

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."

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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

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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

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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".

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

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

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

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

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

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1 speak to his psychotic motivation." [As read]

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

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

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

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

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

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

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

5 **MS CAREY:** Yes --

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

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

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

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

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

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

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

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

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

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

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1 behaviours.

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

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

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

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

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

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1 attacks. Nothing smelt on him.

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

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

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

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

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

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

5 You know that once remanded to prison he remained
6 unwell.

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

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

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

13 **THE CHAIR:** Yes.

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

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

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

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

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

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

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

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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

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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

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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

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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

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1 before the sentencing court the relevant evidence which
2 had -- might have reflected the judge's decision.
3 It was suggested that no decision was given to VC's
4 culpability for not taking his medication. In fact,
5 both Dr Blackwood's report and his addendum did consider
6 VC's resistance to taking medication, and Dr Blackwood
7 made plain that VC's failure to comply with his
8 prescribed oral antipsychotic medication was not, in his
9 view, a culpable admission, but one determined by VC's
10 lack of insight into his illness, an integral feature of
11 his disorder.

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

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

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

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1 judgement of Mr Khalil King's Counsel.
2 What is important is that the sentencing note did
3 speak about the planning, the extensive use of weapons
4 that had been bought many years before, the hiding in
5 the shadows, the loss of the bag. A number of features
6 which may have persuaded the judge a different route
7 were properly before the court.

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

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

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

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

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

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

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1 it. It was dismissed, wasn't it, on that basis

2 -- (overspeaking) -- we got this?

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

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

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

16 **THE CHAIR:** Yes.

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

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

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

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

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

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

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

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

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

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

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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

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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

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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

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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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 **MS CAREY:** Absolutely.

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

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

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

25 James Coates told you his preferred method of

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

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

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

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

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

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

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

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

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

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

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

17 **MS CAREY:** No.

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

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

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

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

9 **THE CHAIR:** Thank you.

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

11 **THE CHAIR:** Thank you.

12 Yes, Mr McNamara.

13 **CLOSING SUBMISSIONS ON BEHALF NOTTINGHAM CITY COUNCIL BY** 14 **MR MCNAMARA**

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

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

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

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

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

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

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

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

11 **MS CAREY:** Yes.

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

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

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

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

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

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

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

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

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

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

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

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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

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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

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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

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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

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

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

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

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

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

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

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

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1 written closing. The Care Act assessment was not
2 engaged.

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

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

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

25 He underscored the importance of multi-agency

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1 that it is self-evident that if there were vulnerable
2 members of the household of a mentally unwell person, of
3 course a referral to a colleague would be made.

4 Furthermore, once a person is in hospital, the local
5 authority expects and is entitled to rely upon the fact
6 that the Trust will look at the wider picture, including
7 a safeguarding referral, as part of discharge planning.

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

15 Section 117 wasn't engaged.

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

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

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

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

7 Next, availability of information.

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

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

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

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

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

17 Pre-MHAA planning.

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

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

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

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

9 Pithy, yes, but on the money.

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 NCC's commercial and housing estates.

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 of VC were from private CCTV inaccessible to NCC
2 contemporaneously.

3 As the Inquiry will recall, Ms Harvey gave sincere
4 and emotional evidence about the search and the efforts
5 that she and Mr Pykett made to locate VC. Both of them
6 looked at the CCTV feed, even during the period between
7 0438 and 0441 when Ms Harvey was making a report when VC
8 was subsequently seen on CCTV on Gregory Boulevard.

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

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

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

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

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

5 It also transpired, as I've already referred to,
6 that the software update had resulted in the renumbering
7 of the cameras. During the period from 12 to
8 13 June 2023, it's Mr Bussey's evidence that nine of
9 those cameras were affected.

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

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

16 The CCTV system was extensive, appropriately
17 staffed, effectively utilised, admittedly awkwardly
18 renumbered but suffering from no material faults on
19 13 June 2023.

20 The local authority vigil.

21 In the aftermath of the shocking events of 13 June
22 2023 the local authority organised a vigil which took
23 place on 15 June. Over 5,000 people assembled in Market
24 Square in Nottingham to mourn and reflect.

25 The families of the deceased delivered emotional

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

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

10 Chair, those are my submissions.

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

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

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

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

15 **THE CHAIR:** We'll take a break now and we'll start again at

16 3.20, thank you.

17 (3.04 pm)

18 (A short break)

19 (3.20 pm)

20 CLOSING SUBMISSIONS ON BEHALF OF THE ROYAL COLLEGE OF 21 PSYCHIATRISTS BY MR STEIN KC

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

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

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

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

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

23 Chair, you have those. By way of conclusion, on
24 13 June -- forgive me, 13 June 2023 was a tragedy for
25 the individuals who were killed and injured and their

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

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

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

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

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

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

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

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

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

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

24 So how are errors made?

25 The College submits that harm to patients and others

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

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

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

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

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

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

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

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

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

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

25 The standard caseload for psychiatrists includes

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

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

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

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

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1 crisis is a problem in and of itself.
2 Sometimes it's important to make the obvious point,
3 and here is one. People who are more unwell, and who
4 are not being properly treated, pose greater risk to
5 themselves and others.

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

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

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

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

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

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

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

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

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

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

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

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

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1 negligent and not in line with training or guidance.

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

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

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

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

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

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1 with better knowledge of their condition.

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

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

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

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

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

24 **MR STEIN:** You can.

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

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1 that you have somebody who comes into a ward and then
 2 their care is followed out from the ward through the
 3 gate into the community.
 4 **MR STEIN:** Yes.
 5 **THE CHAIR:** That one person would be supervising that.
 6 **MR STEIN:** One person if possible. Now, there may be
 7 changes.
 8 **THE CHAIR:** Well, that's the difficulty, isn't it? I think
 9 in relation to perhaps the Assertive Outreach approach,
 10 what Dr Dissanayaka said was that the Assertive Outreach
 11 Team would be present and effectively working with the
 12 person whilst they're still in the ward before they go
 13 back out into the community to establish a relationship.
 14 Is that any different? It's a relay rather than
 15 somebody continually carrying the torch, if you like.
 16 **MR STEIN:** You may be assisted by, in fact, a further
 17 reference to the 2026 Mental Health Personalised Care
 18 Framework. Now that is a suggested -- going very
 19 squarely in the direction of one person in charge. Our
 20 step that we suggest should be taken is that if
 21 possible, subject to changing in staffing, there should
 22 be carry-through from the hospital into the community.
 23 Of course teamwork can provide some assistance and
 24 oversight, but we have to say and suggest that the
 25 build-up of a trusting relationship between those

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1 stored across various different systems even within the
 2 same organisation.
 3 It should not take, Chair, 40 to 50 clicks to get
 4 through to the information required. It should take two
 5 or three clicks to access a proper, succinct assessment
 6 of a patient, showing their history, medical
 7 information, and risk profile.
 8 **THE CHAIR:** I think Professor Lade Smith said that RiO, for
 9 example, does have a search function. You can find --
 10 well, search and find within that system, but you're
 11 talking about a much wider joined-up system, are you?
 12 **MR STEIN:** Yes.
 13 **THE CHAIR:** Is this a system that currently is being
 14 proposed and is receiving a certain amount of attention
 15 as to the provider of it?
 16 **MR STEIN:** There has been for some time, as we've seen,
 17 a proposal to pull together essentially a digital
 18 framework for which -- which to work. I won't, on my
 19 feet, make any further submissions in relation to that.
 20 **THE CHAIR:** Thank you.
 21 **MR STEIN:** The third key recommendation is the
 22 standardisation of the format of accessing information,
 23 as we say, it should be faster, it should be easier to
 24 establish the information possible.
 25 I'm now going to turn to a comment made by

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1 providing therapy and those receiving therapy is one of
 2 the vital factors in understanding what may happen next.
 3 **THE CHAIR:** Yes. All right, thank you.
 4 **MR STEIN:** So the second key recommendation concerns Advance
 5 Choice Documents. They previously used to be known as
 6 Joint Crisis Plans. Now, Advance Choice Documents,
 7 ACDs, are written and developed by everyone involved in
 8 the patient's care and the patient is involved as well.
 9 This means all involved know what is meant to happen
 10 if that patient goes into crisis. Such documents embed
 11 trust and understanding in a therapeutic relationship.
 12 Whilst the College is supportive of Community Treatment
 13 Orders, ACDs should be required because they have been
 14 shown to reduce the likelihood and severity of any
 15 recurrence. Again, there is agreement across the board,
 16 we submit, in relation to their use.
 17 The July 26 framework states that the use of these
 18 documents is expected to become legislation as part of
 19 the Mental Health Act reforms. The College asks that
 20 this Inquiry supports and monitors this express
 21 intention.
 22 The third key recommendation. That is the
 23 standardisation of the format of accessing a patient's
 24 information. Currently it can take a psychiatrist
 25 several hours to find a patient's records that can be

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1 a different Inquiry Chair, Baroness Lampard, at the 2026
 2 opening which happened to be on 6 July 2026, when she
 3 stated this:
 4 "I have asked my team to consider what we may learn
 5 from the findings and recommendations made in other
 6 reviews and inquiries into mental health care and their
 7 potential relevance to our work."
 8 The College suggests that this Inquiry and others
 9 work towards the implementation of recommendations by
 10 challenging the commissioning bodies to provide evidence
 11 of how recommendations can be implemented.
 12 Let me finish with this.
 13 The College, the College's past president, Dr Lade
 14 Smith, the College's current president, Professor Subodh
 15 Dave, are clear: mental health services cannot continue
 16 with a model that overly relies on crisis management and
 17 poorly-resourced inpatient care and variable community
 18 mental health provision.
 19 Chair, urgent change is required.
 20 That change is required to take us to commissioning
 21 that focuses on population need, is evidence led, and
 22 clinically driven.
 23 Chair, as we all know, the risks from inaction are
 24 simply too great.
 25 **THE CHAIR:** Yes, thank you.

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1 Yes, thank you, Mr Davies.

2 Again, I've read your closing statement.

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

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

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

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

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

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

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

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

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

25 Madam, in a narrow sense, for the officers

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

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

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

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

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

25 Powers that would have been available on sentence

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

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

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

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

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

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

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

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

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

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

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

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1 **THE CHAIR:** Thank you.

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

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

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

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

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

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

2 **MR DAVIES:** Of course.

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

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

7 **THE CHAIR:** Paragraph 58.

8 **MR DAVIES:** Yes.

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

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

18 **THE CHAIR:** Yes.

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

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1 to that risk.

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

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

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

21 We agree, respectfully.

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

25 Firstly, unremarkable, almost too obvious to state:

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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,

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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.

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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

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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 imprisonment. 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

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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

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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

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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

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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

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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

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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,

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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

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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

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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.

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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

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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

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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

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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)

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