIL BY MR MCNAMARA

**MR McNAMARA:** Good afternoon Chair, these are the closing submissions on behalf of Nottingham City Council.

Chair, we begin by paying tribute to the victims of VC and to their family members and their commitment to ensuring that the circumstances leading to, and the terrible events of 13 June 2023 be scrutinised by your Inquiry.

NCC supports the Inquiry's valuable work and is grateful to have taken part. This Inquiry has been forensic, thorough, and has amassed a great deal of evidence to show that agencies could have done better.



To that end, the focus has to be on failings that left VC in the community untreated, unmonitored, and able to perpetrate the attacks.

It's my submission that NCC has been candid and thorough with this Inquiry. It has volunteered information, dealt with all requests made of it, and will, of course, comply with your direction in relation to the Duty of Candour, and remains ready to take appropriate action once the recommendations have been -- (overspeaking) --

**THE CHAIR:** There has been some late disclosure, hasn't there, about the CCTV?

**MR McNAMARA:** There's been -- forgive me, Chair, I missed the start.

**THE CHAIR:** There has been some late disclosure about the CCTV.

**MR McNAMARA:** There has, and I'm sorry that that has emerged in the way it has, but as you will appreciate and the CTI will appreciate, the issue of CCTV was something of an evolving issue throughout the course of the evidence.

NCC continues to rely upon the opening statement, in particular the legal framework in respect of the statutory role of the Approved Mental Health Professional, or AMHP, and that is not repeated in these submissions.

As you appreciate Chair, having read them, the written closing sets out 12 headings but given the time constraints this afternoon, these oral submissions are limited.

I deal very briefly with the data breaches. NCC remains, as do they, sorry for and embarrassed by the actions of its officers who committed data breaches. Those staff were investigated by the police, they were disciplined, retrained, and their records remain marked by their mistake.

In the aftermath, the local authority revised the way its officers could access information and has adopted a rigorous audit process.

The families called for consequences for those who failed them. Where it identified a failure, NCC has acted.

So the first heading is attitudes and role of the AMHP. The risk management of individuals such as VC within the police and criminal justice system and the wider mental health landscape is a thread that runs through this Inquiry and about which the Inquiry has heard extensive expert evidence, largely focused on the assessment of risk from a policing and health, rather than a social care context.

Therefore, from the perspective of NCC's AMPHs, it



is necessary to reflect on the contemporaneous context of risk posed by the likes of VC within the field of mental health. The approach of NCC's AMPHs should be considered through the prism of what is essentially the orthodoxy that developed in the 40 years following the passage of the 1983 Act as expressed in the ministerial foreword to the Code of Practice, namely care and treatment should always be a means to promote recovery, be of the shortest duration necessary, be the least restrictive option, and keep the patient and other people safe.

This Inquiry has an opportunity to challenge that orthodoxy or consensus and to decide if it remains fit for purpose in the light of any findings you might make.

The next subheading is the AMHPs' interactions with VC. Chair, I don't detain you in relation to that. Those facts are now a matter for the Inquiry and time does not permit detailed submissions.

**THE CHAIR:** Yes.

**MR McNAMARA:** I address you next about the use of sections 2 and 3 of the Mental Health Act of 1983.

It's submitted that the notion that Section 2 is essentially a once-and-for-all process in the context of evolving and/or waxing and waning mental illness, risks a rigidity which fails to reflect the difficulties of



psychiatric diagnosis. It also ignores the fact that the power to deprive somebody of their liberty and subject them to a psychiatric assessment or treatment against their will is a draconian measure that must be based on solid evidence. The NCC resists the suggestion that it overused Section 2.

Although it is incontrovertible that VC did not engage with his treatment, given the time span across the Mental Health Act Assessments, broadly the spring and summer of 2020 all the way through to January of 2022, it would have been questionable reasoning in, say, January of 2022 to rely upon a conclusion formed over 18 months previously.

In any event, NCC's AMHPs are not clinicians and on each occasion they were reliant on the input of clinicians in order to assess diagnosis.

The proposition that NCC's AMHPs were driven by a desire to be less restrictive is also not borne out given the number of times VC was detained. On five out of the seven occasions he was assessed, between May of 2020 and January 2022. And it was open to the Trust of course to recall NCC's AMHP service, as occurred in September of 2021, to reassess VC with a view to detaining him under Section 3. And indeed NCC's Ms Jacques travelled all the way to Darlington to do



exactly that.

The duty of candour in notifiable safety incidents. The law is uncontroversial set out in regulation 20, subsection 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as follows:

"[A health services body] must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity."

Regulation 20 is set out further in the lengthier written submissions, but the crucial words above are "provided to service users" and "regulated".

It is the local authority's submission that VC was not a service user. No incident occurred during the Mental Health Act Assessment, and Feven was never part of the local authority's adult social work caseload. Accordingly, neither she nor VC were users of any service provided by the local authority. As Ms Cullen pointed out in her evidence, it was not until she heard the evidence presented to the Inquiry she became aware of the extent of Feven's injuries.

Respectfully, this section was not engaged.

Furthermore, NCC did not fail to carry out reasonable enquiries. And rhetorically, by what process is a busy AMHP or social worker to discover all those

who require medical treatment or hospitalisation as a consequence of the criminal or violent conduct of others, including those who might be affected by a mental illness?

As Ms Cullen pointed out, other agencies were closer to those details and could have referred Feven to local safeguarding.

Activity we regulate is listed in schedule 1 to the Health and Social Care Act Regulations, and the Inquiry has referred to the list set out at paragraph 57 of the written submissions in this regard.

As you can see from that list, since she was not a service user, the injury to Feven was not related to a regulated activity vis à vis the local authority and her. The fact of the Mental Health Act Assessments in respect of VC did not trigger the reporting requirement in respect of the injury to Feven.

Accordingly, it is respectfully submitted that the local authority was neither engaged in a regulated activity at the time of the injury to Feven and nor was it obliged to make a report of the notifiable safety incident to the CQC.

Next, the evidence of Christopher Atherton and the Care Act.

As a prelude to this submission, it's NCC's position



that it is self-evident that if there were vulnerable members of the household of a mentally unwell person, of course a referral to a colleague would be made. Furthermore, once a person is in hospital, the local authority expects and is entitled to rely upon the fact that the Trust will look at the wider picture, including a safeguarding referral, as part of discharge planning.

As the recently disclosed note from 19 October 2021 reveals, the Priory asked NCC to assist with accommodation, but VC secured somewhere else to live before discharge. That was not Section 117 aftercare and VC's social needs were met. He was in education, he had a fixed address, and he was about to be discharged without a Community Treatment Order.

Section 117 wasn't engaged.

Mr Atherton was questioned extensively by CTI Ms Cartwright KC in relation to the applicability of the Care Act, the interplay with section 117, and the nature of the AMHP involvement with VC. I repeat, VC did not become a service user by reason of the Mental Health Act Assessments, since the local authority acquired no attendant assumption and responsibility.

The role of the AMHP is confined to the statutory duty and that is set out in the case of Khamba v Harrow, which is quoted extensively in the opening and in the



written closing. The Care Act assessment was not engaged.

In any event, on each occasion NCC's AMHPs assessed VC, his social needs were met. By and large he had a place to live, he was able to feed and clothe himself, he was in education or employment. He did not require the assistance of the local authority to secure the things necessary to sustain independent living.

Nonetheless, Mr Atherton's evidence demonstrated a clear understanding of how social care and mental health services must work together to support vulnerable individuals. He acknowledged the need for better integration and communication between health and social care teams and accepted the need for formal protocols to ensure that local authorities are notified when patients are discharged from hospital, enabling timely assessments and support.

He identified the value of embedding social care expertise within clinical teams, which would strengthen oversight and reduce the risk of individuals slipping through the net. Mr Atherton also pointed to the challenges faced by local authorities, such as the risk of being overburdened with referrals in the face of limited resources and the need for more training.

He underscored the importance of multi-agency



safeguarding frameworks and the local authority's unique position to coordinate complex cases drawing upon involvement in risk management in the fields of public protection, for example, MAPPA and MARAC.

His evidence reflects a commitment on the part of NCC to learning and systemic change where required.

Next, availability of information.

Mental Health Act Assessments concern people who are often in crisis and urgency is regularly vital. The assessments can take place at short notice, with limited information, and in sub-optimal locations. There is a risk when carrying out analysis at a granular level, like here, of superimposing a system that is perfect which risks delay and dither for fear of repercussions.

As Dr Skelton articulated in relation to the assessment conducted on 19 January 2022 with Ms Crane, the AMHP and the clinicians have to assess the person in front of them. To suggest, as Mr Carr did, that anything other than detention in the prevailing circumstances was a gamble ignores the point that an assessment is not a paper exercise and nor is it a once-and-for-all decision, since individuals may frequently and repeatedly present.

He was detained nine days later, when it was clear that community treatment was not working.

What was undesirable was the haphazard nature of access to relevant information in the first place. The historical -- that is, before the events about which the Inquiry is concerned -- decision to decouple the AMHP team from the local Mental Health Trust meant that access to the RiO system thereafter became inconsistent for AMHPs and in particular new joins.

Although NCC's AMHPs do not seek access to police records, and neither is it suggested that the police should have access to health and social care database, until there is a single database, there needs to be a unified frictionless information-sharing system between agencies that is underpinned by simple, easily understood protocols, mutual training, and dedicated and, significantly, appropriately-resourced staff to facilitate that exchange of information.

Pre-MHAA planning.

Chair, you asked some questions of a number of witnesses about this. It is submitted this already happens. NCC submits that expedition urgency is often required, and, in those circumstances, any such briefing may have to take place at short notice and may lack formality as all agencies converge on the address of the potential detainee. Unlike, say, the calm reflection of a Multi-Disciplinary Team meeting in a clinical setting,



AMPHs ought not to be fettered by cumbersome process or the desire for formality in such a dynamic situation.

Risk assessment. Dr Tully and Professor Fazel, amongst others, highlighted the risk -- that risk assessment of individuals such as VC is complex and that a range of models exist.

Their evidence focused upon clinical risk models. As Dr Tully suggested, there is probably no justification for the rolling out of the complex and lengthy HCR20 model to non-forensic situations. NCC agrees that although the gold standard is structured professional judgement tools, from NCC's perspective it requires a degree of involvement that does not lend itself to a Mental Health Act Assessment, given the likely circumstances in which they are carried out.

NCC's AMHPs are not clinicians. The risks they assess relate to the social stresses faced by the individual. Chapter 14 of the Mental Health Act Code of Practice deals with applications for detentions in hospital.

The approach of the AMHP is a holistic one which is aimed at the integration of social care needs with health needs. Fundamentally, the risk assessments undertaken by AMHPs focus on such factors as housing, isolation, relationship breakdown, here, specifically,



educational pressures, financial strains, and their impact upon the person's distress and any consequential risk to the public.

For example, on 28 January 2022, on the last occasion NCC's AMHPs assessed VC, Fiona Parker summed up the situation from a social perspective as follows:

"Unable to complete academic studies and risk of losing accommodation ... Stigmatisation from peers."

Pithy, yes, but on the money.

Returning to Dr Tully's evidence, her view that there is a need for better policies and working agreements to facilitate reliable and efficient information sharing between agencies is incontrovertible.

Further, the compelling evidence of Dr Dissayanaka cannot leave this Inquiry in any doubt that a return to a genuine Assertive Outreach system is crucial, not merely a model or behaviours, but genuine assertive outreach.

With all due respect to Sir Andy Marsh, although it is fair to say that treatment of those suffering from mental illness requires a health response, some related training would also be valuable for police officers rather than the retreat behind Right Care, Right Person he seems to suggest.



What NCC is hesitant about in the context of dynamic risk management is the prospect of additional layers of cumbersome bureaucracy. That will add delay in dealing with individuals in crisis and who may pose a risk to public safety, and risk replacing a dynamic process with one that is akin to a dropdown menu with limited options and less room for thought.

There is also the risk that resources will have to be shifted in order to cope with increased administrative burden.

Next, Chair, CCTV, where I do deal with some of the particulars.

On 26 May of this year you heard live evidence from Brian Bussey, Jayne Harvey, and Colin Wilderspin. You now have additional statements from Kenneth Cromwell, James Pykett, Gregory Hague, Andrew Clarke, Kirsty Gregson and Anton Wilde on the subject of CCTV and disclosure. It has been an evolving issue and, in my submission, NCC has acted appropriately, candidly and promptly in relation to the point.

There is no statutory duty to install CCTV, and as the Inquiry has heard, NCC is unusual nationally in that the system is staffed 24/7. There is an extensive network of 288 public space cameras, along with 15 redeployable cameras and cameras in carparks and within

NCC's commercial and housing estates.

They are controlled from the Woodlands CCTV Centre from staff including Ms Harvey and Mr Pykett. Within the control room is a large wall of monitors from which a selection of live feeds is visible from each numbered camera across the city. The staff also had access to limited police radio communication channels. Contrary to Chief Inspector Mather's evidence, specifically and regrettably, not the firearms channel.

The CCTV system includes what is known as a FollowMe feature which permits views from six cameras to be shared directly with the police. The evidence heard and in the possession of this Inquiry includes the efforts made by those at NCC's Woodlands CCTV Centre to locate VC following the report of the killings of Barney and Grace on Ilkeston Road, liaison with the police, including the limited access to police communications, the location of VC after he had killed Ian and taken his van, along with software and connection issues and that the camera at the point of arrest had an erratic PTZ, that's pan tilt zoom, function.

NCC repeats the observation made by Mr Wilderspin that unlike the way CCTV is regularly characterised as seamless in film and television, the reality is rather more difficult, and in the absence of facial recognition



technology, NCC was and is dependent upon being provided with clear information as to location and a description from police to begin an effective search and then it is down to observation.

Ms Pykett -- forgive me, Ms Harvey and Mr Pykett began searching from the point of the initial incident on Ilkeston Road. From there, and contrary to the inaccurate evidence of Chief Inspector Mather suggesting inactivity or a lack of initiative, the CCTV team did indeed use their initiative and conducted a systematic search, including searching in the area around the cathedral, making assumptions about movements towards Alfreton Road and the region of the city called Bobbers Mill, and reviewing footage from flats in the Radford area.

Again, contrary to the impression from Mather's evidence, as TDCC Griffin explained, the police trust and rely upon NCC's CCTV operators, hence his evidence that "They're really, really good at this".

Sadly, where there is a dispute on the facts in this respect, NCC therefore is left in the position where it must invite the Inquiry to reject the evidence of Chief Inspector Mather as not credible and to prefer the sincere evidence of Ms Harvey and the witness statement of Mr Pykett.



They knew that they were looking for a black male dressed in black clothing. The Inquiry has heard that the initial intelligence was thrown off the scent by what turned out to be an unrelated incident close to the cathedral, which is some way east of the killings of Barney and Grace and closer to the city centre.

In the meantime, as it turned out, VC had gone north and east.

An after-the-fact frame-by-frame analysis of the CCTV revealed that there were sightings of VC as he emerged from Radford into the forest area of Nottingham, along Gregory Boulevard and made his way towards Mapperley where he sadly killed Ian. It is a tragedy that he was not seen and apprehended.

CCTV staff did not have access to the firearms channel so the crucial bit of intelligence that VC might have headed north on Hopedale Close never made its way to them.

As TDCC Griffin pointed out, in the absence of that prompt, the team was left to guess as to VC's direction of travel.

After the fact he was believed to have headed northeast through Radford where, coincidentally, there is a lower concentration of cameras than in other parts of the city. As he did so, some of the initial images



of VC were from private CCTV inaccessible to NCC contemporaneously.

As the Inquiry will recall, Ms Harvey gave sincere and emotional evidence about the search and the efforts that she and Mr Pykett made to locate VC. Both of them looked at the CCTV feed, even during the period between 0438 and 0441 when Ms Harvey was making a report when VC was subsequently seen on CCTV on Gregory Boulevard.

Ms Harvey's noticed Ian's van, now driven by VC on Milton Street and followed VC as he struck Wayne. She and Mr Pykett tracked VC's movements using the FollowMe feature to give the police a live video feed and informed the police of VC's location via the police radio.

Due to the recent renumbering of the cameras it was necessary for Mr Pykett to call out those numbers to Ms Harvey so the van could be followed from point to point and the police given a seamless view. Ms Harvey and Mr Pykett continued to relay information about VC's location to the police who then pursued and apprehended him. Again, tragically, during the pursuit, VC mowed down Sharon and Marcin.

As Mr Bussey's evidence revealed, albeit in rather exaggerated terms, he regrets in those emails that NCC had experienced issues with the system following

a recent software upgrade and what NCC understood to be issues with the BT telephone link.

A consequence was that on some cameras, from time to time, the PTZ function was erratic.

It also transpired, as I've already referred to, that the software update had resulted in the renumbering of the cameras. During the period from 12 to 13 June 2023, it's Mr Bussey's evidence that nine of those cameras were affected.

On the day, only camera 167 behaved erratically and that was the one on Bentinck Road close to the point of VC's arrest.

Ms Harvey made clear that there were no other functional issues for any of the cameras they used that evening or that morning.

The CCTV system was extensive, appropriately staffed, effectively utilised, admittedly awkwardly renumbered but suffering from no material faults on 13 June 2023.

The local authority vigil.

In the aftermath of the shocking events of 13 June 2023 the local authority organised a vigil which took place on 15 June. Over 5,000 people assembled in Market Square in Nottingham to mourn and reflect.

The families of the deceased delivered emotional



tributes to their loved ones and urged the City of Nottingham to look after each other in the days that followed the attacks. A book of condolences was opened at the Council House, the flag lowered to half mast to represent the city's mourning. Citizens were also invited to lay flowers on the steps of the council house and the lights of the building were lowered at night as a mark of respect.

Some suggested recommendations, Chair, these are merely highlights essentially --

**THE CHAIR:** Well, I think I've got those in writing. Is there anything particularly you wanted to raise at this stage?

**MR McNAMARA:** Only this really, please, Chair: I appreciate I'm simply repeating what other agencies have said to you, but the difficulty with making recommendations in this situation is that one has to assume that the resources will be made available for any changes that will take place. We all know anecdotally, and my client understands painfully well the realpolitik of local authority finance, and without additional resources, some of these recommendations would be difficult.

Chair, you have those. By way of conclusion, on 13 June -- forgive me, 13 June 2023 was a tragedy for the individuals who were killed and injured and their



loved ones and it was a dark day for the City of Nottingham. NCC hopes that this Inquiry and its recommendations serve to reassure the Core Participants and the city's residents and helps to restore faith in the institutions that serve them.

These submissions began and end by paying tribute to the families of Ian, Grace and Barney, and to Wayne, Sharon and Marcin and repeat the condolences and sympathies expressed at the outset of the hearings.

Chair, those are my submissions.

**THE CHAIR:** Thank you, Mr McNamara.

**MR McNAMARA:** Do you have any questions?

**THE CHAIR:** No, I don't, thank you.

**MR McNAMARA:** Thank you very much.

**THE CHAIR:** We'll take a break now and we'll start again at 3.20, thank you.

**(3.04 pm)**

**(A short break)**

**(3.20 pm)**

**CLOSING SUBMISSIONS ON BEHALF OF THE ROYAL COLLEGE OF PSYCHIATRISTS BY MR STEIN KC**

**THE CHAIR:** Thank you. Yes. Obviously, I've read your submissions, and I have in mind the evidence which Dr Lade Smith gave to the Inquiry, and there is just one matter that I just was going to raise with you and with



the Royal College, in fact, which is that since 2023, I think in 2024, UCL, Professor Kirkbride, has done some work which has been published, I think in the PLOS Mental Health, about migration during adolescence being a particular high risk factor for psychosis, and I think that Professor Lade Smith raised that and migration as a particular issue and I just wondered whether she wished to add in any way and send the Inquiry a further update on that or anyone from the Royal College would, because it is something that she had raised earlier.

**MR STEIN:** Chair, thank you for that. As you're aware, we make these submissions on behalf of the Royal College of Psychiatrists and yesterday we saw that there was a document asking for further guidance in relation to the guidance issued as regards experts.

If you'd allow it, we would reply and include that issue, and address that in those submissions.

**THE CHAIR:** Yes, thank you very much.

**MR STEIN:** So may we, at the start, repeat what was said by Dr Lade Smith in her evidence on 1 June:

"These tragic attacks should never have happened and nothing I can say can lessen what you've lost or the impact on your lives, but I'm truly sorry for your loss. I wanted to thank you again for your determination and perseverance in making sure this Inquiry took place.

Mental health services need to be good but they can fail and when they fail, the consequences are devastating for the patients and for the public ..."

Now, Chair, as you're aware, the College is the professional medical body responsible for supporting psychiatrists. It works to secure the best outcomes for people with mental illness, for those people with intellectual disabilities and developmental disorders and it does that by promoting excellence in mental health services, in the training of outstanding psychiatrists, setting standards, and being the voice of the profession.

But it is crucial to understand that the College does not commission, regulate, or provide services. Those responsibilities sit with commissioners, regulators, and service providers.

At present, Chair, there is no national commissioning requirement to integrate the guidance issued by the College into psychiatric clinical practice. It is therefore vitally important that commissioners such as NHS England, take account of, and set standards which follow the guidance issued by the College.

So how are errors made?

The College submits that harm to patients and others



are the result of systemic failures, particularly insufficient service capacity, and we would highlight the lack of beds.

There is also, of course, increased demand, fragmentation between services, unsafe transitions, and inadequate risk management.

These systemic issues, Chair, mean that the psychiatrist's norm is firefighting. Psychiatrists struggle to maintain people in the community because of inadequate community care provision, and psychiatrists make the hardest of decisions as to who should receive inpatient care because of the short supply of beds.

In 2025 a Royal College of Psychiatrists survey found that 81% of psychiatrists who responded had directly experienced feelings of guilt, shame, burnout, frustration, distress or isolation, because they lacked the resources to provide safe, timely and continuous care.

This morning we listened to the comments and questions that you raised with Ms Scolding King's Counsel. You focused on the question of severe mental health illness and the question of what attention is being paid to that level of mental health illness at the level of severity.

The standard caseload for psychiatrists includes



people with paranoid schizophrenia, VC's illness, and other comparable serious mental health conditions. And psychiatrists do, for the very large part, keep those people and those they interact with safe.

But, but the risk caused by the current fragmented system, operating mostly in crisis mode, needs to be understood against that context.

Currently, the significant and longstanding resource issues in mental health care in the United Kingdom means that there is a funding shortfall of over 50% of what is needed. Mental health illness accounts for 20% of the disease burden, but it is expected to receive only 8.4% of the healthcare budget in 2026-27. And we heard figures today, as regards increases in funding, those increases in funding are simply insufficient to make a real difference.

To give you an example of the sort of differences that exist, there's been discussion of an increase in staff by 8,000 across mental health staff care. But that needs to be set against the fact that we lose per year 9,000, leading to a net loss.

Chronic underinvestment in mental health services affects both the quantity and type of services that can be delivered, and most importantly, the quality and therefore the safety of services that can be provided.



In too many areas within mental health services in England, there are simply not enough inpatient mental health beds, which is the result of a 73% reduction in beds since the eighties. This reduction in inpatient capacity has not been matched by an increase in community care provision, which of course would help reduce the need for admission.

This leads to patients failing to receive longer-term proactive care and support to prevent relapse, a lack of strategically commissioned community interventions, and patients being in the community without appropriate support, even when it is recognised that they are so unwell that admission should be considered.

The lack of beds and the lack of adequate community care means that more patients going into crisis but having to wait until the crisis reaches a critical point, usually when they are deemed an imminent risk to themselves or others, before being considered for admission.

Chair, the problem created by a lack of inpatient beds is then exacerbated by a lack of step-down care in the community, effectively what we might call halfway houses. The lack of appropriate places in the community to discharge those recovering from a mental health

crisis is a problem in and of itself.

Sometimes it's important to make the obvious point, and here is one. People who are more unwell, and who are not being properly treated, pose greater risk to themselves and others.

Now let me turn to a particular part of our community.

Black or black British people are more likely to be vulnerable to the risk of developing both common and severe mental health disorders, despite the fact that there is no increased genetic risk, but because of over-representation in areas of deprivation.

However, black people are less likely to present early or access mental health services through primary care, meaning that they are far more likely to end up in crisis, and then 40% more likely to access care through the criminal justice system.

The College has been calling for change in this area for a very long time and has designed a Patient and Carer Race Equality Framework, but implementation of that framework has been, at best, patchy.

Let me make one simple point. The College is crystal clear that decisions on detention are not and should never be taken on a racial basis. Any detention decisions based on a racial basis would be clinically



negligent and not in line with training or guidance.

So let me now turn to the changing nature of risk, as Dr Smith discussed in her evidence, you will recall. And obviously this is an important point for the Inquiry to consider when considering how the risk presented by VC was assessed.

As Dr Smith explained, changeable dynamic factors need to be properly and periodically assessed. Let's take an example. It is futile to assess at a single point in time the potential impact on risk of how much cannabis a person smokes. What is required is an assessment of the risk that accounts for the fact that the amount and type of cannabis available and smoked may change over time.

I now turn to recommendations, and in the interests of the time, I will not repeat the written submissions, but we would like to take the opportunity to highlight three which the college believes are of cardinal importance.

First, the importance of continuity of care for patients. Second, the significant benefits of advanced choice documents. And third, the need to standardise and improve the format in which patient information is accessed.

As to the first, you will recall Dr Smith's



evidence, and the College considers that services would be improved and risks reduced if the Inquiry recommended the implementation of continuity of care between hospital and community settings.

Dr Smith emphasised the value of continuity of care and we don't believe, having listened to submissions made so far, that this is challenged.

Baroness Merron, as the minister for women's health and mental health, has recognised that fragmentation of mental health services has led to a reduction in continuity of care.

The Community Mental Health Framework for Adults and Older Adults, published in September 2019 -- I'll give the Relativity reference: DHSC0000092 -- states that we need to maximise continuity of care.

This, in turn, is cited with approval in *NHSE Mental health personalised care framework: the modern care programme approach* published in July of this year. Reference NHSE0003019.

So the issue does not appear to be whether continuity of care is agreed. It is about implementation.

If introduced effectively, continuity of care will reduce duplication of assessments and of internal referral processes and increase oversight of patients



with better knowledge of their condition.

Now, Chair, at the very beginning of my submissions you were seeking out the College's input in relation to certain matters. Well, can we suggest going back to the Inquiry in relation to one other aspect. The College would welcome the opportunity to work with the Inquiry to crystallise the practicalities of this recommendation -- how can this be done? What needs to be done? -- in time for the Inquiry's final report.

Simply put, the College urges the Inquiry to require that there should be coordination between all staff and agencies, one person in charge of a person's mental health, from inpatient care into care in the community. This can be achieved through mandatory implementation of the new Personalised Care Framework and the Modern Service Framework for Severe Mental Illness.

The College urges the Inquiry to require commissioning bodies to produce their proposals for how continuity of care will be implemented in as short a timeframe as possible.

The second key recommendation concerns advance choice documents. They --

**THE CHAIR:** Can I stop you there for a moment?

**MR STEIN:** You can.

**THE CHAIR:** Because what you're proposing is, in effect,

that you have somebody who comes into a ward and then their care is followed out from the ward through the gate into the community.

**MR STEIN:** Yes.

**THE CHAIR:** That one person would be supervising that.

**MR STEIN:** One person if possible. Now, there may be changes.

**THE CHAIR:** Well, that's the difficulty, isn't it? I think in relation to perhaps the Assertive Outreach approach, what Dr Dissanayaka said was that the Assertive Outreach Team would be present and effectively working with the person whilst they're still in the ward before they go back out into the community to establish a relationship. Is that any different? It's a relay rather than somebody continually carrying the torch, if you like.

**MR STEIN:** You may be assisted by, in fact, a further reference to the 2026 Mental Health Personalised Care Framework. Now that is a suggested -- going very squarely in the direction of one person in charge. Our step that we suggest should be taken is that if possible, subject to changing in staffing, there should be carry-through from the hospital into the community. Of course teamwork can provide some assistance and oversight, but we have to say and suggest that the build-up of a trusting relationship between those



providing therapy and those receiving therapy is one of the vital factors in understanding what may happen next.

**THE CHAIR:** Yes. All right, thank you.

**MR STEIN:** So the second key recommendation concerns Advance Choice Documents. They previously used to be known as Joint Crisis Plans. Now, Advance Choice Documents, ACDs, are written and developed by everyone involved in the patient's care and the patient is involved as well.

This means all involved know what is meant to happen if that patient goes into crisis. Such documents embed trust and understanding in a therapeutic relationship. Whilst the College is supportive of Community Treatment Orders, ACDs should be required because they have been shown to reduce the likelihood and severity of any recurrence. Again, there is agreement across the board, we submit, in relation to their use.

The July 26 framework states that the use of these documents is expected to become legislation as part of the Mental Health Act reforms. The College asks that this Inquiry supports and monitors this express intention.

The third key recommendation. That is the standardisation of the format of accessing a patient's information. Currently it can take a psychiatrist several hours to find a patient's records that can be



stored across various different systems even within the same organisation.

It should not take, Chair, 40 to 50 clicks to get through to the information required. It should take two or three clicks to access a proper, succinct assessment of a patient, showing their history, medical information, and risk profile.

**THE CHAIR:** I think Professor Lade Smith said that RiO, for example, does have a search function. You can find -- well, search and find within that system, but you're talking about a much wider joined-up system, are you?

**MR STEIN:** Yes.

**THE CHAIR:** Is this a system that currently is being proposed and is receiving a certain amount of attention as to the provider of it?

**MR STEIN:** There has been for some time, as we've seen, a proposal to pull together essentially a digital framework for which -- which to work. I won't, on my feet, make any further submissions in relation to that.

**THE CHAIR:** Thank you.

**MR STEIN:** The third key recommendation is the standardisation of the format of accessing information, as we say, it should be faster, it should be easier to establish the information possible.

I'm now going to turn to a comment made by



a different Inquiry Chair, Baroness Lampard, at the 2026 opening which happened to be on 6 July 2026, when she stated this:

"I have asked my team to consider what we may learn from the findings and recommendations made in other reviews and Inquiries into mental health care and their potential relevance to our work."

The College suggests that this Inquiry and others work towards the implementation of recommendations by challenging the commissioning bodies to provide evidence of how recommendations can be implemented.

Let me finish with this.

The College, the College's past president, Dr Lade Smith, the College's current president, Professor Subodh Dave, are clear: mental health services cannot continue with a model that overly relies on crisis management and poorly-resourced inpatient care and variable community mental health provision.

Chair, urgent change is required.

That change is required to take us to commissioning that focuses on population need, is evidence led, and clinically driven.

Chair, as we all know, the risks from inaction are simply too great.

**THE CHAIR:** Yes, thank you.

Yes, thank you, Mr Davies.

Again, I've read your closing statement.

**CLOSING SUBMISSIONS ON BEHALF OF PC TAYLOR, PC AMOS-PERKINS, AND PC READ BY MR DAVIES KC**

**MR DAVIES:** Thank you, Madam.

They're made, for those that don't know, on behalf of three individual Leicestershire police officers responsible in different ways for the investigation into the Arvato warehouse incident in May 2023.

Madam, as the evidence has emerged in the last few months, the necessity of this Inquiry has become painfully obvious. It's time, if it wasn't before, to confront some uncomfortable realities, for hard-edged analysis, for equally hard-edged practical solutions, and in terms of my oral submissions, I will be concentrating, in the necessarily limited time, on practical considerations in terms of potential recommendations.

But to provide some context for that, if I may. On our analysis, albeit the officers I represent played in the overall narrative a limited part, but it is significant, the evidence we say, for the purpose of understanding where we start, is that aside from individual poor decision making, fundamental questions arise as to how society, through multiple state



agencies, manages those with mental health conditions such as paranoid schizophrenia which, if not actively managed, produce significant risk of serious harm and death to members of the public.

These questions do not arise for anything like the first time. Any changes in the law or procedures or resources, and all would appear necessary, will need to be coupled with changes in culture within organisations in their thinking, and between organisations as to the management of this species of risk.

Policies, after all, existed, not least within policing, that were wholly explicit as to the fact that even if mental health was the reason a crime may have been committed, this did not justify a diversion away from the criminal justice system to mental health services.

That, however, was unquestioningly and clearly the operative culture within both policing and mental health services, even with repeat offending, and when serious injury had been caused.

Where a young Italian student breaks her back and it's written off almost immediately as a mental health incident, something is fundamentally wrong in the culture.

Powers that would have been available on sentence



were, accordingly, not engaged. Perceived legal impediments to information sharing as to risks between agencies were more imagined than real. This was a chronic and damaging cultural failure of understanding. The law as to this needs reform. Whatever the law is, agencies need to reset operational norms.

The cultural failure reduced the effective assessment and proactive management of the serious risk to the public from those with paranoid schizophrenia. Within mental health services, the interests of the person with the mental health condition were, without any obvious exception, elevated, again as a matter of culture, above those of the significant risk to the public.

On repeated occasions this cultural bias has proved fatal. This cultural failure must be gripped to avoid it recurring under the new statutory provision. We observe that the language of the Mental Health Act 2025 appears again to promote repetition of this bias, and requires review as to the threshold test as to risk.

"Least restrictive option" must mean the least restrictive option consistent with protecting the public. No more, no less.

Madam, in a narrow sense, for the officers



I represent, the bulk of the written submissions are directed at their operational performance, their recognised failures, and your analysis of the implications of all of that.

At its core the key operational failure, and it was a basic one, however it occurred and whyever it occurred, was on 24 May 2023 when VC's full identity was made known to PC Taylor.

If you conclude that that information was on her screen, and on the evidence you would be justified in that, the next question is: did she absorb it? And our analysis is that she did not. She should have done but she did not.

The next question is -- and it's the perhaps more difficult one, is whether the question of causation emerges from that. That was 24 May. VC's homicidal behaviour was 21 days later, 13 June. We have seen competing analysis and submissions to you on behalf of perhaps in particular of the bereaved families, and we respect the analysis, of course.

But we say objectively that, starting from 24 May, for VC to have been identified, his address, for necessary liaison with Nottinghamshire Police, for that warrant to be executed, for him to be taken to court, through some power or other him to be made subject to,

at least, if not detention, a further Mental Health Act Assessment and, by 13 June, subject to an effective mandated course of medication, however much one would have wished that to be the likely series of events, we say that would not be more than ambitious reasoning.

We do recognise you should approach that question on two bases: one, what would have happened in a properly and effectively functional system? Secondly, what would have happened in the system as it existed here?

Nottinghamshire Police have recognised the execution of warrants at the time was wholly deficient. Mental health services for their part, as you know, repeatedly discharged VC, not least, and catastrophically, in September of '22, back to his GP for non-compliance.

So I don't make further submissions today orally as to that. You have detailed representations. In the end I hope the competing positions are defined.

And they are not competing positions with any hostility to the bereaved families or survivors. It is simply identifying objectively what we say are the safe conclusions.

So I jump, if I may, to the end of our oral submissions, which is themes and wider recommendations. If anybody wishes to see our detailed analysis, of course it's in the written document -- (overspeaking) --



**THE CHAIR:** Can I just ask about one aspect of it?

**MR DAVIES:** Of course.

**THE CHAIR:** Which is that you accept that the address given for VC was obtained on 24 May. That that was available to the police on 24 May.

**MR DAVIES:** An address, yes.

**THE CHAIR:** Paragraph 58.

**MR DAVIES:** Yes.

**THE CHAIR:** And the point that I raised, in fact with Mr Berry, that at that point the -- if the officer had seen the warrant, that that could have been executed, couldn't it?

**MR DAVIES:** If that was still his address then, they could have considered establishing that, and acting accordingly. My understanding is it wasn't his address then. But that would have required coordination with the Derbyshire force.

**THE CHAIR:** Yes.

**MR DAVIES:** We fully accept, of course, that if someone presents to you in person and you identify they're subject to a warrant, any constable can execute it there and then. But this would have been a pre-planned execution of a warrant, necessarily, once an address was identified, and it wasn't the Derby address, by May, in coordination with other forces.



**THE CHAIR:** Thank you.

**MR DAVIES:** So, albeit perhaps at a headline level, some wider themes and recommendations we invite you to consider.

Of course, I only represent three operational officers, but, in a way, they are proxies for the interests of many tens of thousands of other operational officers.

The context for the inquiry is understood. Time and again, wholly innocent members of the public have been caused serious injury and killed by those with acute mental health disorders, who, by any objective diagnostic criteria, should have been treated and proactively managed on the basis they represented a significant risk to the public if not so adequately treated and managed.

As the data sadly demonstrates, such cases of homicide are by no means exceptional.

Whilst the documented violence is repeatedly against members of the public selected at random, albeit reflecting paranoid and delusional thinking, emergency workers, including but not limited to police officers, are those required to confront such acutely dangerous individuals. And we say they are entitled to expect that the management of risk will give appropriate weight



to that risk.

History demonstrates, at risk of repetition, that the interests of the patient have assumed a cultural domination over the risks to both the public and emergency workers.

In making recommendations, we invite you to reflect the necessity of forcing cultural change. I've covered some of the policies and so on that are engaged in this. A culture of writing off serious crime as mental health. A culture, on the other side of the emergency response, or medical response, of inadequately proactive management of risk. And we agree with the accuracy and force, if you will forgive me, of Dr O'Malley-Kumar's evidence on this, which was, to quote:

"A point I've been making from the beginning is that psychiatry is the only medical specialty where poor treatment, lack of treatment, failure to treat or negligent treatment or refusal of the patient to take treatment can result in the death of a third party and I think people need to understand that." [As read]

We agree, respectfully.

So we invite you to consider the following matters and I summarise some of them at a headline level. Some are more radical than others.

Firstly, unremarkable, almost too obvious to state:

necessary changes in the law and inter-agency protocols as to sharing and accessing information for those members of the public with mental health conditions such as paranoid schizophrenia. This theme goes back to, for example, the Bichard inquiry report, into the Soham murders, about neighbouring police forces.

Within policing it is surely unacceptable that there is in 2026 no single nationally-accessible database equivalent to NICHE for operational policing.

We set out suggestions as to what should be accessible and included.

Two, the necessity of accessible data for people of qualifying risk, because of a diagnosed mental health, condition between clinical and policing services, is equally obvious.

The evidence demonstrates that in diagnostic terms, conduct that may appear insignificant to the police could be highly relevant, to a psychiatrist. Dr Smith's evidence about the death of a cat. Dr Dissayanaka's evidence about scratching cars. There is a corresponding necessity of police sharing such evidence with the managing clinicians.

We address what the threshold of risk should be before there is proactive, mandated intervention for people in this category of risk, whether that's CTO,



depot, Assertive Outreach, or otherwise. The two considerations are what level of risk should engage and at what level of harm.

We say as to the level of risk, this should be defined as "significant" or even "more than minimal". And defining that word in the context in which it would occur, "significant" means that mandated medical intervention and supervision is directed at mitigating objective risks of harm. After all, the same medical intervention is in the interests of the patient in that context. It is not directed at punishment.

Secondly, under the Mental Health Act 2025, grounds for detention require a risk of serious harm. The Inquiry is invited to recommend that this definition is amended to remove the requirement that the risk is serious. Firstly, why is it acceptable that members of the public or emergency workers will be exposed to a clinically objective qualifying risk of harm amounting to actual bodily harm rather than serious harm? Surely any level of physical harm should qualify?

Secondly, there is no evidence that clinicians can calibrate what level of harm between actual and serious an individual with the qualifying mental condition will cause in a state of acute paranoid psychosis.

Five, public safety should be entrenched culturally



in the approach to mental health orders.

Six, consideration should be given to a national risk ownership protocol for qualifying individuals, modelled on the analysis that is emerging from the Southport Inquiry. We say the owner of risk should be the clinicians, but they must have access to relevant police data to exercise their duties.

Seven, police powers, section 62. We recognise that what we say here as to critical time testing of somebody arrested for a sufficiently serious offence would be, to some extent, new ground.

Consent is presently required under PACE. The only outcome, if consent is reviewed, is the possibility of an adverse inference at some point in proceedings from the refusal. It's very hard to see how that grips the challenge and significance of a toxicological test at a time-critical moment for somebody arrested in these circumstances.

The potential relevance of the toxicology result is almost too obvious to state. Was it a drug-induced psychosis, on the one hand? On the other hand, would the toxicology demonstrate a failure to take prescribed antipsychotic medication that would go to culpability? There are other bases of relevance. It is time critical.



Under the Road Traffic Act, somebody required to give an intimate sample for driving offences, if they fail to do so, may be subject to implement. Under RIPA section 49, somebody required to provide a code to their mobile phone or encrypted data, if they fail to do that, they are liable to two years' imprisonment.

There is no equivalent sanction under section 62. And any such review of that power could even consider -- and of course it would have to be evidence led -- whether taking such samples in appropriate circumstances forcibly could be considered. But one recognises that is a leap beyond anything that presently exists, and would probably strike the balance in the wrong place.

We recommend that -- invite you to consider, rather, that any decision to offer -- to take no further action in relation to an investigation on mental health grounds should be subject to a superintendent or senior officer approval, or even that of a CPS lawyer. This may help break the culture of flawed thinking, even in the presence of clear policies.

And Madam, finally, we -- whatever recommendations you make, we invite you to somehow find a mechanism to review for yourself, with the unique detailed exhaustive corporate knowledge this Inquiry now has, as to all the issues that are engaged, as to the effectiveness of any

provisional recommendations you make as to changes in operation or practice at some date in the future.

If this is achievable, it will promote public accountability from affected organisations, and as importantly, an iterative process whereby the final outcome is informed and improved by subsequent operational experience, albeit not under the Inquiries Act 2005. This is exactly the approach that was taken by Sir Michael Bichard in his reports, provisionally June 2004, followed by a final report reflecting operational experience from the implementation of his first report on 17 March 2005.

We invite consideration of whether this is possible within Section 14 of the Inquiries Act 2005, which says, in terms of the end of the Inquiry, 14(1):

"For the purposes of [the] Act an inquiry comes to an end --

"(a) on a date, after the delivery of the report of the inquiry, on which the chairman notifies the Minister that the inquiry has fulfilled its terms of reference ..."

Obviously, I can't say more than this, but there's a report and there's a separate notification that you fulfil your Terms of Reference.

History demonstrates, I'm afraid, Madam Chair, that



detailed, informed inquiry recommendations, even where they are accepted on the date by Government, implementation is a separate matter and accountability for that implementation is lost from the Inquiry.

It's simply something we invite you to consider, if it is possible, within the terms of the Inquiries Act because there could be no worse outcome here than your recommendations, even if accepted, get lost in government machinery over time.

**THE CHAIR:** Thank you.

**MR DAVIES:** Thank you, Madam.

**THE CHAIR:** Thank you.

Yes, Ms Milligan.

## CLOSING SUBMISSIONS ON BEHALF OF GARY CARTER BY MS MILLIGAN

**MS MILLIGAN:** Thank you very much.

Thank you, Chair. My oral submissions on behalf of Mr Carter will focus on two decisions and moments in time: the decision to transfer the role of care coordinator to Mr Carter in April 2022. That's going to be the focus of my submissions. Some brief comments on the decision to discharge VC in September 2022 and then I'll finish with a remark on behalf of Mr Carter, if I may.

**THE CHAIR:** Thank you.

**MS MILLIGAN:** It's important for me to be clear at the



outset, that you will recall Mr Carter gave frank and candid and, I would say, reflective evidence to the Inquiry. Nothing that I say ought to detract from that or be taken to be in any way a retraction or resiling from what he had to say or, indeed, the manner in which his evidence was given, but it is important to have regard to some contextual matters. Not only out of fairness to Mr Carter, but also because, in my submission, if we only focus on the individual acts and omissions of individual members of the EIP team and, indeed, the broader Trust, we would be ignoring the more important questions of how and why those individuals came to be in the position that they were.

Dealing first, then, with April 2022. In my submission, the way in which the role of CCO was thrust upon Mr Carter was lackadaisical and it was entirely predictable and indeed unsurprising that Mr Carter would struggle to create a therapeutic relationship with VC.

You will recall, Chair, that the decision to transfer that role was made in Mr Carter's absence and without consulting him. His caseload consistently exceeded the nationally recommended limit of 15 patients in the EIP standards, but not only that, a number of witnesses told you that he had some of the most complex patients, the most aggressive, violent, and risky



patients. And that ought to have led him to have had fewer patients, in my submission.

The decision to transfer the CCO role to Mr Carter also specified that preferably there should be two CPNs acting as VC's CCO. Now, that of course would have doubled the amount of time that was available to seek out and attempt to engage VC at a time when he was known to be increasingly disengaging.

No second CCO was ever appointed, and the inquiry has never been given a clear answer as to why that was. The consequence of that is that although the EIP policy required staff to adopt "an assertive approach to engagement with patients", combined with Mr Carter's excessive caseload and indeed his lack of training on how to engage patients who were disengaging, meant that in reality, it is unclear how he ever could have lived up to the expectations of that policy, notwithstanding that he did acknowledge that he could and should have done more.

Because in the context of a complex mental illness, an assertive approach requires one to have training, skills, and time, time to seek out the patients who, by definition, do not walk through the door. And so Mr Carter endorses the conclusion in the Theemis Report that that policy is disconnected with the reality of

what it is possible to deliver within the constraints of service budgets and resources.

Importantly, what Mr Carter never knew until this Inquiry was that VC made it clear to Ms Birtles, his previous and only previous CCO, that he did not want his CCO to change.

The day after the decision was made to transfer that role to Mr Carter, Ms Birtles met with VC at the Stonebridge Centre. This on 29 April '22. She did not inform VC of this change in person. She didn't invite Mr Carter to that meeting or otherwise arrange a joint meeting.

Instead, on 3 May '22, she gave this information to VC by text message. VC replied:

"You should move someone else. Since you've been looking at my case since the beginning it's not really convenient having to build a rapport all over again."

To which Ms Birtles simply said:

"Unfortunately I won't be able to do that."

[As read]

And she said she was "really sorry".

She did not engage VC further on this issue. And critically, she didn't inform anyone, least of all Mr Carter, of VC's reservations.

In short, that text exchange extinguished the



remains of any therapeutic relationship that the EIP team had with VC. And it was a critical missed opportunity.

Importantly, this was all in the context of Mr Carter having limited interactions with VC, particularly within the previous year prior to taking on the role of CCO.

His two most significant interactions with VC were two ends of the spectrum. The first in September 2020 was when VC presented as pleasant and stable, albeit a man of few words and seemingly wanting to be focused on his shopping. Come 31 August 2022, which is I say the second significant interaction that Mr Carter had with VC, he was, in Ms Birtles' words, "floridly psychotic" and seemed a very, very different man, in the words of Mr Carter.

Between those two ends of the spectrum, Mr Carter saw VC sporadically and also for very limited amounts of time. Often, as Mr Carter explained to the inquiry, he saw VC for a matter of minutes and couldn't really get him to engage or to stay and have a conversation.

In my submission, that was not a promising or adequate foundation for a therapeutic relationship.

The implications of the failed transition from Ms Birtles to Mr Carter were immediately obvious,



because over the next coming weeks, in May 2022, Mr Carter saw VC on two occasions when he collected his medication from the Stonebridge Centre. Again, as I've said, Mr Carter told the Inquiry how he was unable to engage with VC and how he was unable to have a proper conversation with him before VC promptly left.

He never saw VC again.

The next 13 entries in RiO that Mr Carter makes regarding VC all concern attempts to engage with him in different methods, text messages, calls, cold calls at his address, calls with family members.

And there is no evidence, critically, of the remainder of the EIP team, including Dr Lloyd and the managerial supervisors, doing or advising anything different.

So, as I've said in my closing written submissions, the Inquiry must ask itself why it is that Mr Carter was to be expected to come up with a radical new solution.

May I just address you briefly on the issue of the cold call that VC and Mr Williams undertook on 4 August. It was put to Mr Carter in his oral evidence that he attended an address that was not VC's and that VC had not lived at for a long time, and the issue has been picked up in some others' closing submissions to say that Mr Carter didn't visit the correct address. That's



not quite accurate.

Mr Carter went to the last known address that the EIP held, the 209 Ilkeston Road address, that the EIP team had been provided by Nottingham University in January 2022. There was no reason or no event to believe that the -- there was an alternative address at that stage. There is nothing on the records or in the evidence the Inquiry has heard to suggest that the evidence -- or, sorry, forgive me, the address ought to have been updated.

The confusion appears to have arisen because VC, on 21 February '22, submitted a request for his medical records when he was remaining at the Raleigh Park student accommodation. But that request for his medical records was not processed by the Trust until August 2022.

There were two consequences of that. The first is that Ms Birtles emailed Mr Carter to say, in effect: We have had this request through and there's a new address on it, the Madison Court address.

And secondly, Mr Carter said it wasn't him. The address on VC's records was therefore updated to the Madison Court Raleigh Park student accommodation address, and that meant that when Mr Carter sent or requested that the administration team sent VC a letter

requesting him to disengage, it went to the Madison Court address.

Ms Birtles, in indicating to Mr Carter that that was a new address, seemed to forget or failed to make the link that that was the student accommodation in respect of which she'd had extensive conversations with Ms Turner about VC being evicted from, or a mutual agreement to leave.

So, in summary, yes, Mr Carter accepts that he could have done more to seek out and engage with VC in the few months that he was his CCO, but in my submission, rather than simply resting on those concessions, it is vital that the Inquiry ask itself why it was that Mr Carter found himself in that position. And in my submission, the working arrangements and the systems of the EIP team at the time, and how Mr Carter was given that role, are critical to understanding any of his omissions.

Can I turn much more briefly to VC's discharge.

As you know, Chair, Mr Carter was not present for, nor privy to, the decision to discharge VC, the 22 December MDT meeting. I'm not going to address you in detail as to Dr Lloyd's alternative suggestion that there'd been an earlier decision to discharge VC in August spearheaded by Mr Carter which she rubber stamped.



You have my closing extensive submissions on that, and no one, not even the Trust, considers that to be plausible or likely.

In my submission, the concession that the Inquiry has received from the Trust that VC ought not to have been discharged on the basis of non-engagement is pivotal, because yes, none of us can predict what would have happened in the counterfactual had he not been discharged, but if VC was not fit for discharge in September '22 on the basis of his non-engagement then it seems likely that from September '22 to June '23, something, in terms of his care, would have happened. Whether that might be a further inpatient admission perhaps leading to a CTO, forensic input, consideration of the so-called Cluster 17 Assertive Outreach pathway, we know not.

But the consensus in the evidence that you heard was that the entirety of the EIP team were at a loss as to what to do. And as I say, if one takes discharge off the table, something had to be done because the EIP team was not working for VC.

Might I then make a concluding remark on behalf of Mr Carter. Irrespective of the precise situations that may or may not have been foreseen, Mr Carter is clear in his mind that he personally, as well as members of his



team, could have done more, and that the service that he could have delivered could and ought to have been better.

He has spent a long time reflecting on that, and thinking about things that he did wrong or could have done better. I hope you will agree he's done his best to assist this Inquiry and he's given assistance in a candid and frank manner, and he hopes that this Inquiry will bring about meaningful changes and improvements in the provision of mental health services in this country.

But he asks me and it is very important to him, to apologise to those who have lost loved ones, to those whose lives have been permanently affected, and falling within that category, we include, but of course it's not limited to, the bereaved, the survivors, and the Calocane family. And as I say, Mr Carter wants to express his unreserved and unqualified apology.

Chair, those are all the submissions I intend to make. Can I assist you with anything further?

**THE CHAIR:** No, thank you very much, Ms Milligan. Thank you.

**CLOSING REMARKS BY THE CHAIR**

**THE CHAIR:** So we find ourselves, once again, at the end of these hearings after a very intense two days in which



the issues have been rehearsed in detail and the horror of what occurred on 13 June of 2023 has been revived in our minds.

I've no doubt about the enduring effects of those events, and indeed the process of this Inquiry, on all concerned, and also, about how the period from now until the publication of the report may seem to you as being interminable. It doesn't appear so to me.

I'm fully aware of my task, and what is at stake, both in detailed and accurate analysis of what happened and what went wrong in the past, and also in looking forward towards necessary change in the future, and I intend to keep to the timescale required.

I'm reminding Core Participants of the direction that I've made underlying and underlining the importance of those with public duties reviewing and reflecting on the evidence provided for errors and omissions which need corrective action, and that's in order that the evidence which forms the basis of the report is as accurate as it can be at the time of publication.

When we leave Mary Ward House today, there will be ample time for those Core Participants to ensure that's done in time for my report and the product of their reviews to be considered and dealt with in the report.

But for those most closely affected by these

terrible events, bereaved families who have worked so hard to achieve the Inquiry, and who, with the survivors, have borne the weight of it all, all it's revealed day by day, you have no such obligations, and I hope that these few months will give you much needed time for reflection and healing and gathering strength for the publication of the report and what may then follow.

So we'll finish there now. Before we go, I'd like to thank, once again, Mary Ward House. I think we've been lucky in the accommodation that we've had here, and the service that we've had from all those in Mary Ward House who have assisted us during the course of the Inquiry, and all those who have taken part, and so I thank you all.

Thank you.

**(4.20 pm)**

**(The hearing concluded)**



I N D E X