
WRITTEN CLOSING STATEMENT ON BEHALF OF THE BEREAVED FAMILIES CPs¹

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1. In opening, the Bereaved Families invited the Inquiry to remember Barney, Grace and Ian, and to consider the lives they each ought to have been living had they not been unlawfully killed on 13 June 2023 by Valdo Calocane (“VC”). The evidence received by the Inquiry during the four months of hearings sadly compounded the knowledge that nobody should have to *remember* Barney, Grace and Ian: they should still be with us.
- 1.2 The Bereaved Families also invited the Chair to consider six overarching questions within the Inquiry’s Terms of Reference (“TOR”).² The Bereaved Families consider the answers to those questions provided by evidence to the Inquiry are:
 - (a) There were failures in both the healthcare and criminal justice systems to learn the well-known, ill-managed, and oft-repeated lessons of the past.
 - (b) There were tragic and predictable flaws in the healthcare and criminal justice responses to VC’s deteriorating presentation from at least May 2020.
 - (c) The emergency response on the morning of 13 June 2023 was inadequately managed, co-ordinated and executed.
 - (d) The emergency response failed adequately to consider the continuing risk to life between the time the first attacks on Barney and Grace were reported in 999 calls, and the arrest of their killer 91 minutes later.
 - (e) The steps taken by police and prosecutors in the subsequent investigation and prosecution failed adequately to consider and scrutinise all lines of inquiry relevant to VC’s mental health and culpability.

¹ These submissions are prepared on behalf of the Bereaved Families CPs represented by Hudgell Solicitors and Fletchers Solicitors throughout this Inquiry. They seek to comply with the Directions of the Chair on Closing Submissions which require any submissions made to be in sections which address and correspond to the Terms of Reference for the Inquiry (“TOR”); in the same order as the TOR. The process of investigation and disclosure has continued following the conclusion of the public hearings in June. Some of this material was obtained following requests made by the Bereaved Families and consider critical questions, including in expert evidence. Further requests have been made by the Bereaved Families for additional statements to be obtained and information to be pursued by the Inquiry as a result of new disclosures. Such requests continue as new disclosure continues to be provided. Some of this material has not been explored with witnesses (including as identified below) and may require further submissions, including at the final hearings in September 2026. We raise a specific issue in relation to the NHFT EIP team in Section A, at [2.44], below, for example. The continuing disclosure process means that there are disclosed documents we have not yet had time to analyse before meeting the deadline for filing these submissions.

² In the interests of avoiding repetition, where not otherwise addressed in this closing statement, the submissions made on behalf of the Bereaved Families in opening are repeated: SUBS0000010.

- (f) In each of the investigations which followed, the deceased, and their families and the survivors who were seeking transparency and accountability about the events of 13 June 2023, were not treated seriously and with respect.
- 1.3 The remainder of this submission is in the following sections, as directed, and designed to address each of the Inquiry's TOR; highlighting how the Inquiry might safely reach those conclusions:
- A. Timeline:** Red-Flags, Missed Opportunities, Individual and Systemic Failures
 - B. Events and response on 13 June 2023:** 91 minutes Call to Cuffs
 - C. Unauthorised access and disclosure:** Protecting Privacy in Public Tragedy
 - D. Understanding, assessment and management of risk**
 - E. Multi Agency working:** Working Together
 - F. Care, actions, policy and procedures in custody:** All reasonable lines of inquiry?
 - G. CPS handling of the case:** Investigation and prosecution of VC
 - H. Recommendations:** Legacy, learning and loss
- 1.4 Though it is inevitable that not every aspect of the evidence before the Chair can be considered, we identify evidence and possible recommendations to assist the Inquiry. For ease of review, we identify key themes and recommendations in **bold**.
- 1.5 There are a number of propositions on the role of the Inquiry, the approach to the TOR and the evidence, that the Bereaved Families invite the Inquiry to consider, as follows:
- (a) Firstly, respect for the rights of people living with mental ill-health who are known to be violent can only be ensured with treatment and care which considers action necessary to protect public safety. Nothing in these submissions seeks to stigmatise mental illness or people living with serious mental illness. Clearly not all people who live with serious mental illness are violent, however, the Inquiry heard important statistical evidence on the numbers of homicides connected to mental illness. Data first published in 2017, from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness ("NCISH") identified an average of 11% of homicides are committed by patients; and 6% of all of those convicted of homicide had schizophrenia or a primary psychotic disorder.³ Over 20 years alone, there were 14,776 perpetrators and 15,512 victims.⁴ While shocking: those figures are an understatement of the known risk to public safety associated with serious mental illness. The Inquiry heard consistent evidence on risk factors for violence present in cases of mental health homicide: most patient homicides are committed by men; with an average age of 32; most had a history of drug or alcohol abuse; and 59% of patients with schizophrenia who kill were non-adherent with treatment or had missed their final appointment with services.⁵ Despite this consistency in understanding; the evidence from experts was that in the past three decades critical concern for public safety may have been lost, superseded by a focus on positive risk-taking, patient autonomy and "*least restrictive*" practice.

³ WITN0069001_0005-6 (Professor Appleby), WITN0069003.

⁴ WITN0069007_0003 (Second Statement Professor Appleby).

⁵ WITN0069001_0005-6 (Professor Appleby); See also WITN0069004, WITN0069005 including on the significance of maintaining engagement with patients who are likely to lose contact.

- (b) Secondly, many failures patent in the evidence reflect concerns identified by previous Inquiries: from the Clunis Inquiry, and repeated Inquiries in the decades which followed.⁶ Many of the failures patent in this Inquiry appear time and again: failures in risk assessment and management; failures to exercise available powers, including Community Treatment Orders (“CTOs”); non-concordance; information sharing; failures in family engagement; treatment and care planning failures; and failures in discharge planning.⁷ The conclusions and recommendations in the Ritchie Report were predicated on there being an identified group of individuals for whom assertive outreach and support would be critical in order to address known risks to public safety.⁸ Yet there was no Assertive Outreach Team in Nottingham. When VC disengaged from services, he was discharged from care, unassessed, unmanaged, and unsafe. He ought never to have been discharged as he was. That the learning and reforms which followed the death of Jonathan Zito were lost such that many of the same failures were patent in Nottingham three decades later is a cause of considerable anger and frustration for the Bereaved Families.
- (c) Thirdly, failures which led to the attacks on 13 June 2023 were both systemic and individual. Neither can be considered to the exclusion of the other. The Inquiry may conclude there were serious systemic failures, including in governance and in management, which contributed to the circumstances which allowed VC to kill Ian, Barney and Grace on 13 June 2023. However, there were individuals who simply failed to do their jobs. Any suggestion failure might be explained away by Covid, or by funding pressures in the NHS is unsustainable.⁹ Where the evidence warrants it, the Inquiry may conclude that - regardless of any wider systemic failure - steps to address the risk posed by VC which ought to have been taken, were not taken.
- (d) Fourthly, the Chair is tasked to “*take into account*” and to “*build upon*” the disparate investigations and reviews which followed the attacks of 13 June, but she is not bound by their conclusions. This Inquiry has a critical role in taking a “*holistic view*”, asking what exactly went wrong, in order that lessons might be learned for the future.
- (e) Fifthly, while the Inquiry will not be the final step in the process of accountability, this cannot prevent the Chair reaching conclusions on the facts and making recommendations necessary to discharge the TOR. Where justified by the evidence, conclusions which identify failures which causally contributed or may so have contributed to the events of 13 June 2023 are not only warranted, but may be required. Whilst it is not for this Inquiry to determine any question of civil or criminal liability, this cannot inhibit the Inquiry’s duty to reach necessary conclusions on the facts and to make recommendations.¹⁰

⁶ See, for example, INQY0000033 (Inquiry Legal Team Review); RLIT0000056 (Framing Implementing and Monitoring Public Inquiry Recommendations, Emma Ireton, Nottingham Law School, NTU, September 2025. Contextual Briefing for the Lampard Inquiry).

⁷ INQY0000033

⁸ DHSC0000160, including _0126-0129. Oral Submissions on Behalf of the Bereaved Families, AM, 24 February 2026, INQT0000002_0003-4, [9] – [11].

⁹ For example, Dr Dissanyaka explained that his work with patients like VC continued “*as normal during Covid.*” INQT0000051 88/18/89/18; TCLT0000754_0023: Dr Seedat to Theemis: “*I think, in terms of the overall decision-making and planning, I wouldn’t say that COVID had a bearing on it...overall I don’t think it significantly impacted in terms of the care, and the decision-making we made.*”

¹⁰ Inquiries Act 2005, s2

- (f) Finally, the attacks on 13 June 2023 and the events which followed illustrate both the importance of candour, and the significance of embedding the learning from past tragedy. As this Inquiry concludes, the passage of the Public Office (Accountability) Bill – known as the “Hillsborough Law” - is anticipated. Despite repeated individual investigations and inquiries following the deaths of Barney, Grace and Ian, these Bereaved Families have faced revelation upon revelation in the evidence disclosed to this Inquiry. Concessions were made in evidence by witnesses which had never previously been made. Each new day brought a new shock; a new concern. This not only underlines the importance of this Inquiry, but the significance of candour. In identifying where public bodies may have been less than candid in their approach, this Inquiry can illustrate why compliance with the new statutory duties of candour may bring radical change to the experience of all affected by events of State related tragedy. There can be no question that this Inquiry would never have happened without the efforts of the Bereaved Families. Sir Robert Behrens said: “[T]oo often the successful resolution of these cases had depended upon bereaved families campaigning at a time when they are least well prepared to do that, and it is an outstanding public service that they perform.” This public service is one that comes with a price: it “*absolutely*” compounds the trauma experienced by those in tragedy and fighting for change.¹¹

Time and again, the efforts of these Bereaved Families to discover the truth about the events of 13 June have compounded their trauma and frustration. Transparency and accountability ought never to depend upon the emotional resilience of grieving victims and survivors. Those we represent tentatively hope that no family will again need to fight at every turn, to seek answers following the death of their loved ones in circumstances where the failures of the State may have played a role.

- 1.6 The hearings in this Inquiry began 32 years to the day the Ritchie Report was signed. We urge that the work of this Inquiry must not just be for Barney, Grace and Ian, but must be for all those unnecessarily deceased and unnecessarily bereaved at the hands of those known to be seriously mentally ill and known to be a risk to public safety. The Inquiry heard impactful and moving evidence from Julian Hendy of Hundred Families. He has been of support to many bereaved families, not just the Webber, O’Malley-Kumar and Coates families.¹² Mr Hendy described meeting a “*wall of silence*” when he tried to learn the truth about the circumstances of his father’s death.¹³ The Inquiry Review considered 44 cases identified by families responding to the Inquiry. There are many families who have not had the opportunity to have their questions aired in a public inquiry: the learning from this process is for them and for their lost loved ones too.¹⁴
- 1.7 And families continue to be devastated by such avoidable tragedies. Repeated acts of violence in high profile incidents and convictions have been reported time and again, even since this Inquiry began in February 2026. Those we represent regret that some of the evidence heard may suggest a continuing, and dangerous lack of regard for risk to public safety in the approach of police and clinicians working to provide care for those who are seriously mentally ill. Any commitment to assertive care in the NHS Ten Year Plan, as opposed to a commitment to the

¹¹ INQT0000107 30/6 – 31/21.

¹² WITN0258001, INQT0000100.

¹³ INQT0000100 4/5.

¹⁴ INQY0000033. INQT0000099 3/12 – 15.

assertive outreach model, must therefore be considered with some scepticism.¹⁵ This tragedy must not be followed by another decade of unmanaged risk and wishful thinking.

- 1.8 Fundamental change must ensure that neither the risk to public safety in the treatment of people known to be ill and violent, nor the public interest in the full and proper investigation of culpability when those with serious mental illness kill, is ever again lost, forgotten or unduly diminished. The facts adduced by this Inquiry underline that the State must do more to protect public safety. This must include properly grappling with the evidence required to allow for effective prosecution in cases where the Courts may be asked to answer difficult questions related to culpability and appropriate disposal.
- 1.9 The changes in the Mental Health Act 2025 (“MHA 2025”) must not be permitted to put patients and the public at even greater risk by placing misguided reliance on the language of “*least restriction*”. The only fitting legacy for Barney, Grace and Ian is a future where the risk to public safety is taken seriously in the management of mental health.

A. Timeline: Red-Flags, Missed Opportunities, Individual and Systemic Failures

- 2.1 The evidence heard by the Inquiry has confirmed that VC’s history of contact with public agencies is one of repeated failure in the face of clear and growing risk. There were repeated individual and systemic failures in the assessment and management of the risk VC posed to others and to public safety; and repeated failures of organisations to share information they had available to them. We return to address recommendations on risk-management and information sharing and multi-agency working in Sections D and E.
- 2.2 The Bereaved Families regret that despite efforts on the part of the Inquiry, gaps in VC’s critical history before 2020 remain. The Inquiry may conclude that information about VC’s history, relevant both for the purposes of a full understanding of his clinical presentation and for a full exploration of his violent actions on 13 June 2023, suggests behaviour of concern before 2020 when he was first arrested and seen by mental health services in Nottingham.
- 2.3 The evidence before the Inquiry (and available to be discovered during the prosecution and his treatment (as highlighted below)) points to:
 - (a) VC having left home and isolated himself from his family as a young adult;¹⁶
 - (b) There being some evidence of disturbed behaviour by VC in 2013-15;¹⁷
 - (c) By 2020, VC being troubled about his position in life and expressing regret that his progress and attainment compared poorly to his siblings and other young people;¹⁸
 - (d) His linking of feelings of disappointment and comparison, competition and pride to evident frustration, thoughts of violence and misogyny in his own contemporary writing and communications;¹⁹

¹⁵ WITN0409001 (Baroness Merron), [49]-[55].

¹⁶ INQT0000086 35/1 – 20.

¹⁷ WITN0428001(Tessa Page-Harries); see also NGPF0011499_0003.

¹⁸ NHFT0000168_0011, INQT0000061 13/19 – 15/20, TCLT0000754_0013 (Dr Seedat).

¹⁹ For example, “*Wanted to hurt... permanently...*” [NGPF0002527_0017]; “*I was thinking about red rum not 120 minutes ago*” [NGPF0002527_0018]; “*He says he knows the voices/people wouldn’t dare say anything/mock him to his face. Pride spikes dramatically. Makes a remark about harming the people he’s hearing (hard to tell when he’s making a distinction between the voices as people and just voices*” [NGPF0002527_0006]. See also: “*Some thoughts about*

- (e) VC being isolated, with limited evidence of friendship or a network of support beyond the limited contact he sustained with his family.²⁰ (Evidence of any connection he had sustained appears to be limited to Bil Monteiro, whose police intelligence in June 2023 identified risks including for firearms, weapons, violence and drugs);²¹
 - (f) VC having lied about his own alcohol and drugs use, including to the police²² (and little being done to objectively test his statements);
 - (g) VC being repeatedly and deliberately non-concordant with prescribed medication and communicating his intent not to comply with treatment to clinical staff;²³
 - (h) Violent incidents in VC's life and periods of admission to hospital being linked to periods of particular stress including around education and accommodation (and there being little to nothing done to recognise and act upon those triggers by those responsible for his care and treatment); and,
 - (i) Repeated incidents of violence during 2023 leading, finally, to his eviction on 11 June 2023.
- 2.4 The Bereaved Families remain concerned that this information may have been ignored, dismissed, diminished and explained away in the context of his treatment or in the process of his prosecution. For the avoidance of any doubt, the Bereaved Families do not dispute that VC experienced serious mental illness and periods of psychosis which required more effective treatment and management by all agencies between 2020 - 2023. They remain deeply concerned as to adequacy of the response to his presentation and the exploration of his history. They invite the Inquiry to question - given all that was known or ought to have been known about VC during 2020 - 2023 - whether all lines of inquiry relevant to the issue of his culpability for the purposes of his sentencing were effectively explored by NGPF and by the Crown Prosecution Service ("CPS") in 2023 - 2024.
- 2.5 The Inquiry has copies of VC's own writing, texts, notes of conversations made by his brother and some information about VC's online life gleaned from downloads of material seized in the investigation which followed the 13 June attacks. This material is incomplete. We have recently learned that a mobile telephone which was within VC's bag at 165 Burford Road was somehow missed, and never examined.²⁴ We understand that VC's laptop has never been discovered. It does not appear that access to VC's social media and WhatsApp activity / messaging has been pursued whether by request for VC's consent to access those platforms or direct request to providers. The material sourced from phone downloads during the police investigations of the attacks on 13 June 2023 does not generally appear to extend prior to 2022.²⁵ Nevertheless, the material available provides some important insight into VC's state of mind and his reflections on the events which led to 13 June 2023. It highlights a definite intent to harm and suggests preoccupation with themes

sexual dynamics from the male perspective." including *"What's the meaning / value of PiPing them?"* [NGPF0011506_0004], *"I forgot 3 situations for quite a while: at home (dinner), the university visit, with the bitches in the library."* [NGPF0011504T_Page 11] and *"Whatever it is, fucking bitch"* [NGPF0011504T_Page 61].

²⁰ For example, PAGR0000159. MDT record dated 7 October 2021. Under *"keeping connected"*, the clinicians record that *"[VC] has not appeared to make any contact with his friends or family..."*; INQT0000015 5/13 - 16; INQT0000011 54/12 - 13.

²¹ NGPF0001671.

²² NGPF0000070_0006.

²³ See, for example, NHFT0000168_016; NHFT0000168_0234.

²⁴ WITN0471001 (Jeffrey Julious, Police Staff Investigator). See INQY0000003. We note that the summary prepared by the Inquiry is not a complete picture of these notes (e.g. compare INQY0000003 at 87(a) with NGPF0011504_59: *"the cure for the other is Repayment fuck it! Repay, that's our name. Avenger"*).

²⁵ INQY0000001; WITN0386001 (PC Shaw); NGPF0003744.

of extreme violence, including mass casualty events, by 2022.²⁶ The Bereaved Families are particularly distressed by evidence of misogyny which has only come to light very recently.²⁷

- 2.6 The Bereaved Families urge the Inquiry to examine this material rigorously; and to treat with considerable caution any suggestion that its only relevance is to further illustrate the extent of VC's serious mental illness.
- 2.7 As to VC's online activity: the Inquiry heard repeated reference, particularly during his third and fourth admission to VC being in his room and on his devices. By 2022 (at least), deterioration in VC's behaviour occurs in the same period he is accessing violent and extreme content. There is no evidence his online activity was checked at any time while he was detained or in the community (and little evidence of any engagement with him on what he was doing).²⁸ There may be a particular risk online behaviour may inhibit treatment in patients experiencing persecutory delusions around mind control.²⁹ Yet, in a general adult unit, there would be no general monitoring of online behaviour. The RCP evidence is that "*this is an area where new guidance is likely to be needed as evidence and practice evolve*". She said "*all the world is playing catch up*".³⁰ This position appears archaic and that VC's online life was never explored by those working most closely with him (including his Responsible Clinicians and his Care Coordinator) meant a crucial opportunity to gain perspective and greater understanding of his risk was lost.³¹
- 2.8 Guidance on monitoring for access to violent and extremist material by people who are seriously mentally ill, who have a known history of violence and who pose a risk to others and to public safety is long overdue. **The Department of Health must produce clear national Guidance on patients with serious mental illness, a history of violence and online activity and must consider and whether new powers to restrict or monitor access to the internet for persons detained pursuant to MHA, or subject to CTOs are necessary.**
- (a) **Before 2020: Gaps in VC's known history**
- 2.9 While there is no suggestion in the limited GP and school records disclosed of any formal mental health concerns or violence prior to 2020, the Inquiry still has a relatively incomplete picture of VC and his history. However:

²⁶ INQY0000001. See also NGPF0002527.

²⁷ See for example, "*Some thoughts about sexual dynamics from the male perspective.*" including NGPF0011506_0004; "*The meaning of sex is sport and pleasure. Sport means competition/ and pleasure means triumph. Differentiation / grading.*" We address below the connection seemingly drawn in VC's writings between rape and the events of 24 May 2020 (and his having first overheard a couple having intercourse).

²⁸ See for example, INQT0000079 130/21 – 131/22; INQT0000066 11/18 – 13/14; INQT0000082 33/18 – 34/24.

²⁹ WITN0272001_009, [16]: Professor Vaughan Bell on his research concerning psychosis and online communities focused on mind control: "*In terms of risks relevant to people with psychosis, engagement with a community that validates or appears to validate delusional beliefs may discourage them from accessing treatment.*" WITN0272001_009, [16]

³⁰ INQT0000103 – 43/1 – 45/1. See also WITN0320001_0034.

³¹ See also RLIT0000067, Vol 1, [38] – [39], [64] – [67]. Sir Adrian Fulford will explore in Phase 2 of the Southport Inquiry whether there should be a further ability to restrict or monitor access to the internet for children and young people who pose a risk to others. The Inquiry has a statement from Professor Vaughan Bell on his research concerning psychosis and online communities focused on mind control (WITN0272001): "*In terms of risks relevant to people with psychosis, engagement with a community that validates or appears to validate delusional beliefs may discourage them from accessing treatment.*" While concerned with a secure hospital environment, the report of the Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital recognised the evolving position on digital technology and the internet and the need for restriction as long ago as January 1999 (Cm 4194-ii).

- (a) There was some suggestion that VC had been bullied in school both in Portugal and in the UK and this was due to the family living in a predominantly white community.³² This was walked back in evidence by Mrs. Calocane.³³
 - (b) VC left home after becoming unhappy with his father's rules.³⁴
 - (c) Evidence from VC's school confirms that a meeting was called shortly after VC left home and shortly before VC withdrew from secondary education. The school were aware he was no longer attending church with the family. While at school he had been extremely focused on succeeding; yet he later chose to abandon his studies.³⁵
 - (d) Tessa Page-Harries gave evidence that she lived with VC in 2014-2015. She spoke of VC's concerning behaviour, which may have involved the remains of an animal.³⁶
 - (e) VC records a confession to illegal actions in 2013-2014: "*mea culpa*".³⁷ There has been no opportunity to address this with witnesses, including VC's family, as the material was disclosed after the close of the hearings.
 - (f) VC enrolled in pre-University education in Birmingham in 2015³⁸ and then thereafter moved to Nottingham in 2017 to begin his degree. VC worked in a variety of factory and industrial settings. He may have met Bil Monteiro (who had connections to addresses near Seely Hirst House) in around 2019-20.³⁹
- 2.10 Beyond his formal college and University records and short statements from teachers, the Inquiry's knowledge of VC between the time he left South Wales in 2015 to Spring 2020 when he first came to the attention of mental health services and the police, relies principally on the evidence of his mother and brother. Mrs Calocane confirmed that after VC left Wales, his direct contact with the family was extremely limited even before the Covid pandemic.⁴⁰
- (b) 2020: Liam and his Partner, Feven and VC's First and Second Mental Health Act Admissions**
- 2.11 On 23 May 2020, VC called an ambulance. He self-reported to the paramedics that he had a history of mental ill health: "*admits to having mental health problems in the past but would not say what*".⁴¹ This has never been explored with VC but emphasises the importance of the evidence of Ms Page-Harries and the gaps in VC's history.
- 2.12 In the next 24 hours, on 24 May 2020, there followed two violent attacks by VC on neighbouring properties which led to life-changing injuries for Feven and to VC's arrest and thereafter, his first compulsory MHA detention (pursuant to s.2 MHA). These were attacks on two people who were strangers to VC: their only connection being proximity. Shortly after his first release, VC was again detained after an incident of violent trespass on 13 July 2023 and his second MHA detention (pursuant to s.3 MHA) followed.

³² WITN0391002.

³³ INQT0000086 16 – 18.

³⁴ "*He had issues with my Dad, arguing and not wanting to live by my Dads rules*" NGPF0008987_0004 (Elias Calocane MG11). We have not been able to ask questions of VC's father about whether VC was unhappy with his rules.

³⁵ WITN0476001 (Nigel Thomas, former Learning Support Assistant Sir Thomas Picton Secondary School).

³⁶ WITN0428001 (Tessa Page-Harries).

³⁷ NGPF0011499_0003.

³⁸ Matthew Boulton College: WITN0431001 (Lisa Hutchinson).

³⁹ NGPF0000322_0024-25: In June 2023, Bil Monteiro says he met VC variously 2-3 years ago; and 2-4 years ago while working at an Aldi warehouse in the Mansfield Area of Nottingham.

⁴⁰ INQT0000086 35/1 – 20.

⁴¹ EMAS0000002_0002.

- 2.13 In recently disclosed notes VC appears to reflect on the first incidents and demonstrates that he knew a lot about the impact of his actions before the attacks in June 2023. For example, on the Feven incident, he wrote: *“I knock down the door of an apartment in the next flat and the female occupier jumped out the window and broke her spine. Police were called and I was arrested again.”*⁴²
- 2.14 The Inquiry may conclude that the inadequate response to these first incidents by the local authority (“NCC”) (through its Approved Mental Health Professionals (“AMHPs”)), by the local police (“NGPF”) and mental health services (“NHFT”) set a pattern which continued in VC’s contact with agencies between 2020 and his killing Barney, Grace and Ian in 2023.
- 2.15 With every incident between 2020-2023, there were failures to follow existing policies and failures to adequately consider the harm that VC had caused and the risk that VC posed to others and to public safety. Police were too quick to resort to diversion in the face of criminality, avoiding any option that would see VC face meaningful investigation for actions which were increasingly violent acts of criminality. Clinicians were quick to adopt an untethered concept of “least restrictive” practice which ignored patent risk to restriction of the rights of his victims. Together these practices repeatedly operated to divert VC away from a forensic pathway; and away from effective and, if necessary, compulsory treatment, regardless of the evidence that he was non-compliant with treatment in the absence of compulsion. Together, they failed VC and the people he affected.
- 2.16 **First, the Inquiry might question whether the circumstances of the first MHA assessment conducted for VC illustrated this approach from the start.** Not least, it wrongly proceeded on the basis that bloods had been taken from VC for toxicology and drugs-related behaviours ruled out.⁴³ There was no effective drug testing for VC between 2020-2023.⁴⁴ Nurse Annette Palmer attended VC’s assessment as the “gatekeeper” for the City Crisis Team. A decision was taken not to detain VC but to pursue community treatment. VC said he would “consider” taking medication.⁴⁵
- 2.17 Reliance was placed on the NHFT Crisis Team’s assertion that VC could be effectively managed in the community,⁴⁶ despite the fact that he would be returning to the same place from which he had just been arrested; without any support network; and, without having received any treatment. Instead, he was released and attacked Feven within hours. The Inquiry heard Dr Gandhi, one of the two doctors to first assess VC, said when interviewed in 2025 that *“the team of professionals considered the research evidence that shows over representation of young black males in detention and recalls that [Annette] Palmer was able to persuade us that CRT could provide a safe and reasonable alternative of supervised medication and 2 visits / day. With the option to*

⁴² NGPF0011505_0016. See also Inquiry Summary at INQY0000003.

⁴³ INQT0000058 5/13 – 9/13.

⁴⁴ Rio notes suggest that on 28 May 2020 VC had given a urine sample which came back negative for everything except benzodiazepines. (Witness statement of Faizal Seedat at [216] WITN0163001_0088). Given that VC had been detained since 24 May 2020 and the evidence of Professor Kim Wolff as to the duration of drugs in urine, this could not be said to be definitive in excluding single use or possibly even moderate use of cannabis in the days before the incident. [Report of Professor Wolff WITN0394002_0010: Table].

⁴⁵ NOCC0000044_0002-0003.

⁴⁶ INQT0000057 130/18 – 132/17.

admit if the community treatment plan failed".⁴⁷ In evidence, Dr Gandhi suggested this was his hypothesising after the fact or a "*reflection*"⁴⁸ whilst Dr Malik and Ms Palmer said they did not recall such a conversation.⁴⁹ Regardless, each of the decision makers concluded that community care was appropriate following the "*least restrictive*" principle.⁵⁰ Problems in the interpretation of that principle extend throughout the relevant period. A critical question for the Inquiry must be how risk to the patient or others is considered in reaching a view on "*least restrictive*" options for treatment. The Bereaved Families consider that the treatment of VC reflects the "*least restrictive*" resulting in a failure to adequately consider risk of harm to the patient and others because of a default mentality of "*avoiding restriction*". The least restrictive option possible *must* first incorporate understanding the risk posed by a patient.

2.18 Second, the Inquiry might consider that the failures by the police in these first incidents, lost sight of the lessons learned in the Clunis Inquiry and were repeated time and again. Following the offences on 24 May and 13 June:

- (a) **There was a failure to accurately record relevant information and facts about the incident, and a failure to adequately investigate VC's actions and his presentation.** There were no statements taken in relation to the first incident and information taken from Feven as to the incident appears to have been taken without a translator and while she was recovering in hospital from major spinal surgery. Importantly, there was no record of VC having tried to attack Feven again when he was escorted from the property, for example.⁵¹ On 13 July 2020, whilst it had taken three members of the public to restrain VC and "*the neighbours were very anxious and it was felt he [VC] was a significant risk to himself and others and with a mental disorder*"⁵², PC Plant only recorded VC's details.⁵³
- (b) **There was a failure to take an account from VC in Feven's case; and a failure to act on the information given by VC when interviewed in connection with the first incident.** Contrary to clear policy guidance,⁵⁴ PC Marsden gave evidence that once he had Dr Seedat's input, he never considered whether VC could be interviewed while detained or whether a decision on interview could wait until he was discharged.⁵⁵ Despite the officer attending at the scene for the first incident on 24 May 2020 (PC Eustace), suggesting that VC may be under the influence of drugs⁵⁶ and VC's initial equivocal response to questioning as to whether he used illicit drugs ("*not really*"⁵⁷), no drug testing of VC took place.⁵⁸
- (c) **The offences were inappropriately categorised and wrongly treated in isolation.** PC Eustace reflected on whether the first offence ought to have been treated as burglary rather than criminal damage. PC Marsden and PS Sparks asserted that Feven's case was treated as

⁴⁷ NHFT0004927_0002.

⁴⁸ INQT0000058 9/12 – 13.

⁴⁹ INQT0000057 13/13 – 14/14; INQT0000058 97/2 – 98/7.

⁵⁰ WITN0302001 (Dr Rahul Gandhi), at [94].

⁵¹ Compare NGPF0000082 and INQT0000006 31/17 – 32/5.

⁵² NGPF0007320_0001.

⁵³ NGPF0004261.

⁵⁴ NGPF0006002.

⁵⁵ INQT0000007 28/8 – 28/5.

⁵⁶ NGPF0000068_0010.

⁵⁷ NGPF0000070_0006.

⁵⁸ PS Wilde's expressed view was that with the removal of drug testing for 'trigger offences', such testing 'wasn't in existence' at the time, but independent of the scheme which had been shelved over COVID, forensic drug testing facilities clearly remained. INQT0000008 25/6.

GBH as soon as the extent of her injuries were known but the records suggest otherwise. No evidence of the seriousness of the offence would have appeared on the PNC (which would refer to ABH). No consideration appears to have been given as to whether the CPS ought to be involved in any decision on disposal.⁵⁹ Internal reflection by NGPF after 13 June 2023 would suggest that the offence against Feven ought never to have been closed without consultation with the CPS.⁶⁰ PS Sparks accepted there should have been consultation.⁶¹ The Feven file was closed within days; despite clear policy guidance that there are circumstances where it might be desirable to prosecute an offender to allow for treatment, Hospital Orders or other statutory support, even where a conviction or custodial sentence may not be the outcome.⁶² Officers accepted that it would have helped if both were formally linked.⁶³ There appears to have been no consideration of arrest and investigation at all on 13 July 2020 despite evidence of assault and a pattern of behaviour in the earlier two offences.⁶⁴

- (d) **Both offences were inappropriately closed with no further action.** Both relied on a single opinion procured by PC Marsden from Dr Seedat to the effect that VC did not have any memory of the events during the attack on Feven. PC Marsden suggested this approach – obtaining informal statements from treating clinicians before disposal – was systemic.⁶⁵
- (e) **There was scant regard for the rights of victims in each of the offences and a failure to act in accordance with the Victims’ Code.** There was no statement taken from Liam despite concern VC would return. Liam gave telling evidence that VC continued to return after the events in 2020, with a threat made by VC to rape his partner in 2021 or 2022.⁶⁶ It took an Online Report by Feven’s friend criticising the police for having failed to visit her in hospital for the police to take note that she had fractured her vertebrae⁶⁷ and to attend on her again, some 5 days after the incident.⁶⁸ Feven was never informed of any right of review of the decision not to proceed. She was never afforded access to Victim Support. She expressed her anger and frustration: PC Marsden recalled she was “going to be fine about it”⁶⁹ and that she was understanding and kind.⁷⁰ These were observations he made having communicated the decision not to proceed even before it had been formally recorded as closed by PS Sparks. The communication with victims gives a clear impression that the police simply wanted to ease the way for the cases to be concluded with as little effort on their part as possible. For the Bereaved Families these matters are indicative of a lack of care for victims and for public safety which they regret runs through their own experience with NGPF.

⁵⁹ INQT0000007 31/7 – 32/8.

⁶⁰ NGPF0007833.

⁶¹ INQT0000008 94/25 – 95/4.

⁶² INQT0000006 64/1 – 18.

⁶³ INQT0000007 16/19 – 22; see also INQT0000007 50/3-6; INQT0000008 73/7.

⁶⁴ See, e.g. INQT0000011 4/22 – 9/17, INQT0000010_0003.

⁶⁵ INQT0000007 13/8 – 11.

⁶⁶ WITN0307001_at [34]. The Inquiry has been unable to explore whether VC’s writing connecting the events of May 2020 to rape and his hearing a couple having sexual intercourse ought to cast the evidence of VC’s repeated return to Liam and his partner’s door in a different light: NGPF0011505_0009: “*The context of the introduction was the sexual act. Not performed by me but rather overheard. The scenario that the system created in my mind was that the couple upstairs were having intercourse...I did not give it the reaction it wanted ie curiosity and excitement the system gave me the sensation of being aroused...The gist of the exchange was that my reaction showed or betrayed pervert inclinations*”. These writings were available to the police but disclosed to the Inquiry only after the hearings concluded.

⁶⁷ NGPF0000082_0013.

⁶⁸ See for example NGPF0000068_0020.

⁶⁹ WITN0163014_0001.

⁷⁰ WITN0019001_0004.

- (f) **There was a failure of supervision and a failure to comply with local policies throughout.** The Inquiry heard officers had not been adequately trained in dealing with suspects with mental health issues.⁷¹ The Inquiry might conclude many were unfamiliar with (or ignored) the local policies on mental health and disposal. There was a lack of supervision; Inspector Powar confirmed that the case relating to the first incident was not properly supervised between 24 May 2020 to 20 January 2021.⁷²

2.19 **Third, and significantly, the Inquiry might consider that, in 2020, the actions taken by NFHT in community and in-patient care during in respect of both VC's first and second admissions, failed to adequately consider the risk to public safety posed by VC.** As a result, they failed to manage his care through appropriate treatment.

- (a) **By 3 June 2020, the Trust was aware (or ought to have been aware) that VC had expressed thoughts which extended to the intent to seriously harm others. VC had been violent to strangers, and these actions had resulted in very serious injury. This degree of risk was not reflected in the approach to diagnosis, care planning and risk assessment.** In evidence, Dr Seedat accepted that the information communicated in the journal based on VC's messages and conversations prepared by Elias Calocane ("Elias' journal")⁷³ and shared on 28 May was "*really dangerous*" and "*very chilling*".⁷⁴ He accepted that these were messages indicating VC's experience was "*very volatile*". He was thinking about murder, feeling anger and hatred and feeling the darkest thoughts you could imagine.⁷⁵ The notes in the journal are horribly and painfully prescient: (i) They record VC experiencing repeated thoughts of inflicting harm on others ("*Because I think that they are watching I know that I can break their heads with my hands*";⁷⁶ "*Wanted to hurt...permanently*" and "*I was thinking about red rum not 120 minutes ago*"; (ii) They show his expression of shame and pride being linked to an intent to harm others ("*He says he knows the voices/people wouldn't dare say anything/mock him to his face. Pride spikes dramatically. Makes a remark about harming the people he's hearing (hard to tell when he's making a distinction between the voices as people and just voices)*";⁷⁷ (iii) They record VC releasing his frustration by walking late at night and "*shadow-boxing*".⁷⁸ They also confirm VC told his family he was hearing voices and believed there may be technology which was responsible; he told his family he was paranoid, including about their safety. They make clear that he is reluctant to share his experiences with his family (other than Elias, who he warns not to share this material with others). VC assures Elias that VC is not himself in danger.⁷⁹ Dr Seedat accepted that the summary he produced on 3 June was not adequate.⁸⁰ He said there were parts of the notes he did not understand (including "*red rum*"). He revealed that he did not share the notes with others nor did he question VC about the

⁷¹ For example, PC Marsden WITN0019001_0006; INQT0000007 44/18 – 21.

⁷² INQT0000008 40/22.

⁷³ NGPF0002527.

⁷⁴ INQT0000061 47/12 – 48/1, 57/1 – 9, 57/15.

⁷⁵ INQT0000062 57/1-15. NGPF0002527_0017 (12 April 2020, 14:52) "*I felt immense anguish, paranoia, anger, hatred*"; then at 14:54: "*Couldn't sleep, had the darkest thoughts of could imagine; then again at 14:54: Wanted to hurt...permanently...*". The Inquiry has not seen the original messages and we assume that the ellipses appear as they did in VC's original message.

⁷⁶ NGPF0002527_0014 (18 May 2020, 17:02).

⁷⁷ NGPF0002527_0006: Paraphrasing a call at 11:02 on 20 May 2020.

⁷⁸ NGPF0002527_0011 (18 May 2020, 04:04).

⁷⁹ NGPF0002527_0003 (20 May 2020, 08:32).

⁸⁰ INQT0000061 57/1-15.

substance of these messages. He accepted that he did not tell VC that he knew about these messages.⁸¹ He accepted that he ought to have asked VC about each of these messages to understand VC's insight.⁸² Dr Ludvigsen had not seen the journal entries but said that the information recorded in Dr Seedat's note entered on 3 June was enough for them to consider VC "*high risk*". She accepted there was already a high concern VC could seriously injure people.⁸³ She said that had she seen the underlying materials it would have further informed their existing concerns. She would have recognised "*red rum*" as murder spelled backwards. This all stands in stark contrast to VC's contemporary risk assessment ("*There have been no incidents of violence yet*").⁸⁴ Explanations seeking to distinguish aggression from violence were, and are, not credible. Both doctors maintained the record of an MDT discussion recording that VC may end up "*killing someone*" was a frank exchange designed to shock rather than any true reflection of the risk which clinicians believed he posed to others.⁸⁵ Given that Dr Ludvigsen accepted there was a high risk of VC seriously injuring people, that may ultimately be a distinction without a difference. The Clinicians were aware that VC was willing to act with violence. His actions towards strangers had resulted in serious injury for which he had shown little empathy or remorse.⁸⁶ The evidence of Dr Seedat suggests a blinkered lack of longitudinal risk assessment and an utterly unwarranted confidence in VC's candour.

- (b) **Relevant history and triggers for VC were indicated in clinical notes but do not appear to have been explored directly with VC or incorporated effectively or at all into care and risk planning for VC.** Clinicians repeatedly confirmed the significance of understanding patient history including for the purposes of understanding risk.⁸⁷ Dr Seedat accepted for example, that it would have been helpful to have had the evidence of Ms Page-Harries as to his earlier behaviour and it may have been helpful to have information from others who knew VC.⁸⁸ However, he suggested that having seen Elias' journal he said he appreciated that VC may have been affected by illness for a time prior to 2020.⁸⁹ The Inquiry might consider whether there was information in the materials which could have been discovered through more active engagement with VC and his family throughout the relevant period. However, there was evidence of triggers which were simply unexplored or which appear to have been given insufficient consideration in the context of VC's care planning and risk assessment. Dr Seedat confirmed and recorded that VC told him that he was disappointed with where he was with his trajectory of life and confirmed that VC was

⁸¹ INQT0000062 59/1 – 60/12.

⁸² INQT0000062 72/4 – 72/22.

⁸³ INQT0000059 72/11 – 73/21.

⁸⁴ NHFT0000168, INQT0000059 99/2 – 100/13.

⁸⁵ Compare with her acknowledgement that VC was considered high risk by clinicians in light of his recorded intent to harm others when unwell and her assertion that none of the clinicians thought VC killing someone would be a likely outcome (INQT0000059 16-25/97). Dr Seedat appears to accept with some reluctance that, in order to posit as a worst-case scenario that VC might end up killing someone, he must have considered this a risk: INQT0000062 119/1 – 120/17.

⁸⁶ Dr Ludvigsen accepted that clinicians would have been aware that the second incident on 24 May had led to a back injury that required surgery during VC's admission and that the injuries were serious, although this was not reflected in risk assessments. INQT0000059 41/3 – 46/12. Dr Seedat accepted that he was aware of significant injury and found out that she had had surgery after contact with the police (he suggested after the email from police on 1 June). INQT0000061 25/23 – 26/4.

⁸⁷ Dr Ackroyd said that history can effectively identify a pre-illness state. See also "*the witness statement from the housemate that gives it a pretty clear description of at least a prodrome, or a more accurate term of being at risk mental state, or even psychotic symptoms being present.*" INQT0000059 12/2-16 & 13/2-6.

⁸⁸ INQT0000061 79/2 – 80/21.

⁸⁹ INQT0000061 40/10-25.

concerned younger students, including his own siblings, were doing better at a younger age (*“there were aspects of his self-esteem that he was struggling with”*).⁹⁰ Dr Seedat accepted that pride and sensitivity to insult were sensitivities in VC’s presentation. He said it was *“different when he was under treatment”*. There is little or no evidence in the care planning documents that the link drawn between pride and harm to others is drawn. The reference to pride spiking in Elias’ notes is omitted in Dr Seedat’s note of 3 June for example. Dr Seedat asserted many times in his evidence that conversations took place but were not recorded: we urge the Inquiry to treat these explanations with considerable caution, if not scepticism (we note he agreed with the adage drawing on good medical practice *“if you didn’t write it down, it didn’t happen”*).⁹¹

- (c) **VC’s history did not include any recorded risk of self-harm, suicidal ideation, planning or attempts to harm himself.**⁹² Instead, clinicians record any risk to VC as arising from others retaliating in response to his aggressive behaviour (*“He is clearly a risk to others and to himself from retaliation”*).⁹³
- (d) **Dr Seedat accepts that he should not have given a view on VC’s mental health for the purposes of criminal investigation as he did during VC’s first admission.** He accepts his response was inappropriate.⁹⁴ He was not a forensic psychiatrist. The information he gave the police about VC’s lack of recall was inaccurate. There is no evidence that at any time Dr Seedat considered whether the notes of VC’s discussions with his brother ought to be passed to the police for the purposes of any ongoing investigation.
- (e) **There was little or no evidence of any therapeutic input for VC beyond medication whether in in-patient care or while VC was in the community in 2020 (including for example, access to CBT or other forms of psychological therapy). Offers of such input were refused by VC.**
- (f) **While there was evidence of some insight, VC’s non-concordance and his intention not to comply with treatment was communicated to the Trust from an early stage. Evidence of masking or manipulation was patent from these early admissions but there was little evidence of this being actively considered, challenged and countered.** Dr Seedat was forced to admit that he would have been aware during the first admission that VC was providing a different explanation to him than that he had provided during his MHA assessment. Yet, there is little contemporary evidence that this inconsistency was considered during VC’s first admission or at any later time. VC’s own writing provides yet further insight into his own observations of the circumstances leading to 24 May 2020. But, by 3 July 2020, he had run out of medication and had taken no steps to obtain more. When later questioned, VC stated that he had read that the medication could *“slow his mind”*.⁹⁵ This was information relayed to clinicians aware that study and exam stress may be a trigger for VC but there is little or no evidence of this being challenged or otherwise informing the care plan. By July there was clear evidence of deliberate non-concordance and limited evidence

⁹⁰ INQT0000061 19/13-20/15

⁹¹ INQT0000062 71/1-4.

⁹² For example, Dr Ludvigsen confirmed that there was no reference to self-harm in the messages in Elias’ journal which she had been shown: INQT0000059 72/3-5.

⁹³ NHFT0000037_0014, INQT0000061 107/19 – 108/2.

⁹⁴ INQT0000061 34/13 – 38/8.

⁹⁵ NHFT0000168_0064.

of efforts being made to deal with that. His mother contacted the Crisis Team to record her concerns.⁹⁶ No-one from the Crisis or EIP team attended to see VC. Three days later, he was later restrained after aggressively forcing himself through a resident's door.

- (g) **There was a view on VC's functional diagnosis and on the critical aspects of his care plan by the time of his discharge in July 2020.⁹⁷ As Drs. Ludvigsen and Seedat confirmed, the priority was compliance with medication.** Regardless of specific nomenclature, the Bereaved Families find it difficult to comprehend any claim that the family of VC did not understand from at least July 2020 that VC had a serious mental illness which required such consistency in medication that Depot was considered an option.
- (h) **While Depot was considered during VC's second admission, clinicians appear to have been inappropriately guided by VC's preferences without regard to the risk to public safety VC posed when unwell. There appears to have been little or no discussion as to whether medication was effective and the doses prescribed properly therapeutic.** Dr Ludvigsen's evidence is that they considered VC a high risk: including that he would seriously injure others. VC had communicated to his family feelings of murderous intent, and this had been communicated to the Trust. His aggression and violence to strangers had led to serious injuries. Had the patent risk posed by VC to others properly informed the approach to his care Depot ought to have been more seriously considered at this stage: together with a CTO. Instead, the approach taken by Dr Seedat appeared entirely driven by a misplaced confidence in VC's candour and assurances that he would comply with treatment in the community. All evidence he had pointed to those being untrue and calling for scepticism. Dr Seedat told Theemis that: *"And that is the, I guess, decision I made to continue with, rather than pressing the matter around depot injection. Because, as I said, I think, it's common, we know people from ethnic minority backgrounds do feel that they're somehow more harshly treated within inpatient services. And they tend to then distrust services."* Dr Seedat has since consistently denied race played any role in his decision making (*"that did not influence me, despite knowing that evidence"*).⁹⁸ Regardless, it is clear that there was considerable deference to VC and his preferences which ought not to have been warranted in the face of what the Trust, and in particular, what Dr Seedat knew or ought to have known about VC's untruthfulness and the degree of risk he posed to others.
- (i) **VC was discharged on both occasions after a brief admission and without adequate coordination with the EIP or others engaged in supporting VC in the Community.** Concerns expressed by both VC's family and the University on the circumstances of VC's first discharge were ignored or dismissed. No one in any of the Community teams, including both of VC's Care Coordinators (Claudia Birtles and Gary Carter) saw the journal notes passed to Dr Seedat by VC's brother at any time. Even in the absence of that information, Claudia Birtles said that ward staff had not properly appreciated his risk, and that she would have expected more clarity regarding risk, insight and medication concordance before discharge.⁹⁹ Yet her concerns did not cause her to update VC's risk assessment after his discharge.

⁹⁶ NHFT0000168_0055.

⁹⁷ Dr Seedat's evidence was that he had diagnosed VC with paranoid schizophrenia on 31 July 2020 and that VC was exhibiting classic symptoms: INQT0000062 86/13-16 – 87/2.

⁹⁸ TCLT0000754_0018, INQT0000062 62/3 – 64/22.

⁹⁹ WITN0348001_0061, at [177].

- (j) **While VC’s deliberate non-concordance and risk of violence were well-known: there was no dedicated Assertive Outreach team in Nottingham and no adequate replacement for the Assertive Outreach model in the alternative.** Following his discharge on 31 July 2020, VC spent approximately two weeks under the Crisis Team before he was transferred back to the EIP team. In 2020, the EIP team failed to meet national standards and the ongoing transformation highlighted systemic gaps in the provision available in Nottingham to meet the needs of VC.
- (k) **VC’s non-concordance and superficial insight became even more questionable following his second discharge.** The Inquiry might consider the response by the Community teams to any concern that VC was being discharged prematurely, first in June, and again after the second admission was wholly inadequate. VC refused to complete medication concordance with the Crisis Team on multiple occasions and was only seen to take his medication on one occasion.¹⁰⁰ He considered this step to be “*a bit excessive*”¹⁰¹, despite having told the Clinical Psychologist during his admission that he found the Crisis Team “*supportive and reassuring*”. Moreover, the fact that VC had immediately stopped taking his medication following cessation of the Crisis Team’s involvement after his last discharge does not appear to have been raised with him.¹⁰² Dr Burri and Ms Birtles saw VC on 10 November 2020, after VC phoned Dr Seedat and then requested an urgent face to face appointment with a Doctor. VC disclosed that he had only said he could no longer hear voices because he was “*tired*” of being in hospital (the lie being one he then repeated to the Mental Health Tribunal during his third admission).¹⁰³ He did not think the voices he could hear were as a result of a mental illness.¹⁰⁴ Despite this information having been provided, no new risk assessment was completed by the EIP team. VC’s care plan was not updated. Not long after this, on 17 December 2020, Ms Birtles recorded that VC had medication left over when he should have run out.¹⁰⁵ Nonetheless, the EIP team were happy to accept his platitudes that he was taking medication and improving, so no action was taken.¹⁰⁶

2.20 The good practice guide issued by the Royal College of Psychiatrists, *Assessment and Management of Risk to Others* advises: “*Be curious and look beyond face value*”.¹⁰⁷ During VC’s second admission there was a conspicuous lack of professional curiosity and too great a degree of unwarranted trust placed in VC’s saying the “*right things*”. There is evidence that Dr Seedat (and his team at NHFT) were blinkered to the information they had which pointed to the serious risk VC posed to others. Worse still, Dr Seedat was plainly sufficiently concerned when contacted by VC, to contact Dr Lloyd by e-mail on 9 November 2020.¹⁰⁸ He ought to have understood from Dr Lloyd’s response that VC was again non-concordant. Yet, there was no clinical conversation about risk nor any sharing by Dr Seedat, for example, of the information shared by the family in Elias’s journal. Instead, he asserted that Dr Lloyd would have understood

¹⁰⁰ NHFT0000168_0118-125.

¹⁰¹ NHFT0000168_0122.

¹⁰² NHFT0000168_0115.

¹⁰³ CYGN0000056_0004.

¹⁰⁴ NHFT0000168_0138.

¹⁰⁵ NHFT0000168_0141; NHFT0018624_0001.

¹⁰⁶ NHFT0000168_0143.

¹⁰⁷ NHFT0015099_0007.

¹⁰⁸ WITN0163009.

there were concerns about VC's concordance and that she would have drawn the knowledge available from the RiO documents.¹⁰⁹

- 2.21 **Fourthly, the Inquiry might consider that at each stage, including during these early admissions, there were failures to share information and to work cohesively across the agencies concerned for VC's care.**
- 2.22 **Finally, the Inquiry might consider that there appears to have been no process of reflection by any of the agencies involved and no investigation as to what may have gone wrong in the failed assessment and release of VC, in circumstances which led to Feven's very serious injuries.** Annette Palmer accepted that Feven's injury following contact with VC would amount to a serious incident and confirmed she did not complete a Datix report despite the duty of candour reflected in the Health and Social Care Act Regulations.¹¹⁰ There is no evidence of any consideration of any internal reflection by NCC or NGPF until after 13 June 2023. This is symptomatic of an apparent lack of understanding or respect for serious incident reporting and investigation which this Inquiry has heard time and again. Concrete examples of opportunities to learn and opportunities missed are replete in the treatment of VC (and in each of the investigations following 13 June).
- 2.23 Because VC was diverted from the criminal justice system despite repeated resort to violence, he was not directed down a forensic pathway. A referral could still have been made to forensic services whether by Dr Seedat or the Community team, but it wasn't. Each failure which masked or diminished the degree of risk VC posed undermined the narrative on risk considered at the next crisis and by the next individual Officer or Clinician who bothered to check VC's contemporary medical records. There was an inappropriate deference to VC which allowed him the benefit of the doubt on every occasion. There was a lack of professional curiosity or clinical rigour in each assessment of his risk despite there being material which pointed directly to his being really dangerous; having active thoughts of serious injury and murder; his being willing to act on his thoughts which motivated him to harm others; being willing to act to seriously harm strangers; and, a complete lack of remorse for what he had done. The Inquiry may conclude that the failures at this initial stage could have been resolved by later effective intervention as VC's presentation deteriorated. Sadly, later poor practice, in particular by the Trust, built upon and compounded the errors made at this early stage.

(c) 2021: Visiting MI5, Attacks on Sebastian and PC Pritchard and VC's Third Mental Health Act Admission

- 2.24 The period between VC's second and third MHA admissions was described by his Care Coordinator as a period of "*fairly superficial*" engagement.¹¹¹ However, there were numerous red flags and missed opportunities, which individually and collectively highlight the lost opportunity to create a picture of VC's instability and the significant risk he continued to pose to others.

¹⁰⁹ INQT0000062 41/1-24.

¹¹⁰ INQT0000058 119/5 – 121/25.

¹¹¹ CYGN0000052_ 0045.

- (a) VC's attendance at MI5 on 31 May 2021 failed to impact upon any analysis of the risk he posed. The Fixated Threat Assessment Centre ("FTAC") could only have checked VC's medical records had they *"taken it on as a case"*¹¹², but they did not, so no such checks were conducted. Dr Farnham said checks needed to be proportionate, but said: *"you don't know what you don't know."*¹¹³ He said it might have impacted how VC's case was assessed if the attack on Feven had properly been recorded as GBH (*"GBH is, if you like, at that kind of tipping point where one would want to be a little bit more inquisitive"*).¹¹⁴ Neither the attending Officers or FTAC were aware that VC had been sectioned twice in the last 12 months; nor that he had previously been aggressive when suffering from psychotic episodes; nor that his mother had recently disclosed that she thought VC was once again unwell.¹¹⁵ Despite NGPF being alerted to the incident by FTAC on 1 June 2021, NHFT and his Care Coordinator were never informed. This incident was a clear indication VC was in crisis, but it was another opportunity missed.
- (b) When Sebastian reported that he had been attacked by VC on 5 July, and made his later report in July, the response by NGPF again came up woefully short. It demonstrated a lack of thought; inadequate training and supervision translated into poor victim care; a failure to follow policies, and inadequate communication. VC's behaviour towards Sebastian was consistent with his past pattern of behaviour: he had violently assaulted Sebastian for seemingly no reason. Sebastian told PC Pannell that VC had visits from healthcare but, astonishingly, she failed to make checks on the PNC and Niche for VC failed to contact local mental health services. If she had done so, it is likely that the information concerning VC's visit to MI5 would also have come to light. Her evidence on her inaction was wholly unsatisfactory. Although she initially suggested she would have checked Niche, there is no evidence any check was done. In any event, she claimed: *"I wouldn't have looked at all the previous jobs, I wouldn't have looked into those jobs and I wouldn't have access to the Police National Computer at the time"*. She didn't ask anyone else to conduct a PNC check because she *"didn't have the time"*¹¹⁶. PC Pannell suggested that she *"didn't have any information in order to be able to complete a PPN"*.¹¹⁷ She ultimately said that a lack of resources explained her failure to act: *"we simply don't have the time or the resources to spend hours and hours on -- unfortunately, in this case, it was an extremely low, low level, non-complaint, no injury, although it was assault, but it was a no injury complaint. So the process is to sign the pocket notebook, record that the incident has occurred and then for it to be filed."*¹¹⁸. In the absence of information, a perceived *"low level"* incident was erroneously conflated with *"low risk"*. Adding insult to injury, when he called in July to report continuing, concerning behaviour by VC, PC Pannell's work phone was turned off for a month, with no provision for the re-direction of calls. Sebastian heard no more.
- (c) VC committed driving offences which incurred fines during this period. VC chose to continue driving with disregard for the safety of others. On 11 July 2021 and again in August 2021, VC travelled by car to see his family in Wales. When he arrived, he refused to enter

¹¹² INQT0000011 23/11-15.

¹¹³ INQT0000046 48/3 – 49/1.

¹¹⁴ INQT0000046 49/20 – 51/7.

¹¹⁵ NHFT0000168_0153.

¹¹⁶ INQT0000012 31/6.

¹¹⁷ INQT0000012 15/25 – 16/1.

¹¹⁸ INQT0000012 18/21-25.

the house, stating that the people in his head would put his family in danger.¹¹⁹ VC's family did not share this information with professionals.¹²⁰ The Bereaved Families find this difficult to understand when his presentation suggested he was unwell. Professionals were alerted to VC's driving later in 2021, around his third admission: when he was seen driving, it appears no action was taken nor was this identified as a particular continuing risk.¹²¹ **The Inquiry is invited to question whether notifications to the DVLA ought to depend on self-reporting by patients who are diagnosed with serious mental illness.**

- (d) On 16 August 2021, VC attended Rowan Ward in person and tried to speak to Dr Seedat about whether staff "*communicated with Artificial Intelligence*". When staff refused to let him speak to Dr Seedat, he instead engaged with Ward Manager Annette Smillie.¹²² Despite informing Ms Smillie that "*police had information about the services*", no contact was made with NGPF and a further opportunity for healthcare staff to learn of VC's visit to MI5 was missed.
- (e) Claudia Birtles told the Inquiry that by the end of August 2021, VC needed "*urgent assessment and admission to hospital*". She had first reported he may be relapsing on 9 August, and it took four further home visits for a Mental Health Act ("MHA") assessment to be suggested. She recorded on 31 August that VC "*may require MHA*". It may be thought that assessment was long overdue.

2.25 The circumstances leading to VC's third MHA admission on 3 September 2021, which culminated on VC's attack on PC Barnaby Pritchard and other officers attending, placed beyond any doubt that VC was willing and able to resort to extreme, unprovoked violence. There was reason to believe that VC could be violent both when well and unwell. The Bereaved Families consider that by this time it ought to have been beyond a doubt that VC required more assertive care and a longer period of compulsory treatment to support him and secure his concordance with medication. The circumstances of both his admission and his discharge are replete with evidence of individual and systemic failures.

- (a) The Inquiry has the powerful footage of VC's attack. VC took off his glasses and indicated that "*I don't have a history of ...mistreating women*"... "*Gentlemen, if you want to take me out.*" After attacking PC Pritchard, VC commended him, "*You did good*" "*You didn't go down*"¹²³. The CPS reviewing lawyer noted that there was some element of planning involved, and VC actions suggested a desire to hurt PC Pritchard to the extent that he couldn't fight back.¹²⁴ Dr Lomas, the consultant psychiatrist present at the attack, gave evidence that what happened looked like a serious assault to him and just because somebody is psychotic doesn't mean that any criminal act they commit is caused by their psychosis.¹²⁵ (He further observed that the assault on Christopher in January 2022 had none of the

¹¹⁹ WITN0085001_0017.

¹²⁰ INQT0000067 103/1-3.

¹²¹ NHFT0000272, INQT0000072 94/15 – 98/22.

¹²² NHFT0000168_0160.

¹²³ INQY0000005_0002, 9, 10.

¹²⁴ HMCP0000547_0001.

¹²⁵ INQT0000065 102/17 – 104/20. (This was inconsistent with an earlier account of his he described as having a "*degree of fantasy*" and "*not evidence based*"; at 45/4-46/5 (see WITN0316005).

hallmarks of psychotically driven violence. He examined VC at the time and saw no overt signs of psychosis¹²⁶ – and see 8.23 below).

- (b) Once again, NGPF failed to follow its own policy by first diverting VC away from criminal investigation and when the decision was taken to proceed with the prosecution of VC, the process was inordinately delayed. Once again contrary to policy, VC was never interviewed, and even when he was discharged from hospital the police did not keep themselves informed of which address he would be discharged to.
- (c) VC's time in detention at Cygnet Darlington PICU provided yet further evidence of his masking, manipulative behaviour, lack of insight and intended non-compliance with medication. The Inquiry heard powerful evidence from Dr Shoilekova about the concerns she presented to the Mental Health Tribunal.¹²⁷ The Tribunal recorded "*unequivocal evidence*" that, when VC was unwell, his risk to others was high, relapse occurred rapidly and his risk was difficult to manage.¹²⁸ Dr Shoilekova's evidence was that VC had not fully recovered since the onset of his illness and his history of swift discharge and consequent medication non-compliance was expressly highlighted. She was concerned about the risk of harm both to VC and to others if he were discharged. She confirmed that when unwell the risks were "*serious*".¹²⁹ Ms Birtles' evidence was similarly stark. She described VC's engagement since his last discharge as "*fairly superficial*"; that he had merely gone "*through the motions*"; and she too was concerned he had previously been discharged prematurely.¹³⁰
- (d) One of the reasons the Tribunal refused VC's application to be discharged was the fact that he minimised his violence to others. At that stage, VC had aggressively refused in July 2021 to accept a conditional caution for his actions in respect of damage caused during the first incident on 24 May 2020.¹³¹ On the very night of the Tribunal decision, he wrote to PC Collins to ask if he could accept the conditional caution.¹³² When she did not reply, he wrote on 4 October to remind PC Collins of his offer.¹³³ His obvious capacity to try and manipulate the system to his own advantage was manifest.
- (e) NHFT chose to approve the transfer of VC to the Priory Arnold at a time when the Priory Arnold had been placed into Special Measures (following inspections in March 2021) by the CQC. His transfer therefore required considerable care and attention, but it was wholly lacking. It appears the inadequate rating was not considered at all by NHFT when sourcing VC's placement.¹³⁴
- (f) The evidence and conclusions in the Tribunal judgment ought to have been impossible to miss for both VC's Care Coordinator and for the staff at Priory Arnold. The Tribunal stressed

¹²⁶ INQT0000065 104/10-13.

¹²⁷ INQT0000076 52/6 – 56/24.

¹²⁸ CYGN0000052_0047.

¹²⁹ As recorded in the Tribunal decision: CYGN0000056_0002-03. INQT0000076 52/6 – 56/24.

¹³⁰ CYGN0000056_0003-4.

¹³¹ WITN0036001_0011.

¹³² NGPF0007677_0001.

¹³³ NGPF0007677_0001.

¹³⁴ INQT0000078 33/19 – 34/18 and 36/3 – 37/4. Yet, there is no question that Senior Leaders were aware of the rating: NHNB0006177_0014, NHNB0006181 (The Inquiry has a statement from Julie Attfield: See WITN0329001_0051-52).

the importance of maintaining and optimising VC's medication.¹³⁵ The significance of that finding is obvious: the very protective factor on which future risk management depended needed careful consideration and a significant degree of probing by VC's Responsible Clinician. Medication compliance needed to be the key concern. In the absence of a fundamentally changed presentation, VC required Depot medication and a CTO ought to have been secured (or at least considered) before his release.

(g) Yet, VC's treatment in the Priory was completely superficial and entirely failed to engage with his known risks of masking and non-concordance. When VC told the MDT that the assault on PC Pritchard was because "*he got too stressed and overreacted*", he was not challenged.¹³⁶ When VC failed to engage fully with his medication regime and therapy, he was not challenged.¹³⁷ When VC brought a hammer back on to the ward following section 17 leave, there is no record he was challenged and the subsequent explanation that Dr Gurusinghe has provided as to why VC said he had the hammer – to hang items – is entirely implausible.¹³⁸ The incident was not recorded in any of VC's risk assessments, purportedly because there was no harm that occurred from it¹³⁹ (The Inquiry may wish to consider Dr Shoilekova's evidence on this point, that she would have found such an incident worrying¹⁴⁰, and evidence from Dr Milton that this would have been a "*red flag to a forensic psychiatrist*"¹⁴¹). The Priory Arnold failed to follow the incident up.¹⁴² Most significantly, Dr Gurusinghe failed to have *any* conversation with VC about Depot medication or a CTO.¹⁴³ Instead, he took VC's request to switch from Haloperidol to Aripiprazole as a significant turning point in his recovery and was content to release him back to the public on the very same oral medication that he had stopped taking previously.¹⁴⁴

(h) On 22 October 2021, VC left the Priory after having been admitted there for just 17 days of formal detention and four days of informal detention.¹⁴⁵

2.26 It is clear that the Priory's approach to assessing and managing VC's risk failed throughout his admission. His future risk was not properly assessed and reliance was placed on the EIP team to ensure he remained concordant with his medication, despite the considerable evidence that this protective measure had completely failed in the past. The Inquiry may consider that, in circumstances where the community mental health provision was expected to play such a pivotal role in managing the risk of a dangerous and violent individual, more should have been done to involve them in the discharge planning, and more weight should have been placed on their views regarding the necessity of Depot medication. Remarkably, the evidence heard was that VC's hammer would have been returned to him by the Priory upon discharge¹⁴⁶, demonstrating that the Inquiry should have little confidence that they understood the nature or seriousness of the risk

¹³⁵ CYGN0000052_0047.
¹³⁶ INQT0000080 53/13 – 54/3.
¹³⁷ INQT0000080 54/23 – 55/24.
¹³⁸ INQT0000080 61/8 – 22.
¹³⁹ INQT0000080 63/1-10.
¹⁴⁰ INQT0000076 22/11 - 23/3.
¹⁴¹ INQT0000032 56/11 – 21.
¹⁴² INQT0000080 139/9 – 12.
¹⁴³ INQT0000080 65/15 – 66/12.
¹⁴⁴ INQT0000080 70/18 – 20.
¹⁴⁵ PAGR0000025_0001 and _0003.
¹⁴⁶ INQT0000080 92/12-19.

they were managing. This was not just a failure at the margins: it was a wholesale failure to recognise, record and respond to the very risks that VC's admission was supposed to address.

- 2.27 David Waldron explained according to Continuity of Care principles there is an expectation that “*there is no difference*” between patients being seen locally and when admitted to a subcontracted or a spot purchase bed.¹⁴⁷ NHFT retained responsibility for VC's care throughout this period.¹⁴⁸ He explained that it was the responsibility of NHFT to: ensure that they were sharing relevant information about risk and to ensure they had the up-to-date notes. He explained that it would be the responsibility of bed management at NHFT to ensure that they were sharing relevant information, including about risk.¹⁴⁹ Similarly, it was the responsibility of the Trust “*to make sure we've got, you know, the up-to-date notes.*”¹⁵⁰ This was a two-way exchange which fundamentally failed.¹⁵¹ David Waldron was aware of a “*huge hammer*” being in VC's possession at the hospital. It is never entered into RiO notes or further considered by NHFT: Mr Waldron described this as a “*a miss*”.¹⁵² The Trust accepts that this ought to have given rise to an incident investigation: that it did not is perhaps a reflection of the wider evidence that NHFT was failing to learn from incidents when they occurred.¹⁵³ That the electronic systems at the Priory and NHFT were incompatible and the human systems were inconsistent was a systemic failure which NHFT knew about during VC's third MHA admission.¹⁵⁴ There was no enhanced support for patients on discharge from the Priory.¹⁵⁵ Yet, at the point NHFT disinvested in the Priory in 2022: it appears no consideration had been given to checking on patients discharged who had been placed under the inadequate rating.¹⁵⁶
- 2.28 VC's Care Coordinator, Claudia Birtles told the Inquiry she felt that discharge was premature and Depot ought to have been considered. Yet, there is no evidence of her (or anyone else) raising this with the Priory at the relevant MDT or in correspondence.¹⁵⁷ It appears that VC's hollow statement that he would have no problem working with her on discharge went unchallenged by NHFT.¹⁵⁸

¹⁴⁷ INQT0000078 4/22 – 5/8.

¹⁴⁸ See, for example, INQT0000078; INQT0000092 68/9 – 13.

¹⁴⁹ INQT0000078 7/25 – 8/3, 9/8-15. “*we are duty bound to make sure that information goes forward, and also with the CCO or CPN in place that could be further discussed at the weekly meetings or MDT reviews.*”

¹⁵⁰ INQT0000078 9/20 – 10/22.

¹⁵¹ For example, Mr Waldron accepted that the risk information he passed in the referral form was flawed: NHFT0018311, INQT0000078 14/11 – 15/23.

¹⁵² WITN0389018, INQT0000078 40/16 – 42/12.

¹⁵³ INQT0000092 48/13 – 49/18.

¹⁵⁴ See for example: CQCM0034872: In a record of a call between the CQC and Priory Arnold, on 6 October 2021 (while VC is a patient at the Priory) it is recorded: “*At last contract meeting with Notts HC they requested that all nurses at Arnold have full access to RiO so that they can see the information needed about the patient.*” Disclosed on 31 July, this is a document not put to witnesses.

¹⁵⁵ INQT0000092 69/9 – 24.

¹⁵⁶ INQT0000092 69/25 – 70/11.

¹⁵⁷ Dr Lloyd said she would have relied on CB to have raised their shared concerns (“*I believe that's what Claudia did. I think she did make clear that was our strong wish...that we wanted this man on a depot.*”) INQT0000073 111/16 – 112/23. On the contrary: Ms Birtles prepared a social circumstances form for VC on 15 October 2021. On how adequate or effective the proposed care plan would likely be there is no mention of premature discharge or Depot: “*VC will need to be recognised that he has been unwell in order for his care plan to be effective, this will allow his care team to work with VC on his recovery and improve future outcomes.*” NHFT0024052_0005.

¹⁵⁸ INQT0000068 1/5 – 4/14. See also CB to Priory by email on 15 October 2021, confirming she has prepared a second social circumstances form but: “*I believe it is likely the Consultant is going to be taking VC off his Section next week if everything goes to plan.*” (Emphasis added). This document was not disclosed until 31 July 2026 and has not been considered with witnesses.

(d) 2022: Attack on Christopher and VC's Final Mental Health Act Admission

- 2.29 VC's non-concordance was clear almost immediately after his discharge from the Priory. On 5 November 2021, VC expressed that his admission to hospital following the assault on PC Pritchard had been "*awful and unnecessary*". He did "*not agree with medical professionals that he [had] been unwell*". He was taking one 10mg tablet, rather than two.¹⁵⁹ It had taken just two weeks for VC's apparent insight, which Dr Gurusinghe had so steadfastly relied upon, to be renounced. There were further concerns about his engagement throughout November 2021 and, despite the centrality of the EIP team's role in keeping VC well, not one of the EIP spoke to him for a period of four weeks.¹⁶⁰ By mid-December, when contact was resumed, VC was described as angry and confrontational.¹⁶¹ VC's presentation had once again become one of paranoia and avoidance, but, in a foreshadowing of what was to come in September 2022, the EIP team's response to this was to consider discharge rather than exercise professional curiosity as to whether this indicated an acute relapse.¹⁶²
- 2.30 By that stage, on 15 January 2022, VC had already assaulted Christopher and held his flatmates hostage. The police response was again, wholly inadequate. The evidence points to Christopher's complaint being dismissed out of turn, without interrogating the video he took and without recording witnesses' details. Christopher described the Officers asking about his injuries and their being "*dismissive in a way, like they were trying to basically tell me that nothing would happen*".¹⁶³ VC was not brought to the station for interview. PC Zacharia failed to conduct any check of police systems for VC. The police discouraged pursuit of the case and Christopher agreed to endorse a police notebook recording he did not wish to pursue his complaint.¹⁶⁴ On 17 January, VC was evasive and hung up when PC Zacharia referenced help for his mental health.¹⁶⁵ When faced with this reaction, the Officer recorded: "*there are no further lines of enquiries*".¹⁶⁶
- 2.31 The EIP team were informed of the assault on 18 January 2022; the day after the police had told VC there would be no further action. The EIP team's response was one of immediate concern for the staff going to visit him in his home.¹⁶⁷ By contrast, on 19 January 2022, VC was assessed as not requiring admission to hospital and placed under the care of the Crisis Team in the Community.¹⁶⁸ The "*Community*" referred to was student accommodation, where he had taken his flatmates hostage. The "*safety*" of that plan was of course entirely dependent on his flatmates having to leave.¹⁶⁹ Yet those matters appear to have been given scant regard. The Inquiry may question why the EIP team were concerned for their own safety, and the Crisis Team would only see VC in pairs,¹⁶⁹ but it was safe for students to live with him and members of the public to face that same risk without warning. That was not safety planning or the application of the least restrictive measure in line with the MHA; it was the outsourcing of danger.

¹⁵⁹ NHFT0000168_0198.

¹⁶⁰ From 19 November 2021 to 16 December 2021: NHFT0000168_0199-200.

¹⁶¹ NHFT0000168_0201.

¹⁶² NHFT0000168_0203.

¹⁶³ INQT0000015 13/10 – 11.

¹⁶⁴ NGPF0000056_0002-0003.

¹⁶⁵ NGPF0000055_0007.

¹⁶⁶ NGPF0000055

¹⁶⁷ NHFT0018114_0001.

¹⁶⁸ NHFT0000168_0205.

¹⁶⁹ NHFT0000168_0205.

- 2.32 VC was finally admitted for the fourth time on 28 January 2022 after evidence that he was once again non-concordant with medication. He had missed visits with the Crisis Team and had been observed spitting out medication.¹⁷⁰ He did not believe he was mentally unwell and continued to present as “*very superstitious and paranoid*”. He felt mental health professionals were “*interfering with his thoughts*” and that there was “*technology designed to deliberately annoy and upset him*”. He felt “*targeted and persecuted by people*”.¹⁷¹ His flatmates had also reported that VC had heard screaming (that was not there) and had been trespassing into their rooms,¹⁷² albeit this information was not relayed by the University to the Trust at this stage.¹⁷³ Despite the evidence the Trust *did* have, VC was only considered to be “*possibly*” experiencing psychosis.¹⁷⁴ Dr Lomas’ evidence was that.: “*the information I had was described as a hostage-taking event, which is, you know, incredibly serious [...] but then the police had attended and no arrest had resulted in it [...] I was kind of like how, if somebody has been held hostage, can an arrest not result?*” He added: “*It made me unclear as to the exact nature, the seriousness of it*”. No further enquires were made of the police to establish why they had not arrested VC, and what the level of seriousness was; Dr Lomas “*didn’t have a chance*” to do so.¹⁷⁵
- 2.33 When the decision was taken to detain VC, he ought to have been detained pursuant to s.3 MHA for treatment rather than s.2 for assessment. In any event, his detention ought to have been converted to a s.3 MHA detention from 4 February 2023, when Dr Gibson recorded the circumstances of VC’s strange behaviour towards his flatmates; including that that behaviour closely mirrored the pattern of behaviour which preceded his earlier admissions.¹⁷⁶
- 2.34 The principles for a s.2 or s.3 admission are clearly set out in the Mental Health Act Code of Practice; they were simply not applied properly in VC’s case. Section 2 should only be used if the full extent of the nature and degree of the condition is unclear, or there is a need to carry out an initial in-patient assessment to formulate or re-formulate a treatment plan.¹⁷⁷ VC had a known mental health disorder. He had been admitted three previous times. His treatment plan remained the same and was clearly established by this point. Section 3 should have been used, as per the statutory guidance. Dr Manzar’s oral evidence made clear that he considered s.2 to be a less restrictive option because the period under which an individual could be detained was shorter.¹⁷⁸ This was a position agreed by Dr Lomas, who suggested that s.2 was a less restrictive option because VC could challenge his detention quicker.¹⁷⁹ (In considering Dr Lomas’ view the Inquiry will also consider his approach to VC’s third section: where despite the evidence presented VC was again, initially detained pursuant to s.2).¹⁸⁰ This view is not reflected in the MHA Code of Practice and is highly problematic. As succinctly set out by Mr Ruck Keene KC, both sections are providing for compulsory admission, both sections are providing for treatment against one’s will, and “*an ethos which says [...] I should always try and steer myself towards using section 2*

¹⁷⁰ NHFT0000168_0206-212.

¹⁷¹ NHFT0000070_0008.

¹⁷² UNIN0001788.

¹⁷³ INQT0000065 72/16 – 25.

¹⁷⁴ NHFT0000070_0010.

¹⁷⁵ INQT0000065 90/4.

¹⁷⁶ NHFT0000168_0228.

¹⁷⁷ NHSE0000312_0118-119.

¹⁷⁸ INQT0000064 41/25 – 42/11.

¹⁷⁹ INQT0000065 92/17 – 25.

¹⁸⁰ INQT0000065 61/10 – 63/11 (“*the need to promote autonomy and independence and the other kind of guiding principles of the MHA Code of Practice.*”)

because it feels less restrictive, is a problematic challenge".¹⁸¹ It is therefore of genuine concern that not only was this the view of clinicians at the time, but that they maintained it during oral evidence.

- 2.35 Two of four of the clinicians involved in decision making for VC accept that s.3 MHA admission was appropriate (Dr Manzar) or that there were grounds for a s.3 MHA admission (Dr Gibson¹⁸²). "With hindsight", Dr Manzar accepted that s.3 would have been a better option for VC's fourth admission.¹⁸³ The Inquiry may well find that, consistent with the findings of the Trust's Comprehensive Investigation Report¹⁸⁴ the CQC Report¹⁸⁵ and the evidence of Dr Dracass,¹⁸⁶ hindsight is not required for this reflection. This is significant because, as the Inquiry has heard, admission under s.3 MHA would have allowed for the initiation of Depot medication in conjunction with a CTO. This was treatment which VC plainly needed if concordance with medication (his only treatment plan) was to be achieved.
- 2.36 Defending his decision to discharge without Depot, Dr Thangavelu relied on VC's assurances that he would continue taking oral medication. He said he "*did not have any reason to believe [VC] was not being true in his statements*"¹⁸⁷ when he said he would do so. Yet, at the same time, he also appeared to accept that there had been several clear instances where VC did not tell the truth.¹⁸⁸ The inherent contradiction between these two positions is difficult to reconcile. The Inquiry is invited to consider that there is no contemporary record of Dr Thangavelu's input into VC's care and may wish to consider the evidence of Dr Thangavelu critically. His evidence was that he faced an ethical dilemma and chose to give VC another chance, focusing on the goal of building a therapeutic relationship.¹⁸⁹ He said he had only read such of VC's notes as he had to and did not recall reading Dr Seedat's entry on 3 June referring back to Elias' journal and VC's thoughts of harming others when unwell.¹⁹⁰ Dr Gibson said he did not recall that he had read that entry. He accepted it was relevant to an understanding of VC's risk.¹⁹¹ There was information that both clinicians did not have and which he ought to have had to inform his decision making. For example, Dr Thangavelu said he asked for a PNC record, did not obtain one but did not contact the police to ask for any further information.¹⁹² He said that if VC had asked he would have, far from imposing a Depot, dropped his Aripiprazole dosage to 10mg.¹⁹³ The Chair pertinently asked who determined the question of medication, the psychiatrist or the patient.¹⁹⁴ He conceded that he took his decision to discharge despite others who knew VC's history, including Dr Lloyd and Claudia Birtles, pressing for a more robust management plan, incorporating Depot.¹⁹⁵ He and Dr Gibson appreciated that VC had been given latitude in relation to s.17 leave; he had abused that leave by returning to the flat where he had assaulted Christopher and held the others hostage. There appears to have been no investigation and instead the privilege of unescorted leave was

¹⁸¹ INQT0000053 43/24 – 44/22.
¹⁸² INQT0000082 55/13 – 16, 91/25 – 92/10.
¹⁸³ INQT0000064 63/14 – 18.
¹⁸⁴ TCLT00000818_0018.
¹⁸⁵ WITN0155033_0033; INQT0000108 8/11 – 23.
¹⁸⁶ INQT0000054 24/7 – 18.
¹⁸⁷ NHFT0004709_0002.
¹⁸⁸ INQT0000083 44/25 – 45/2.
¹⁸⁹ INQT0000083 116/19 – 117/14.
¹⁹⁰ INQT0000083 70/25 – 71/2 and 71/17 – 72/1.
¹⁹¹ INQT0000082 68/12 – 69/25.
¹⁹² INQT0000083 90/7-13.
¹⁹³ INQT0000083 113/24 – 114/4.
¹⁹⁴ INQT0000083 114/22 – 24.
¹⁹⁵ NHFT0018527. See also, NHFT0000168_0250 (Sue Middleton).

instituted swiftly. There was evidence VC had said outright that he was going to engage as “*minimally as he could, keeping out of people’s way and not being a management problem until he can go back to his life and continue with his education.*” Dr Gibson accepted that this was another indication VC would not be concordant without compulsion.¹⁹⁶ Dr Gibson again, expressed his visceral feeling as to the “*socio-cultural climate*” and “*accusations that psychiatrists were uncaring, overly coercive, or even outright racist*” and “*constant discussion about reform of the [MHA] to reduce coercion as a result*”.¹⁹⁷ The Inquiry might conclude that, given all that was known of VC’s revolving door admissions; his non-concordance in the community and the risk he posed to others when unwell: the benefit of the doubt lay unreasonably with VC throughout this admission.

- 2.37 The attitude of Dr Seedat at this time was evidence of yet another opportunity missed: and illustrative of a lack of continuity of care evident throughout VC’s care. Dr Gibson approached him as someone who VC wanted to speak to: describing VC at “*tricky*”. A few minutes’ walk away: Dr Seedat brushed off the request asking only if he was required.¹⁹⁸ At a point in time when VC was said to be distrustful of his treating team: a request to speak directly to Dr Seedat may have been a significant opportunity missed. In circumstances when Dr Seedat had been responsible for VC’s treatment at an early stage - when VC had expressed some insight and when he had been willing to at least discuss Depot; and circumstances where Dr Seedat knew the full contents of Elias’ journal – this may have been a considerable opportunity missed.

(e) 2022: Non-Concordance, Stalking, and Responsibility for Discharge from Care

- 2.38 The final months leading to VC’s wholly inappropriate discharge by the EIP shows a lack of care for patent signs of deterioration in VC’s presentation and determination to discharge which wholly disregarded the terms of the Trust’s formal policy.
- 2.39 The allied failure by NGPF to address VC’s continuing risk with an effective police response continued in parallel. Sebastian’s concerns about VC’s return to stalking him were, all too predictably, dismissed. In circumstances where the significance of stalking behaviour was a known indicator of risk, and there was evidence of VC also returning to the Raleigh Park address again, in April 2022, this is an example of a time when joining the dots may have been critical. The Inquiry has evidence, of course, of the material VC was looking at online in 2022.¹⁹⁹
- 2.40 After months and months of delay, VC was finally charged with the assault on PC Pritchard, but nobody bothered to go and see him to inform him of the proceedings. He was requisitioned by

¹⁹⁶ NHFT0000168_0234, INQT0000082 63/21 – 24 (“*It pushes in that direction, yes.*”)

¹⁹⁷ WITN0205001_0039, INQT0000082 71/6 – 72/18.

¹⁹⁸ NHFT0018830, INQT0000082 47/4 – 48/25.

¹⁹⁹ Sebastian had told the police that VC had asked him to befriend him on ‘Facebook’ [NGPF0000004_0005]; he had the details of VC’s social media account on his ‘phone [CPSE0007848_0005]. Notwithstanding the NGPF Stalking Procedure [NGPF0007427_0006] which required them to “*Check wider sources of information ... other sources (i.e. friends, family, social networking) should be taken into account to inform the understanding of the ... suspect’s motivation and context of the behaviour*”, the police failed to make any inquiries of VC’s Facebook account. The Inquiry may consider whether in the light of what was known about VC’s online activity in 2022, the failure to revisit this in Summer 2022 highlights a particular missed opportunity to learn more about VC’s online life and the rising risk of violence he posed; and that he was fixated with those young people he had been surrounded by, and to whom he had compared himself, in his student life.

post on 24 August 2022, sent to an address he had left in February 2022 (Flat 15, Madison Court), requiring him to attend court in September 2022.²⁰⁰

2.41 The last time VC was seen by EIP staff was on 4 July 2022.²⁰¹ On 18 July 2022, he texted Ms Parsonage to say he was abroad and did not need medication because it “*won’t make much difference*”.²⁰² VC’s mother later informed the EIP team that he was still in Nottingham²⁰³ - a further concern, given VC’s history of lying to professionals.²⁰⁴ On 9 August, a new address was recorded for VC (derived from an application for his medical records dated February 2022).²⁰⁵ The EIP team failed to recognise that VC could not be living at this address because it was the student accommodation in which he had assaulted Christopher and had been forced to leave by the University. Regardless, no attempt was made to visit him there (or at any of his former addresses). Instead, a letter was sent asking if he wished to continue involvement with the EIP team,²⁰⁶ an action which, given VC’s history of engagement, had no realistic prospect of eliciting any response. Another address provided by VC at 209, Ilkeston Road was visited by Mr Carter.²⁰⁷ Police intelligence was that it was a “trap house” - a place to take drugs - but Mr Carter was unaware of that.²⁰⁸ The Inquiry now has at least some evidence VC was working during this time:²⁰⁹ another route by which the police, if contacted may have located him.

2.42 On 23 September 2022, after months of inaction, it is recorded that VC was discharged from the EIP service at an MDT meeting on 22 September 2022 where neither Mr Carter nor Ms Birtles were present.²¹⁰ There were no notes taken. There were no notes taken of any MDT meetings in the EIP. The EIP policy at the time was explicit: a patient could not be discharged for non-engagement unless increased risk factors were absent.²¹¹ All of the known information about VC demonstrated his risk to others when unwell. His disengagement was a clear indicator of increasing risk. The Inquiry has considerable evidence that by this time many of the factors associated with a violent outcome were present: Drs Fazel and Appleby confirm the significance of disengagement as a factor present in mental health-related homicide.²¹² Despite this, the relevant policies were not discussed.²¹³ This was a serious failure, and one which no individual clinician was willing to take ownership of. The Inquiry will recall Dr Lloyd’s evidence that the decision to discharge had in fact been made long before the 22 September, back in August.²¹⁴ The Inquiry may wish to compare this with Dr Lloyd’s witness statement²¹⁵ and the RiO records, which show that on 31 August 2022 Mr Carter was still planning on visiting VC in person, not discharging him, although this never actually occurred.²¹⁶ That discharge had been considered long before in January 2022 in response to failure to engage might suggest a practice within the

²⁰⁰ NGPF0000017_0039.

²⁰¹ NHFT0000168_0268.

²⁰² NHFT0000168_0269.

²⁰³ NHFT0000168_0269.

²⁰⁴ INQT0000069 48/7 – 18.

²⁰⁵ NHFT0000168_0270; WITN0163002.

²⁰⁶ NHFT0000122.

²⁰⁷ INQT0000070 62/14 – 23.

²⁰⁸ NGPF0008856_0004; NGPF0008809_0011; INQT0000070 62/24 – 63/11.

²⁰⁹ WITN0408001_0005 (Joanna Komanowska). VC registered for work with an agency in July 2022.

²¹⁰ NHFT0000168_270-271.

²¹¹ NHFT0000417_0007–0008

²¹² WITN0069001_0005-6 (Professor Appleby); See also WITN0069004, WITN0069005 including on the significance of maintaining engagement with patients who are likely to lose contact.

²¹³ INQT0000069 50/4 – 11.

²¹⁴ INQT0000074 55/9 – 17 and 72/1 – 25.

²¹⁵ WITN0357001_0125-126.

²¹⁶ NHFT0000168_0270.

EIP had evolved contrary to the Trust policy.²¹⁷ Dr Lloyd accepted she was in the relevant MDT meeting. She first suggested Gary Carter had been present at discharge in September: when clear he was not, her evidence became that discharge was agreed in August.²¹⁸ That is simply incredible on the contemporary evidence. The failure by Dr Lloyd to accept any responsibility for the care of VC is deeply troubling for the Bereaved Families.²¹⁹ The Bereaved Families invite the Inquiry to seriously question her repeated reliance on her junior staff and the Care Coordinators - staff significantly less clinically qualified – when asked about care planning and responsibility for VC.²²⁰ She held professional responsibility for VC's care. The Inquiry heard confirmation from the Senior Leadership Team that the Consultant retained responsibility for clinical decisions within the EIP Team.²²¹ It was the Consultant leading the MDT that “*leads*” the decision to discharge.²²² This was the consistent evidence before the Inquiry.

- 2.43 It is undeniable that VC was discharged without any clinical consideration of his risk. No one contacted the police for assistance. Mr Carter accepted that he should have done so. He explained that the police had a good chance of locating VC, and in another case had done so within 10 days.²²³ In Mr Carter's view, it was “*blatantly obvious*” that VC needed admission to hospital for a lengthy period and treatment.²²⁴ He considered VC's mental health to be on a “*knife-edge*”.²²⁵ He believed the EIP team had simply given up on VC.²²⁶ It is difficult to see, with all the evidence it has before it, how the Inquiry could reach any other conclusion. Disengagement and non-adherence with treatment was a red flag signal to escalate care for VC: not reason to discharge.²²⁷ The EIP under Dr Lloyd's leadership had reallocated VC to a new Care Coordinator and failed to undertake any steps to properly rebuild an important therapeutic relationship. They failed to follow their own discharge policy, and discharged a high-risk, non-engaging, violent individual without any assessment of risk. They failed to act on clear warning signs, including VC's deteriorating engagement, suspicious behaviour, clear medication non-concordance, and dishonesty about his whereabouts. They failed to undertake any form of proper outreach, despite knowing VC's history, risk profile, and the availability of practical steps such as police checks. They failed to scrutinise basic information. They discharged VC without the input of the people who were meant to know him best. The EIP team did not merely continue their mismanagement of VC's care; they ceased to care at all.

- 2.44 NHFT knew there were systemic failures within the EIP. The organisation was in a period of transition and reform which began in 2020 and which the Inquiry might conclude had not

²¹⁷ NHFT0018181.

²¹⁸ See WITN0357001_0125 at [347] – [348]: describing the MDT on 22 September: “*It was decided to discharge VC from the service as a non-engaging patient.*” INQT0000074 75/19 – 76/7.

²¹⁹ For example, she said that VC's medication ought to have been checked on 9 August 2021, when she delegated a home visit to her ST6. This perhaps highlights the significance of consultant input into care. Dr Lloyd's explanation, not posited in her statement, is that she was attending another home visit. The Inquiry has not seen a copy of her diary. VC is, of course, admitted on 3 September 2021. INQT0000074 21/1 – 22/8.

²²⁰ This ought to be self-evident. However, see, for example, INQT0000067 33/22: she confirms she would conduct mental state examinations of patients but “*Not in the way a doctor might do it and document it in their records.*”.

²²¹ INQT0000091 98/2 – 4.

²²² INQT0000091 97/5 – 98/4.

²²³ INQT0000070 48/17 – 49/12.

²²⁴ INQT0000070 60/7 – 11.

²²⁵ NHFT0004882_0007.

²²⁶ INQT0000070 76/19 – 21.

²²⁷ INQT0000101 14/10 – 16: 59% of patients in mental health related homicide were either non-adherent or missed their final contact with services. These are figures published by NCISH long before 2022. See also INQT0000055 16/4 – 18/3 on antipsychotic treatment and violence.

completed by 2022.²²⁸ Both Dr Lloyd²²⁹ and Mr Carter²³⁰ said there were staff pressures within the EIP. Others, including Dr Sue Elcock²³¹ have suggested no concerns were raised.²³² Dr Elcock accepted that there was a collective responsibility at executive level for the discharge policy and ensuring that in 2022, it was embedded in practice.²³³ Again, Dr Lloyd's reluctance to accept any responsibility for oversight and decision making in respect of VC's care must be met with scepticism. Dr Thangavelu (as Dr Lloyd's line manager)²³⁴ said she raised capacity in her 2022-3 job plan meeting: "*I was already aware that there are no additional sessions in medical budget for EIP...so I could not have allocated any more resources.*"²³⁵ There is evidence that in 2019 she raised concern over pressure to discharge patients on the AO pathway. She states: "*Pressure continued to be put on the care coordinators to discharge high risk AO patients on the grounds of non-engagement from 2019 to 2023*".²³⁶ This pressure stopped after June 2023. While she claims this refers to AO patients and not EIP patients, the Inquiry will consider the evidence and the implications such pressure may have had on Care Coordinators and Consultants within the Trust. The Inquiry continues to receive and to consider substantial disclosure concerning the EIP including in respect of its operation between 2020-2022. Further submissions may be required when the disclosure process is complete. There were long-standing systemic problems across the Trust, and within the EIP, of which the Board ought to have been aware. Regardless, there were basic tasks in the care of VC that simply were not done. When action was taken, it was sadly lacking or, in the case of the discharge, hopelessly and obviously wrong. We return to this issue in considering risk in Section D.

(a) The Final Missed Opportunities

(i) The FTA Warrant

- 2.45 There was a period of almost 9 months between the issuance of the failure to attend warrant (issued on 22 September 2022) and 13 June 2023, during which time NGPF simply failed to take any steps to locate and arrest VC
- 2.46 While there was National Police Chiefs Council ("NPCC") Guidance on a risk based method of prioritising warrants for execution: there was no local policy or procedure in place in Nottingham to monitor warrant activity.²³⁷ Despite instruction in October 2022 to Local Neighbourhood Policing Inspectors, to ensure there was a clear process in place: beyond tasking the Operation Reacher team to execute warrants in addition to core duties, there is no evidence that any

²²⁸ INQT0000092 65/22 – 66/20.

²²⁹ INQT0000073 101/16 – 103/12. Dr Lloyd said she would, if time, have consulted with Dr Seedat. When asked if she had raised concerns over capacity, she said "*Absolutely*".

²³⁰ INQT0000070 88/8 – 15 "*I remember speaking to Sharon Heath about my caseload size, and at its worst, I had 24 people. The national recommendation is 15.*" (Noting, Gary Carter did not start work with the EIP until after August 2020).

²³¹ WITN0356092_0019 (Third Witness Statement of Sue Elcock); INQT0000091 98/5 – 101/16.

²³² The Inquiry has records of Dr Lloyd's job plans and can consider her evidence she was allocated limited time for the EIP. See, for example, WITN0206034_0004.

²³³ INQT0000091 98/2 – 4.

²³⁴ WITN0206015_0007-8 (Second Statement of Dr Thangavelu). The Inquiry has the recommendation in the EIP review prepared after 13 June 2023 recommending a full-time consultant for EIP. At [25], Dr Thangavelu notes that there had been additional funding obtained for 1.0 WTE additional consultant time, but this money was used to recruit senior pharmacist prescribers.

²³⁵ WITN0206015_0009 (Second Statement of Dr Thangavelu).

²³⁶ WITN0357004_0003, [10] – [11].

²³⁷ T/ACC Leona Scurr, WITN0440001_0002, [4] – [8].

dedicated action was taken to ensure that outstanding warrants were being routinely examined for risk.

- 2.47 The execution was assigned to PC Sutton on 23 September 2022; and re-assigned to PC Myers on 23 January 2023. There is evidence that the warrant entry on Niche was accessed on 11 November 2022 and on 18 December 2022 (on the second occasion, this was by PC Pritchard himself).²³⁸ PC Myers was the OIC and told the Inquiry: *"It is very difficult to almost think I will do extra bits and pieces and especially as a Response Officer you are that overworked that you will do what's just needed"*.²³⁹ However, he was *"gobsmacked"* when the case was assigned to him in January.²⁴⁰ This was a very serious case; and he had good evidence to charge. He contacted PC Pritchard on 20 January and told him that *"If he is still wanted next week we can try and locate him."* Instead, PC Myers marked the action as closed.²⁴¹
- 2.48 T/DCC Rob Griffin accepted that the failure to act on the warrant was a *"serious systemic operational failure on the part of Nottinghamshire Police."*²⁴²
- 2.49 That VC remained at large failed both to recognise the continuing risk of serious violence he posed to others and the public interest in pursuing charges against him for the violent assault of PC Pritchard.²⁴³
- 2.50 **The Inquiry may wish to invite the Home Office and the Ministry of Justice together to consider binding guidance for Police and the Courts on the execution of bench warrants; with default provision for prompt execution and for monitoring, incorporating a requirement for assessment and consideration of risk to public safety in the event of any delay. A history of violence connected to mental ill health ought to be significant in the setting of any priority or triage considerations and any Guidance should include clear prompts on the importance of sharing information with local mental health services and multi-agency working.**

(ii) February 2023

- 2.51 On 14 February 2023 VC violently attacked a male colleague whilst working in another warehouse, for an employment agency. VC had worked the agency which placed him in this

²³⁸ See IOPC0000133_0011 and IOPC0000213 (PC Pritchard Statement 18 June 2026). The IOPC continues to investigate individual actions in relation to the FTA warrant. They are considering access to the FTA Warrant OEL before PC Myers actions in January 2023 in November and December 2022.

²³⁹ INQT0000014 98/1-5.

²⁴⁰ INQT0000014 99/4 - 100/25.

²⁴¹ INQT0000014 102/6 - 105/15.

²⁴² WITN0074001_0105 [473]. There were by June 2023 potentially over 1000 warrants outstanding: NGPF0007844_0002. We note the NGPF Individual Management Review in Operation Hawking, concerning another mental health related death in 2022, and pre-dating June 2023, included a recommendation to *"ensure efforts to arrest suspects circulated on the PNC are undertaken and efforts to locate and arrest them are progressed by the OIC"* albeit this concerned police bail: NHFT0014967_0011.

²⁴³ WITN0040001_0010 [40] (PC Pritchard): *"Greater effort could have been made to detain [VC] and put him before the courts for the assault against me, once he failed to appear. I am disappointed he was never prosecuted for the assault on myself however, I am under no illusion, this would not have led to a custodial sentence. This failure has left me with an undeserved sense of guilt, however, as a victim, I know that the onus was not on me to investigate my own assault."*

warehouse from 20 July 2022 until this incident.²⁴⁴ VC was notified his employment would be terminated after he failed to contact his employer or provide a statement.²⁴⁵ The police were not called to attend the incident.²⁴⁶ The Inquiry has seen CCTV of this attack and the Chair can reach a view on VC's presentation.²⁴⁷ He is, objectively extremely aggressive. There is a sustained attack with multiple punches thrown. There appears to be no overt evidence of psychosis nor any record of unusual behaviour by VC in any of the contemporary records disclosed. The Bereaved Families are concerned at the possibility that there are further incidents which evidence further violent criminality and which have never been considered.

- 2.52 Yet, if PC Myers had taken the steps he said he would, and had sought to locate VC and enforce the warrant in the week of 27 January, the Inquiry may consider whether VC would have been arrested and this opportunity to again resort to extreme violence with apparent impunity would have been avoided.²⁴⁸ We return to the relevance of this incident below in considering culpability and the approach to the investigation and prosecution of VC.

(iii) 5 May 2023

- 2.53 The evidence before the Inquiry confirms the belief of the Bereaved Families that the failures in the Leicestershire Police ("LEPF") response to the further attack at Arvato on 5 May 2023 proved significant and devastating.
- 2.54 The Inquiry is invited to consider the evidence of Volodimir, Matthew and Louisa: the violence used by VC was disturbing and VC is described as "*very violent*"²⁴⁹; his victims both were injured; and all the witnesses at Arvato thought the involvement of the police was critical. No-one was trivialising this unprovoked attack.²⁵⁰ Volodimir describes VC as being quiet and his being slower than other employees ("*he can't complete proper task like, for example, other employees*").²⁵¹ He is consistent that he showed police a knife which he had kicked under a conveyor as he was concerned VC could have used it as a weapon.²⁵²
- 2.55 The Inquiry heard evidence about mistake upon mistake made by the LEPF Officers concerned and in the systems operating at LEPF. The Bereaved Families were devastated to learn that while it appeared BWV of this incident was thought lost, it may be possible that it could in fact, have been retrieved by LEPF after the 31 day period for deletion until October 2023: it simply was not done.²⁵³

²⁴⁴ BRGR0000009. During this time, it is recorded that he had continuing attendance problems / uneven attendance at work. This incident did not come to light until this Inquiry was underway and there has been no comment on it by any of the forensic psychiatrists or police witnesses.

²⁴⁵ BRGR0000008

²⁴⁶ Emma Reid, WITN0426001_0004-0005 [11].

²⁴⁷ FRGR0000001R, FRGR0000002R

²⁴⁸ VC had a place of employment (generating tax and NI payments through HMRC) which may have been helpful to police seeking to locate him for the purposes of execution of the warrant.

²⁴⁹ INQT0000019 35/9.

²⁵⁰ INQT0000019 40/3 – 20; Matthew, 10 March 2026 PM, 55/21 – 56/15.

²⁵¹ INQT0000019 31/17 – 32/13.

²⁵² INQT0000019 33/13 – 34/4, 35/21 – 38/24, 39/7-12.

²⁵³ INQT0000021 64/15 – 65/7.

2.56 The Chief Constable sought to underline the inexperience of these Officers and the relative inexperience of his force in 2023.²⁵⁴ There are critical factors which undermine the reliance on resource pressure or inexperience by LEPF:

- (a) First, witnesses accepted that the mistakes the Officers made (and in particular, the failure to check the PNC or to properly consider and act on Niche intelligence) were basic.²⁵⁵ They were purported mistakes made not only by PC Taylor, weeks on the job; but by PC Amos-Perkins, her supervisor, who was three years in and who had tutored a number of new recruits before PC Taylor.²⁵⁶
- (b) Second, regardless of pressures, T/PS Read said that neither PC Taylor nor PC Amos-Perkins raised concern over their job queue with him.²⁵⁷ Indeed, both he and PC Amos-Perkins accepted evidence that T/PS Read had encouraged the tutor officer to do more as it was in his own interest to advance his career progression.²⁵⁸
- (c) Finally, the Inquiry might consider that the evidence of both PC Taylor and PC Amos-Perkins has been at times inconsistent, contradictory and self-serving. Much was made of the Officers' acceptance of the mistakes which they had made. While this is welcome, the Bereaved Families struggle to accept the inconsistencies in the evidence of both Officers, including as to the handling of the BWV (the original position of PC Taylor being that she could not recall whose BWV was used)²⁵⁹ and on the handling of Niche data once VC's identity was known. The Bereaved Families invite the Inquiry to treat with some considerable scepticism the suggestion that neither PC Taylor nor PC Amos-Perkins saw the list of occurrences on Niche relating to VC. PC Taylor points to the potential for her being distracted:²⁶⁰ there is evidence she opened the list of occurrences not once, but twice. She accepted that if opened, she would have been aware that the list of previous contacts was not empty. These were not fleeting glances: the evidence suggests two instances when the list was open: 30 seconds; and again, another 42 seconds.²⁶¹ She told the IOPC in her own pre-prepared statement that she had considered investigations relating to VC: "*I believe that when I did this I had a look at some of the previous investigations linked to him*".²⁶² She repeated this in her first interview. This is consistent with the evidence of the audit. The Inquiry might consider whether a new appreciation of VC's history might explain that by 7 June, PC Taylor records then a justification for failing to progress arrest attempts, adopting a reference to arrest for the first time.
- (d) Each of the Officers has since been interviewed again by the IOPC, with both PCs Taylor and Amos-Perkins under caution for gross misconduct.²⁶³ These no-comment interviews have been disclosed to the Inquiry. In PC Taylor's pre-prepared statement she states: "*I do not accept that I) that (sic) I necessarily saw the entry on this page that VC was wanted on*

²⁵⁴ INQT0000021 69/2 – 70/12.

²⁵⁵ INQT0000021 62/19 – 63/8; INQT0000021, 31/9-11

²⁵⁶ PC Taylor was PC Amos-Perkin's fifth probationary officer he had supervised: WITN0010001_0001 [4].

²⁵⁷ INQT0000021 16/23 – 17/16, 21/13 – 23, 30/13 – 22.

²⁵⁸ INQT0000021 20/15 – 21/7; INQT0000020, 138/10-21.

²⁵⁹ Compare LEPF0000438_0024 and WITN0009001_0004 at [16].

²⁶⁰ INQT0000020 88/14 – 20. See also: 40/17-25.

²⁶¹ See, LEPF0000660; PC Brian Gardner (WITN0429001). See also: LEPF0000271, LEPF0000658, LEPF0000258 (Email from T/Detective Chief Inspector Christopher Gamble (LEPF) dated 26 February 2025).

²⁶² IOPC0000018_0016.

²⁶³ IOPC0000210 (T/PS Read); IOPC0000211 (PC Amos-Perkins); IOPC0000212 (PC Taylor).

*a warrant or two, even if I saw that I mentally absorbed the information at the time so as to take further actions in relation to it. This is wholly consistent with what I said to the Nottingham Inquiry in oral evidence.*²⁶⁴ The Inquiry will be able to reach their own view in due course. We make no further comment at this stage.

- 2.57 While the Inquiry will be cautious not to prejudice any ongoing IOPC investigation nor any continuing misconduct proceedings: it is anticipated these proceedings must conclude before the Inquiry is due to report in 2027. We deeply regret that the Inquiry has, as yet, been unable to consider the work done by the IOPC in the context of this investigation. The Inquiry is aware that the Officers concerned and their Federation Representatives have made allegations of improper conduct by the IOPC, including in providing assurances that the investigation was driven by the families and politically motivated.²⁶⁵ This is consistent with the Bereaved Families own criticism that the IOPC investigation of LEPF failed to consider reasonable lines of inquiry (requiring the investigation to be re-opened) and gave inappropriate assurances to the Officers during interview. The Inquiry has not been able to consider the significance of those allegations for the Officers' evidence while the IOPC investigations continue. Further updates provided by the IOPC, including in relation to the conclusion of the staff investigation have proved deeply unsatisfactory. In so far as is possible within the confines of the undertakings in place, the Bereaved Families will keep the Inquiry updated on their concerns. The Bereaved Families consider the conduct of the IOPC in each of these matters has been disappointing: they retain no confidence that these matters will be dealt with independently or effectively in the course of the outstanding IOPC investigations. (Subject to the progress of the IOPC's work, the Bereaved Families may seek to make further submissions to the Inquiry, as appropriate.)
- 2.58 The Inquiry is invited to consider that had LEPF acted as it should following 5 May, VC would have been arrested shortly after the attacks at Arvato. If they had acted as they should following receipt of his name on 24 May 2023: VC ought to have been arrested shortly thereafter by either LEPF or NGPF. The Inquiry may conclude that either LEPF or NGPF ought to have contacted NHFT when his previous occurrences showed pattern of his previous contact with the police linked to mental illness. There can be no question the failures in Leicestershire were a missed opportunity.²⁶⁶ At a minimum, it is likely, on evidence of previous events, that VC would have been subject to a further MHA assessment,²⁶⁷ with the equally likely prospect of further detention whether for assessment or treatment and an opportunity to implement the CTO and Depot that the evidence overwhelmingly suggests was warranted.
- 2.59 Instead, VC remained at large and we do not know if he was able to access work after 5 May 2023. It appears he was unable to pay his rent and was evicted on 11 June 2023.²⁶⁸ The failures

²⁶⁴ IOPC0000212_0005.

²⁶⁵ INQT0000051_33/2 – 35/24. LEPF0000125_0008-0009. WITN0289001_0038-39 (Emma and David Webber); WITN0312001_0032-33 (Drs Sinéad O'Malley-Kumar and Sanjoy Kumar); WITN0339001_0026-0027, WITN0339015_0004-006 (First and Second Statements of Rachel Watson, Director General, IOPC)

²⁶⁶ The consideration of failure to arrest as a possible or probable contribution to a subsequent death is a matter of evidence and ought not to be dismissed out of hand as mere speculation: *R (O'Brien) v HM Assistant Coroner for Sefton, Knowsley and St Helens* [2026] EWCA Civ 499, RLIT0000106 [31], [42], [44] – [45], [48] – [49].

²⁶⁷ Arrest on the warrant for the serious assault of a police officer, while at large for another serious unprovoked assault would have opened up consideration of the forensic options open to the Court pursuant to the MHA, including assessment with view to remand in a secure hospital or if not so remanded, subject to bail conditions. See MHA 1983, s35 and also, INQT0000035 2/17 – 8/10.

²⁶⁸ See the Report of PC Beddoe (addressed further below): NGPF0000474_0006, referencing MG11 of VC's flatmate, Lulian: NGPF0002965_0003.

in the investigation of the assaults on 5 May 2023 created yet another circumstance where VC had resorted to serious violence with seeming impunity. The Inquiry heard about the efforts made by VC to evade detection: on 9 June 2023, he asked the Sky Recruitment Agency to destroy any records they held on him.²⁶⁹ Had there been any further contact by LEPF, even as PC Taylor and T/PS Read explored closing the file on 10 June, they would have known both about these efforts and that VC had been in contact (and potentially, that there was a mobile phone number connected to him). VC had begun looking for alternative accommodation and he was in contact with Bil Monteiro. The days between 5 May and the attacks must be considered in the light of the apparent triggers and stressors patent in the history of VC's contacts with police and mental health services including his diagnosis (and evidence of paranoia); and stress connected to housing insecurity and feelings of inadequacy. The Inquiry might consider whether a failure to intervene at this stage was not only a critical missed opportunity to divert VC away from the attacks on Ilkeston Road: it may have helped plot the course towards tragedy.

B. CALL TO CUFFS: EVENTS AND RESPONSE ON 13 JUNE 2023

- 3 On 13 June 2023, the press release issued by Nottinghamshire Police exclaimed:
*"Officers managed to track down the van ... and arrested [VC] ... in Bentinck Road at 5.35am - 91 minutes after the first 999 call."*²⁷⁰

- 3.1 Thus NGPF gave itself a collective pat on the back for its sterling police work in capturing VC so quickly after he had brutally killed Grace, Barney and Ian. The truth is that they did not track down the van and VC got himself arrested by trying to continue his killing spree: driving a van stolen from Ian into Wayne, Marcin and Sharon in broad daylight in city centre Nottingham. Nottinghamshire police had given him up as "long gone" after the killings of Grace and Barney. And, if VC had not been intent on killing as many people as possible, Nottinghamshire police would likely not have found him that day. On that day, NGPF also failed to inform the families of the deceased of what happened in a timely way and treated the remains of Ian Coates with insufficient regard. Taking each in turn:

(a) NGPF did not track down the van

- 3.2 At the commencement of the Inquiry hearings, whilst NGPF accepted criticism of its dealings with VC in 2020, 2021 and 2022, it rejected any criticism of its actions on 13 June 2023. The evidence which emerged in the course of the Inquiry hearings revealed that such a stance was indefensible. There were basic errors at crucial points of the morning of the killings and attempted murders. Many of the problems stemmed from the laconic leadership of CI Mather in the Force Control Room ("FCR"):

- (i) The working assessment of the nature of the incident was untenable;**
- (ii) The Deployment of Armed Response Vehicles ("ARVs") was inefficient and ineffective;**
- (iii) Time and resources were wasted on a false alarm close to Nottingham cathedral;**
- (iv) Any search by officers was uncoordinated;**

²⁶⁹ NGPF0002310_0002.

²⁷⁰ NGPF0004527_0016 (which is not the original release; but a compilation of statements in a single word document). In our opening, we explain how the draft release went further and exclaimed there were 91 mins "call to cuffs": NGPF0004449_0005 (Reference to the warrant only being released if asked at NGPF0004449_0004).

- (v) **Information was not properly shared;**
- (vi) **CCTV was not effectively used to search for VC;**
- (vii) **Other important resources were not deployed to search for VC.**

3.3 Taking each in turn:

(i) The initial working assessment of the nature of the incident was untenable

- 3.4 When officers first attended on the scene to witness the appalling crimes that VC had committed, the information fed back to CI Mather somehow led him to form two possibilities as his working assumptions of the reasons for the killings. The first, and primary working assumption, was that what had occurred was part of a robbery. The second, was that Grace and Barney had been killed as part of a domestic incident.²⁷¹ Neither assumption was tenable.
- 3.5 So far as robbery was concerned, it is utterly implausible that this could have been a working assumption if CI Mather had taken even the slightest care to enquire of officers the most basic details of the scene. The fact that Barney still had his wallet was notified to the control room at 04.21, and he still had his phone. Grace was still wearing her favourite jewellery; which included a Tag Heuer watch, a Cartier bracelet and pearls. Knowing that, it should have been obvious to anybody - senior police officer or Deliveroo driver – that what had happened in Ilkeston Road was not a robbery. CI Mather did not ask a single question of any officer at the scene to clarify whether robbery was a tenable working assumption.²⁷²
- 3.6 In respect of the secondary working assumption, a domestic incident, the basis for that being a working assumption was not explained. Beyond there being both a man and a woman killed, there is nothing to support such an assumption.
- 3.7 Working assumptions are important. If an incident occurs because of a botched robbery or, especially, because of a “*lover scorned*” (as Mr. Beggs KC described it),²⁷³ then there can reasonably be a degree of confidence that the offender is unlikely to very quickly repeat his crimes. However, apparently motiveless killings reasonably present the possibility that they will be repeated – as Ian, Wayne, Sharon and Marcin tragically found to their cost.
- 3.8 Recognition of the possible nature of the first killings would inevitably lead to an urgency which was conspicuously absent from the laconic actions of CI Mather in the control room that morning. But he did not ask obvious questions, the answers to which should have told him that he had a determined killer on his hands. The Bereaved Families are concerned that the failure of CI Mather to ask any questions meant that the nature of VC’s killings remained unappreciated, and consequently there was a lack of urgency to catch VC. That lack of urgency may have contributed to the death of Ian and the serious injuries suffered by the Survivors. If CI Mather had confronted the true horror of the attacks at Ilkeston Road, it is inconceivable any person would have described VC as “*long gone*”.

²⁷¹ See for example, NGPF0007689. INQT0000024 88/15-9, 91/8-92/4: “*in my experience, people that commit robberies then run away.*” See also, 92/15-24: “*it was another hypothesis that this could have been some sort of domestic incident*”.

²⁷² INQT0000025 77/1 to 20

²⁷³ INQT0000025 87/2-5.

(ii) The Deployment of Armed Response Vehicles (“ARVs”) was inefficient and ineffective

- 3.9 The APP on Armed Policing guidance on deployment, threat assessment and working strategies counsels:

*“Along with the primary aim of securing public safety, consideration should be given to whether it is possible to identify, locate and contain the subject and take appropriate action to neutralise the threat posed.”*²⁷⁴

- 3.10 All three ARVs in Nottingham that morning went to the scene at Ilkeston Road. They stayed there for some considerable time and were not deployed to search for VC. The scene video shows that the OFC for the day, PC Speeden, was (beyond providing emergency equipment to officers) not engaged in first aid at the scene. Instead, the OFC became involved for a considerable time in securing access to an empty property at 316 Ilkeston Road and took some time to repacking cutting gear into a toolbox before putting it back into his ARV. At 4:09:11, PC Speeden can be heard on radio as he asks of the FCR: *“I know our priority is the victims at the moment, my only concern is the offender. We have an unknown whereabouts for him. There could be future victims, or the offender might return to the scene”*.
- 3.11 PC Speeden was very frustrated that no firearms authority had been issued and that he remained at Ilkeston Road, scrolling through the log whilst in the front seat of his ARV, when a dangerous killer was at large. PC Speeden is heard on recordings from his BWV, being openly critical in his feedback to control of the failure to provide full firearms authorisation and the lack of direction from CI Mather. No firearms authority had been issued by CI Mather. If it had been issued, he would have been able to ensure that other firearms officers were released from the scene once there was sufficient medical cover in order to carry out an armed search.²⁷⁵ PC Speeden’s evidence was that if that had happened he would have had control of the search with CI Mather and it would have been run through a single radio channel - the firearms channel - with other officers patched into that channel. The first thing he would have asked for was checks of CCTV as well as drone assistance and police air force assistance. Areas would have been designated for officers to search so there would not be duplication and they could cover a greater area²⁷⁶.
- 3.12 CI Mather said, irrespective of any direction from him, PC Speeden could have *“been out searching. He didn’t need an authority to search”*²⁷⁷. The Inquiry may think that remark represented a serious abrogation of responsibility by CI Mather who had deployed PC Speeden to Ilkeston Road in the first place and neither issued a firearms authority nor took any steps whatsoever to inquire as to whether the continued presence of important ARV resources at Ilkeston Road was necessary. VC was a dangerous, out of control, killer. ARVs are fundamental to dealing with somebody of that profile.

(iii) Time and resources were wasted on a false alarm close to Nottingham cathedral

- 3.13 The Inquiry heard that a false alarm had attracted enormous police resources. The response to the killings by VC does not bear comparison to the coordination and resource targeted at the response to a call made by an off-duty police officer some five to six minutes after the first 999 call about

²⁷⁴ NGPF0010086_0090

²⁷⁵ INQT0000031 80/14

²⁷⁶ INQT0000031 87/1

²⁷⁷ INQT0000025 82/6

the killings by VC. A woman had been heard screaming and shouting "fuck off" near St Barnabus Cathedral. This incident was immediately linked in the FCR to Ilkeston Road. There were significant co-ordinated resources tasked to search in respect of this call. That was despite there being no victim; no known perpetrator, and, in fact, no attack. It saw the dispatch of ARVs, dogs, drones and response officers to search. Information subsequently emerged that VC had gone in a different direction, through Hopedale Close. Crucially, whatever mistake was first made, when that information emerged, those same resources were not used to continue the search for VC.

(iv) Any search by officers was unco-ordinated

- 3.14 There was no attempt in the FCR to co-ordinate any search for VC in the early hours of 13 June 2023.
- 3.15 Officers who were searching were left to co-ordinate themselves with the assistance of local dispatchers and without any overall direction. What should have been done is that which PC Speeden said he would have done if a firearms authority had been issued: namely, areas should have been designated for officers to search so there would not be duplication and they could cover a greater area.
- 3.16 But no attempt was made to ensure that sort of rigorous search. The Inquiry heard from officers who were essentially searching on their own initiative.²⁷⁸ The prospects of catching VC before he killed Ian and tried to kill Wayne, Sharon and Marcin were therefore substantially reduced.

(v) Information was not properly shared

- 3.17 Police communications in relation to the aftermath of VC's first killings went through different police radio channels. That meant that communications were fractured and not properly shared between officers who wished to search for VC. Superintendent Allardice accepted things could have been missed.²⁷⁹
- 3.18 As PC Speeden said, a firearms authority should have been issued and if it had been all communications would have gone through the firearms channel, and he would have asked for other teams to be patched in.²⁸⁰ As it was, some information was relayed on the firearms channel that was not accessible to others.²⁸¹ CI Mather failed to ensure that all communications were accessible or that all information pertinent to the search was passed.²⁸²

²⁷⁸ CI Mather accepts "*oversight over coordination I think could have been better, and I will ultimately take responsibility for that as the senior officer on duty.*" INQT0000025 21/3-12.

²⁷⁹ WITN0311001_0114.

²⁸⁰ INQT0000031 87/1-16

²⁸¹ INQT0000022 17/20-18/2. Jayne Harvey confirms CCTV operators don't have access to the firearms channel: INQT0000095 82/15-17. CI Mather would have been aware some information was limited to the Interops or "Firearms" channel accessible only to specialist officers (ARV, dogs, drone) unless "*patched*" to other channels: INQT0000025 38/25-36/4.

²⁸² See Manchester Arena Inquiry, Manchester Arena Inquiry: Volume 2: Emergency Response · 3 Nov 2022: Recommendation R53 The emergency services should prepare, train and exercise for how they will maintain effective radio communications between emergency responders on the ground, commanders and control rooms, during the response to a Major Incident. INQY0000021_0153.

3.19 Use of one channel would have meant that the accurate description of VC as a black man, dressed all in black and carrying a black rucksack would have been available to all officers. Full information would have been available on VC's direction of travel as it became available.

3.20 **In future, when the police are searching for an offender following a major incident, all officers involved in the search should be patched into the same radio channel.**

(vi) CCTV was not effectively used to search for VC

3.21 There was initial confusion as to the direction in which VC had gone after killing Grace and Ian. Police were first told by a witness that he had gone towards the city centre. But at some point between 4.19 and 4.22 it became apparent that VC had gone in a different direction; towards Hopedale Close. There appears to have been no further communication between officers and CCTV operators to try and find VC once that direction was clear.²⁸³ CI Mather had not been in touch with CCTV operators to ask them to search. He did not know if any other officer had contacted CCTV operators and accepted that he should have known that. CCTV Operators confirmed they were not told about VC having gone in the direction of Hopedale Close. If they'd been given a direction, this would have changed their search.²⁸⁴ CI Mather did not dispute that it only needed a modicum of intelligence and common sense to ask that CCTV be used to search for VC in the area he had been seen to head towards.²⁸⁵

3.22 PC Speeden was, of course, absolutely right when he gave evidence that CCTV should have been used to search for VC. But that did not happen.

3.23 The Bereaved Families are left with the strong feeling that nothing was done because the belief of CI Mather, as expressed by him to Inspector Shaw at 04.32 that morning, that VC was "*long gone*".²⁸⁶

3.24 We now know that there were crystal clear images of VC captured on local authority CCTV walking along Gregory Boulevard towards Mansfield Road between 04.38 and 04.41.²⁸⁷ It was early morning on a bright and sunny day. T/DCC Griffin confirmed that local authority cameras were able to zoom in on a subject.²⁸⁸ Not many people were out and about at that time of the morning. If the CCTV operators had located a person matching the description of VC, they would have been able to magnify his image. Those bereaved by Ian's death and the survivors of VC's attacks are now faced with the awful reality that VC was there for all to see as he walked towards Magdala Road before he killed Ian and stole his van to use as a weapon against Wayne, Sharon and Marcin.

²⁸³ It was the evidence of Jayne Harvey that any searching done at Woodlands was on their own initiative: INQT0000095 89/3-8. She could not remember being asked to take any action. (INQT0000095 89/13-17).

²⁸⁴ INQT0000095 93/18-94/6.

²⁸⁵ INQT0000025 84/18 - 86/11.

²⁸⁶ NGPF0007311. INQT0000025 17/9 – 19/11.

²⁸⁷ NGPF0004340.

²⁸⁸ INQT0000037 34/4 – 35/14.

(vi) Other important resources were not used to search for VC

- 3.25 The drone that was available for the Cathedral false alarm was not used to search for VC. The failure to deploy the drone was not explained by any police officer.²⁸⁹
- 3.26 PC Speeden was obviously right when he said that it would have been used if firearms authority had been granted. As would air assistance.
- 3.27 Once again, those bereaved by VC's killings are concerned that all opportunities were not taken to locate VC before he could continue his killing spree.
- 3.28 It was only because VC ran down Wayne, Sharon and Marcin that police found him when they did. They did not track down the van. They saw it because it was right in front of them being used as a weapon to attack people and they were able to stop it. The press release from Nottinghamshire Police was a complete travesty and the very senior officers involved in its formulation must have known that the van was not "*tracked down*". In evidence Det Supt Sanders claimed that officers "*followed*" the van²⁹⁰. More disingenuity. They followed it because it was being used as a weapon directly in front of them. By that point no connection had been made between the killings of Barney, Grace and Ian and the attempted murder of the survivors. In the context of what had happened to Barney, Grace, Ian and the survivors the press release from NGPF was an insult to those affected by the attacks.

(b) NGPF did not inform the families of the deceased in a timely way about what had happened

- 3.29 The Major Crime Investigation Manual²⁹¹ stipulates that, on taking command of an investigation, the Senior Investigating Officer should as a priority ensure that the victim's family have been notified. Timely notification of the families of victims of high-profile homicides is essential if they are not to discover their loss through social media. It took NGPF much too long in this case to inform the families of the deaths of their loved ones.
- 3.30 Emma and David Webber's evidence was visceral in its account of their anguish as news developed of an incident in Nottingham. They rang the hospitals and police to see if their son was involved.²⁹² The dread of Sanjoy and Sinéad grew throughout that morning until they were actually informed of Barney's death and the likely death of Grace by one of her friends²⁹³.
- 3.31 In the event, Emma and David Webber were not officially informed of Barney's death until just after 10 o'clock on the morning of 13 June. Sinéad and Sanjoy were not officially informed of Grace's death until well after 11 that morning.²⁹⁴ That was despite the police having all necessary details to notify Emma, Dave, Sinéad and Sanjoy from the driving licences of Barney and Grace recovered from the scene by 4.25 that morning.²⁹⁵ Whilst Elaine Newton was informed by local response officers not long after Ian was pronounced dead, she was told he had been killed in a road traffic incident. Ian Coates' sons only found out about his death from Elaine Newton's son.

²⁸⁹ INQT0000025 42/17-23, 96/11-19.

²⁹⁰ INQT0000031 44/3.

²⁹¹ NGPF0008898_0028.

²⁹² INQT0000041 1/17-4/6.

²⁹³ INQT0000040 4/12.

²⁹⁴ INQT0000041 1/17-4/6.

²⁹⁵ NGPF0006136_0013

- 3.32 Det Supt Sanders claimed that any delay in notification was a result of the amount of work that was needed to be done on other tasks that morning before they could complete notification.²⁹⁶
- 3.33 Whilst recognising that there were 11 crime scenes to investigate, Inspector Gould acknowledged that the families should have been notified much earlier. She attended a briefing at 9.30 on the morning of 13 June 2023 and discovered that, whilst Elaine Newton had been informed of Ian's death by local response officers, the families of Barney and Grace has not been contacted. She raised concerns about that in the briefing. She was of the view that the task of informing the families had not received the attention it deserved amongst other competing factors²⁹⁷.
- 3.34 The Major Crime Investigation Manual guidance should be followed. **Ensuring families have been notified of the death of their loved ones should be a priority.²⁹⁸ It should not only be a priority if there is nothing else to do. Though inevitably a difficult task, it is a task that should be carried out as soon as reasonably possible if bereaved families and friends are to be spared deep, unnecessary anguish.**

(c) NGPF did not treat the remains of Ian Coates with sufficient regard

- 3.35 The remains of Ian Coates lay in the street for all to see for two hours before covered with a tent when the Crime Scene Investigators attended. The distress caused to the family of Ian by knowing that to be the case is substantial. There were 11 crime scenes to be investigated that morning but surely a scene where the deceased Mr. Coates remained *in situ* should have received priority. T/DCC Griffin accepted that should be the case in the future.²⁹⁹
- 3.36 Alan Tribe, Director of Forensic Services for the Metropolitan Police Service said that the combination of events which created problems with the forensic tents on 13 June was uncommon. He said small disposable tents have been used at the MPS since 2013 before the arrival of a larger forensic tent. He pointed to the Forensic Science Regulator's statutory Code of Practice³⁰⁰ **The Inquiry may conclude that the practice of deploying temporary small forensic covers ought to be standard to protect the dignity of the deceased.**
- 3.37 In a further lack of attention to Ian's dignity that has caused distress to his family, Ian's remains were not removed from the scene until half past eight on the night of 13 June 2023.³⁰¹ That is almost 15 hours since he was pronounced dead at the scene at 05.55 that morning. The Coates brothers – James, Lee and Darren – all gave powerful evidence on the profound impact this had upon them. T/DCC Griffin acknowledged the distress that would cause for Ian's family. He recognised that in future the removal of a body from the scene of the killing should be prioritised if possible.³⁰² **The Inquiry is invited to recommend the Forensic Science Regulator, EMSOU and the NPCC consider guidance as to how the Code of Practice can be observed with express consideration for the dignity of victims (and bereaved families).**

²⁹⁶ INQT0000030 47/23 - 50/6.

²⁹⁷ INQT0000041 81/9.

²⁹⁸ NGPF0008898_0028

²⁹⁹ INQT0000037 30/18-32/9.

²⁹⁴ NGPF0010084; INQT0000037

³⁰¹ WITN0074002 (Second Statement of T/DCC Rob Griffin), at [15].

³⁰² INQT0000037 32/10

C. PROTECTING PERSONAL PRIVACY IN PUBLIC TRAGEDY

- 4 Mawkish and disturbing violations of the privacy of the deceased and their families were occurring from very soon after the attacks on 13 June 2023. The trauma of bereavement has been compounded significantly for the Bereaved Families by the drip-feed of disclosures from numerous organisations confirming unauthorised access to records concerning the death of their loved ones. These notifications continue.
- 4.1 Witnesses repeatedly raised privacy and data protection as a barrier to effective information sharing to protect public safety but it appears that public employees repeatedly ignored precisely those protections to indulge their terrible human curiosity over the events of 13 June 2023; seemingly without concern for the personal horror of those most closely impacted by that very public tragedy. Digital and human systems proved inadequate to protect the integrity of data intended to be secure. Breaches occurred despite the threat of criminal liability and disciplinary sanction.³⁰³
- (i) Nottingham Police (NGPF)
- 4.2 As the Inquiry began, the Bereaved Families believed there were three identified cases of unauthorised access.³⁰⁴ Superintendent Katherine Craner accepted that the families were not notified of these proceedings as they should have been.³⁰⁵ That these investigations were allowed to continue in the dark while tension over the acceptance of VC's pleas was high, leaves the unfortunate impression that a choice was made to avoid exposing the force's misconduct to scrutiny. While this has been attributed to a breakdown in communication between PSD and the investigating team, the Bereaved Families are concerned there is evidence of a clear direction from Det Supt Sanders on a number of occasions that information should not be shared.³⁰⁶
- 4.3 The acts of Special Constable Skenderaj are truly shocking. He had no official duties relevant to the body worn footage of the attacks. He viewed 12 separate pieces of footage from his home. These included graphic images of medical assistance provided by paramedics to Barney and

³⁰³ Together the UK General Data Protection Regulation ("UKGDPR") and the Data Protection Act 2018 ("DPA") provide protection for personal data, including against unlawful processing. DPA Section 170 makes it a criminal offence for a person knowingly or recklessly to obtain, procure or disclose personal data unlawfully. It is a separate offence to sell on personal data obtained so obtained (DPA 2018, s.170(4)). DPA/GDPR would not cover the personal data of the deceased but do protect the personal data of survivors and any living person included in the records generated in the aftermath of 13 June (including the personal data of the bereaved) (Recital 27, UK GDPR). The right to private and family life guaranteed by Article 8 ECHR also protects the privacy of survivors (including bereaved families) and the dignity of the deceased (e.g. *M.L. v. Slovakia* (App. No. 34159/17, October 14, 2021)). All public authorities are required to act compatibly with Convention rights, including Article 8 (Human Rights Act 1998, s.6). These protections sit alongside common law duties of confidence. Unauthorised access to digital data may involve other offences including contrary to the Computer Misuse Act 1990. Data abuse may involve an offence of misconduct in public office ("MIPO") where a public officer acts in wilful neglect or breach of their duties without reasonable excuse.

³⁰⁴ We do not propose to address the case of Ms Rutherford beyond to say that she was permitted the breadth of access in her staff role which allowed her to commit the breaches she did illustrates the considerable systemic weaknesses in the NGPF digital systems.

³⁰⁵ INQT0000049 36/5-39/6.

³⁰⁶ NGPF0009920. INQT0000042 22/7 – 24/27 (13 October). See also IOPC0000214_0005, Statement of Stephen O'Connell concerning a date approaching Christmas 2023: *"I raised the fact that the Bereaved Families were Interested Persons under the Police (Complaints and Misconduct) Regulations 2020 and should be invited for comment and/or to attend the Hearings if in public as per the regulations. I recall that Det Supt Sanders specifically stated that he wasn't going to update the families in relation to PSD proceedings as "they had enough on their plate to worry about".*

Grace as they were dying.³⁰⁷ He self-reported on 1 September 2023 and minimised the seriousness of his actions. He resigned on 13 September 2023 before proceedings against him could be concluded.³⁰⁸ The investigation conducted was cursory: no devices were seized and it appears there has been no investigation as to whether copies, screengrabs or photographs of this material may have been taken and retained by SC Skenderaj or shared.³⁰⁹ If the Bereaved Families were notified of the reason for the misconduct proceedings against him they would have become fully engaged in those proceedings. It is frankly incomprehensible that no criminal investigation of SC Skenderaj's actions was seemingly considered until a formal report was made by Mrs Webber during this Inquiry.

- 4.4 Separately, PC Gell appeared before a Misconduct Panel on 19 January 2024 after accessing Niche occurrences concerning VC and forwarding a WhatsApp message to his wife and a friend which had been posted by PC Ashley Small to a police WhatsApp Group known as “*The Section*”.³¹⁰ The language used was degrading in its description of Barney and Grace’s injuries. It included operational information. It confirmed that VC was wanted at the time of the attacks. The disciplinary action against PC Gell exposes the failure of NGPF to take the disciplinary matters arising seriously. First, there was simply no serious investigation of PC Small or the other members of the WhatsApp group whether in relation to the activities on the Group (disappearing messages were enabled which increased security but prevented scrutiny); the circulation of the original message; or, the failure to report receipt of the original message. The ethical interview conducted with PC Small on 23 June 2023 was simply poor. No significant action appears to have followed.³¹¹ Second, the failure to notify the Bereaved Families deprived them of any opportunity to attend and participate in PC Gell’s hearing and to ask the Chair to pursue particular questions.³¹² The involvement of the Chief Constable’s son was communicated to the Bereaved Families by someone who attended the hearing. Third, there appears to have been an attempt by NGPF to have the hearing held in private (refused by the legally qualified chair).³¹³ Finally, taken together, especially given the involvement of the Chief Constable’s son, all of these factors created an overwhelming and enduring suspicion, that these steps were constructed (whether by design or otherwise) to protect NGPF and to keep these acts of misconduct away from the Bereaved Families and out of the public eye.
- 4.5 Senior Officers were aware from the earliest stages that unauthorised access to the files was occurring. The action taken in response operated in effect as an amnesty to sanction wholesale data abuse. The first report of unauthorised access came in on 14 June: this prompted an internal discussion and the observation: “*I think if we start looking there will be countless Officers that have looked without a policing purpose.*” The practice of “*self-briefing*” appeared to operate with little oversight at all.³¹⁴
- 4.6 The human and digital systems in place at NGPF were inadequate to protect against wide access across the force by Officers and staff with no legitimate need to access the records generated

³⁰⁷ NGPF0011091_0013, at [11] and [12].

³⁰⁸ NGPF0011091_0017 at [27].

³⁰⁹ INQT0000049 42/2-4.

³¹⁰ NGPF0005538. INQT0000049 32/9 – 40/11.

³¹¹ NGPF0005569. INQT0000049 36/5-39/6.

³¹² See also: INQT0000049 53/2-14.

³¹³ IOPC0000129_0003, Witness Statement Oliver Thorne (Legally Qualified Chair). An application by the parties was refused: it is the evidence of PC Gell he did not seek a hearing in private.

³¹⁴ NGPF0007863. See also INQT0000049 9/15 – 12/24.

during the investigation of the murders of Barney, Grace and Ian. No digital restrictions were placed on Niche or NICE Investigate (which stored video) to prevent open access: although it appears this was possible. A positive decision was taken not to so restrict.³¹⁵ The “*Big Job Drive*” operated in a way which made it near impossible to control or audit access. PC Skenderaj’s actions would never have been caught if he had not self-reported.

- 4.7 Any investigation of unauthorised access by NGPF has been largely driven by self-interest in the preservation of the reputation of the force rather than any concern over the privacy and dignity of the victims, survivors and Bereaved families. For example, as above, misconduct by PC Gell was discovered only after a proactive investigation to try to identify a source of leaks to the press (“Operation Glint”). Former Chief Constable Meynell confirmed that no officer in her force, beyond PC Skenderaj, self-reported. No Officer in the What’s App group self-reported.³¹⁶
- 4.8 Where investigations took place these were blinkered and limited in scope. For example, despite an appreciation of the potential for unauthorised access being investigated by both the IOPC and this Inquiry, no general audit of unauthorised access to NICE Investigate (and all audiovisual material, photographs) had been conducted. One is now belatedly underway following a complaint by Dr Kumar subsequent to the evidence of T/DCC Griffin.³¹⁷ No investigation or audit of the “*Big Job Drive*” has been attempted. Superintendent Craner was unable to say which files concerning 13 June were stored on the Big Job Drive nor how many people had access.³¹⁸
- 4.9 Moreover, the failure to notify the Bereaved Families of the relevant misconduct proceedings was known by NGPF to breach the statutory requirement for notification to be provided pursuant to the Police Reform Act 2002 and the Police (Conduct) Regulations 2020.³¹⁹
- 4.10 Additionally, misleading information was given about the scope and outcome of these investigations both to the Bereaved Families and the media by NGPF. For example, both the Bereaved Families and the media were wrongly told that SC Skenderaj had been dismissed by the Chief Constable when he had in fact resigned. Again, what may appear to be a mistake once, repeated engenders substantial suspicion.³²⁰
- 4.11 The current NPCC guidance, *Policy guidance use of social media and instant messaging* (May 2025), makes clear that decisions on WhatsApp use are at the discretion of the individual force. It begins: “*Messenger apps such as WhatsApp are popular forms of communication for teams and shifts.*” It continues: “*groups should be kept for personal use only*”. The evidence underscores why this approach is problematic: if disappearing messages are enabled there is no effective means of scrutiny. The Bereaved Families regret such tacit acceptance that platforms on social media may be used on personal devices for semi-sanctioned, un-auditable group “*chat*”. If such informal platforms for shift information are required: use of auditable police devices and messenger platforms should be the default (the NPCC includes this only as a “*consideration*”

³¹⁵ INQT0000049 18/8 – 22/20.

³¹⁶ INQT0000035 10/20 – 11/2.

³¹⁷ INQT0000049 25/11 – 27/24.

³¹⁸ INQT0000049 23/3 – 24/11.

³¹⁹ IOPC0000214_0005. See, for example, Regulation 40(5) and the discretion of a Chair in misconduct proceedings concerning questions IPs may request are put.

³²⁰ NGPF0011347, NGPF0011160, INQT0000034 90/7-91/4, 102/2 – 7.

within force rationales). The Guidance includes a reminder of the duty to challenge and report. The Chair may question how realistic self-reporting may be given the evidence in this Inquiry.³²¹

- 4.12 **There should be a nationally consistent position across all forces which rules out the use of WhatsApp and personal devices for “group chat” and messaging amongst Officers for shift and other police contacts incorporating a default prohibition on the use of personal devices for this purpose, incorporating a clear and consistent message on the prohibition against the sharing of police information and communications in breach of Professional Standards, emphasising sanctions which may follow.**

- 4.13 We consider guidance on restrictions on all public systems generally and wider guidance on the protection of privacy in the aftermath of events which attract a public profile and which lead to the loss of life and/or serious injury, below. The Bereaved Families consider there is an urgent need for a consistent cross-Government message that unauthorised access in circumstances of tragedy will not be tolerated.

(ii) Nottingham City Council

- 4.14 Three members of the Council Antisocial Behaviour Team were found to have accessed a NICHE occurrence linked to the attacks. NCC appears to have taken little or no action to challenge or otherwise address what motivated the actions of their staff pointing to the breach being in respect of police systems.³²² NGPF notified the Local Authority of the data breaches in July 2023. The Bereaved Families were only notified of NCC’s unauthorised access when Dr Kumar questioned an explanation by the police that their audit had identified unauthorised access by a partner agency. Former Chief Constable Meynell confirmed NCC’s involvement on 6 March 2024. Only then, did this prompt a public statement by NCC and subsequent correspondence.³²³ The Inquiry may conclude that the lack of rigour with which NCC has approached their consideration of the breaches by their staff suggests a limited understanding of Data Protection and privacy standards.

(iii) Nottingham University Hospitals Trust

- 4.15 Nottingham University Hospitals Trust (“NUHT”) are responsible for Queens Medical Centre, where the victims and survivors were taken after the attacks on 13 June. The Trust knew it had a problem with its clinicians, nurses and other staff accessing records inappropriately.³²⁴ An audit of NHFT systems followed inquiries made by the Bereaved Families. As a result, a query was passed to NUHT on 4 October 2024. An inexcusable delay ensued before an audit in February 2025 identified access by around 20-30 members of staff. The Trust is considering fact finding (Stage 1) and disciplinary investigations (Stage 2) in each case of alleged unauthorised access. Since February 2024, three distinct cohorts have been identified for investigation. The figures are shocking. In the first cohort, 98 were investigated, and 35 progressed to Stage 2. Doctors, nurses and staff, including administrators appear in the numbers under investigation. Hearings began in November 2025.³²⁵ (The figures in Cohort 2 which relate to the Survivors records are even greater: it appears astounding that this work did not begin until 27 March 2025. That a Cohort 3

³²¹ H0MF0000156_0013.

³²² INQT0000096 48/14 – 56/13.

³²³ NOCC0000237, WITN0224016.

³²⁴ INQT0000097 5/1-4.

³²⁵ NUHT0000222.

is required may illustrate both the scale of the problem and the incremental approach taken by the Trust to effective audit).

- 4.16 Dr Manjeet Shehmar, the Trust’s Executive Medical Director accepted the Trust would not have known about these data breaches but for the work done by the Bereaved Families. She confirmed the investigations were considering the Trust’s local policies on confidentiality and the General Medical Council (“GMC”) and Nursing and Midwifery Council Codes (“NMC”) and associated guidance. An update sent in the days before Dr Shehmar was due to give her evidence confirmed the conclusion of the first round of concluded investigations: 11 dismissals, 12 final written warnings, two first written warnings and two found to have no case to answer. No doctors were dismissed, although four were given a written warning. Four nurses were sacked and five given a written warning.³²⁶
- 4.17 The first the Bereaved Families knew about the investigations was in the letters of notification sent by Dr Shehmar on 20 February 2025.³²⁷ The Trust neglected to notify Elaine Newton. Dr Shehmar did not even know that Ms. Newton had been an employee of the Trust for many years.³²⁸
- 4.18 None of the Bereaved Families yet understand enough to appreciate what has been accessed in their loved ones’ files and how the Trust has come to the conclusion disciplinary action has been necessary (or not). Dr Shehmar promised “*ongoing consideration*” as to whether families would get detailed breakdowns and reasons given. Subsequent correspondence in July has taken this no further than a promise the Board would consider the position. If there has been consideration of mitigation and if these included personal apologies, none have been passed to the Bereaved Families.³²⁹ The obligations the Trust has to their employees to secure a fair process are clear: including, ironically, the duty to protect their privacy. However, the Inquiry may conclude that the process of conducting and concluding these investigations has been altogether too slow; and too incremental. Families have repeatedly asked the Trust to confirm whether any of the instances of unauthorised access have been referred either to the GMC or the NMC. While the Trust has confirmed both Regulators are engaged pending outcomes:³³⁰ no referrals have yet been made and the families cannot prepare effective referrals themselves without more information.

(iv) Ministry of Justice

- 4.19 Illegitimate access within His Majesty’s Probation Service (“HMPPS”) and His Majesty’s Courts and Tribunals Service (“HMCTS”) was first discovered in January 2024. Seven probation staff were investigated by HMPPS and three considered to have had unauthorised access.³³¹ HMCTS investigated separately and seven cases were referred to the police in May 2024. Two agencies, both under the Ministry of Justice (“MOJ”) reached wholly different conclusions. Following wider investigation by the Counter Fraud Team at HMCTS, unauthorised access by four members of HMCTS staff was investigated. Two were dismissed and one resigned. The fourth was an intern. All four are subject to ongoing criminal investigation.³³² While that investigation is

³²⁶ NUHT0000351

³²⁷ NUHT0000100, NUHT0000101, NUHT0000102

³²⁸ INQT0000097 66/18—67/21.

³²⁹ INQT0000097 70/8—71/16.

³³⁰ INQT0000097 59/16-61/16.

³³¹ INQT0000049 86/1 – 88/5.

³³² Three in August 2024; the intern in April 2025, after an error: INQT0000049 86/1 – 88/5.

ongoing, there has been no explanation as to what data on the file was accessed illegitimately, by whom and when.

- 4.20 The Bereaved Families were first notified by the police investigating (South East Regional Organised Crime Unit “SEROCU”). The first they knew anything of the dismissals was when the story broke in the press.³³³ No consideration was given by the MOJ to contacting the Bereaved Families until December 2024. Again, the MOJ now accept there should have been earlier notification.³³⁴ Despite existing functionality, no restrictions were applied to VC’s prosecution file until 23 May 2025³³⁵ A default requirement for restricted access in all murder cases was being “*considered*” by the MOJ.³³⁶ That this is only now being “*considered*” is astonishing. **Restricted digital access to Court and Probation files should be a default in all homicide cases, not limited to murder. There may be other cases likely to attract public attention, including for example sexual offences and serious offences involving children as perpetrators and clear categories and direction on restriction must be considered by HMCTS and the MOJ to protect against illegitimate access.**

(v) **Protecting personal privacy and dignity in public tragedy**

- 4.21 Despite repeated efforts to secure clarity including in this Inquiry and beyond, the Bereaved Families and Survivors do not yet understand the full extent and nature of the unauthorised access which has occurred. More than three years beyond the attacks, inaction may suggest impunity. A lack of candour has generated justified concern over cover-up which undermines delayed efforts at openness. The experience of these Bereaved Families is not unique.³³⁷ There is a pressing need for robust action now. In a digital age, simple precautions should have been taken long ago to guard against privacy invasion in the wake of tragedy. When things go wrong, investigation and any warranted disciplinary action or prosecution must quickly follow. Where not warranted, an explanation should be proffered. Public employees must be told in certain terms: data breaches by you will result in you losing your job and being reported to your Regulator and/or prosecuted. It must be clear that all available sanctions will be pursued without hesitation. Transparency should inform notification to allow for accountability and individuals affected to take action to protect their interests if necessary. A consistent approach across public authorities is needed to protect victims and survivors facing the aftermath of any public tragedy involving the loss of life or serious injury.

- 4.22 **The Cabinet Office and the Information Commissioner’s Office should issue clear national Guidance on the management of data within public agencies in the aftermath of events which attract a significant public profile, including events which lead to a loss of life and/or serious injury. NHS England, the NPCC, the IOPC and the GMC and NMC should be amongst those consulted. All public digital systems ought to be capable of “invite-only” restriction and appropriate restrictions applied.**

³³³ WITN0065031

³³⁴ INQT0000049 97/17 – 98/23.

³³⁵ WITN0065009.

³³⁶ This position is subject to review by the Chief Digital Officer for HMCTS expected to conclude before oral submissions are heard in this Inquiry. INQT0000049 84/22 – 85/11.

³³⁷ RLIT0000046. NHS staff accessed Southport victims' records, BBC News, 5 May 2026.

- 4.23 **Tailored Guidance should make clear that where unauthorised access to records is being investigated (and this may include access to records held in confidence containing personal information about victims, survivors or Bereaved Families) notification should happen promptly to allow the affected persons to take action as necessary to protect their privacy including their right to respect for private and family life as guaranteed by Article 8 ECHR and the Human Rights Act 1998. The Guidance should encourage notification to the ICO, recognising that records (including records which relate to persons who are deceased) may include familial information rendered particularly sensitive in the context of an event with a significant public profile which has resulted in a loss of life and/or serious injury (including but not limited to addresses and phone numbers). Guidance should include a presumption by way of warning that all sanctions, including criminal prosecution, regulatory referral and disciplinary action will be pursued.**
- 4.24 **The Inquiry is invited to consider, in the light of the serious existing consequences which follow from data breach, including potential offences and regulatory consequences, whether a specific offence criminalising acts of unauthorised access to public records following any alleged homicide would be appropriate.**

D. UNDERSTANDING, ASSESSMENT AND MANAGEMENT OF RISK

- 5 The Inquiry heard expert and professional views on different models and structural tools used for the management of risk in mental health. Tools aside: there were repeated and simple failures by organisations and individuals to use the skills and information available to them to appropriately assess and manage the risk VC posed to public safety.
- 5.1 There were questions to be asked throughout of all of those who had contact with VC as to how their actions and omissions may have offered missed opportunities to reduce the risk that VC posed. That the function of a local authority Approved Mental Health Professional (“AMHP”) continues to be critical is illustrated in the approach to VC’s first and final negative MHA Assessments. The Inquiry heard how VC’s presentation was linked to times of stress in study; and the role that concern for his studies may have played in the decision not to require Depot medication in his fourth discharge. And yet: when the University raised concerns the Inquiry may consider they were dismissed. The actions of the University in 2022 after the final admission may raise significant questions as to whether they appreciated the possible risk VC continued to pose as he worked towards graduation. Statements from academic staff regretted that they – or other appropriate staff members - had never been properly informed about VC’s history in circumstances where they or others may have been exposed to personal risk.³³⁸ Information ought to have been more effectively shared between all the agencies and organisations concerned for the risk VC posed: management of VC on a truly multiagency basis was never even notionally possible in the absence of a flow of that information. We return to information sharing and multiagency working in Section E.
- 5.2 We focus in this section on some key issues arising in the management of risk in policing and in healthcare: reflecting the complex relationship between mental health and public safety; treatment, criminality and culpability at the heart of this Inquiry.

³³⁸ WITN0045001_0008 [32]; WITN0047001_0014 [44]; WITN0053001_0028 [102]; WITN0046001_0014 [47].

(a) **“Spinning the wheel”: Risk, Policing and Mental Health**

5.3 Each of VC’s interactions with the police pre-13 June 2023 offered an opportunity for assessment and management of VC’s risk to others. But on each occasion, the Inquiry may consider the police minimised VC’s offending behaviour as opposed to properly investigating it, and they shirked the question of his risk to others. They also failed either to properly record incidents, or review that which had been recorded, let alone to apply common sense and a longitudinal assessment to his risk to others. And the upshot of all the failings: VC was not directed down the forensic pathway. He did not have a full assessment by a forensic psychiatrist trained in forensic risk assessments. And crucially, the records failed to adequately flag VC as a man who was capable of extreme violence when suffering from psychosis.

5.4 As any risk model is reliant on full and accurate base data, the failure to properly record the severity of the incident involving Feven in particular, and the delays in prosecuting the assault on PC Pritchard, would necessarily impact on risk assessments in the future.

(i) ***Police policies not reflected in practice, reducing the opportunity to manage risk***

5.5 The NGPF local policy made clear that *“The fact that a suspect is believed to have mental ill health [...] must not preclude full investigation of an offence and should only rarely prevent arrest and/or interview of a suspect. A healthcare response [...] should not be seen as an alternative to criminal investigation or vice versa. In many cases there may be a need for both responses to take place alongside each other.”*³³⁹ Yet the evidence before the Inquiry leaves the distinct impression that police wanted rid of VC’s cases; for them to be removed from their in-tray regardless of what corners would be cut in so doing.

5.6 Thus, for example, the case relating to Feven was closed within days of the occurrence, despite clear policy guidance that there are circumstances where it might be desirable to prosecute an offender to allow Mental Health treatment, Hospital Orders or other statutory support, even where a conviction or custodial sentence may not be the outcome.³⁴⁰ VC was never interviewed in relation to the Feven case of 24 May 2020, nor the incident on 13 July 2020, nor the assault on PC Pritchard, nor the incidents with Sebastian, despite clear guidance that this should occur.³⁴¹ By minimising the offending behaviour, and diverting VC from the criminal justice system, VC was not assessed using forensic risk assessment tools, nor did his record adequately reflect the harm he had caused, and therefore may cause, to others.

5.7 The same policy states that where there are concerns about an individual, *“details of the person, together with the grounds for concern, should be passed on to the local Social Services department via a PPN”*.³⁴² But this did not take place; neither when the Nottinghamshire police were alerted of VC’s attendance at MI5 by FTAC on 1 June 2021,³⁴³ nor when reports were made of his assault on Sebastian or possible stalking. The police failure to follow their own policies meant that the management of VC’s risk was curtailed.

³³⁹ “Dealing with Persons with Mental Health”³³⁹ (August 2019) NGPF0006002_0019 [3.5.1].

³⁴⁰ INQT0000006 64/1-18.

³⁴¹ NGPF0006002_0020 [3.5.1].

³⁴² NGPF0006002_0014 [3.2.2].

³⁴³ METF0000007_0003.

- 5.8 There was evidence that the local policy “*Dealing with Persons with Mental Health*” was not one with which all Officers were familiar. However, at its most basic the guidance offered in the College of Policing National Decision Model (“NDM”) ought to provide a simple framework for the structured evaluation of risk: gather information and intelligence, assess threats and risk, consider powers and policy, identify options and contingencies, and take action and review.³⁴⁴ This structured approach – colloquially “*spinning the wheel*” – ought to be familiar to even the most junior or raw of officers. It sits at the heart of the Authorised Professional Practice (“APP”).
- 5.9 We repeat that CI Mather on the morning of 13 June 2023 failed entirely to effectively assess (and then act on) the risk which VC posed on the streets of Nottingham.³⁴⁵

(iii) *Police failure to use their own intelligence systems prevented a much-needed longitudinal assessment of risk.*

- 5.10 At no stage was proper consideration given to VC’s risk of harm including the escalation of such, as no consideration was given to VC’s history. For example, by the time she closed the file on VC’s 24 May 2020 criminal damage case, PI Powar was not aware of the level of injury to Feven³⁴⁶ nor had VC’s record for subsequent incidents involving the police been checked.³⁴⁷
- 5.11 When Christopher reported an assault and hostage-taking by VC, PC Zacharia did not give consideration to the factual bases of previous incidents of aggression by VC towards those in proximity to him, as he considered that it would not have been ‘proportionate’ to do that.³⁴⁸
- 5.12 On learning of Sebastian’s report of possible stalking, PC Pannell did not check VC’s history. She stated, “*I wouldn’t have looked at all the previous jobs [...] because I didn’t have the time*” and she didn’t have access to the PNC at the time. There was no evidence she had asked anyone else to conduct a PNC check on her behalf;³⁴⁹ despite the Protocol on the appropriate handling of stalking or harassment offences between the NPCC and the CPS which states, “*The police will ensure that alleged incidents are not considered in isolation, and where complainants report incidents that may be typical of stalking behaviour, the police will interrogate their systems to identify whether there are any linked incidents that could indicate a pattern of behaviour.*”³⁵⁰
- 5.13 Lest this failure be dismissed as inexperience, PS Langham was dismissive of the same incident and assessed it as “*low risk*” without any consideration of VC’s previous assault *on the same complainant*, let alone his violent assault on PC Pritchard, the relatively recent incident involving Christopher, and of the fact of VC’s previous hospitalisations under MHA.³⁵¹

³⁴⁴ WITN0349013_0001-0002.

³⁴⁵ INQT0000024 70/16-73/14, INQT0000025 53/3 – 59/3.

³⁴⁶ INQT0000008 45/21-22.

³⁴⁷ INQT0000008 57/20 - 58/8.

³⁴⁸ INQT0000017 5/9-24.

³⁴⁹ INQT0000012 32/5-24.

³⁵⁰ NGPF0007452_0005 at [3.8].

³⁵¹ INQT0000018 15/6 - 16/24.

- 5.14 No “mental health marker” was placed on VC’s file in relation to the ‘Feven incident’³⁵² nor subsequent to the assault on PC Pritchard.³⁵³ Ultimately, the lack of markers meant the inadequate flagging of risk to others. Yet, Officers continued to expose themselves to danger by continuing to act without checking NICHE or the PNC even after PC Ellis put a marker for extreme, unprovoked violence on the record.³⁵⁴
- 5.15 The apparent ease with which the FTA warrant for VC on NICHE was ignored within NGPF is attributed to a systemic failure accepted by NGPF. We address the evidence of PC Taylor and PC Amos-Perkins Leicestershire above: the Inquiry will consider whether or not the suggestion that VC’s list of occurrences with a warrant not marked for bail appearing listed in bold and red went unseen when opened twice is credible.

(iv) Police failures cannot be explained away by insufficient resourcing or inexperience

- 5.16 Time and again, the Inquiry heard that police officers had not been adequately trained in dealing with suspects with mental health issues³⁵⁵, and many were unfamiliar with relevant policies³⁵⁶. Investigative failures were compounded by instances of misunderstanding of the law³⁵⁷, again indicative of lack of training. There was also a clear lack of supervision of the cases; for example, PI Powar confirmed that the case relating to the first incident on 24 May 2020 wasn’t properly supervised for seven months³⁵⁸.
- 5.17 However, the repeated police failures cannot be explained away by insufficient resourcing; time and again the Inquiry heard evidence which speaks to incompetence, or a sheer lack of common sense.
- 5.18 For example, Feven’s case wasn’t properly re-classified as a Grievous Bodily Harm; the initial police file submission regarding PC Pritchard’s assault was “*clearly deficient and was always going to be returned*”³⁵⁹ as it did not even contain detail of previous incidents; even when Sebastian reported a second incident of stalking, PC Barnes didn’t consider that checking previous incidents of violence by VC, including against the same victim, was relevant to her decision-making³⁶⁰ before determining that VC’s following Sebastian was “*coincidental*”³⁶¹. It took 19 days for the police to obtain VC’s name from Sky Recruitment after the Arvato incident, and even then no proactive and urgent steps were taken to deal with the suspect.³⁶²
- 5.19 In the face of VC’s immediate and obvious risk to others, victims were given either no, or wholly impractical advice. Sebastian was advised to speak with nurses whenever they next visited VC “to explain that something had happened and to make them aware of the situation”³⁶³ and,

³⁵² INQT0000009 7/16 - 8/14.

³⁵³ INQT0000013 69/18-70/3.

³⁵⁴ INQT0000018 68/3-7 and 69/13-70/19.

³⁵⁵ For example, PC Marsden WITN0019001_0006 [26]; INQT0000007 44/18-21.

³⁵⁶ PC Barnes was unaware of, and had received no training on the Stalking Screening Tool, NGPF0000113, INQT0000018 75/6-16. See also INQT0000034 31/9 - 32/25, regarding knowledge of the Mental Health Policy [NGPF0006002] by officers on the ground.

³⁵⁷ “*This case is in fact well over the 6 month STL*” NGPF0000068_0022.

³⁵⁸ INQT0000008 40/12-22.

³⁵⁹ NGPF0007835_0008.

³⁶⁰ INQT0000018 62/19-22.

³⁶¹ INQT0000018 67/8-16.

³⁶² LEPF0000004_0009.

³⁶³ INQT0000012 13/17-18.

moreover, to “keep a continued distance from [VC]”, his flatmate³⁶⁴; and the police did not consider warning Christopher that VC had perpetrated a violent and unprovoked attack on a police officer³⁶⁵.

5.20 The Inquiry is invited to recommend:

- (a) **The College of Policing revisit the APP, including the APP on Mental Health to introduce clear guidance on the prosecution of suspects experiencing mental ill health: amendments to the existing guidance should address the risk which may be posed where a person has a known history of violence and serious mental illness. It should provide simple, clear guidance and direction on circumstances when criminal investigation will be in the public interest.**
- (b) **The NPCC and the College of Policing, together with the CPS devise compulsory training on suspects with mental ill health and a known history of violence and serious mental illness.**
- (c) **The Home Office and the NPCC adopt consistent digital “markers” and alerts for violence, including violence linked to known history of mental ill health, for stalking and fixation, and for extant warrants for arrest. The recommendation should be for a national standard consistent and accessible across police areas. This should be accompanied by clear guidance and training on their consistent use across all forces.**

(b) Tragedy waiting to happen: Managing Mental Health in Nottingham

(i) *Learning from the past*

5.21 Between 2019 and 2023, there were 15 incidents in which patients either under the current care of the Trust, or recently discharged from it, perpetrated serious violence towards members of the community. Disturbingly, the majority involved stabbings.³⁶⁶ The Inquiry Legal Team has examined six cases involving homicide, attempted homicide or other serious violence by individuals known to NHFT.³⁶⁷ The Theemis Report identified, amongst other criticisms, an absence of action plans, review of actions or shared learning arising from those known incidents,³⁶⁸ limited thematic analysis;³⁶⁹ and limited evidence of dissemination of learning.³⁷⁰ The evidence confirms that criticism was warranted.

5.22 The Trust’s senior leadership were well aware of these concerns; the Inquiry has heard significant evidence of local coroners raising concerns from 2019, both in meetings and through a high volume of Prevention of Future Death Reports sent directly to the CEO.³⁷¹ Senior leaders from NHFT attended those meetings, with issues fed through to the Executive Leadership Team.³⁷²

³⁶⁴ NGPF0000043_0008.

³⁶⁵ INQT0000017 13/18-24.

³⁶⁶ NHSE0000298_0227.

³⁶⁷ INQY0000034.

³⁶⁸ NHSE0000298_0227.

³⁶⁹ NHSE0000298_0230.

³⁷⁰ NHSE0000298_0231.

³⁷¹ NHNB0019232; WITN0356017; NHNB0012044; NHFT0009667; INQT0000033 24/5 – 19.

³⁷² INQT0000088 15/3 – 9; INQT0000090 22/6 – 9.

The repeated concerns were stark and reflected those of the CQC: risk assessment, lack of family involvement, discharge processes, and the sharing of risk information with community teams and GPs. Dr Brewin accepted that NHFT took insufficient steps to address those deficiencies.³⁷³ The Board also knew the seriousness of what was occurring. It knew of numerous serious incidents resulting in death or very serious injury.³⁷⁴ Yet the Inquiry has heard evidence of significant delays in finalising Patient Safety Plans because NHFT believed it needed to wait for police investigations to conclude.³⁷⁵ There was no proper questioning of whether that position was correct. More importantly, there was no adequate consideration of what could and should have been done in the interim.³⁷⁶ They were content to accept assurances that “*processes were underway*”.³⁷⁷ Any learning that might have prevented further harm came far too late.³⁷⁸ Both Mr Majid and Mr Devlin accepted that this was a “*serious failure of governance*”.³⁷⁹

5.23 These failures arose despite the duty of candour in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Section 20 and the fanfare revision of the Patient Safety Incident Response Framework (“PSIRF”) in the NHS Patient Safety Strategy in August 2022. We return to candour in Section H.

5.24 The Board and Executive Leadership Team were alerted to patterns of risk, to coronial criticism, and to fatal and near-fatal incidents involving members of the public. In those circumstances, it was wholly inadequate for the Trust to treat police investigations as a reason to defer serious internal examination. The obvious question should have been what action NHFT could take, then and there, to reduce the risk of further harm. Waiting passively for the police, without interrogating what safeguards, learning, or interim measures were available, was not caution. It was inaction. On the evidence before the Inquiry, that inaction left known concerns unaddressed at the highest level within NHFT. There were structures in place intended to provide effective oversight: the Inquiry may seriously question any role and purpose the CQC, the ICB and NHS England (including through its Medical Director for the Midlands Region), played.³⁸⁰ The Bereaved Families consider there is no question that the failures, both individual and systemic led to the events on 13 June 2023. They consider it safe for the Inquiry to conclude these failings made a more than minimal or trivial contribution to the deaths of Barney, Grace and Ian.³⁸¹

(ii) *Unassessed, Unmanaged and Unsafe*

5.25 As set out in the Bereaved Families’ Opening submissions, the Recommendations of the Clunis Inquiry were intended to ensure that the statutory regime found in the MHA and the Care Programme Approach (“CPA”) and structures of care designed to support patients in the

³⁷³ INQT0000087 45/3 – 12.

³⁷⁴ INQT0000090 25/16 – 19.

³⁷⁵ INQT0000090 26/20 – 27/8.

³⁷⁶ INQT0000090 28/1 – 14.

³⁷⁷ INQT0000090 31/20 - 32/17.

³⁷⁸ INQT0000090 37/7 – 16.

³⁷⁹ INQT0000090 37/19 – 24; INQT0000088 58/12 – 24.

³⁸⁰ We note, in particular, the reluctance of Dr Sokolov to accept when questioned about the assurance role of NHSE that she held the Interim Medical Director for NHS England Midlands Region role in 2022. When asked about the knowledge of NHSE of the attacks prior to June 2023, she insisted this was a time before she was in post which the Inquiry may wish to question. She admitted NHSE were aware of the delays in responding to specific incidents: INQT0000107 82/21-84/10; 86/9-87/4-10, 89/16 -25. The Inquiry might consider that the CQC approved VC’s admission at the Priory, for example: INQT0000108 39/21-24.

³⁸¹ The Bereaved Families invite the Inquiry to subject the position of the Trust that their actions only “*may*” have impacted on the outcome to close scrutiny: INQT0000093 61/7-63/2, 68/6-16.

community worked well both for patients and for public safety. The Bereaved Families suggested that the Inquiry may consider that in VC's case, despite those recommendations having been established for 32 years, there were repeated failures in the approach to risk assessment (including in the failure to consider longitudinal risk). The evidence which emerged during the Inquiry hearings demonstrates that this was undeniably the case.

- 5.26 The process of risk assessment is one designed to identify, manage, and reduce risk to an individual and the public.³⁸² It requires consideration of risk factors, whether static or dynamic. It also requires consideration of the consequences of that risk materialising. The Inquiry has heard that VC presented with a significant number of risk factors for violence. He was male. He was young. He did not have a strong support network in Nottingham. He had a demonstrated lack of empathy. He had expressed grievance thinking, restricted insight and capacity, and paranoid delusions. From May 2020, he had a known history of violence. From September 2021, there was no doubt that he was experiencing a severe mental illness in the form of Paranoid Schizophrenia.³⁸³ Importantly, the symptoms VC experienced included auditory hallucinations that had resulted in violence, hostility, anger, and impulsivity (additional factors associated with a heightened risk of violence).³⁸⁴ He had a known history of non-compliance with antipsychotic medication (the evidence of Professor Fazel being that medication was an important protective factor).³⁸⁵ These factors are consistent in the NCISH research: again, 59% of patients with schizophrenia who kill are non-concordant with medication and disengage with services. Everything pointed to VC being a high-risk individual who needed careful management and risk reduction to keep the public safe.
- 5.27 However, the principle of keeping the public safe had all but disappeared from the NHFT EIP service, the team under which the vast majority of VC's care took place. The Inquiry will note that the Operational Policy of this team had limited focus on risk management in relation to the protection of the public. Neither the 'Ten Essential Capabilities' for Mental Health Workers, nor the 'Aims of the Service' included reference to the protection of the public from harm.³⁸⁶
- 5.28 The importance of public protection was then compounded by the clear evidence that VC ought to have been an Assertive Outreach patient but he was treated on an EIP pathway.³⁸⁷ The importance of properly funded, dedicated, Assertive Outreach teams with fidelity to the Assertive Outreach model has been made clear throughout the course of the Inquiry, in particular by the powerful written and oral evidence of Dr Dissanyaka. The model is there for a specific category of individuals: those with severe mental illness; who are disengaged from services, who do not reliably take medication; who repeatedly become unwell; who have risks associated with relapse; who are repeatedly detained for treatment; who have social instability; and, who have offending behaviour histories (regardless of convictions).³⁸⁸ In other words, it is a specific model designed for patients like VC. No such pathway was available in Nottingham at the time, as the Assertive Outreach Team had been disbanded in 2015. Previously, it had run as *“resourced with smaller caseloads to work with patients who represented a particular challenge in terms of engagement*

³⁸² INQT0000052 9/6 – 15.

³⁸³ INQT0000080 21/25 - 22/4.

³⁸⁴ INQT0000046 76/5 – 12; INQT0000055 14/4 – 15/2 and 21/11 – 19.

³⁸⁵ INQT0000055 16/23 – 25.

³⁸⁶ NHFT0000460_0003 and _0006.

³⁸⁷ INQT0000069 58/9 – 1; INQT0000071 20/16 – 23.

³⁸⁸ INQT0000051 51/24 – 52/25.

when they suffered a psychotic illness”.³⁸⁹ Mr Culpin, from Nottingham City Council, who managed the integrated team until 2015, said that “*having a defined caseload of people within Assertive Outreach meant that those people were getting a very high standard of care*”.³⁹⁰ In Nottingham, by 2019, it appears there was pressure felt by Consultant Psychiatrists to discharge high risk Assertive Outreach patients on the grounds that they were not engaging.³⁹¹ Clearly, by this time, the steps needed to engage this cohort of patients and manage their risk had been forgotten.

- 5.29 The Inquiry will note that this disbanding reflected a broader national approach to the risk of patient homicide and the reduction of dedicated Assertive Outreach teams that had been introduced, alongside Crisis Teams, as part of the National Service Framework for Mental Health following recommendations in the Ritchie Report. That these teams were being slowly disbanded across the country through changes in commissioning arrangements and the fragmentation of services was known for many years before VC entered the mental health system. By 2013, the Royal College of Psychiatrists had decided a revision was required to the 2008 CR150 ‘Rethinking risk to others in mental health service’ Report³⁹², as a result of those changes and “*ongoing concerns about how risk was conceptualised and managed*”.³⁹³ “*Philosophies that underpinned crisis services, based on Assertive Outreach teams, have been lost through the asset stripping of these teams to cut costs*”.³⁹⁴
- 5.30 This de-prioritisation was also reflected in the move to the Community Mental Health Framework³⁹⁵ that subsumed the CPA. The framework specifically envisaged “*a shift away from risk assessments and ineffective predictive approaches to safety planning and ‘positive risk taking’*”.³⁹⁶ Guidance on mental health related homicide was not a prominent feature of NHS England’s thinking³⁹⁷ and funding had been cut for data collection on homicides by NCISH from 2018.³⁹⁸
- 5.31 However, it would be misguided to lay the failures in risk management in VC’s care solely at the door of the missing Assertive Outreach team or confusion over guidance on risk management. Whilst its importance is undeniable, the EIP team remained responsible for VC’s care. That they could, and should, have done more is clear. What their Operational Policy *did* require was an “*assertive approach*” to be taken to engagement.³⁹⁹ Assertive principles were said to be a part of the EIP team’s operation.⁴⁰⁰ It is hard to conceive, when the timeline of VC’s care is considered, how it could be said that any form of proactive approach was taken towards VC, even within the available resourcing of the EIP team; especially after his fourth discharge from inpatient care. That more was left to be done was frankly recognised by one of the care coordinators, Ms Parsonage: “*I think perhaps the reason we didn’t, as assertively as I know we have and can pursue*

³⁸⁹ INQT0000065 2/10 – 14.

³⁹⁰ INQT0000063 34/1 – 7.

³⁹¹ NHFT0021261.

³⁹² WITN0058004.

³⁹³ INQT0000056 8/2 – 18.

³⁹⁴ Professor John Morgan, 20 April 2026 PM, 8/19 – 22.

³⁹⁵ NHSE0000015.

³⁹⁶ NHSE0000015_0016 [3.2.2].

³⁹⁷ INQT0000094 103/15 – 19.

³⁹⁸ Professor Sir Louis Appleby: WITN0069001_0003 [10].

³⁹⁹ NHFT0000460_0006.

⁴⁰⁰ INQT0000092 59/6.

*a patient, is because [...] he was working, and I think AO patients, often they have a lot of other issues such as homelessness, substance misuse, in and out of prison”.*⁴⁰¹

- 5.32 VC would in fact go on to become homeless in June 2023 (after his discharge from services and shortly before the attacks). During each of his admissions he explained that he was coming to the end of a tenancy: he was known to be using multiple addresses for reasons said to be linked to his illness. Indeed: at the time of discharge the EIP team did not in fact know if VC was homeless or in employment because they did not take adequate steps to find him and speak to him. The Inquiry will no doubt have serious concerns that despite all of the known risk factors VC had, the fact that he was considered to be housed and employed was seemingly sufficient to satisfy the EIP team that they did not need to pursue him assertively.
- 5.33 The Inquiry has heard considerable evidence about the care VC received under NHFT for over a two-year period. As stated by Dr Dissanyaka, *“it’s very difficult to separate violence risk management from good clinical care”*.⁴⁰² For VC, both were lacking. During that time, only one piece of substantive work was done with him in January 2021 to understand his risk, triggers, early warning signs, and relapse indicators. That document was two pages long and failed to reference any specific triggers for VC’s behaviour (such as a lack of medication concordance) or acknowledge that he had on multiple occasions become violent when unwell.⁴⁰³ This was not simply a lack of documentation; the EIP team simply did not have the discussions about safety and contingency planning for VC that were necessary.⁴⁰⁴ Robust discussions about behaviour were considered to be too *“triggering”* for VC⁴⁰⁵, despite the importance of having difficult conversations about violence and risk with an individual.⁴⁰⁶ Although information is required for risk management to map behaviour to know what the risks are when someone becomes unwell⁴⁰⁷, the available information about him was not considered, and his actions were never thought about with professional curiosity and a risk management approach.
- 5.34 Risk assessments were not updated or failed to include key information. The vulnerability of the move from inpatient to community settings was not recognised, recorded, or acted upon. The result was a siloing of knowledge between individuals. Key documents, such as VC’s texts and conversations with his brother, were not properly summarised or added to his records. Key information, such as VC disclosing a history of mental illness to ambulance workers, was not discovered. Key considerations, such as the longitudinal picture of VC’s presentation, went unmarked. Despite the fact that VC had remained under the care of NHFT until his premature discharge in September 2022, the evidence is awash with an entirely static approach to risk assessment. Dynamic factors were not captured.⁴⁰⁸ Incidents were not followed up. Agencies were not contacted. The evidence of NHFT witnesses acknowledged that VC’s risk assessments became a list of historical factors.⁴⁰⁹ Collectively, they considered a timeline of events, but failed

⁴⁰¹ INQT0000069 59/12 – 18. The incongruity of this over-simple position is highlighted in the confirmation that VC was working during the week in September 2021 when he attacked PC Pritchard and was detained thereafter: WITN0480001_0004-0005, [11].

⁴⁰² INQT0000051 60/16 – 20.

⁴⁰³ NHFT0000270.

⁴⁰⁴ INQT0000068 41/18 – 42/20.

⁴⁰⁵ NHFT0017933_001; NHFT0000168_0150.

⁴⁰⁶ INQT0000051 63/8 – 16.

⁴⁰⁷ INQT0000051 63/8 – 16.

⁴⁰⁸ INQT000054 97/ 15 – 20; INQT0000068 43/12 – 14.

⁴⁰⁹ INQT0000065 19/13 – 15.

to look into the future.⁴¹⁰ The past can sometimes be a good indicator of the future, but it appears that scant regard was paid to what that meant in practice.

- 5.35 VC had clear patterns: lack of medication concordance with accompanying violence and aggression. Time and time again reliance was placed on the information that VC was telling professionals, despite it being glaringly obvious that he was entirely capable of saying what he thought they wanted to hear to achieve the result he wanted. The requirement of professional curiosity, to look holistically at his patterns of behaviour and known risk factors, was lost. The result was that there were minimal consequences for his actions⁴¹¹ and VC was discharged from secondary mental health services in September 2022, unassessed, unmanaged and unsafe; contrary to a policy⁴¹² that staff did not have proper awareness of.⁴¹³ His word was too readily accepted when there was so much reason to doubt his veracity.
- 5.36 These were basic failures. Clinicians were regulated, whether by the GMC or NMC. They were bound by regulatory standards of professionalism and care. The Inquiry heard about the role of the CQC in inspections and in highlighting failures in risk assessment and care planning. Again, the conclusions in the Ritchie Report are apt: *“(i) An accurate record should be made of any incident of violence and the details should be included in the patient’s discharge summary. (ii) An assessment of the risk of dangerousness should be included in the discharge summary whenever the patient has acted with violence. (iii) Everyone who has contact in his professional or service work with mentally ill people who may pose a risk of violence should have training in the assessment of dangerousness and understand when to refer the patient for expert guidance.”*⁴¹⁴ The Inquiry heard that these jobs were often done by junior clinicians and by nurses whether in the Ward or in the Community. There was no question that changes to planning and assessment documents were required but not completed when changes ought to have been recorded and appropriate plans put in place. There was, we repeat, no referral for VC to forensic services. There was a complete breakdown in any continuity of care. Witnesses confirmed the significance of transitions between in-patient and Community care, which remained a point of tension and an opportunity to consolidate risk assessment and care planning documents.⁴¹⁵ The Inquiry may consider that the role played by lead consultants in VC’s care – whether each of the Responsible Clinicians during each of the admissions or Dr Lloyd in the Community - played an inappropriately perfunctory and superficial role.
- 5.37 **Discharge should never be a clinical choice made as a result of frustration as a matter of convenience or as a result of administrative pressure. Discharge (or transfer) summaries should be habitually authorised by the Responsible Clinician. They must include accurate information on any factors relevant to risk of violence (including early warning signs) and on known historic acts of violence not limited to acts of violence during the patient’s latest admission. There should be a required handover of care meeting between the two professionals before discharge occurs and the discharge summary should be endorsed by the receiving Consultant. Within a specified time of discharge a revised Care Plan and Risk Management Plan should be authorised by the lead Consultant with care in the**

⁴¹⁰ INQT0000069 7/1 – 19.

⁴¹¹ INQT0000082 33/8 – 9.

⁴¹² NHFT0004725.

⁴¹³ See, for example: INQT0000068 44/25 - 45/5.

⁴¹⁴ DHSC0000160_0130 [49.0.4].

⁴¹⁵ See, for example: INQT0000054 25/16-23; INQT0000069 38/15-19; Professor John Morgan: WITN0058001_0005 [26].

Community. This process should be formalised, whether in the revised MHA Code of Practice or changes to statute.

(c) Learning from the past; planning for the future

(i) The plan for community treatment

- 5.38 The future of the understanding, assessment and management of the risk to others must also be a focus of this Inquiry's Report. The 2025 NHS "*Fit for the Future 10 Year Health Plan*" sets out the plan for the transformation of mental health services into 24/7 neighbourhood care models with improvements to assertive outreach care and treatment.⁴¹⁶ That model is meant to be an enhanced version of the Community Mental Health Framework, premised on the idea that the service will be "*so attractive that people want to engage with it, so they are less likely to disengage*".⁴¹⁷ Yet the premise is troubling to the Bereaved Families: there is no identified revenue stream to fund these services; rather, the hope is that they will fund themselves.⁴¹⁸
- 5.39 There is also no specific commitment to Assertive Outreach Teams, with the decision on whether to implement them being left to local commissioners.⁴¹⁹ Dr James, giving evidence on behalf of NHS England, accepted that an Assertive Outreach Team may still be needed "*sitting above*" the neighbourhood model.⁴²⁰ That concession matters. The Inquiry should scrutinise what appears to be the epitome of '*wishful thinking*' in the current plans: that these centres will be effective for severely mentally unwell individuals simply because they are accessible or well publicised. It does not matter how much "good publicity" the centres receive, or how positively a Local Residents Association may regard them⁴²¹. If a person does not accept that they are mentally unwell, they will not walk through the door that is being held open for them; especially if they are care-avoidant like VC was.⁴²² Community Hubs may be compatible with Assertive Outreach Teams, but they cannot replace them.
- 5.40 It was precisely this recognition – that a specific cohort of patients requires a specific, assertive response - that led to the recommendations of the Clunis Inquiry and the establishment of Assertive Outreach Teams. We note in particular the specificity of the Clunis recommendations, which envisaged ring fencing and small caseloads consistent with the operation of the Assertive Outreach Model. The goal was as Jean Ritchie put it when describing her "*Special Supervision Group*": these patients are those "*who are difficult to care for, and need to be followed up intensively, with assertive and close supervision.*"⁴²³ This must sit alongside a recognition that this group must always be "*cared for by a specialist multi-disciplinary team who have a limited and protected case load.*"⁴²⁴ Her conclusion was based on the understanding that for Community care to work for this group then tailored provision for these patients was necessary: "*if the needs of that small group are not properly met, care in the community will be discredited.*"⁴²⁵ Every

⁴¹⁶ NHSE0000524_0035.

⁴¹⁷ INQT0000094_43/23 – 25.

⁴¹⁸ INQT0000094_45/24 – 46/6.

⁴¹⁹ INQT0000094_43/1 – 9; 50/18 – 23.

⁴²⁰ INQT0000094_44/12 – 18.

⁴²¹ INQT0000094_48/10 – 22.

⁴²² INQT0000051_118/11 – 25.

⁴²³ DHSC0000160_0127 [47.0.5].

⁴²⁴ DHSC0000160_0127 [47.0.5].

⁴²⁵ DHSC0000160_0126 [47.0.3].

lesson of VC's case – and every lesson which ought to have been learned long before the death of Barney, Grace and Ian – points to that result when difficult patients simply become too difficult and are left to their own devices. And it is precisely that understanding which appears to have been lost over time, and lost in the 2025 NHS 10 Year Plan. We urge this Inquiry, for the good of public safety, to make sure that is not the case.

5.41 Furthermore, the Bereaved Families are gravely concerned that if the Community Hubs do not even have funding, the prospect of properly resourced Assertive Outreach Teams sitting above them is even more uncertain. The risk is obvious: the lessons learned from this Inquiry may be diluted, dismantled, and forgotten once again.

5.42 **The Bereaved Families urge the Inquiry to recommend a clear central mandate from the Department of Health⁴²⁶ recognising true Assertive Outreach teams as essential.** They must not be optional. They must not be left to local discretion. They must be a priority approach for patients like VC, and they must be funded to succeed.

(ii) *The new era of the Mental Health Act*

5.43 Future risk management also requires careful scrutiny of the MHA 2025 and its revised Code of Practice. The Inquiry has heard evidence about the new detention criteria: the test is now whether “*serious harm may be caused*” to the health or safety of the patient or another person unless the patient receives medical treatment or is detained. There is also an express criterion of likelihood of harm.⁴²⁷ That represents a significant shift. It has generated serious concern about the interpretation of “*serious harm*”, the introduction of a causation test into the MHA, and uncertainty about what the likelihood criterion will mean in practice.⁴²⁸

5.44 The difficulty is not technical or semantic. It goes to the heart of decision-making under a risk-based Act. As the Chair recognised in questioning, causation “*is one of the most contested concepts in both civil and criminal law*”.⁴²⁹ Sir Simon Wessely accepted that the new statutory language was “*badly worded*”.⁴³⁰ If, as Sir Simon also accepted, “*everything is about risk*”⁴³¹, then the statutory test should clearly say that. The Royal College of Psychiatrists call for an amendment to the new statutory language expressing considerable concern that it will drive defensive rather than clinically reasoned practice.⁴³² **The Inquiry is invited to recommend that the statutory wording be amended to ask whether there is a “*risk of harm*” and to remove the requirement that clinicians conduct an analysis of the likelihood of harm. In the alternative, at a minimum the Act should necessarily be amended to ensure the threshold is: “*risk of serious harm*”.**

5.45 The Bereaved Families recognise, however, that legislative amendment may not be possible or achieved quickly. The Code of Practice will be fundamental to the operation of the new Act. It will shape clinical understanding, guide decision-making and influence how risk is assessed in

⁴²⁶ Where recommendations refer to the Department of Health, the Bereaved Families are conscious that NHS England may also have a role, before the body ceases to exist, consistent with current Government policy.

⁴²⁷ RLIT0000036_0010.

⁴²⁸ INQT0000103 54/1 - 55/4; WITN0320001_0067, [210]–[213].

⁴²⁹ INQT0000106 64/11-1.

⁴³⁰ INQT0000106 64/25 - 65/1.

⁴³¹ INQT0000106 64/21.

⁴³² WITN0320001_0066, [205] – [222]. The wording of the proposed amendments are at [220].

practice. The Code must therefore do three things with clarity: define “*serious harm*”; make clear that the consideration is one of risk, not proving causation; and, explain how likelihood is to be assessed in a way that supports, rather than inhibits, protective clinical action.

- 5.46 It is understood that work on the Code of Practice is taking place this year, with consultation anticipated in 2027. As Mr Ruck Keene KC put it, it is “*blindingly obviously important*” that the Code of Practice should not be finalised before the Inquiry has made its recommendations.⁴³³ **If there were any possibility this process would conclude before the Inquiry reports: the Chair is invited to consider interim recommendations on the Code of Practice before publication of its full final report, if necessary, so that those recommendations can be considered, reviewed and properly actioned.**
- 5.47 VC ought not to have been discharged: he should have been subject to a CTO. There is no question that the option to make CTOs must remain a central tool in the management of those who are seriously mentally ill and non-concordant. Professor Appleby told the Inquiry that in the whole history of collecting homicide data only three cases had ever involved persons on CTO.⁴³⁴ Research relied upon to denigrate CTOs fails adequately to consider the needs of those a CTO would most benefit.⁴³⁵ However, for a patient like VC who sought to avoid taking medication and sought to avoid detention: the use of a CTO may have proved a valuable clinical option in achieving concordance. The Inquiry heard powerful evidence from Dr Dissanyaka on use of CTO: “*We have looked at [CTO] use in our service, and as much as I’ve said negative things about hospital bed days, they are massively reduced by the use of Community Treatment Orders*”.⁴³⁶ However the value ought not to be limited to AOT patients. In a future which protects public health: the availability of a CTO ought not to be demonised as a restriction to be avoided but an important tool to be used when a patient is non-concordant to preserve the safety of the patient and others. Dr Dissanyaka said that the changes to the MHA 2025 concerned him. He agreed that there had not been sufficient consideration of risk to the public and his main area of concern was the impact on CTOs: both in respect of time limits and the new thresholds in the Act. He expressed particular concern over the requirement that “*likelihood of harm*” be assessed: “*That really concerns me, because risk is dynamic, so you can have somebody who is stable for quite a long time, but if you remove treatment then that can change very quickly*.”⁴³⁷
- 5.48 **As the triggers for detention should be revised before the MHA 2025 comes into force, the same amendment should be made in the threshold for CTOs. The critical trigger should be risk of harm.**
- 5.49 **The revision of the Code of Practice ought to approach the availability of a CTO constructively: with a view to explaining how they might best protect both the health of the patient and public safety.**
- 5.50 If the MHA 2025 is to manage risk safely, the Code must not entrench uncertainty. It must convert the lessons of this Inquiry into clear, practical instruction before the new regime takes effect. We return to the Code of Practice in Section H.

⁴³³ INQT0000053 7/15-22.

⁴³⁴ W ITN0069005, INQT0000101 59/12-13.

⁴³⁵ INQT0000101 36/18 - 41/22; INQT0000106 41/13 - 42/3.

⁴³⁶ INQT0000051 100/19 - 101/19.

⁴³⁷ INQT0000051 125/7 - 125/23.

E. WORKING TOGETHER

6 The story of the missed opportunities, missed flags and failures in VC's care shows enough was known about who he was and the risk he posed that he ought never to have been left unassessed, unmanaged, and unsafe between September 2022 and June 2023.

6.1 However, the timeline of VC's contacts between 2020 and 2023 is replete with moments when individuals and organisations working with VC ought to have shared what they knew about his growing risk; ought to have been more curious as to what others knew about him; and ought to have recognised when a multi-agency approach was critical. A few themes are easy to illustrate even by reference to a few examples of many:

(a) **Clinicians taking decisions about VC's care were acting without a full understanding of the nature and extent of VC's offending behaviour.** The most stark example of this may be that VC was discharged from the care of NHFT in ignorance of his being charged with the assault of PC Pritchard. The Trust were never told about the warrant issued for VC's arrest on 22 September 2022.⁴³⁸ There were others: Dr Ludvigsen said detail about the assault on 13 July and that VC was "kicking off" and had assaulted someone, requiring restraint, was not shared which would have changed the approach to risk assessment during VC's second admission.⁴³⁹ Dr Seedat failed to share Elias' journal: numerous later clinicians said they would have understood "*red rum*" as a reference to murder backwards. Clinicians were never made aware of Sebastian's allegations of assault and stalking, or VC's attendance at Thames House. A referral to forensic services was never made, meaning a specialist view on VC's risk and history of violence was never obtained.

(b) **Critical decisions about VC's offending behaviour were taken without a full appreciation of his mental health history and associated risks.** At one end of the spectrum, even the specialists in FTAC, for example, did not access VC's mental health history.⁴⁴⁰ Many examples are given above, of failure to check police systems including, for example, in connection with Sebastian's repeated reports of stalking behaviour.

(c) **VC was repeatedly discharged to a Community considered critical to his care without information sufficient to understand and manage any risk safely.** Taking only one of many examples, the Inquiry has heard VC was known to use multiple addresses and that this appeared to be an aspect of his illness, from the first admission. This was never identified as a red flag in his behaviour.⁴⁴¹

(d) **Where information was shared it was often inappropriately ignored or diminished even when shared by clinicians or professionals with close contact with VC.** The Community team's plea for the implementation of a Depot went unaddressed. Their concerns about managing VC within the community were not fully considered in his third and fourth

⁴³⁸ INQT0000074 54/7-8.

⁴³⁹ INQT0000059 62/1-24.

⁴⁴⁰ INQT0000011 4/13-21 and 7/7-15.

⁴⁴¹ "If they're saying they're away or are giving false addresses [...] those would be red flags with somebody who is very psychotic and disengaged, and we'd be looking to other people to confirm that and try and find the person" (INQT0000051 73/7 – 11).

admissions.⁴⁴² The Theemis Report rightly questioned “*why the culture appears to promote an individual in a specific role making the decisions even if this is at odds with the guidance and views of others involved in an individual’s care.*”⁴⁴³

6.2 Every piece of public learning since the Ritchie Report appreciates and understands the critical importance of multi-agency working in the management of risk for safeguarding purposes. Yet, time and again, the systems predicated on an understanding that multi-agency working is important, fail. Agencies and organisations retreat to silo working under pressure when all learning points to the need to share resources, expertise and experience. The Inquiry may consider that the failures in VC’s case are stark.

(a) The quality of record keeping throughout was poor. The importance of recording information for the quality of risk assessment and the quality of decision making is plain. Taking one extreme example: there is no note of the discussion concerning the decision to discharge VC in September 2022 because the MDT discussions at the EIP were not recorded.

(b) There were clear failures to share information even within organisations. For example: PC Gail Collins didn’t know about the details of the second attack on 24 May when she began her investigation as she believed data protection prevented her from considering it.⁴⁴⁴ The University team working on VC’s wellbeing failed to share what they knew with their academic staff.

(c) Patterns in VC’s behaviour which were patent would have been all the more stark if organisations were working together effectively. A critical example is found in the evidence of VC’s stalking behaviour and the emergence of fixated behaviour. In Spring and Summer 2022, the police ought to have seen a pattern of behaviour emerging in VC’s stalking of Sebastian. Yet, in late April 2022, at around the same time Sebastian reported VC’s stalking behaviour to the police, University of Nottingham Res X staff reported VC hanging around his previous home in a balaclava for hours.⁴⁴⁵ This had striking similarities to his unwanted return to Raleigh Park in February 2022.⁴⁴⁶ Although the University told the Trust about the incident, they also did not know about Sebastian. When VC was challenged about his return in April 2022, he said he was picking up his mail.⁴⁴⁷ The lost opportunity to learn from this pattern of behaviour is all the more stark in the light of what is now known about VC’s online activity in 2022 and that he was carrying the names of Christopher and his other flatmates in his backpack when arrested on 13 June 2023.

(d) Individuals and organisations did not act even when there were known problems with information sharing and known risks in the management of VC’s information. The Theemis Report highlighted particular problems in the co-ordination of data when patients are placed with private contractors: “*The current system capability does not allow for the timely sharing of important clinical information between the Trust and independent providers who are placing the Trust’s patients in their services*”.⁴⁴⁸ The Inquiry heard evidence that

⁴⁴² NHNB0018966_0152, 154 and 158.

⁴⁴³ NHNB0018966_0016.

⁴⁴⁴ WITN0036001_0007 [23].

⁴⁴⁵ UNIN0002328_00010 (21 April 2022).

⁴⁴⁶ UNIN0000734_0013; NHFT0000168_0227.

⁴⁴⁷ UNIN0000633_0003.

⁴⁴⁸ NHNB0018966_0029.

the Trust and its providers knew that their systems did not speak to each other. They knew that their records for VC would remain in silo without steps being taken to ensure coherence.⁴⁴⁹

- 6.3 Over three decades ago, the Ritchie Report said resolving the tension between concern for confidentiality and the protection of patient and public safety was “urgent”.⁴⁵⁰ Despite repeated efforts, the problem of individuals and organisations pointing to “data protection” as a barrier to collaboration and resorting to patient privacy as a justification for inaction remains. The evidence of Mr Ruck Keene KC and other witnesses confirm the issue is not in the law but in encouraging confidence in its application.⁴⁵¹ This reflects the evidence of Mr Majid for NHFT: “*In the Trust's experience, some external bodies and clinical staff are sometimes too risk adverse to sharing information for fear of breaching a patient's confidentiality*”.⁴⁵² The need for greater clarity and consistency in the power to share information in the interests of public safety runs through the Inquiry’s evidence. The Inquiry may take some comfort in the evidence of Dr Dissanyaka who talked about the approach to information sharing in the support of AOT patients: “*Wherever we can get the information from, we'll seek it out*”.⁴⁵³ However, he too said that there was now more bureaucracy in the system than there had been historically and people are more conscious of sharing information and prejudice to ongoing investigations.⁴⁵⁴ He accepted the sense of a specific scheme or form of multi-agency working format directed to adults who pose a risk of violence to the public but ultimately said: “*just better systems generally of information sharing would be a better way forward*”.⁴⁵⁵
- 6.4 The Inquiry heard that there were Protocols in place which ought to have governed how information was shared between each of the organisations involved in VC’s care. This included Protocols for information sharing with the University.⁴⁵⁶ There was evidence these Protocols were being actively revised or had been replaced during, or as a result of, this Inquiry. The Inquiry might conclude that without something more, VC’s experience proves that the existence of a Protocol alone cannot ensure that public safety will be properly considered in the assessment as to whether information ought to be shared.
- 6.5 The Inquiry may consider the approach in the existing MHA Code of Practice does not help.⁴⁵⁷ Chapter 10 “Confidentiality and information sharing” starts with the obscure instruction “*The law on confidentiality is the same for patients subject to the Act as it is for any other patients, except where the Act says otherwise. Under the Act, there are some situations where confidential information about a patient is legally authorised to be disclosed, even if the patient does not consent*”.⁴⁵⁸ The guidance offered on sharing information to manage risk (10.15 – 10.17) is extremely brief.⁴⁵⁹ It provides no positive encouragement that sharing information may not only

⁴⁴⁹ See, for example, INQT0000078 7/18 - 9/4 and 10/1-19.

⁴⁵⁰ DHSC0000160_0129 [48.0.2].

⁴⁵¹ See, for example: WITN0288001_0064 [142]: “*As has been repeatedly expressed in a number of public inquiries over the years, the law relating to confidentiality in this area is not intended to get in the way of appropriate information sharing*”; Mr Ruck Keene KC (Hon), 16 April 2026 AM, 82/4-14.

⁴⁵² WITN0263001_0133 [563.b].

⁴⁵³ INQT0000051 54/22-23.

⁴⁵⁴ INQT0000051 55/3-6.

⁴⁵⁵ INQT0000051 56/2-12.

⁴⁵⁶ UNIN0001829.

⁴⁵⁷ NHSE0000312.

⁴⁵⁸ NHSE0000312_0078 [10.2].

⁴⁵⁹ NHSE0000312_0081.

be lawful but necessary: “Where the issue is management of the risk of serious harm, the judgement required is normally a balance between the public interest in disclosure, including the need to prevent harm in others, and both the rights of the individual concerned and the public interest in maintaining trust in a confidential service.”⁴⁶⁰ This provides no help on what “serious harm” may be. It does suggest that even where faced by a risk of serious harm, there are considerable barriers to disclosure. The Code then points to specific guidance on information sharing and suicide, providing no such specific help on risk to third parties or to public safety.⁴⁶¹ Recalling again that Mr Ruck Keene KC invited the Inquiry to consider the difference between legal literacy and legal confidence:⁴⁶² the Code currently does little to assist. Again, the Bereaved Families consider there is a pressing need for amendment to the MHA Code of Practice which places a greater focus on circumstances where information sharing is not only permitted but necessary.

- 6.6 The Inquiry heard evidence on the GMC’s good practice guide on handling patient information⁴⁶³ which was described as more helpful.⁴⁶⁴ However, even in that case, where in cases of uncertainty clinicians are pointed to their Caldicott Guardian, there is a risk that uncertainty and a reminder of the importance of confidentiality might together lead professionals to take an overcautious approach (“Well, if in doubt, don’t”⁴⁶⁵). This was not helpful.⁴⁶⁶
- 6.7 **The new revised MHA Code of Practice must be drafted with a view to creating greater confidence in the requirement to share information in the interests of public safety. Guidance must include a clear statement on the positive responsibility for information sharing and must incorporate worked examples and case studies designed to increase confidence. NHS England or the Department of Health should be invited to produce specific guidance on information sharing and public safety, working with the ICO, the NPCC, the GMC, the NMC, the Royal College of Psychiatrists and other relevant stakeholders.**
- 6.8 **Compulsory training must follow the introduction of the Code of Practice. The Inquiry is invited to recommend regular refresher training on information sharing consistent with the DPA and other legal obligations. This should have a practical focus.**
- 6.9 The Inquiry is encouraged by both NGPF (in the evidence of T/DCC Rob Griffin) and the College of Policing to make recommendations to encourage engagement with formal structures for multiagency working.⁴⁶⁷ However, this is not the first time that the need for close coordination between police and local Trusts on mental health has been explored. For example, the Mental Health Crisis Care Concordat was signed as long ago as February 2014: “We commit to work together to improve the system of care and support are kept safe and helped to find the support they need – whatever the circumstances in which they first need help – and from whichever service they turn to first.”⁴⁶⁸ Thresholds and eligibility for referral are set high for both MAPPA

⁴⁶⁰ NHSE0000312_0081 [10.16].

⁴⁶¹ NHSE0000312_0082 (‘Related Material’).

⁴⁶² INQT0000053 82/4-14.

⁴⁶³ WITN0356077.

⁴⁶⁴ INQT0000053 83/11-21 and 85/19-21.

⁴⁶⁵ INQT0000053 86/24.

⁴⁶⁶ INQT0000053 85/10 - 87/3.

⁴⁶⁷ WITN0074001_0389 [1686] – [1689]; WITN0349001_0023 [79] - [82]

⁴⁶⁸ HOMF0000013

and for many potentially dangerous person (“PDP”) pathways.⁴⁶⁹ PDP pathways are established on a local basis with the police as lead agency, but we note that an example given of the triggers for PDP offered by APP (as last amended in March 2026) suggests the threshold may generally remain high: *“where a community psychiatric nurse (CPN) or other mental health worker shares information with the police that a patient with mental ill health has disclosed fantasies about committing serious violent offences. The patient is not cooperating with the current treatment plan, and the informant believes serious violent behaviour is imminent.”*⁴⁷⁰

- 6.10 There had been a PDP process in Nottingham. There is no evidence it had ever been considered for VC. It had seemingly become dormant: partners were unaware of it and it may as well not exist.⁴⁷¹ The Inquiry heard that NGPF and NHFT are now focused on the development of a Potentially Dangerous Persons Panel and a Dangerous Persons Policy. It is proposed that within the Trust it is intended to call this pathway the “Mental Health High Risk Oversight Panel”. Mr Majid, for NHFT, underlined that this is because *“the negative connotations of identifying a person as potentially dangerous could be stigmatising”*.⁴⁷² The Bereaved Families are concerned that, regardless of the label, a process which is intended to recognise that some people may pose a risk to others’ safety, ought not to be deterred from its task for fear of stigma.
- 6.11 However, even beyond any formal structure for multiagency working, management of the risk to public safety when dealing with a person known to have a history of mental ill health and to pose a risk to others requires an acknowledgment that the sharing of information and joint working is not only to be justified in the face of concerns over patient privacy but necessary. It requires organisations to view the management of public safety as a joint responsibility. Too often in VC’s care, there was a claim that others, especially the police, simply would not act if asked.⁴⁷³ The Inquiry will take a view on whether those explanations were credible in circumstances where efforts were simply not made to try to contact others or to proactively seek information relevant to risk. The fact that VC was discharged from care in circumstances where Gary Carter made no contact with the police is testament to how dangerous this kind of attitude may be. A change of culture is essential to engender trust and a commitment to shared responsibility.
- 6.12 Policing bodies point to “Right Care, Right Person” (“RCRP”) and urge the Inquiry to ensure that the police are not treated as *“the default agency for providing access to mental health services, particularly when a patient is already under the care of health professionals.”*⁴⁷⁴ It is clear RCRP would have had no role to play in the policing response to VC: his violent offending behaviour required a police response. The Inquiry may question whether the high-profile focus on RCRP and continued police push-back on engagement in response to mental health crisis may undermine any efforts towards true multiagency working when shared responsibility is key. The citation of RCRP by Coroners in multiple, repeated Preventing Future Deaths reports must be a

⁴⁶⁹ Section 325 to 327B of RLIT0000132 established multi-agency public protection arrangements (MAPPA) in each of the 42 criminal justice areas of England and Wales. These arrangements are designed to protect the public, including victims of crime, from serious harm by sexual or violent and other dangerous offenders.

⁴⁷⁰ INQY0000027_0001.

⁴⁷¹ INQT0000088 83/6 – 83/17.

⁴⁷² WITN0263001_0131-32 [559].

⁴⁷³ Dr Seedat was one of many clinical witnesses who said it had been difficult to obtain information from the police: INQT0000062 27/11-29/20. Dr Lloyd was another who said that the police had historically not provided help and this influenced her decision to stop asking: INQT0000074 53/16 - 54/1. Dr Dissanyaka reflected that the evidence from Sir Andrew Marsh about Right Care Right Person was *“not the reality on the ground”*; *“when we make the calls and we ask for police assistance, ‘It’s a mental health issue, it’s not to do with us’”*: INQT0000052 103/15-23.

⁴⁷⁴ WITN0074001_0391 at [1694].

reason for considerable caution and concern. Sir Adrian Fulford, in the Southport Inquiry has already expressed a need for caution: “RCRP is a policy which if not carefully and properly implemented, risks police failing to attend incidents which they ought to attend.” And “RCRP, that it is an approach which requires high levels of care in design and policy drafting, thorough and effective training, and a high degree of supervision if it is to be relied upon.”⁴⁷⁵ Any framework for multi-agency working must not accept RCRP as a default without critical consideration, especially where the existing models for formal multi-agency working (MAPPA, PDP) may operate with the police as the lead agency by default.

- 6.13 **There must be a clear formal structure or pathway to require and facilitate true multi-agency working where mentally ill adults are known to pose a risk to others. Whether by amendment to MAPPA; the formalisation of a requirement for all policing areas to adopt and implement effective potentially dangerous persons protocols or a new statutory provision: there should be a clear national expectation that where a person with a serious mental illness and a known history of violence (or evidence of risk of violence to others in their risk management plan) becomes non-concordant with treatment then the management of risk to public safety will draw on the expertise of all agencies and organisations who have information and resources relevant to that risk. The threshold or trigger to access this framework should not be limited to circumstances where the risk to others is considered “imminent” or “immediate”.**
- 6.14 There is long standing multi-agency, cross-Government guidance on safeguarding children which brings together agencies and organisations invested in keeping children safe: *Working Together to Safeguard Children*.⁴⁷⁶ While owned by the Department of Education, this comprises statutory guidance spanning local authorities, police, health services, schools and many others. While the MHA Code of Practice highlights previous Department of Health guidance on information sharing and multi-agency working on suicide risk, we have seen no near equivalent on the safeguarding risks involved in adult mental health services. The revision to the MHA Code of Practice must be undertaken with sufficient care to inform the actions of all organisations and individuals involved in the multi-disciplinary care of patients whether on an in-patient or a community basis. It may be that the scope of the Code of Practice (by reference to the MHA) is insufficiently broad to bear the weight of all that is necessary for the provision of guidance relevant to aspects of community care critical to the management of risk. The Inquiry may wish to recommend there is free-standing guidance capable of being read and implemented by the range of agencies, organisations and individuals who may be involved in managing the risk to public safety posed by patients experiencing serious mental illness and posing a risk of violence to others.
- 6.15 **There should be new clear cross-Government guidance designed to foster confidence in information sharing and to promote effective multi-agency working in the care, treatment and risk-management of people who are seriously mentally ill and who pose a risk to others. This should include guidance on working with all stakeholders in a patient’s life, including employers, Universities and other educational organisations and services and it should**

⁴⁷⁵ RLIT0000113. See also INQT0000050 92/2-25.

⁴⁷⁶ This is a document not without criticism. We note that Sir Adrian Fulford has included failures to work together, including failures in information sharing and multiagency working in the Southport Inquiry. He calls for a single multi-agency body to deal with children who present a high risk of serious harm and a single multi-agency risk assessment tool. See RLIT0000114.

specifically confront risk to public safety including the risk of serious violence and fatal injury.

F. ALL REASONABLE LINES OF INQUIRY?

7 VC was arrested hours before the Bereaved Families knew about the fate of their loved ones. As they grappled for information, the investigation under the Senior Investigating Officer (“SIO”) Leigh Sanders and the Gold Command, T/DCC Rob Griffin began. After the critical 91 minutes passed and the cuffs were on: VC spent five days in police custody. Those were important hours and days which set the tenor for the events which followed.

7.1 The investigation was obliged to: “*identify and follow all reasonable lines of enquiry to gather all reasonably available material and ... investigate towards and away from the suspect*”.⁴⁷⁷ They were required to do so in the glare of national press interest. From Gold to the Officers on the now notorious Section WhatsApp group, it was known on 13 June that VC had been wanted on a warrant which NGPF had failed to execute.⁴⁷⁸

7.2 The Bereaved Families have been concerned since October 2023 to understand whether all reasonable lines of inquiry critical to the criminal prosecution of VC for murder were pursued effectively. They remain concerned at the conclusion of this Inquiry that there were serious gaps in the investigation. They believe and regret that from the critical first days following 13 June until the start of this Inquiry, they were treated as a problem to be managed and concerns they raised with both the police and the CPS were dismissed without due consideration and care.

(a) Fitness, Mental Health and the role of Forensic Psychiatry

7.3 At the heart of this Inquiry is the assessment that on 13 June 2023 VC was so mentally unwell that his ability to form a rational judgment and to exercise self-control was substantially impaired. Yet, between 13 June 2023 and 17 June 2023, VC was deemed fit for detention and, from 16:00 on 13 June, fit for interview. He was interviewed six times. He was deemed to have the capacity to refuse to give bodily samples. On 17 June 2023 he was remanded to a prison as opposed to a high secure hospital unit. It would be over four months before VC was transferred to Ashworth, on 1 November 2023.⁴⁷⁹

7.4 It is a difficult circle to square. The Bereaved Families are left with enduring concern that a retrospectively-created picture of VC’s mental health has determined the course of justice for Barney, Grace and Ian.

7.5 There were at least some concerns over VC’s mental health history on 13 June 2023. Despite an early offer to help extended to the NHFT Liaison & Diversion (“L&D”) team by Dr Taylor, the Associate Medical Director in the NHFT Forensic Services Care Group,⁴⁸⁰ and the swift retention of Professor Blackwood by the CPS, there was no proactive consideration by the police or CPS of a contemporary assessment by a consultant forensic psychiatrist. Consistent with current general custodial practice: the only assessments relating to VC’s capacity, fitness for detention,

⁴⁷⁷ RLIT0000131.

⁴⁷⁸ IOPC Referral, NGPF0011132_0001. WITN0074001_0049 (T/DCC Griffin) at [217].

⁴⁷⁹ Report by Dr Mirvis, CPSE0000484_0004.

⁴⁸⁰ WITN0388013_0001.

and fitness for interview were conducted by contracted nurses acting as custody Healthcare Professionals (“HCP”). They did not have expertise in mental health. Dr Taylor requested that the case be passed to an experienced practitioner,⁴⁸¹ but Mitie did not have a forensic psychiatrist or doctor on their books.⁴⁸² Louisa Hagan, for L&D, ultimately reported “*no issues re: fitness etc rumbling after yesterday*”.⁴⁸³

7.6 In practice, L&D are treated by NGPF custody sergeants as the mental health experts.⁴⁸⁴ L&D offer a triage process conducted by unregistered support workers, who may escalate any concerns to a mental health nurse or social worker for assessment.⁴⁸⁵ The Inquiry heard: (a) no consultant forensic psychiatrist works in L&D; (b) it is not within L&D’s service specifications to conduct mental health assessments;⁴⁸⁶ and (c) consent of the detained person was critical.⁴⁸⁷ As soon as VC refused his consent, the referral was closed,⁴⁸⁸ any question as to his capacity going unchallenged.

7.7 This situation is unsatisfactory both for the quality of evidence as to presentation proximate to any serious offence, and for the effective assessment of healthcare needs for detainees in custody. A detailed mental state examination by psychiatrists would only have been available if there had been an assessment for admission under the MHA.⁴⁸⁹ Thus the custody log records, “*L&D Service Manager - Louisa Hagan [...] called back and advised that the Trust stance is that he [VC] will not be admitted to a psychiatric unit, therefore there no need for a Mental Health Act assessment to be requested*”.⁴⁹⁰ Modern forensic services offered in custody simply do not cater for those held on suspicion of very serious crime with complex mental health issues, and where such status may become critical in the determination of charges against them. In Opening, the Bereaved Families underlined the view of Dr Latham:

*“There is a legitimate question about the extent to which it is possible to ‘reconstruct’ someone’s mental state when considering diminished responsibility (or insanity). However, given the law, it is inevitable that psychiatric expert evidence will need to engage with this need for reconstruction.”*⁴⁹¹

7.8 Dr Latham’s view is that “*Ideally, a psychiatric assessment would be carried out as soon as possible after someone is arrested.*”⁴⁹² Dr Kumar,⁴⁹³ Dr Taylor⁴⁹⁴ and Professor Blackwood,⁴⁹⁵ were among those who identified access in custody as an area where forensic practice has deteriorated over the past three decades. Previously, an on-call psychiatric consultant or a higher trainee, whether in general or forensic psychiatry, would have been called to assess that individual in police custody.⁴⁹⁶ Professor Blackwood said that “*an extra layer of scrutiny by an experienced*

⁴⁸¹ WITN0388013_0001.

⁴⁸² INQT0000078 68/11-13.

⁴⁸³ WITN0388016_0001.

⁴⁸⁴ “*..the way that it operates in custody is that if Liaison and Diversion are on duty, they are the mental health experts, as opposed to Mitie who are the clinical experts*” per INQT0000029 19/4-14.

⁴⁸⁵ INQT0000029 31/12 – 32/2.

⁴⁸⁶ INQT0000029 29/10-15.

⁴⁸⁷ WITN0346001_0002 (Louisa Hagan).

⁴⁸⁸ INQT0000029 43/23.

⁴⁸⁹ INQT0000043 2/4-7.

⁴⁹⁰ NGPF0002195_0075, Custody record entry 13/6/2023 17:37.

⁴⁹¹ Richard Latham, at [14] WITN0126001_0004.

⁴⁹² WITN0126001_0004 at [9] (Richard Latham).

⁴⁹³ INQT0000040 19/23-20/14.

⁴⁹⁴ INQT0000078 64/3-13.

⁴⁹⁵ WITN0308001_0018 (Nigel Blackwood).

⁴⁹⁶ WITN0308001_0018 (Nigel Blackwood).

*psychiatrist would be helpful*⁴⁹⁷ as it would provide “*a recognised baseline from the police station that may be a little bit more developed or detailed than what was available here from healthcare professionals*”.⁴⁹⁸ He explained that delay meant “*the possibility that long periods of seclusion, for example, with little access to the outside world may exacerbate an individual's psychosis*.”⁴⁹⁹ This is a possibility with which these Bereaved Families continue to struggle. They have repeatedly heard that VC was intelligent and had the capacity to mask symptoms and manipulate services including by lying. In police custody VC had been able to engage calmly with his solicitor in conferences and was able to distinguish between evidential and non-evidential questions in interview. His solicitor had not suggested he was unfit for interview. VC's appropriate adult had not suggested he was unfit for interview. It was some weeks down the line when his prison records suggest more symptoms in the disorganisation domain.⁵⁰⁰ Had VC been assessed by a forensic psychiatrist trained to recognise masking, the families could have known whether or not that applied in his case in those crucial days following the 13 June 2023.

- 7.9 **In cases of alleged homicide where complex mental health presentation may be in issue such that fitness to plead, insanity or diminished responsibility may form part of the defence, an assessment by a suitably qualified, consultant forensic psychiatrist should be obtained as proximate in time to the alleged offence as possible, and, ideally, while in police custody. Where consent is withheld whether for examination or access to medical records: a contemporary assessment of capacity should be recorded by a suitably qualified, consultant forensic psychiatrist.**

(b) Toxicology, homicide and mental health

- 7.10 From the moment that VC was remanded in custody, the clock was ticking to secure key evidence. The most obvious step was testing for illicit drugs. As Dr Sanjoy Kumar so powerfully said, “*They took samples from our children to test for drugs... and alcohol... our children were tested, but the culprit wasn't*”.⁵⁰¹
- 7.11 To establish or discount recent drug use in VC in the run up to the attacks on 13 June 2023 a blood or urine sample was needed.⁵⁰² This would have enabled the detection of any drugs and metabolites used within the previous 24 or 48 hours.⁵⁰³ VC had been arrested shortly after the attacks; the window for such testing was still open. And even once that window closed, hair sampling may still have provided historical information about drug use in the preceding weeks,⁵⁰⁴ which would have been relevant to the issue of culpability. VC refused consent to blood testing; there was no further strategy for testing VC.⁵⁰⁵ As toxicology was not in the police strategy, VC was never asked to consent to the giving of urine.

⁴⁹⁷ INQT0000043 24/25 – 25/1.

⁴⁹⁸ INQT0000043 23/21-24.

⁴⁹⁹ INQT0000043 4/23-25.

⁵⁰⁰ INQT0000043 19/5-9.

⁵⁰¹ INQT0000040 24/6-12.

⁵⁰² Expert Report Kim Wolff WITN0394002_0017.

⁵⁰³ Expert Report Kim Wolff WITN0394002_0015.

⁵⁰⁴ Expert Report Kim Wolff WITN0394002_0009.

⁵⁰⁵ SUBS0000010, Bereaved Families Opening Submissions, [133] – [138].

- 7.12 VC was asked if he had ever taken “*street drugs*”. The question was plainly known to be relevant. VC’s ‘no comment’ did not prompt a change in strategy.⁵⁰⁶ Nor did the discovery that VC had been associating with Bil Monteiro in relation to whom there was significant relevant police intelligence;⁵⁰⁷ nor indeed the fact that Bil Monteiro was associated with 27 Mapperley Road⁵⁰⁸ which was geographically close to Seely Hirst House. There was no consideration that his only previous response in police interview to a similar question had been ambiguous (“*not really*”).⁵⁰⁹
- 7.13 Professor Blackwood indicated that from an early stage he would expect to see toxicology⁵¹⁰; he never did. That the consideration of toxicology results is standard fare for psychiatrists, renders the police failure all the more obvious. Even if VC had not taken drugs on that day, previous recreational drug use is relevant to the culpability of a mentally ill offender and thus relevant to the ultimate disposal of the case.
- 7.14 When VC did not consent to give a blood sample requested by the police for the purposes of proving/disproving his physical involvement in the attacks,⁵¹¹ the police failed to warn him that there may be adverse inferences drawn from his refusal.
- 7.15 Former Det. Supt. Sanders view remains that, had testing taken place, that this would likely have shown that VC did not take illicit drugs.⁵¹² Granted, it *may* have been that a test would have been negative, but the Inquiry can never know. As Professor Blackwood said: “*There ... will always be residual uncertainty about the extent of his substance use .. there is no testing in the police station, no testing at remand and into imprisonment, and then there is testing when he comes to Ashworth which is all negative many months later.*”⁵¹³
- 7.16 What the Inquiry can know, is that in a case as serious as this, and where mental health was in question, it was a reasonable line of enquiry which clearly should have been followed while he was in police custody.
- 7.17 **Testing for toxicology should form part of the forensic strategy as a default in all homicide investigations; especially where the suspect has a history of mental illness known to the police. As a default, where consent is refused for samples, a record should be taken that capacity has been considered and if in doubt, assessed. The seriousness of the offence and the potential significance of drug use to any mental health defence and culpability renders that this should be a matter of common sense.**
- 7.18 The Inquiry heard evidence of occasions when VC was understood to have refused consent while detained: over access to his medical records, over engagement with L&D, and over providing a blood sample. This is an issue which arises throughout the evidence on VC’s care: in relation to

⁵⁰⁶ Police Interview of VC 15 June 2023 NGPF0008803_0014.

⁵⁰⁷ NGPF0001671_0002.

⁵⁰⁸ NGPF0001671_0010.

⁵⁰⁹ Police Interview of VC 24 June 2020 NGPF0000070_0006.

⁵¹⁰ CPSE0000789_0002: In an email from Professor Blackwood to Alan Murphy on 26 June 2023 in response to what documentation he would need to see in order to prepare his report he replied, “*All the usual stuff in due course but nothing urgent! ... Toxicology etc*”.

⁵¹¹ At 15:50 on 13 June 2023 Insp 717 Boylin authorised the taking of an intimate sample, namely blood. See Custody Record, NGPF0002195_0073 the grounds were that “the detainee may have left blood at the scene, and the blood sample would tend to confirm or disprove alleged involvement”, as opposed to toxicology assessment.

⁵¹² WITN0359001_0109, [327] (Leigh Sanders).

⁵¹³ INQT0000043 12/16 - 13/2.

his choice to refuse treatment or medication. Mr Ruck Keene KC was unaware of any specific guidance issued by the Royal College of Psychiatrists as to when there will be “*good reason for concern*” or “*legitimate doubt*” as to capacity to make a decision.⁵¹⁴ In circumstances where there was reason to doubt whether VC had capacity to withhold his consent, clarity was important. In circumstances where a refusal might impact upon both the effective administration of justice and also on the credibility of any defences which might be open to him, clarity on capacity might be considered all the more significant.

- 7.19 **The Inquiry is invited to recommend that the Home Office and the Department of Health (working with the Royal College of Psychiatrists together with the College of Policing, the NPCC and NHS England) produce practical guidance specific to decisions on capacity of persons detained in police custody or pursuant to the MHA; including specific guidance on (a) when there may be reason to doubt a person has capacity sufficient to displace the presumption in s1(2) Mental Capacity Act 2005 (“MCA”); and (b) what steps should be taken to assess whether a person has capacity or decisions must be taken pursuant to the MCA. Clarity in respect of the distinction between capacity and the tests to be considered when considering the elements of any offence; the practical relationship between the MCA and the MHA, particularly when a person is suspected of being a danger to others and/or suspected of having committed a violent criminal offence, is a matter which the Department of Health should expressly be invited to consider in the anticipated consultation on amendments to the MHA Code of Practice.**

(iii) *Candour and institutional defensiveness*

- 7.20 The police were so concerned over publicity surrounding the extant arrest warrant that they rushed to charge VC without CPS authority. The Inquiry can contrast former Det Supt Sanders’ explanation⁵¹⁵ with the contemporaneous record made in his notes⁵¹⁶ and by Samantha Shallow.⁵¹⁷ The CPS record is clear: “*the issue is that they have been contacted by the press who want to run an inaccurate story on the warrant case. Over-stating the position in terms of the level of charge, age, etc.*”⁵¹⁸ Ms Shallow said this reflected that the inaccuracy was linked to the type of offence on the warrant and how long it had been outstanding⁵¹⁹. The reason for the premature charge was obvious. “*Gold said would we be in a position to charge in as much that if it became sub judice, then quite clearly there could be no damage to the investigation.*”⁵²⁰ The Inquiry will consider former Det Supt Sanders’ contemporary Policy Decision 53 which made clear the reason for the rush was protection of the reputation of the force: “*Communication from COT that press were going to run in the media a fake / embellished news report that would cause serious reputational damage to the organisation, undermine public confidence in local policing and cause unnecessary suffering to families. The case however would be sub-judice should VC be charged*”.⁵²¹ It appears that Senior Officers at NGPF hoped to clamp down on publications

⁵¹⁴ Expert Report from Alex Ruck Keene KC (Hon), WITN0288001_033

⁵¹⁵ INQT0000030 72/1-6 and INQT0000031 39/10 - 40/11.

⁵¹⁶ Policy Decision 53: NGPF0003863 [Excel File, line 55].

⁵¹⁷ CPSE0000600

⁵¹⁸ CPSE0000600

⁵¹⁹ INQT0000047 6/14-19.

⁵²⁰ INQT0000030 72/8-11.

⁵²¹ NGPF0003863 [Excel File, line 55]. See also INQT0000031 39/10 - 40/11.

by way of contempt considerations and that this concern was prompted if not entirely, at least in part, by a desire to avoid negative reporting on their embarrassing failure to execute the warrant.

7.21 The Inquiry may consider this defensiveness is replete in the approach taken by NGPF throughout the prosecution of VC: from the first press messages lauding their “*call to cuffs*” response, through to the decision by the Chief Constable to call a wholly inappropriate behind-closed-doors briefing for the press to respond to criticism by some of the Bereaved Families,⁵²² and beyond. Briefly, that defensive attitude is manifest in, amongst others, the following few examples:

- (a) “*He had not been arrested*”: T/DCC Griffin told the Inquiry that he realised in January 2024 that the Bereaved Families may not have been told all they should about the circumstances of VC’s prior contact with VC⁵²³. He confirmed that Det Supt Sanders had failed to explain the warrant “*in a way that I would have wanted him to*”.⁵²⁴ When questioned he reluctantly accepted that when information was passed to Emma Webber in response to her questions in January 2024, it was completely absent of any explanation as to why VC had not been arrested. Rather than provide an explanation as to what had happened between September 2022 and June 2023, the language approved by Det Supt Sanders and communicated by DC Gemma Piggott said only: “*At the time of these offences (June 2023) he had not been arrested.*”⁵²⁵
- (b) “*Nomadic lifestyle*”: T/DCC Griffin confirmed that a reference to VC having had a “*nomadic*” lifestyle was removed from the draft press release prepared for NGPF to release on VC’s sentencing before its issue. This was plainly inaccurate and designed to diminish the failure to act on the warrant. There was evidence this language may have come from Det Supt Sanders.⁵²⁶
- (c) Det Supt Sanders presided over repeated failure to inform the families of the misconduct issues arising in the context of this investigation. This becomes all the more serious when the second Witness Statement of former Det Supt Hayley Williams is considered. Both she and other Senior Officers were aware and concerned that Det Supt Sanders had previously been directed to notify another Bereaved Family of misconduct concerning misuse of WhatsApp, and had failed to do so. He may, on that occasion, have failed to act on a direct order of the Chief Constable.⁵²⁷
- (d) Former Chief Constable Kate Meynell accepted that she did not tell the Bereaved Families she had called the non-reportable press briefing on 22 February 2024. She should have done⁵²⁸. That briefing purported to be candid and to provide “*a little bit of context*”⁵²⁹. Instead, the Inquiry may conclude it was replete with empty assurances and errors designed

⁵²² NGPF0011160

⁵²³ INQT0000036 57/9-17.

⁵²⁴ INQT0000036 63/14-15.

⁵²⁵ NGPF0002572

⁵²⁶ INQT0000036 58/24.

⁵²⁷ NGPF0010695, WITN0417002_0013 (Hayley Williams), concerning Operation Magpie. Including, that on another similar matter: “*CC Meynell agreed and essentially ordered T/DSU Sanders to explain his decision making to the child’s mother. He replied that he couldn’t remember why he made that decision and would have to get access to his policy books in PSD to understand it before making contact. Arrangements were made for him to do this. To date, I am not aware that he carried out CC Meynell’s instruction to contact the family.*”

⁵²⁸ INQT0000034 94/3-6.

⁵²⁹ NGPF0011160_0001.

to paint NGPF in a more flattering light and VC's history of contact with NGPF was massaged. For example, the attack by VC on Sebastian became a "*tussle*".⁵³⁰ Despite the promise of candour, she went into that briefing unable to answer the obvious question. When asked for more details for what NGPF had done on the warrant, the Chief Constable replied: "*I haven't got that information to hand ... wouldn't be able to give you that, effectively.*"⁵³¹ The answer was that nothing had been done. Far from candour, the Inquiry may consider this exercise belies the institutional self-interest that appears to have been patent since VC was arrested on the morning of 13 June 2023.

(iv) Respect, dignity and support for Bereaved Families and Survivors

- 7.22 Against this background of defensiveness, spin and distrust: the Inquiry heard moving and powerful evidence of the impact on each of the Bereaved Families. They remain deeply concerned that their interaction with Nottingham police was tainted by implicit concern for reputation management and the avoidance of embarrassment for the force.
- 7.23 Elaine Newton told the Inquiry had she known what she does now she would not have written letters to the Chief Constable expressing her thanks for the work of the police. Ms Newton feels let down that she accepted the assurances and authority of the Chief Constable and others when her Trust was not warranted. Although she expressed anger and disappointment at all involved, she said: "*I think the police have let the public and myself and all the other families down.*"⁵³²
- 7.24 The Bereaved Families have often felt patronised, managed and treated with suspicion and defensiveness at times which were critical to their understanding of the case against VC and the decisions being taken. This has extended long beyond the disappointment of VC's sentencing in January 2024. NGPF was not alone. Organisational defensiveness continued as they pressed hard to better understand how VC had been left on the streets to kill their loved ones and as they learned that digital and human systems had failed to protect the dignity of their loved ones.
- 7.25 In the interests of avoiding repetition, we return to the significance of this Inquiry's conclusions as the Hillsborough Law is close to enactment, the duty of candour and support for Bereaved Families and victims in the criminal justice system and in the aftermath of public tragedy in Section H, below. We address learning from specific contacts with the family during the prosecution of VC in Section G below.

G. INVESTIGATING AND PROSECUTING VC

- 8 It must be a given that the families of people who are brutally killed are entitled to expect that the police, prosecuting lawyers, and expert witnesses will do all that they reasonably can to ensure a just outcome to the case; whatever that outcome may be. They are entitled to expect rigour. The evidence heard in the Inquiry confirms the concern of the Bereaved Families: there was a conspicuous absence of rigour in the approach taken by the authorities to the prosecution of VC. A number of significant failures meant that the Inquiry may conclude the Judge did not have all

⁵³⁰ INQT0000034 98/19 - 99/4.

⁵³¹ NGPF0011160_0010.

⁵³² INQT0000038 31/12-14.

the information he should have had when he came to make a decision on whether to pass a hybrid sentence for VC's appalling acts.

(a) Failures in investigation

- 8.1 Just as Det Supt Sanders claimed there had been no connection between his rush to charge and media pressure, he also claimed he did not consider Diminished Responsibility at all while VC was in custody:

*"Whilst VC was in police custody between 13 and 16 June ... I did not consciously turn my mind to the potential partial defence to murder of diminished responsibility"*⁵³³.

- 8.2 That is very difficult to accept. By 13:32 on 13 June 2023, NGPF had recorded that VC had a history of mental ill-health, with a working diagnosis of paranoid schizophrenia.⁵³⁴ This was discussed with the CPS at 9am on 14 June 2023,⁵³⁵ and again that afternoon – all still before charge. Alan Murphy, leading for the CPS, contacted Professor Blackwood, retaining him as an expert witness⁵³⁶. Unless the CPS and police were simply not talking to each other at this crucial stage, it must have been clear that questions as to VC's intention, his culpability, and the availability of the partial defence of Diminished Responsibility would be crucial issues in the investigation and preparation of the prosecution.⁵³⁷ The police and CPS should have been acutely aware that for justice to be done, information on the nature and extent of VC's culpability would need to be rigorously explored.
- 8.3 The evidence however, points once again to the police taking a superficial approach, and failing in their duty to explore all reasonable lines of inquiry (as above Section F, [7.1]). The CPS and instructed counsel held an equal responsibility in that regard⁵³⁸. Yet, despite regular meetings and communications between the police and prosecutors, crucial areas of investigation were missed. When, several months later, Professor Blackwood sought to convey a retrospective depiction of VC's state of mind, significant material was missing and pertinent information was not made available to him; nor were critical questions asked to test his approach against evidence available to the police and CPS.
- 8.4 In the judgment of the Court of Appeal on the reference of VC's sentence by the Attorney General ([2024] EWCA Crim 490), Baroness Carr, CJ said [84]⁵³⁹:

"In determining the final disposal, the judge, as he recognised, had to consider whether a penal element was necessary. Because the offender's level of retained responsibility was low, and in circumstances where the offending would not have taken place but for the offender's schizophrenia, the judge was entitled to conclude that a penal element was unnecessary. That is so, despite the number of victims and the extent of the harm caused. The schizophrenia was the sole identified cause of the crimes: thus, for example, there was no history of independent offending (unrelated to the

⁵³³ Statement of Det. Supt. Leigh Sanders, at [320], WITN0359001_0108.

⁵³⁴ NGPF0002195_0019 (VC's Custody Record).

⁵³⁵ CPSE0002484_0001.

⁵³⁶ CPSE0000789.

⁵³⁷ See also INQT0000045_0004 15/8-10.

⁵³⁸ HMCP0000625_0057 para 7.5 "where prosecutors identify further reasonable lines of enquiry, they should set these out in an action plan for the police to consider".

⁵³⁹ NGPF0001124_0020.

schizophrenia), no evidence of substance abuse, no evidence of any culpable failure to take medication or any motive for attacking these victims." (Emphasis added).

8.5 The Inquiry has now heard evidence, however, that police and prosecution failures were such that in each of these areas, information was missed that would likely have impacted on this crucial decision. Those failures include:

(i) Failure to test for illicit drugs

8.6 Regardless of any failures in the police forensic strategy, considered above, CPS lawyers knew that evidence of substance abuse could be key to the question of VC's culpability. On 14 June 2023, the CPS were appraised of the police forensic strategy and were therefore alive to the omission of toxicology testing⁵⁴⁰. They did not seek to rectify the position, and when the Bereaved Families subsequently highlighted toxicology as a key concern, institutional defensiveness pervaded. It is not good enough to dismiss their concerns by asserting that there was no history of drug use by VC: there were patent gaps in his history, which were not researched. VC had been taken at his word throughout his earlier contact with both police and health services. In any event, he did later admit one occasion of cannabis use when he was aged 28.⁵⁴¹ That revelation – confirming VC had lied repeatedly – warranted further investigation which simply did not happen.

(ii) Failure to investigate incident with Bil Monteiro's neighbour

8.7 From 17 June 2023, NGPF had evidence there had been an incident involving VC and Bil Monteiro's neighbour on 12 June 2023; the morning before the attacks. A message left by Bil Monteiro for VC in a voice note suggested this incident was so serious as to potentially warrant police involvement.⁵⁴² Yet, astonishingly, no contact was made with the neighbour, nor was Bil Monteiro asked about the incident. This was against a background where it appears from an email exchange on 18 June 2023 between Det Supt Sanders and another officer identified (in redacted disclosure) only as "Frank" (1390) that Bil Monteiro was permitted to "inform" the search of his premises because of his "background and co-operation". Det Supt Sanders believed they already had the majority of the evidence for the index offence.⁵⁴³

8.8 Det Supt Sanders told the Inquiry that the "text messages offer nothing of significance regarding the investigation,"⁵⁴⁴ but NGPF had not had the voice message translated at the time of Bil Monteiro's interview. Det Supt Sanders accepted that investigation should subsequently have been made.⁵⁴⁵ When VC later gave conflicting accounts to psychiatrists, suggesting that the neighbour had pulled a zombie knife on him, again no further steps were taken to pursue this obvious line of inquiry. VC told Professor Blackwood that it was this incident which amplified his sense of threat before his return to Nottingham and led him to obey the voices he heard. Mr.

⁵⁴⁰ CPSE0002484_0003.

⁵⁴¹ Psychiatric Report of Dr Mirvis: CPSE0000484_0021.

⁵⁴² WITN0359001_0037 (Leigh Sanders).

⁵⁴³ NGPF0011917.

⁵⁴⁴ WITN0359001_0070 at [183] (Leigh Sanders).

⁵⁴⁵ Det. Ch. Supt. Sanders, 18 March 2026, PM, 37/6-17, INQT0000031_0010

Monteiro's message suggests VC could have been the aggressor. Given what VC had said to Professor Blackwood,⁵⁴⁶ what had actually happened was crucial to the credibility of his account.

8.9 It is incomprehensible that the investigating Officers failed to make these inquiries.

(iii) Failure to effectively search for VC's Slazenger bag

8.10 By 15 June 2023, at the latest, it was known VC had been carrying a large Slazenger bag in the early hours of 13 June 2023.⁵⁴⁷ The potential import of the bag and its contents would have been patent, and yet a trawl for CCTV from Zulu Road wasn't undertaken until 30 June 2023.⁵⁴⁸ No request from the council for CCTV footage capturing the hours before 03:55 was made until 3 July 2023⁵⁴⁹. The dilatory search is all the more galling since the police have been unable to find the laptop which Iulian saw VC using within days of the attacks.⁵⁵⁰

(iv) Failure to consider VC's own notebooks

8.11 The police and CPS could have been in no doubt that VC's possessions, and in particular, his writing and evidence of his digital life, would provide key insight into his state of mind. On the 16 June 2023, the police searched 165 Burford Road and seized items which VC had left with his former flatmate including a sketchbook, two notebooks, and one A4 notebook⁵⁵¹, each with entries in what appears to be VC's own handwriting. In a stark example of the fundamentally defective nature of Nottinghamshire police's processes, these documents were only disclosed to the Core Participants of the Inquiry on Tuesday 9 June 2026 – a month after the close of the oral hearings. That disclosure was only made after questions were asked on behalf of the Bereaved Families. The police now suggest that although there is no record of such, the contents would have been considered but were discounted as being irrelevant to the investigation. PC Julious writes, *"I seem to recall that I briefly showed DS Cooper some of the pages in the books and he agreed that none of the notes appeared relevant to the investigation. The sketch pad and notebooks were each scan read through by myself. I do not remember any items being in Portuguese."*⁵⁵² It is patently clear that they did not properly consider (or photograph and schedule) the contents of those notebooks,⁵⁵³ nor did they bring them to the attention of the CPS. Mr. Murphy now says that he did not make them available to Professor Blackwood because he did not know about them.⁵⁵⁴

⁵⁴⁶ "He had knocked on a neighbour's door within the building; the neighbour had threatened him with a 'zombie sword', telling him to leave the property. This had amplified his sense of threat: he thought to himself 'the voices are not playing around!' The voices told him that they were going to harm him and his loved ones if he did not do what they said. They said 'disgusting and repulsive things' in his head [CPSE0000011_0018].

⁵⁴⁷ For example, Tram stop CCTV seized by DC Helen HALFYARD on 16.06.2023 10:02 [NGPF0008793]. By the 14 June 2023 the police would have known that it had gone missing before his sighting at the cash point at Sainsbury's on Perry Road at 01:33 [CPSE0000030]

⁵⁴⁸ Medical Centre 2a Zulu Road (Police exhibit NMW 124530062023); and enquiries made down Zulu Road referenced in CPSE0000112.

⁵⁴⁹ WITN0224013_0004; INQT0000096 63/5-16.

⁵⁵⁰ Statement of Iulian NGPF0002460_0003.

⁵⁵¹ Statement of PC Julious NGPF0002916_0001.

⁵⁵² Statement of PC Julious, WITN0471001_0003.

⁵⁵³ Third Witness Statement of Leigh Sanders at [57] WITN0359003_0026.

⁵⁵⁴ WITN0083004, at [29]. Although Dr Blackwood was provided with the exhibit statement covering the search (PC Vasper) and images of the search, there is no evidence that Dr Blackwood requested the notebooks. In the absence of instruction by the CPS that they contained any legible script; this is perhaps unsurprising.

- 8.12 This is a devastating omission. Had the police properly considered those documents, they would have identified a confession in VC's own handwriting to illegal actions in 2013/2014, which reads:

*"mea culpa
Illegal actions 2013/2014
defied lockdown"*⁵⁵⁵

- 8.13 Defying lockdown would have been of marginal significance, but the commission of illegal acts in 2013/2014 was crucial. VC did not admit to acts of historic criminality in the anodyne descriptions of his background he gave to various professionals. 2013/2014 was many years prior to the time when it was recorded VC had begun to experience symptoms of psychosis. It would have been essential to know what illegal acts he had committed, in order to inform both the CPS, and the psychiatrists' understanding of his offending in 2023; especially whether there had been any *"history of independent offending (unrelated to the schizophrenia)"* or *"evidence of substance abuse"*.⁵⁵⁶

- 8.14 Those notebooks would also have revealed relevant information, including:

- (a) Repeated examples of VC's deep-seated misogyny – referring to women as *"bitches"* and ruminating on the value of *"piping"* them.
- (b) Insight into his condition – understanding that mental health problems can be cured and a recognition that he could be violent when unwell.⁵⁵⁷

- 8.15 Whatever Professor Blackwood would say now if asked about these notebooks, there can be no doubt that *all* of the psychiatrists called upon to assess VC for the criminal proceedings should have seen them.

(v) Failure to investigate VC's historical behaviour and actions

- 8.16 The astonishing failure regarding the notebooks is compounded by the police failure to investigate VC's life as a young adult in South Wales.

- 8.17 As early as 6 July 2023, Ms Page-Harries contacted the police to say that she had shared accommodation with VC between 2013-2014. She was aware of an incident which took place during that time, which involved VC and possible violence inflicted on an animal. She believed he was mentally unwell at that time. Investigating Officers never followed up on the line of investigation.⁵⁵⁸ Ms Page-Harries in her statement to this Inquiry describes VC being in the communal areas of their flat in the early hours; standing outside in the garden on his own in the dark; and an incident where soil and something which could have been animal remains were seen in the bath.⁵⁵⁹ This was yet another line of investigation that the police should surely have followed, not least when there were known to be images suggestive of violence to animals on a

⁵⁵⁵ NGPF0011499_0003 This is part of Exhibit DAV1001 referred to in the evidence of Lisa Murray.

⁵⁵⁶ Judgment of the Court of Appeal ([2024] EWCA Crim 490) at [84], NGPF0001124_0020.

⁵⁵⁷ NGPF0011499_0002: *"Either I'm somewhat observant intuitive OR I have become super paranoid Which one I'd rather? Paranoia because it can be cured. The cure for the other is Repayment Fuck it! Repay, that's our name Avenger."* (Emphasis added: not in the Inquiry summary. INQY0000003_0029).

⁵⁵⁸ CPSE0011979.

⁵⁵⁹ WITN0428001. She confirms she lived with VC during approximately 2014-15 for around one year.

memory stick in VC's possession.⁵⁶⁰ It has only now been investigated because the Bereaved Families located Ms Page-Harries' 2023 call to police in disclosed material and asked that inquiries be made.

- 8.18 Professor Blackwood acknowledged that he would have asked VC about this. This was crucial because he was "*looking carefully for evidence of conduct disorder in childhood, with or without traits of callous unemotionality, and you're drawing on any other materials that you have to triangulate the individual's evidence on those points with*".⁵⁶¹ In short, the anodyne self-description of VC's background would need to be properly examined. That could not have been done because comprehensive, objective research into VC's background had not been carried out. Instead, the police, prosecuting authorities and psychiatrists relied on VC's own account as to what had happened between 2013 and 2020, as well as that of his family. It is peers of VC such as Ms. Page-Harries who are likely to provide the most reliable and informative material on VC's true behaviour at that time. In reality, figures of authority such as teachers and parents are unlikely to know the full picture, and VC's behaviour in South Wales should have been properly investigated as part of his criminal case.
- 8.19 The '*mea culpa*' confession throws into sharp relief the police failure to plug the gaps in knowledge as to VC's activities in the subsequent years. VC's family's evidence was that he left South Wales in 2015, telling his family he was moving to Newcastle but refusing to give them an address and ultimately moving to Birmingham instead, without informing them. He did not come home again until Christmas 2016 and left again after Christmas.⁵⁶² Beyond that, nothing is known. Thus, on their evidence, the family did not know where VC was between early 2015 and 2017 and only saw him once during that time when he revealed he was living in an entirely different city than where he had told them he could be found. Professor Blackwood did not ask VC about his leaving home in adolescence and accepted that this could have been important to explore.⁵⁶³ He was effectively missing to his family during early 2015 to 2017; just as contact was extremely limited between August 2020 and June 2023. Moreover, VC's refusal to provide an address when he left South Wales has a greater significance now there is a firm basis for believing he was involved in "*illegal actions in 2013/2014*". At the very least, the Inquiry may consider it unsatisfactory that there is an unexamined and unexplained gap in VC's history when an offender's history is crucial to disposal.
- 8.20 Cannabis and its main psychotogenic component, THC, significantly increases the risk of developing psychosis, typically significant use from teenage years.⁵⁶⁴ Professor Blackwood was satisfied "*that cannabis in this instance wasn't a significant precipitant or perpetuating factor*"⁵⁶⁵ to VC's offending. However, VC's account to Dr Mirvis as to his drug use was that "*the only illicit substance he has ever tried was cannabis once when he was 28. This made him believe that his arm had been cut and that he thought he was going to lose it and die.*"⁵⁶⁶ This appeared at odds with Professor Blackwood's record in his notes of VC's confessed drug use: "*high – not paranoid*"⁵⁶⁷. The extreme reaction to drug use reported to Dr Mirvis was reported to have been

⁵⁶⁰ NGPF0001843_0001.

⁵⁶¹ INQT0000043 6/3-8.

⁵⁶² INQT0000086 34/24 – 36/22.

⁵⁶³ INQT0000043 27/23-24.

⁵⁶⁴ INQT0000043 31/8-14

⁵⁶⁵ INQT0000044 73/5-7.

⁵⁶⁶ CPSE0000484_0020-21, at [9.8].

⁵⁶⁷ WITN0308003_0002

when he was aged 28, which would have been in 2019-2020, at the same age that he first reported symptoms of psychosis began in various accounts, including to Dr Shaffiulha⁵⁶⁸ and Professor Blackwood. Professor Blackwood explained that “*clearly individuals can have idiosyncratic responses to THC. Perhaps that does speak to his underlying vulnerability to psychosis, that there's such an extreme reaction to one dose of THC*”.⁵⁶⁹ The conflicting accounts given by VC undermine any confidence that can be held in his assertion that he had, indeed, only used drugs once. The inconsistency renders all the more stark the failure to investigate fully VC's adolescent and early adult years.

- 8.21 Once again, this investigative failure may have informed the Court in sentencing, and the finding that, “*there was no history of independent offending (unrelated to the schizophrenia)*” nor “*evidence of substance abuse*”⁵⁷⁰.

(vi) Failure to investigate VC's recent history

- 8.22 Police failures to investigate VC's criminality was not limited to the historical. As explained in Section F, above, on 15 Feb 2023 VC punched a man whilst at work. Despite the existence of CCTV depicting the incident, Professor Blackwood was unaware of the assault when he was drafting his opinion.

- 8.23 On the face of it, the footage of the incident does not suggest a man suffering from a psychotic episode, but rather one acting in domineering anger.⁵⁷¹ This is clearly material that would have been relevant to the forensic psychiatrists' assessment of VC's culpability on 13 June 2023. As with other incidents of violence by VC, there is reason to doubt whether this violence was “*informed by his psychosis*” or, instead, could be more aptly described as run of the mill male violence.⁵⁷² An effective investigation by the police of VC's recent history, including his working history could and should have revealed violence by VC which is striking in its banality.

(b) Failure to provide material which was in police possession to the forensic psychiatrists for their consideration

- 8.24 Relevant material which was in police possession was nonetheless not provided to Professor Blackwood. In particular, he was not provided with CCTV footage of VC's previous assaults, including the video footage of the attack on Christopher or, crucially, the body worn video of the assault on PC Pritchard. Professor Blackwood conceded that this material could have been helpful.⁵⁷³ The Inquiry may consider that this was a significant failure because it meant that there could not be a fully informed and rigorous exploration of the extent to which VC's violence was solely attributable to his psychotic disorder.

⁵⁶⁸ Report of Dr Shaffiulha at 9.2.19; CPSE0000013_0010.

⁵⁶⁹ Professor Blackwood, 30 March 2026, 31/3-6 INQT0000043_0008.

⁵⁷⁰ NGPF0001124.

⁵⁷¹ FRGR0000002R.

⁵⁷² See in particular Dr Lomas' evidence that the attack on Christopher did not have the ‘classic hallmarks of psychotically driven violence’.. nor did he present as ‘overtly psychotic’ and that the event did not appear to be driven by VC's belief in ‘a technocratic conspiracy against him’ but rather a disagreement about house rules and cleaning rota. INQT0000065 81/12-82/9, 90/20-91/6, 104/10 – 13.

⁵⁷³ INQT0000043 21/2.

- 8.25 VC's mental health tribunal records were also never examined by Professor Blackwood. Such records should have been scrutinised because they contained VC's own previous inconsistent accounts of his previous violence and the motivation behind it. In respect of the assault on PC Pritchard, VC told Professor Blackwood "*he had been highly fearful that the conspiracy was intent on harming him... in this fearful state he headbutted the police*"⁵⁷⁴. Quite aside from the stark difference between this description and the CCTV recording, Professor Blackwood did not know that VC's own previous account was that his attack on PC Pritchard was "*unfortunate*" and the "*consequence of poor judgment*".⁵⁷⁵ He had also told his Responsible Clinician at Priory Arnold that: "*He did not agree he had a relapse on this occasion -- said he was too stressed and he over reacted when police got involved*"⁵⁷⁶. The Tribunal papers and his records from the Priory Arnold disclose that in several instances VC gave an account inconsistent with that he gave Professor Blackwood; seemingly in order to attempt to secure his release.⁵⁷⁷ Professor Blackwood accepted that, had he known of them, he "*may well*" have asked VC about the palpable untruths which he had told to the Tribunal.⁵⁷⁸ VC's accounts undermining his credibility on a matter unarguably central to his professional assessment of VC could not be appreciated and "triangulated" by Professor Blackwood because he simply did not have the relevant materials. The police and CPS failed to draw them to his attention, and the expert either did not see the gap in VC's clinical record or did not consider it important.
- 8.26 Whilst VC's anger in these previous repeated assaults may have emerged "*in the context of a psychotic illness*"⁵⁷⁹, the fuller evidence we now have points to a more complex picture. Again, this material should have been highly relevant to Professor Blackwood's assessment – and more importantly, the Court's assessment of VC's offending and culpability.

(i) Prosecution failure to critically assess the psychiatrists' reports

- 8.27 Dr McSweeney's report was sent to the CPS on the 2 October 2023. Despite it being a crucial document in determining the likely disposal of the case, the prosecution team appear to have given it little critical analysis. For example, Professor Blackwood confirmed it was necessary in all cases for a psychiatrist to consider all of the prosecution papers before expressing an opinion on the issue of diminished responsibility and appropriate disposal⁵⁸⁰. At no stage did the prosecution team mention, let alone express, concern about the fact, that Dr McSweeney had only had sight of an *outline* prepared by the defence of the allegations, issues and witness statements⁵⁸¹. Nor did they express concern that Dr McSweeney had not had sight of any of the unused material. We have not been able to ask Dr McSweeney whether he thinks he ought to have read the prosecution papers. The prosecution team did not identify that Dr McSweeney's report did not contain any detail as to VC's own account of the events of 13 June 2023. Nor did they identify the report minimised VC's previous violence – for example describing the assault

⁵⁷⁴ Report of Professor Blackwood at [32] CPSE0000011_0009.

⁵⁷⁵ CYGN0000056_0005.

⁵⁷⁶ PAGR0000159_0003.

⁵⁷⁷ PAGR0000016.

⁵⁷⁸ INQT0000043 97/7-16.

⁵⁷⁹ INQT0000043 26/6.

⁵⁸⁰ Professor Blackwood, 30 March 2026, AM, 86/1-5, INQT0000043_0022.

⁵⁸¹ CPSE0000003_0004.

on Pritchard merely as VC having “*resisted arrest*” and excluding any reference to VC’s assault on co-workers at Arvato, his assault on Christopher, and his assault and stalking of Sebastian⁵⁸².

8.28 It is therefore surprising that Mr Murphy’s *immediate* analysis was: “*My impression of the report is that it is balanced*”⁵⁸³. Indeed, Michelle Manion and Andrew Baxter shared concerns that the report hadn’t addressed VC’s apparently rational behaviour around Seely Hurst House, but they still did not identify the paucity of material considered by Dr McSweeney and the gaps in his assessment.⁵⁸⁴

8.29 Only the day after Dr McSweeney’s report was received, Alan Murphy reported a conversation between him and Professor Blackwood:

*“I’ve spoken to Dr Blackwood this afternoon. He has seen Dr McSweeney’s report. His initial impression is that this is a clear case of untreated psychosis and we are most likely heading towards diminished responsibility and a s37/41 disposal...”*⁵⁸⁵.

8.30 Professor Blackwood was equally swift in his response after seeing VC in Ashworth Secure Hospital on 14 November 2023. By 17:22, when he was on the train home he replied to an email from Mr. Murphy, confirming: “*DR, and a 37/41 disposal to high secure in my view*”.⁵⁸⁶ There could have been very little time to rigorously triangulate what VC had told him as Professor Blackwood had said was his practice. That Professor Blackwood’s fitness to plead assessment during his meeting with VC was solely based on VC’s understanding of what would happen if he pleaded ‘Guilty’ or ‘Not Guilty’ to manslaughter further indicates an element of putting the cart before the horse.⁵⁸⁷ VC was not asked about pleading guilty to murder or being tried by the jury for murder, despite that being the main charge he faced. That begs the question “why not?” The only reasonable answer is that Professor Blackwood had prematurely determined murder was not in issue.

8.31 Professor Blackwood’s report was provided to the CPS on 20 November 2023, and Dr Shaffiulha’s on the 24 November 2023. The CPS team had already reached the decision to accept pleas to Manslaughter on the basis of Diminished Responsibility on 23 November 2023. That decision having been made, the prosecution team were intent on defending it. After the receipt of the reports, no challenge appears to have been given to the inconsistencies between the accounts that VC gave to the respective psychiatrists and the known evidence. There are a number of such inconsistencies, yet nobody in the prosecution team, nor any psychiatrist, ever addressed them. VC’s account was unquestioningly accepted and not “triangulated” with the other evidence: until critical questions were asked by the Bereaved Families acting without the benefit of access to copies of the reports and without access to any of the critical disclosure. Their challenge was no substitute for critical analysis by the prosecution team.

8.32 Indeed, leading counsel was required to rewrite his advice on acceptance of pleas when the Deputy Chief Crown Prosecutor, Andrew Baxter observed it read like “*there is not enough time to do a proper advice*”, questioning the brief fee paid for Mr Khalil and his junior.⁵⁸⁸

⁵⁸² CPSE0000003.

⁵⁸³ CPSE0004765_0001; CPSE0004789_0001.

⁵⁸⁴ CPSE0008370_0002.

⁵⁸⁵ CPSE0005782_0001.

⁵⁸⁶ CPSE0008347.

⁵⁸⁷ INQT0000043 119/9-25.

⁵⁸⁸ CPSE0003998_001.

(ii) Failure to consider the inconsistencies in VC's accounts with the evidence

8.33 Nobody addressed the apparent inconsistencies in VC's accounts of his possession of a knife. VC's account to Professor Blackwood was that in 2022 "He bought the knife 'in despair', and sought to resist the commands/ thoughts",⁵⁸⁹ but nobody considered the inconsistency of the fact that he had not disposed of the knife in the meantime, but to the contrary, had bought a sharpener, and had chosen to retain the knife (but leave the sharpener in the care of Akhil [REDACTED]⁵⁹⁰) when packing to leave to London. No-one identified the known untruth in V [REDACTED] Dr Shaffiulha, namely, "9.2.13 Adam reported that he had been carrying a knife in his backpack and stated that he does not always carry a knife and was only carrying it because he was carrying all of his personal belongings that he had because he had no place to live".⁵⁹¹ That claim should have been critically assessed in light of the evidence that VC had chosen to leave many belongings in 165 Burford Road. His reasons for having the knife on 13 June 2023 were crucial. Yet nobody sought to question critically whether VC was telling the truth.

8.34 VC's claim of insanity was summarily rejected by Professor Blackwood without further comment as to the significance of its falsity, and yet the remainder of his account was largely accepted uncritically. Professor Blackwood rejected VC's claim that he did not know the nature and quality of his acts by reliance on VC's call to Elias (wherein he said he had done something stupid and suggested he get his parents out of the country; which Professor Blackwood said was a counter-indicator to insanity⁵⁹²). But the fact that VC made that false claim about such a fundamental aspect of his account of his own appalling acts achieved no profile whatsoever in the report of Professor Blackwood. Nor did the fact that he said something different about his understanding of the nature and quality of his acts to Dr McSweeney⁵⁹³. Despite surprising consistency with notes found in his cell and considered by Professor Blackwood, no-one seemingly considered whether the language used by VC to Professor Blackwood and Dr Shaffiulha appears rehearsed, and could be indicative of VC manufacturing a defence akin to similar attempts to manipulate those determining his discharge from previous hospital admissions.

8.35 Professor Blackwood accepted that he relied on VC's account, triangulated against other sources of evidence.⁵⁹⁴ Moreover, he indicated that a highly significant factor in his assessment as to the causal relationship between VC's illness and the killings were the accounts given by VC to his family of his illness and his accounts to treating physicians after the incident.⁵⁹⁵ By contrast, the numerous incidences where VC had been known to fabricate accounts and manipulate a great many people were either not drawn to Professor Blackwood's attention or he simply ignored them.

(iii) Failures of psychiatrists to ask about important material

8.36 Counter-terrorist police reviewing VC's phone whilst he was in police custody had found videos pertaining to mass shootings in Christchurch (when, in March 2019, 51 people were killed and

⁵⁸⁹ CPSE0000011_0011 at [40].

⁵⁹⁰ NGPF0002383.

⁵⁹¹ CPSE0000013_0009.

⁵⁹² INQT0000043_111/8-25.

⁵⁹³ CPSE0000003_0010.

⁵⁹⁴ INQT0000043_83/2-5.

⁵⁹⁵ INQT0000043_84/1-4.

89 injured), and in Buffalo in May 2022 (when Payton Gendron livestreamed his attack as he killed 10 people, and injured 3 others). They also found a 193-page report titled ‘The Public Inquiry into the Shootings at Dunblane Primary School on 13 March 1996’,⁵⁹⁶ as well as an image of someone holding a gun in a supermarket with what appears to be two dead bodies on the floor.⁵⁹⁷ Not one of the psychiatrists who assessed VC addressed these videos, images and reports of extreme violence on VC’s mobile phone downloads. Nor did they consider the research that VC had seemingly conducted into large venues in Nottingham⁵⁹⁸ in the context of his apparent interest in mass killings. Alan Murphy appeared primarily concerned that “*there is loads on [VC’s] phone supportive of his paranoia*”⁵⁹⁹, despite the fact that the downloads also contained significant and concerning material which had, in other cases, formed the basis of a charge under sections 1, 2 and 58 of the Terrorism Act.⁶⁰⁰ The Inquiry has heard that there was no reference in the CPS letter of instruction to Professor Blackwood to VC’s videos depicting mass shootings, which in and of itself is a surprising omission.⁶⁰¹ It beggars belief that this should not be considered an area for the psychiatrists to ask VC about.

- 8.37 VC had also accessed and stored images of weapons; including fabricated or home-made hammers.⁶⁰² Not a single question was asked of him about that even though a cursory reading of his medical notes would have revealed that VC was found to have brought a hammer into the hospital on return from s.17 leave whilst he was detained at the Priory.
- 8.38 CPS alarm bells should have rung when the list of documents Professor Blackwood said he considered in preparation of the report contained neither the summary reviews nor the phone download itself, and there was no reference in the body of the report to the material.⁶⁰³ When asked if he was concerned by this omission, Alan Murphy told the Inquiry, “*I wasn’t because I read those psychiatric reports, particularly Dr Blackwood’s and in my view it’s very impressive, very thorough*”.⁶⁰⁴ That a senior prosecutor could consider the reports thorough, when none of the psychiatrists had asked VC about such disturbing material is remarkable. Despite the fact that VC’s intentions, motive, and state of mind were known to be of utmost importance to the case, and the obvious importance of the material viewed by VC as to his mindset, Professor Blackwood was never asked to address its relevance. Nor, crucially, was the existence of the material drawn to the attention of the sentencing judge.
- 8.39 It is clear from the evidence of Dr Mirvis (VC’s treating clinician in Broadmoor), that it is *still* the case that no psychiatrist has ever asked VC about why he possessed and looked at those videos of mass shootings. In the context of the horrific killings perpetrated by VC that is simply incomprehensible. Instead of the clinicians asking VC about them, the Inquiry heard for the first time an explanation proffered by the psychiatrists. In evidence to the Inquiry, both Professor Blackwood and Dr Mirvis sought to explain the downloads as VC researching and seeking to understand what is happening to him and how others have reacted when it has happened to them.

⁵⁹⁶ NGPF0003744_0002.

⁵⁹⁷ NGPF0003744_0013.

⁵⁹⁸ Review Log NGPF0009008_0005.

⁵⁹⁹ CPSE0004771_0001.

⁶⁰⁰ NGPF0003744.

⁶⁰¹ On 1 Oct 2023 Mr Murphy wrote to Samantha Shallow and Michelle Manion that “*there is loads on Calocane’s phone supportive of his paranoia. All disclosed at Stage 1 and highlighted to Dr Blackwood*” [CPSE0004771_0001].

⁶⁰² NGPF0001500_0014.

⁶⁰³ CPSE0000011_0004.

⁶⁰⁴ INQT0000045 83/21-23.

8.40 Professor Blackwood suggested (although he plainly had not asked VC about the videos):

*"I interpret those in the context of his untreated psychosis. He's angry. He is perplexed why are my thoughts being monitored? Why are either the government or a rogue computer program etc why am I being tormented by these individuals? And you know in the context of thinking about such things, he is looking at different information about Hitler, the Nazis, shootings et cetera .. It may be that he is searching for an understanding, he's looking at the way in which others have reacted to these things. It may be that he already has murderous intentions by this point and that's why he's looking at such material, so all these things are possible."*⁶⁰⁵

8.41 In his evidence on the same afternoon, Dr Mirvis said:

"I mean, I wasn't aware that he'd been viewing things about shooting, but I've had a little bit of time to reflect on that, and I would highlight, looking at my second report, that VC has a habit of trying to analyse: "why is this experience happening to me? What's going on?"⁶⁰⁶ "... So I think that instance of him looking those sorts of things up is an attempt to maybe try and investigate in his mind what's going on and how has it happened to other people, and, you know, what they have done?"⁶⁰⁷

8.42 The evidence from both is simply nonsense. Neither Brenton Tarrant nor Payton Gendron, who perpetrated the Christchurch and Buffalo atrocities, ever claimed to have their thoughts controlled. They were just racist bigots of one form or another. Whilst we do not have evidence of how many times each video was viewed, Professor Blackwood's and Dr Mirvis's conjecture simply does not explain VC's possession of multiple videos of the shootings at Christchurch and Buffalo themselves, as opposed to research in relation to those killings. It appears VC watched videos of mass killings: that's it, nothing more, full stop. No research, no meditation. Nor can VC's images of violence against animals⁶⁰⁸ be explained by his searching for an understanding of his own illness. VC has never been asked by any psychiatrist (nor, it seems, anybody else) to explain any of this, and it is a gaping hole which cannot now be filled. What we can know for sure, is that these were important questions to have answers to, and which should have been comprehensively explored with VC by the psychiatrists, prior to the disposal of his case by the Judge.

8.43 Difficult questions simply were not asked. The Inquiry may well consider that questions should also have been asked as to the significance of the photographs of school leavers for Herschel Grammar School, Berkshire, Slough found on VC's phone download,⁶⁰⁹ or the video he had filmed from beneath the trees of people coming out of the Tesco Express on Alfreton Road in May 2023.⁶¹⁰ Remarkably, not one of the psychiatrists asked VC about the names found in his backpack on his arrest, despite the proximity of the attacks to Raleigh Park and the attack on Christopher in January 2022.

8.44 It wasn't until the Inquiry proceedings that Professor Blackwood was made aware that seven other people had passed VC on the 13 June 2023 as he waited in the shadows prior to his attack

⁶⁰⁵ INQT0000043 48/22-49/2.

⁶⁰⁶ INQT0000044 73/16-23.

⁶⁰⁷ INQT0000044 74/1-6.

⁶⁰⁸ NGPF0001843_0001.

⁶⁰⁹ NGPF0003744_0011.

⁶¹⁰ NGPF0003744_0007.

on Grace and Barney on Ilkeston Road.⁶¹¹ Noone within the prosecution team appears to have turned their minds to whether it was just coincidence that VC attacked students on Ilkeston Road, as opposed to others seen passing him on his journey through Nottingham. Professor Blackwood believed what VC told him without more.

(iv) *Failure to consider whether VC could be properly diagnosed with “treatment-resistant schizophrenia”?*

8.45 In his 14 January 2024 report, Dr Mirvis diagnosed VC with “*treatment resistant schizophrenia*”⁶¹². Treatment-resistant schizophrenia is defined by “*the presence of at least moderate to severe psychotic symptoms, which are associated with functional impairment and are persistent despite serial trials of at least two antipsychotic medications that were adequate in terms of dosage, duration and level of adherence.*”⁶¹³ This diagnosis appears to have been accepted unquestioningly by the prosecution and not questioned by any psychiatrist. But the Inquiry may well consider that, given VC’s non-concordance with medication in the community, it could not be confidently asserted that he took aripiprazole for a serial trial which was “*adequate in terms of dosage, duration and adherence*”. VC had only been started on Olanzapine on 12 September 2023, which had been increased on 26 September 2023,⁶¹⁴ and in the intervening period there were reports of non-adherence to medication in prison⁶¹⁵. Certainly, VC’s response to treatment with clozapine could not be known at that time. The prosecution, however, did not question whether Dr Mirvis was in a position to make that conclusive finding, and made no challenge to the assertion when it was repeated in the Sentencing hearing.⁶¹⁶

8.46 One result of this collective faulty assessment of VC’s interaction with medication was that the Court did not have accurate information for sentencing. Professor Blackwood stated that VC’s failure to comply with the prescribed oral anti-psychotic medication was not a culpable omission, but that it was determined by his lack of insight into his illness. The Inquiry has heard evidence however that VC actively resisted taking medication including as he felt that it caused issues with his studies⁶¹⁷ and he felt as though they were slowing down his thinking⁶¹⁸. Professor Blackwood was asked in terms about this. He said he didn’t recall seeing that record.⁶¹⁹ The only conclusion to be drawn is that he did not read VC’s notes with care. Moreover, VC actively resisted depot medication; deceitfully claiming that he was afraid of needles when, in reality, he had been injected on numerous occasions without incident.⁶²⁰ Once again, the Inquiry may conclude that the foundation for the expert evidence on which the Judge’s consideration of sentence stood was overly simplistic and inadequate.

⁶¹¹ INQT0000043 59/11.

⁶¹² CPSE0000484_0027.

⁶¹³ RLIT0000013_0004.

⁶¹⁴ CPSE0008702_0003.

⁶¹⁵ CPSE0008702_0004.

⁶¹⁶ CQCM0013355.

⁶¹⁷ NHFT0000168_0075.

⁶¹⁸ NHFT0000168_0099.

⁶¹⁹ INQT0000043 85/10.

⁶²⁰ For example Covid vaccinations on 14 July 2021 and 13 December 2021 CHCA0000030_0002.

(c) Institutional defensiveness

8.47 Rather than highlighting the deficiencies in the evidence against VC and putting them in the balance in order to explain why the prosecutorial decisions were appropriate, when communicating with the Bereaved Families, the Inquiry may consider the Prosecution sought to conceal them. The evidence reveals a prosecution team resistant to challenge, and intent on shoring up their adopted position, as opposed to being open in relation to valid concerns. This defensiveness arguably fuelled mistrust between the prosecution team and the families.

(i) Disingenuous ‘Review as to Material considered by the psychiatrists’

8.48 Alan Murphy produced a document entitled ‘Review as to the Material considered by the Psychiatrists’ dated 26 November 2023.⁶²¹ The basis for so doing was that he had, “*been asked to review the reports of the three psychiatrist and confirm (or otherwise) what material was made available ... to enable them to complete their reports.*”⁶²²

8.49 When considering Dr Shaffiulah, Alan Murphy wrote at [2.32], “*Dr Shaffiulah had the opportunity to access the entirety of the served prosecution case and disclosed unused material. There is no evidence he did so.*” The candid outline of the paucity of the material reviewed by the psychiatrist whose conclusion they were discounting can be contrasted with that in relation to Dr McSweeney. Within his assessment of the material reviewed by Dr McSweeney, Alan Murphy set out in detail that material which could have been made available to the doctor by the defence solicitor, but failed to highlight that this had not, in fact, been made available or reviewed by him. Alan Murphy wrote, “*The unused material disclosed at stage 1 (and therefore available to Dr McSweeney through the defence solicitors) included a huge volume of psychiatric material relating to the period 2020-2022 and also other relevant material in the possession of the police (some of which was recovered from his phone).*”⁶²³ For his own reasons, he simply did not explain in that document that the entirety of that which Dr McSweeney had considered was a defence “*summary of the case and prosecution statements*”. The Inquiry will hopefully have in mind that the families were not allowed to read the psychiatric reports and see for themselves what Dr McSweeney had considered. If they ever saw Mr. Murphy’s document, they would be none the wiser as to its inadequacy.

(ii) Misleading on toxicology testing

8.50 When meeting with the Webber and O’Malley-Kumar families on 24 November 2023, and in response to a direct question from Julian Hendy (whose attendance the prosecution had initially resisted), Mr Khalil KC wrongly indicated that toxicology tests had been carried out, and that drug-induced psychosis had been ruled out.⁶²⁴ No one from the CPS or police who were present sought to correct him. The families were later wrongly informed that “*HCP required for the following samples: ...blood and urine ... they were refused*”⁶²⁵. “*No toxicology was taken due to lack of consent from the defendant in custody*”.⁶²⁶ The reality was that toxicology hadn’t been

⁶²¹ CPSE0007616.

⁶²² CPSE0007616_0002.

⁶²³ CPSE0007616_0003.

⁶²⁴ CPSE0000196.

⁶²⁵ HMCP0000461_0005.

⁶²⁶ CPSE0000806_0003.

taken because it wasn't the forensic strategy, and VC had never been asked to provide urine. Yet another example of a defensiveness; a lack of openness with the families which laid bare the inadequacies in the work done by the prosecution, and fundamentally breached their trust.

8.51 When Dr Kumar requested that hair sampling be carried out, as such tests could still return relevant findings at that time, the SIO closed this down abruptly. Det. Supt. Sanders' reaction was, *"No this will not be done. The defendant has no history of drug abuse"*.⁶²⁷ Again, putting the cart before the horse, there could be no plainer example of defensive dismissal of the Bereaved Families' questions.

8.52 It was only in the course of this Inquiry that Det Supt Sanders conceded that the failure to take a hair sample was an error of judgment, and even then, only because it would have appeased the bereaved families, as opposed to it having been a clearly relevant line of investigation.⁶²⁸

(iii) The 'Beddoe Report'

8.53 At the 23 November 2023 meeting between police and prosecution, Mr Khalil KC asked DC Beddoe for a list of observations of seemingly rational behaviour by VC on 13 June 2023.⁶²⁹ On 15 December 2023, DC Beddoe circulated an analysis of such, highlighting instances when VC appeared to exhibit planning and control.⁶³⁰

8.54 Alan Murphy was disparaging; *"it's a really poor piece of work"*⁶³¹, and sought quickly to close down the conversation. He said:

*"All of the matters referred to in your report have, as far as I can see, been considered by the experts in their assessments ... As I say, I don't want to spend any more time critiquing the report but if part of its intention is to offer an alternative opinion to those of the psychiatrists on the availability of DR in this case, then I'm afraid that for a number of reasons the report is fundamentally flawed."*⁶³²

8.55 What followed however, is a clear demonstration of institutional defensiveness. The prosecution sought to ensure that the questions raised by the report would never become the focus of discussion. Mr Murphy wrote: *"Can I ask that this document is placed on the sensitive schedule of unused material MG6D- it is plainly sensitive in my view. It will not be disclosable to the defence as it doesn't meet the CPIA test and it would plainly not be disclosable to anyone else."*⁶³³ If it was not disclosable, why was the sensitive schedule necessary? If there was any doubt that the "anyone else" was a reference to the Bereaved Families, that is expunged by the follow up email from junior prosecution counsel:

*"I hope that your last sentence got the message across to the police about sharing this view with the families. I am very concerned that this may have been or will be done - whether in the form of the 'report' or in discussion."*⁶³⁴

⁶²⁷ CPSE0000806_0003.

⁶²⁸ WITN0359001_0109 at [327] (Det. Supt. Leigh Sanders).

⁶²⁹ CPSE0009524_0001.

⁶³⁰ NGPF0000474_0001; CPSE0009097.

⁶³¹ CPSE0001996.

⁶³² CPSE0009524_0004.

⁶³³ CPSE0009524_0004.

⁶³⁴ CPSE0009097_0001.

- 8.56 Mr Khalil KC agreed that he was concerned that the views of DC Beddoe might be shared with the families. He stated:
- “there was a real risk that simply providing a document like this would cause further misunderstanding amongst a wider readership that were not as cognisant of the legal definitions which were constraining all of the practitioners, and would lead them to a false conclusion”*⁶³⁵
- 8.57 Adding: *“it would have taken a great deal of time to unravel that”*⁶³⁶.
- 8.58 To place the document on the Sensitive Unused Schedule however was clearly wrong. The test for its entry on the MG6D was known by Alan Murphy to be that *“disclosure of it would give rise to a real risk of serious prejudice to important public interest”*.⁶³⁷ Ms Shallow did not assert that it should be on the sensitive schedule but her suggestion that the report should not have been scheduled at all⁶³⁸, was ill-founded: the report was clearly material generated by the police which could be disclosable, and so fell to be scheduled. But it simply was *not* sensitive. Moreover, this was a report by the police to Counsel; commissioned by Leading Counsel. To describe it as ‘internal police communication’⁶³⁹ is misleading and untenable.
- 8.59 The Report should have been placed on the MG6C (the non-sensitive unused material schedule).
- 8.60 Mr Khalil KC admitted that it could have been put on the non-sensitive schedule and marked clearly *“not disclosable”*, *“but it invites a section 8 process to which it shouldn’t have been vulnerable”*⁶⁴⁰. Ultimately, he sided with the CPS that as a confidential communication that justifies it going on the sensitive schedule.⁶⁴¹ A cursory examination of the MG6D disclosed to this Inquiry shows that practically none of the other many internal police communications were on the schedule.⁶⁴²
- 8.61 What is clear however, is that the intention behind the location was to ensure that it was never seen by the Bereaved Families. That should never be a justification for placing an item on the sensitive schedule and raises broader concerns about the approach taken by Mr. Murphy and others in the prosecution team to the Bereaved Families and to disclosure. The Inquiry will have in mind that many of the serious miscarriages of justice exposed in this jurisdiction have been caused by a failure to act in accordance with disclosure requirements. In that context, we note the response of Mr. Rogers, the Chief Inspector of HMCPSI, when asked how the disclosure of that report would give rise to a real risk of serious prejudice to an important public interest. He said that Alan (Murphy) had already answered that question; continued by saying he couldn’t really answer that question as he wasn’t a lawyer; and concluded by saying: *“It’s a memo between -- the norm is -- to my understanding, the norm is -- I’m no disclosure expert -- that a memo between the police and the CPS of that nature would live on a sensitive schedule”*.⁶⁴³ It does not instil confidence for circumstances when a burying of a document could lead to the conviction of an innocent person.

⁶³⁵ INQT0000048 62/21-63/1.

⁶³⁶ INQT0000048 63/9-12.

⁶³⁷ INQT0000045 77/17-20.

⁶³⁸ INQT0000047 57/25.

⁶³⁹ Disclosure PII code ‘10’ as used against the relevant entry CPSE0000077_0001; NGPF0003194_0003

⁶⁴⁰ INQT0000048 64/10-17.

⁶⁴¹ INQT0000048 65/2-4.

⁶⁴² NGPF0003194.

⁶⁴³ INQT0000073 57/14-17.

(iv) ***The decision to instruct Dr Latham was to shore up the prosecution approach, not to provide a basis for altering it***

8.62 The Prosecution decision to instruct Dr Latham was defensive. It arose from concerns raised by the Bereaved Families following the 24 November 2023 meeting, and the suggestion that they may be considering judicially reviewing the decision to accept pleas to Manslaughter.

8.63 It was Mr Khalil KC's idea, "*This may sound as if we are allowing the families to make or direct the decision making processes in the case but the reality is that they won't - but it will mean that any unhappiness and/or challenge will be dealt with much more easily.*"⁶⁴⁴

8.64 The decision was made to have a review rather than a full report. Peter Ratliff, junior prosecution counsel wrote:

*"if the CPS were minded to instruct an expert in order to reassure the victims that all that could be done has been done, we consider that a middle ground might be to limit the ambit of the instructions to a review of the available material and existing reports, and to provide an opinion on whether the conclusions are properly reached, with a specific focus on whether appropriate weight has been given to the Defendant's presentation at the time of the arrest and immediate period in custody. The benefit of this would be that it would address Dr Kumar's concern but also ought to be achievable in a much shorter timeframe than a full assessment, which would necessarily include an interview with the Defendant (with all that that entails)."*⁶⁴⁵

8.65 The Bereaved Families' primary concern throughout the criminal case was that the proceedings should be rigorous; to the extent that they were prepared to instruct an independent expert at the end of November at their own expense. They wanted a full report, but the prosecution did not want to delay matters. Dr Latham wasn't available for the scheduled trial date (and his initial reaction to being asked to do a report was that he didn't have time) but he was persuaded to do a 'paper' review without meeting VC.

8.66 There was no question that the decision to accept pleas to manslaughter would be reversed. Indeed, Dr Latham's report was not commissioned with that prospect in mind. It is inconceivable that Dr Latham would have decided that diminished responsibility was an incorrect conclusion without seeing VC. Dr Latham's ultimate assessment was that "*the conclusions reached about diminished responsibility are, in my opinion, the proper conclusions based on the information available to, and described by, the experts who have assessed [VC]*".⁶⁴⁶ (Emphasis our own).

8.67 There can be little doubt however that there were significant evidential gaps in information available to or considered by the psychiatrists. In some instances, this was due to the police failure to investigate, in others because the psychiatrists did not address material which was in the possession of the police. Either way, the omissions may have had significant consequences for the conclusions drawn about VC's retained culpability.

8.68 **In any case where the prosecution accepts a guilty plea to manslaughter on the basis of diminished responsibility related to mental health, it must investigate the Defendant's background as fully as possible.**

⁶⁴⁴ CPSE0008516_0002.

⁶⁴⁵ CPSE0008516_0001.

⁶⁴⁶ CPSE0000017_0003.

8.69 Any psychiatrist offering an opinion on mental ill health as a basis for diminished responsibility in homicide proceedings must have considered, at a very minimum, all used prosecution statements and exhibits.

8.70 Any psychiatrist offering an opinion on mental poor health as a basis for diminished responsibility in homicide proceedings must have considered a full set of the Defendant's medical records; including records of any Mental Health Tribunal proceedings.

(d) Trauma compounded: CPS and Family Contact

8.71 The approach of the CPS towards the Bereaved Families throughout the proceedings was profoundly damaging. They described meetings with the CPS as some of the worst things they had ever had to do,⁶⁴⁷ consistently feeling that the prosecution process was being hurried through without proper engagement, and that decisions were being made before they could understand or meaningfully participate in them. The Inquiry may well conclude that early offers to meet the CPS, contained in letters with standard wording⁶⁴⁸, were of little assistance to those experiencing recent and unimaginable trauma: *"If we're failing to absorb it's because you're not giving us the information properly. It's not our fault; it's not our failure."*⁶⁴⁹

8.72 Even though it was recognised from the outset that VC's mental health would be central to his case, contact with the Bereaved Families on this issue was left far too late, and explained poorly. The HMCPSI Report found that *"between late July and 2 October there was no contact between the CPS and FLOs to discuss or make arrangements to meet the bereaved families"*.⁶⁵⁰ Whilst HMCPSI found that the CPS had still met its obligations under the Victims' Code, the Inquiry is invited to consider whether it really is sufficient to rely on an introductory letter's open-ended invitation to meet sent days after a bereavement.

8.73 Further, when the issue of Diminished Responsibility was finally raised with the families, there was no evidence that the CPS provided any form of words for the FLOs to use when explaining that technical legal concept and its implications for the case.⁶⁵¹ Information was not passed from the FLOs to the CPS to communicate that further clarity was required.⁶⁵² Unsurprisingly, the Bereaved Families did not know what it meant, or the implications for the case. James Coates said: *"At the time, I did not understand that this could result in VC avoiding prison altogether."*⁶⁵³

8.74 There was plainly insufficient engagement with the Bereaved Families to prepare them. When meetings with some families finally took place, Ian's family were not invited; James' clear evidence was that he would have wished to attend.⁶⁵⁴

8.75 Throughout the process, the Bereaved Families were denied information, given it piecemeal, or required to extract it themselves. Key facts about VC's history were withheld or minimised. They

⁶⁴⁷ INQT0000039 52/14-16.

⁶⁴⁸ See HMCP0000625_0069, at [9.14].

⁶⁴⁹ INQT0000039 32/17-20.

⁶⁵⁰ HMCP0000625_0071, at [9.26].

⁶⁵¹ HMCP0000625_0072 - 73 at [9.33 - 9.38].

⁶⁵² HMCP0000625_0077 at [9.58].

⁶⁵³ WITN0128001_0011 at [39].

⁶⁵⁴ HMCP0000625_0076, at [9.52]; WITN0128001_0016.

were left struggling with legal terminology and formal processes, with no one to translate or guide them and Julian Hendy, doing his best to assist them, apparently being unwelcome.

- 8.76 It is simply not good enough for the police or the CPS to suggest that these Bereaved Families were too traumatised to engage when information was conveyed or meetings offered early in this process: even in their grief, Dr Kumar and Dr O'Malley-Kumar indicated in early July 2023 that they would wish to be involved and to have a meeting with the prosecuting team in due process.⁶⁵⁵ As to meetings, the Inquiry heard the frustration expressed by the Bereaved Families over the seemingly standard practice of meetings organised immediately before and after hearings at Court. While this may be appropriate in many cases, in cases involving families bereaved by homicide and grappling grief and trauma, the Inquiry may wish to recommend that a trauma-based approach requires more compassion. Elaine Newton explained how unhelpful it was meeting eight people at Court with no explanation of the purpose of the meeting, nor any support to understand what was said. She agreed when asked by the Chair that having a note or an agenda explaining the personnel and issues, and having someone there with you to explain, would help.⁶⁵⁶
- 8.77 Latterly, Former Det Supt Sanders accepted that information communicated to the family ought to be in writing.⁶⁵⁷ Again, we question whether this ought not to have been obvious not only for any experienced, trauma-led policing response, but for anyone exercising any element of compassion and common sense.
- 8.78 Where a preference is expressed for communication in person or by telephone, this should be respected but the information communicated also made available in a written format for later review, consideration and scrutiny.
- 8.79 **The Inquiry is invited to recommend that the CPS and police forces adopt a mandatory written protocol for communication with bereaved people in the course of any mental health homicide investigation or prosecution. In cases involving mental health related homicide, this must include explanation of Diminished Responsibility to bereaved people, including its legal meaning, case implications, and potential sentencing consequences. The Protocol should make clear that an initial indication of possible disposals should be provided at an early stage if the likelihood of a mental health defence is clear and need not wait for the receipt of a defence expert report.**
- 8.80 The Bereaved Families described feeling like “*the bottom of the shoe*”⁶⁵⁸, “*second class*” citizens⁶⁵⁹, and dealt with on an “*if needed, as asked*” basis⁶⁶⁰. They were left to advocate for themselves.⁶⁶¹
- 8.81 The Victims’ Commissioner expressed her real concern that victims are “*very much treated as bystanders in our criminal justice system*”.⁶⁶² In England and Wales (reflecting the position in the other jurisdictions in the UK), prosecutions are for the Crown and the role for the victim is

⁶⁵⁵ CPSE0006188. See also INQT0000042 46/22 - 50/20.

⁶⁵⁶ INQT0000038 37/7 - 40/5.

⁶⁵⁷ WITN0359001_0174 at [495] (First Witness Statement of Leigh Sanders).

⁶⁵⁸ INQT0000039 101/1.

⁶⁵⁹ INQT0000038 77/1 and 76/ 14–15.

⁶⁶⁰ INQT0000039 101/2-3.

⁶⁶¹ INQT0000040 42/16-21.

⁶⁶² INQT0000111 25/25 and 26/1–4.

limited. This reflects the concluding recommendation of HMCPSI that the prosecution team in VC's case ought not to have described their engagement with the Bereaved Families as consultation.

- 8.82 That Bereaved Families should be left to advocate for themselves in circumstances of extreme grief is unconscionable, and yet independent advocacy remains only a “*patchwork provision*”⁶⁶³. The Inquiry heard evidence of other systems, including in Germany, where the role of victims is formalised and may involve representation as a parallel prosecutor. The primary issue, especially for bereaved families, is a lack of voice and representation throughout the process.⁶⁶⁴
- 8.83 Family Liaison teams remain tied to the investigation and no matter how skilled will not be an independent source of support. As Mr Webber said, victims “*need people that can advocate for us, that can say, “Right, okay, we’ve got you, we’ll help you, we’ll guide you, and we’re here for you.”*”⁶⁶⁵
- 8.84 **The Inquiry is invited to recommend the provision of Independent Victim Advocates for Bereaved Families in homicide cases involving Defendants with poor mental health. In the light of the likelihood that any mental health defence may increase the legal complexity of the investigation, prosecution and ultimate disposal, Independent Victim Advocates ought to be available for all those bereaved as a result of mental health related homicide.**

H. RECOMMENDATIONS: LEGACY AND LOSS

- 9 Throughout these submissions the Bereaved Families have highlighted specific recommendations for the Inquiry to consider. There are some failings so stark that their recognition alone ought to stand as evidence of the need for change. At the conclusion of this Inquiry, there are three critical themes which must inform the Inquiry's conclusions and recommendations.

(a) Mental health care which protects patients and public safety

- 9.1 Over the last three decades focus in mental healthcare has turned away from the reality that when some people are unwell they may pose a serious risk to public safety.
- 9.2 Fear of stigmatisation is real. However, the MHA is meant to manage two risks: risk a patient poses to themselves and risk they may pose to others. Statistical and lived reality is that when some people with serious mental illness are unwell, they may seriously injure and kill. That is especially so when they are untreated and without support.
- 9.3 No witness suggested that public safety was not critical. Yet, the Inquiry heard that the emphasis on self-harm ranged from the changes to NCISH priorities to the most critical of forms and guidance utilised by staff on the ground.⁶⁶⁶ As Dr Fazel said: “*You can’t deny the evidence just*

⁶⁶³ INQT0000111 34/17-24.

⁶⁶⁴ INQT0000111 26/17-19.

⁶⁶⁵ INQT0000039 101/20 - 22.

⁶⁶⁶ NHFT0007543, for example. Dr Ackroyd highlighted that the Core Assessment form asking for evidence of self-harm but not harm to others. INQT0000059 19/13 – 22/22.

because you don't want to - just because you're worried about the risk of stigma."⁶⁶⁷ Dr James, for NHS England, took a similar view: *The way to reduce stigma is to increase transparency, isn't it? It is.*"⁶⁶⁸ Finally, Professor Appleby underlined that this approach could damage both patients and public safety: *"the worst thing that could happen to stigma is when incidents occur that cause public anxiety. So if we can help improve the safety of services in a way that makes these incidents less frequent, then that's the way to defeat stigma, not by deciding that we'd rather not talk about it"*⁶⁶⁹

- 9.4 The changes in the MHA 2025 following the major review led by Professor Sir Simon Wessely now pose a direct danger to public safety.⁶⁷⁰ As Professor Appleby said:

*"We're publicly funded, we work in a public service, we're responsible to the public and public safety should be one of our key concerns. It is one of our key concerns but it should be explicitly one of our concerns."*⁶⁷¹

- 9.5 The concerns raised by the Bereaved Families about the language in the Act are reflected throughout the existing iteration of the Code of Practice.

- 9.6 **The General Principles and associated guidance must be amended to reflect the concerns raised in this Inquiry that the approach to the MHA in practice has lost focus on risk to others and public safety.** The General Principles in the Code of Practice and associated guidance currently focus on patient rights without reference at all to public safety (the least restrictive option and maximising independent, empowerment and involvement, respect and dignity, purpose and effectiveness, efficiency and equity).⁶⁷² There is nothing in the amendment to s.118 MHA which would preclude the inclusion of an additional principle focused expressly on public safety. This should be uncontroversial given that the approach to principles in the 1983 and 2025 Acts are consistent: restrictions can only be minimised in so far as is consistent with public safety.⁶⁷³ Protecting public safety ought not to be treated only as a roadblock to removing restrictions: it ought to be viewed positively and constructively. A blinkered, head-in-the-sand avoidance of reality which allows horrors such as occurred on 13 June 2023 to continue can only increase the stigma which patients will face.

- 9.7 **For the reasons outlined above, the Bereaved Families invite the Inquiry to recommend:**

- (i) **Amendment of the MHA 2025 prior to its implementation to alter the threshold for detention and CTO to focus on the risk of harm (suggested text in the Appendix to these submissions);**
- (ii) **The MHA Code of Practice is revised to include clearer guidance on the risk of harm to others and greater respect for public safety in its application (see Section D above, and Appendix, below).**

⁶⁶⁷ INQT0000055 31/18-20.

⁶⁶⁸ INQT0000094 95/12-14.

⁶⁶⁹ INQT0000101 29/22 - 30/2.

⁶⁷⁰ The Inquiry heard that the Government's own ECHR memorandum intimated that detention would be more difficult in practice after the Act's bringing into force. INQT0000110 44/3 - 46/7.

⁶⁷¹ INQT0000101 41/4-13.

⁶⁷² INQT0000101 43/13 - 45/10.

⁶⁷³ MHA 1983, s118 2B(i) [INQY0000031] and MHA 2025, s.1 [RLIT0000036].

- (iii) **Specific Changes to the Code of Practice to include the introduction of a General Principle focused on public safety; amendment to the existing General Principles to ensure that the principle of “least restrictive” practice includes clear consideration of public safety and the risk of harm to others posed by any patient (Chapter 1); specific guidance on information sharing and multi-agency working (Chapter 10) (Sections D and E, above) and changes throughout to reflect the learning in this Inquiry (see Appendix below).**
- 9.8 Baroness Merron and William Vineall indicated that the timetable for the revised Code of Practice will allow Ministers to take into account the Inquiry’s recommendations. In April, Parliament was told the Consultation would be in early 2027.⁶⁷⁴ The Inquiry has not yet seen any proposals for consultation. If the Code of Practice were to proceed in a form which neglects to take on board the evidence in this Inquiry: the implications for the effectiveness of this process and the change which may result would be devastating.
- 9.9 **The Chair is invited to consider an interim report for the purposes of any recommendations she may make on the Code of Practice, in the event there is any indication that the Consultation were to conclude prior to the publication of the Inquiry’s report.**
- 9.10 However, if as it appears, there may be no indication as to the intended content of the Code of Practice prior to the Inquiry’s Report: there is every possibility the learning from this Inquiry may be lost, ignored or fumbled. **The Chair is further invited to delay her conclusion of this Inquiry until such time as the revised Code of Practice on the MHA is published for consultation. While required to report by 2027: tailored recommendations focused on the evidence and pertinent to the Code of Practice may invite the Chair’s ongoing scrutiny, engagement by Core Participants (including the Bereaved Families) and the Inquiry Team.**⁶⁷⁵
- 9.11 **The Inquiry is invited to recommend that the revision of the Code of Practice ought to be accompanied by a requirement for compulsory training for all involved in the care of seriously mentally ill people, including psychiatric consultants, specialist doctors, psychiatric nurses, Care Coordinators and AMHP to focus on risk and public safety.**
- (b) Justice when people who are ill kill**
- 9.12 It is beyond the scope of this Inquiry to question the sentence of VC. The Bereaved Families close this Inquiry still living with a belief he may have gotten away with murder. They believe this is a miscarriage of justice unremedied.
- 9.13 The Inquiry must reach conclusions on the questions raised within scope, concerning the handling of VC by the police and the CPS. If so found, the failings which the Bereaved Families consider patent were critical. If so found, there may be questions for Ministers and for Parliament. If so found, the Inquiry may consider greater respect for the Bereaved Families and survivors (and for

⁶⁷⁴ HC Deb, 28 April 2026, WA, UIN 127509, (tabled on 15 April 2026)

⁶⁷⁵ There is precedent set by Sir Brian Langstaff in the Infected Blood Inquiry to retain the Chair’s function for a period following delivery of an Inquiry Report in order that next steps may be subject to scrutiny. See, e.g. Sir Robert Behrens CBE, WITN0228001_0010.

the concerns proactively raised by the Webber and O'Malley-Kumar families) could have altered that course.

9.14 There are other issues of abiding concern for these Bereaved Families which may be beyond the scope of this Inquiry but which they consider central if considering a truly critical examination as to how the State treats criminality and serious mental illness. First, the Inquiry heard about reluctance to use hybrid orders and the low incidence of disposal by hybrid order. The Department of Health and the Ministry of Justice ought to be invited to consider this evidence by the Chair. Second, the evidence before this Inquiry ought to be drawn to the attention of the Law Commission Homicide Review.⁶⁷⁶

9.15 The Victims Commissioner confirms that these Bereaved Families are not the only ones who feel sidelined in the criminal justice system. Recommendations highlighted in these submissions should seek to ensure no other families are left feeling re-traumatised by their experience in a prosecution:

- (i) **A new protocol for communication between the police and CPS and Bereaved Families impacted by mental health homicide (Section F, at [8.79]).**
- (ii) **Independent Victim Advocates for all families bereaved by mental health homicide (Section F, at [8.84]).**
- (iii) **Further, the Ministry of Justice should introduce compulsory minimum CPD training for all publicly-funded prosecutors acting in homicide cases to cover regular trauma-informed advocacy and the impact of bereavement (with provision for refresher training every 3-5 years).⁶⁷⁷**

(c) A new era where tragedy triggers transparency

9.16 This Inquiry takes place as the Hillsborough Law brings hope of a new era of transparency and accountability in the face of State tragedy. The Bereaved Families find quiet hope in that prospect. They wish to acknowledge the dedicated public service of all of the families and representatives of the Hillsborough families who have worked so tirelessly to achieve this change. While their experience fosters scepticism, they believe this Inquiry has the potential to help end generations of obfuscation, defensiveness and harm.

9.17 This new era will require commitment to make each of the obligations in the Hillsborough Law real on the ground. There has, of course, been a duty of candour in health and social care for many years.⁶⁷⁸ There has been considerable investment in serious incident reporting alongside that duty. Yet, the failings in Nottingham were allowed to occur.

9.18 The Inquiry might see evidence of defensiveness and obfuscation in the reaction of the organisations after June 2023. Some brief examples are highlighted in these submissions: at its

⁶⁷⁶ SUBS0000010, [156] – [157].

⁶⁷⁷ It is anticipated that the Ministry of Justice will shortly make vulnerable witness training compulsory for publicly-funded advocates acting in serious sexual offences. A similar approach could be required for prosecutors expected to have direct contact with people bereaved in traumatic circumstances (whether in Court or in preparation for a hearing).

⁶⁷⁸ RLIT0000133.

most stark, Gary Carter’s evidence on a conversation with Dr Lloyd and Diane Hull is illustrative of an organisation seeking to avoid rather than confront the serious and obvious failures patent in VC’s care.⁶⁷⁹ In the course of this Inquiry information has come to the fore in ways not highlighted in earlier reports, whether in internal reflection or in the scrutiny by Theemis for NHS England or by HMICPS.⁶⁸⁰ Even in this Inquiry, the Chair may conclude that there has been a reluctance to accept responsibility for failure.⁶⁸¹ What everyone must agree is that it ought not to have taken the efforts exerted by these families through their experiences to secure the learning that has ultimately emerged. This Inquiry may not have the final word on accountability: but it can illustrate how without candour, reflection and responsibility there can be no true accountability.

- 9.19 The duties in the Hillsborough Law will require a change of culture across all public agencies and organisations of State. If passed, as expected, Guidance will be produced by Ministers nationally and in Scotland, Wales and Northern Ireland to inform the ethical standards of conduct which each public authority would produce to guide the conduct of officials. Public authorities will take active steps to ensure compliance with these ethical standards.⁶⁸² Elements of these Bereaved Families’ experience may inform this process, if only by highlighting how damaging and counter-productive processes which fail may be.
- 9.20 **If the Hillsborough Law is passed as anticipated, the Bereaved Families invite the Inquiry to recommend that its findings and recommendations are disseminated to all national authorities considering Guidance under the Act and all public authorities considering the new ethical standards of conduct.**
- 9.21 The Bereaved Families have repeatedly invited this Inquiry to recognise that many of the terrible failures which led to the killing of Barney, Grace and Ian could have been prevented had the changes which followed the Clunis Inquiry been respected. Where there is no mechanism for oversight and implementation of Inquiry recommendations the burden will fall to victims, survivors and bereaved families.⁶⁸³ In April 2025, the then Minister committed to potential reforms to “*enhance the framework within which inquiries are established, operated and concluded.*”⁶⁸⁴ No timetable could then be given. Since, the Hillsborough Law has progressed.
- 9.22 Sir Andrew Marsh, Sir Robert Behrens CBE, and other witnesses, highlighted the need to ensure learning from important public inquiries is embedded.⁶⁸⁵ Professor Appleby has urged the

⁶⁷⁹ WITN0368001_0085, INQT0000070 77/1 -78/4 (“*singing from the same hymn sheet*”). The Inquiry has heard other evidence on proposed meetings between clinicians seeking to discuss the approach to the post-June 2023 processes and will take a view.

⁶⁸⁰ Taking only one example: consideration of Dr Seedat’s note on 17 July concerning VC “*killing someone*”. There appears to be no earlier consideration of how this linked to the information provided in Elias’ journal. TCLT0000758, NHSE0000298_0089, NHSE0000298_0142.

⁶⁸¹ There are examples throughout these submissions and others the Inquiry may consider. We note the process of extracting evidence on CCTV from NCC has been far from straightforward: on a question which was posed by the Inquiry (and by the Bereaved Families from the outset in its clearest terms.

⁶⁸² INQY0000013, Clause 10 and 11; Clause 24.

⁶⁸³ RLIT0000056 (Framing Implementing and Monitoring Public Inquiry Recommendations, Emma Ireton, Nottingham Law School, NTU, September 2025. Contextual Briefing for the Lampard Inquiry) at [4.6]: “*In the absence of a formal mechanism for post-inquiry oversight, the burden of monitoring implementation often falls to victims, survivors, bereaved families, and advocacy groups. These individuals and groups have frequently been the driving force behind the establishment of the public inquiry.*”

⁶⁸⁴ RLIT0000055: HL Deb, 25 April 2025, Col 969. See also RLIT0000054.

⁶⁸⁵ Sir Robert Behrens CBE, WITN0228001_0010, at [29] – [30].

Inquiry to consider recommending an independent oversight mechanism specifically focused on mental health: to ensure that learning on mental health is not lost as NHS England is abolished and responsibility repatriated to the Department of Health.⁶⁸⁶ The focus on the risk from violence ought not again to be lost. The personal and public cost is too great: the Inquiry heard the annual economic impact of violence perpetrated by people with severe mental illness in 2015-16 was £2.5 billion in England and Wales alone.⁶⁸⁷ Investment in understanding and monitoring the risk to both patients and the public in the link between violence and mental health is critical.

- 9.23 If the future is to be a future where lessons truly are learned: it may be informed by the experience of these Bereaved Families and the conclusions and recommendations of this Inquiry. The Bereaved Families urge the Chair to take such steps as are necessary to help ensure that the recommendations of this Inquiry (and other Inquiries) mean something and last longer than the lost work of the Clunis Inquiry. This Inquiry has been better placed than many to assist Government in understanding the value of embedding learning from these important (and costly) processes. *“Lessons will be learned”* in this anticipated new era of candour must become something more than a clichéd platitude.
- 9.24 **The Inquiry is invited to recommend that a robust, formal mechanism for the oversight and consistent monitoring of public inquiry recommendations is established without further delay. The Department of Health should be invited to make arrangements for the independent monitoring of mental health practice nationally, with a focus on maintaining long term patient and public safety. This should include long-term ring-fenced funding for the monitoring of data on mental-health related homicide; and for the study of non-fatal violence by mental health patients.**
- 9.25 For the Webbers, the O’Malley-Kumars, for the Coates brothers and for Elaine Newton, this Inquiry has not only profound personal significance but critical public importance. They have listened to apologies and to promises of change. Sadly, for Barney, Grace and Ian, and for each of their Bereaved Families, and for Wayne, Sharon and Marcin and each of their families, change has come all too little, too late. **There must be a legacy of true change that results from this Inquiry. It must be a legacy that lasts.**

**TIM MOLONEY KC
ANGELA PATRICK
PHILIPPA EASTWOOD
RACHEL WOODWARD**

DOUGHTY STREET CHAMBERS

**HUDGELL SOLICITORS
FLETCHERS SOLICITORS**

14 AUGUST 2026

⁶⁸⁶ WITN0069001_0025 (Professor Appleby), [25], Professor Appleby, 29 May 2026.

⁶⁸⁷ WITN0075014_0002.

WRITTEN CLOSING STATEMENT ON BEHALF OF THE BEREAVED FAMILIES CPs:
APPENDIX: MHA 2025 and the MHA CODE OF PRACTICE

- 10 The purpose of this Appendix is to give greater substance to the Bereaved Families' submissions on proposed amendment to the MHA 2025 and on the associated Code of Practice. It is not intended to provide a complete and perfected view on statutory language or a complete survey of the areas of the Code which require amendment. This is not possible within the prescribed length of these submissions. The Bereaved Families stand ready to assist the Inquiry further (including in the event that any consultation on the Code of Practice is published at any time before the Inquiry concludes).

(a) Amendments to the MHA 2025

- 10.1 While the Bereaved Families have wider concerns about the MHA 2025 and its impact, these submissions are limited to the thresholds for detention and the making of a CTO. An example is given for s.5 MHA 2025 below, which can be mirrored for s.3 MHA and for s.17A (Community Orders) (as found in s.6(2)(a) MHA 2025).
- 10.2 If necessary, explanation in the Code (or further amendment) should make clear the risk concerned may be a risk to public safety; and not only to an identified person or group.

(a) Section 2 MHA (Section 5 MHA 2025)

“(b) ~~there is a risk of serious harm may be caused~~ to the health or safety of the patient or of another person unless the patient is so detained; and

(c) given the nature, degree and **likelihood risk** of the harm, the patient ought to be so detained.”

- 10.3 In the alternative, the Inquiry has the formulation proposed by the Royal College of Psychiatrists (WITN0320001_0070 at [220]). The Bereaved Families consider at a minimum the Act should be amended to require that there is a “***risk of serious harm***” to the health or safety of the patient or of another person.

(b) The Code of Practice

- 10.4 The following points of note are by no means comprehensive but are designed as an illustration as to the extent to which the Code of Practice may be impacted by learning in this Inquiry. Other elements of the current Code, including to address the statutory amendments relating to “*nearest relative*”, for example, will necessarily require wholesale revision. These points below are examples only designed to illustrate the significance of the learning in this Inquiry:

- (a) **Chapter 1: Guiding principles [DHSC0000007_0023]:** We address the need for amendment of the Guiding Principles, to add a new standalone principle on risk and public safety. However, the whole of this Chapter needs to be recast (Section H, above).
- (b) **Chapter 3: Human rights [DHSC0000007_0031]:** This Chapter currently states that “*In some instances, competing human rights will need to be considered, which may require finely balanced judgments...Decisions restricting a person’s rights will need to be justifiable as necessary and proportionate in the circumstances of the specific case. Any restriction imposed should be kept to the minimum needed to meet the purpose and aim of the restriction.*” (See [3.6] DHSC0000007_0031). Respect for individual patient rights is not in question. However, the language used in explaining the balancing exercise and the proportionality of any restriction ought not to unreasonably deter clinicians from considering the weight that ought to be afforded to the public interest in protecting public safety and the weight that ought to be afforded to protecting the rights of others (including the right to life protected by Article 2; the right to be free from inhuman and degrading treatment protected by Article 3; and the right to private life protected by Article 8 ECHR).
- (c) **Chapter 8: Privacy, safety and dignity [DHSC0000007_0064]:** This Chapter currently provides that blanket restrictions including for access to the internet or to mobile phones “*have no basis in national guidance or best practice; they promote neither independence nor recovery, and may breach a patient’s human rights.*” This goes on to explain that in some secure setting restrictions may be necessary in order to “*manage high levels of risk to other patients, staff and members of the public*”. Such guidance is currently restricted only to secure settings at [8.8]. At [8.21], policies on access to the internet are left to the discretion of hospital managers, who should have guidance on rules prohibiting inappropriate material, including websites promoting violence. There is no reference to the importance of such rules for managing risk or for therapeutic benefit, only a reminder that a blanket restriction may breach the Article 8 rights of the patient. Guidance on privacy, safety and dignity offered in the revised Code ought to carefully consider how access to material online may be restricted, controlled or monitored in non-secure settings where necessary to meet the best interests of the patient or to manage the risk to others and to public safety. It may require guidance that a longitudinal view of risk must be taken. The Department of Health is invited to consider expressly, the evidence of VC’s viewing extreme and violent material online in this context (See [2.8], above).
- (d) **Chapter 10: Confidentiality and information Sharing:** See Sections C and E, above.
- (e) **Chapter 22: Patients concerned with criminal proceedings [DHSC0000007_0223]:** The Bereaved Families consider the revision of this Chapter must be substantially informed by the evidence in this Inquiry. We note at [22.3] “*Any person...who is in need of medical treatment for mental disorder can be considered for admission to hospital where the criteria are met.*” The Inquiry may wish to consider this against the evidence of L&D’s observations of VC on 13 June 2023. This Chapter begins by placing emphasis on alternatives to custody being considered taking into account all information about the person’s needs: without reference to risk to others or public safety. Again, while this may be considered implicit, explicit consideration of risk may better inform good practice by clinicians who implement the Act.

We note that guidance is given in the current Code for doctors reporting on assessment for the purposes of Part 3 of the Act. This includes at [22.12] that the doctor should, identify and access other independent sources of information about “*the person’s previous history (including convictions). This should include information from GP records, previous psychiatric treatment and patterns of behaviour.*” In the light of the evidence before this Inquiry, the Bereaved Families would invite close consideration of the form of guidance offered to doctors on assessment. As a minimum it should spell out that all previous contact with police (including contact short of conviction) and any history of aggression or violence towards others (and the nature of such) must be considered.

The treatment of hospital orders/remands to hospital in the Code of Practice is brief and states [22.13]: “*Prison should not be the default option.*” In the light of their experience, and the statistics gathered by the Inquiry confirming the low incidence of hybrid orders, the Bereaved Families would invite reconsideration of this approach.

Separately, the Code provides guidance on reports to the Court including recommendations for disposal (at [22.18] – [22.24]). This refers to the guidance produced with the Royal College of Psychiatrists in the *Good Practice Guidance: Commissioning, administering and production of psychiatric reports for sentencing* (2010). The need for updated guidance reflected in the Bereaved Families submissions, and in the evidence, ought to inform any revision. The Department of Health may consider, for example, whether there is a need for guidance to treating clinicians on the provision of statements to police concerning a patient’s presentation in the light of the contrasting experience of Drs Seedat and Lomas.

- (f) **Chapter 27: Leave of absence: [DHSC0000007_0314]** The Inquiry has evidence of how s.17 leave was administered for VC and where risk associated with public safety went unmanaged: for example returning with a potential weapon, or using leave to return to a place where he had attacked and held hostage his former flatmates. The Code of Practice might usefully be amended to provide clear guidance on the consideration of public safety in taking decisions on leave.
- (g) **Chapters 29 and 32: Detention and CTO [DHSC0000007_0326, 0350]:** These Chapters will inevitably require substantial updates in light of the amendments in the MHA 2025. For the same reasons that the Bereaved Families consider amendment to the MHA 2025 is required before it comes into force: considerable care will be needed in formulating changes to this part of the Code to avoid defensive practice which loses sight of risk to others and to public safety. There will be a critical need for clarity on the approach to the definition of “*serious harm*”, causation and “*likelihood*” (see Section D, above).
- (h) **Chapters 33 and 34: After Care and Community Framework (formerly CPA) [DHSC0000007_0355, 0360]:** The evidence before the Inquiry concerning the failures to risk assess and to appropriately care plan for VC ought to inform the consideration of any new formulation of guidance on community care and formal after-care support for patients released from detention. To give one example: at [34.10] – [34.11] the current Code addresses who should be involved in Care Planning for a patient. It states at [34.11]: “*If a different responsible clinician is to take over responsibility for a formerly detained patient, it will be essential to seek the agreement of that clinician, and the community team, at an early stage. It is good practice for the clinician who will be the community responsible clinician and the*

community care co-ordinator to be present at CPA assessments before and after discharge.”

As above, the Bereaved Families invite the Inquiry to recommend that rather than “good practice” there should be a requirement for a Consultant to Consultant level handover when an individual is discharged from hospital to the Community; the discharge summary endorsed by the receiving clinician and any subsequent Care Plan should be specifically approved by the Community Consultant. The approach to amendments to Chapter 36 on the role of the Responsible Clinician ought similarly to be informed by the Inquiry’s evidence on the role of Consultants in VC’s care.

The current guidance offered on risk assessment and care planning in the Community, beyond s.117 MHA, is limited. While this reflects that the Code is focused on the MHA, the need for consistent guidance on the multiagency support in the Community must be a critical reflection of the evidence in this Inquiry (see Section D and E, above).

- (i) **Chapter 35: Receipt and scrutiny of documents [DHSC0000007_0367]:** The revised Code must deal plainly with the importance of accuracy and continuity in record keeping, including where care is provided in a sub-contracted setting. (While this section deals primarily with statutory documents around detention and CTOs the evidence suggests there is a need for greater clarity and consistency in relation to the receipt and scrutiny of all documents, including risk assessments, care plans, discharge summaries and Tribunal papers).
- (j) **Chapter 40: Information for victims [DHSC0000007_0394]:** This Chapter deals with information to be provided to the victims of patients detained under Part 3 MHA. The experience of each of the Bereaved Families must inform the approach taken to this Chapter. The language in the current iteration is legalistic even while directed at clinicians and professionals. A trauma-informed approach will be essential.

The Inquiry has the evidence of Julian Hendy as to the limited information shared with Bereaved Families concerning Tribunal proceedings. This may require a change which goes further than the Code. The Inquiry is invited to consider whether greater transparency may foster greater understanding of the operation of Part 3 MHA and greater respect for victims, including bereaved families: Julian Hendy, 28 May 2026 PM, 17/20 – 20/24.