

IN THE MATTER OF:

THE PUBLIC INQUIRY INTO THE NOTTINGHAM ATTACKS

CLOSING SUBMISSIONS

ON BEHALF OF THE SURVIVORS WAYNE BIRKETT AND SHARON MILLER
AND THEIR RESPECTIVE PARTNERS TRACEY HODGSON AND MARTIN
REED

1. This document is prepared on behalf of the Survivor Core Participants, Wayne Birkett and Sharon Miller, and their respective partners, Tracey Hodgson and Martin Reed, for the purpose of the closing submissions to be advanced on their behalf before the Chair of the Nottingham Inquiry.
2. The volume and scale of highly relevant disclosure provided since June 2026, is such that within these submissions a request is made for the Chair to hold a further week of evidential hearings to examine the significant matters detailed below.
3. The evidence heard at the Inquiry has revealed wide-spread and devastating multi-agency failings, both systemic across the State Agencies and individual failings such that the Chair can find as a fact that the killings by VC of Grace, Barney and Ian and the attempted murders of Wayne, Sharon and Marcin were entirely preventable.
4. The true scale of the multiple and repeated missed opportunities and failures revealed in the evidence each day in the hearings of the Inquiry has been stark. It has been difficult for the Survivors to listen to and has left them in no doubt that VC could and should have been stopped before inflicting on them their devastating and life-changing injuries. The Survivors would urge the Chair to recommend that the National Confidential Inquiry into Suicide, Homicide and Safety in Mental Health [NCI]¹ is expanded to include data collection for serious non-fatal violence with a focus on perpetrators with schizophrenia to ensure robust consideration by the NCI and to assist in lesson learning and prevention of attacks.
5. As residents of Nottingham, the Survivors have been shocked by the scale of the failings and issues revealed by the Inquiry by the State Agents in Nottingham namely the Police, mental health services both in patient and community services operated by Nottingham Foundation Trust, and Nottingham Council. The scale of the failings at Nottingham University Hospitals NHS Trust linked to data breaches and unauthorised access to their private and confidential records is alarmingly still to be determined and has caused great upset and anxiety to the Survivors.

¹ WITN0069007, para 42.

6. The Survivors want to see meaningful change so that public services for the people of Nottingham are made fit for purpose and operate always to keep the public safe. Ministerial and Government oversight of the failing state agents in Nottingham needs to be monitored. Further support for which has been revealed by the Ockenden Review and now the live Corporate Manslaughter and gross negligence manslaughter investigation into Nottingham Foundation Trust by Northumbria Police.
7. Within the recommendations the Survivors ask the Chair to request that the paused College of Policing independent review into Nottinghamshire Police's policing response and regarding the events of 13 June 2023 which was said, "*would constitute an exhaustive examination of police process, actions and policy*" is urgently undertaken.
8. For reasons expanded below there were multiple missed opportunities on each and every occasion VC was involved in incidents of violence and aggression with multiple victims from May 2020 to June 2023, which on each occasion, brought VC into contact with police and mental health services, which if properly handled would have altered the outcome for the victims on 13 June 2023.
9. This is most stark when consideration is given to the Feven incident as detailed and addressed below. Had the Feven incident been properly dealt with by the Trust and Nottingham Police and the index offence of Grievous Bodily Harm properly investigated, as the Victim herself has made clear she was requesting, VC's need for long term treatment would have been escalated. It was clear by the end of May 2020 just how dangerous VC was and the risk he presented to the public requiring detention, whether in prison or hospital, and appropriate medical treatment including effective early intervention in psychosis.
10. Time and time again the Inquiry has heard evidence from front line police officers who did not know, understand or apply Nottingham Police's own policy for the appropriate criminal investigation of offences of those with mental health issues. The Feven offence and the offence of the assault on PC Pritchard are offences where, had the true criminality and context been placed before the court there was an opportunity for VC to have been detained on a s37 Hospital Order with a s41 Restriction Order long before the events of the June 2023. As it was, the offences VC had carried out against multiple victims were improperly recorded, investigated and prosecuted.
11. The adverse consequences that would follow premature and inappropriate discharges from detention in hospital and from the community team were clear and obvious before the June 2023 attacks:
 - a. VC had paranoid schizophrenia relapsing and remitting disorder that required his mental disorder to be treated with effective anti-psychotic medication, a secure environment, monitoring and supervision but also essential psychological therapies to ensure that VC had and developed insight. As it was, VC clearly showed on each admission that he completely lacked insight. It also revealed that VC was highly manipulative.
 - b. VC's mental health would rapidly and seriously deteriorate, with a multiplication and intensification of both psychotic and affective symptoms. VC as well as positive symptoms also had negative symptoms of schizophrenia.
 - c. If VC relapsed then he would pose a very high risk to the safety of other people of psychotically driven violence, as occurred at the time of the Feven offence and with

each of VC's victims. The risk if this occurs included the risk of grave violence leading to life changing injuries to members of the public and also death.

- d. VC's physical health and safety would be at significant risk. His repeated physical aggression would leave him at risk, not just of arrest and incarceration, but of retaliation by others.

12. The failures to ensure VC's schizophrenia was treated with medication is a culpable failure.

It was abundantly clear on each occasion of violence and aggression that VC was not taking his medication, and that detention was required for a sufficient period to ensure VC was concordant with his antipsychotic medication and until he developed insight with the clear need for depot and investigation of the need for clozapine. Dr Mona Ahmed (expert psychiatrist) accepted that the offences were probably preventable if VC's paranoid psychosis had been properly treated.⁴ The need for a CTO with a power of recall was abundantly clear on each discharge from a s3 MHA period of detention but never addressed.

13. In the opening statement the Survivors highlighted NHFT had plain and clear warnings from

other never events in 2023 by the stabbings of other patients who had been patients of NHFT such as **GRO-B**, and **GRO-B** serious incident in **GRO-D** 2023, **GRO-B** a patient said to be under **GRO-D** and incidents involving **GRO-B** **GRO-B** in **GRO-D** 2023.⁵ Significantly the case of **GRO-B** a patient **GRO-D** discharged from **GRO-D** in **GRO-D** who on **GRO-D** 2023, **GRO-D** and attempted to stab members of the public. During the incident **GRO-B** sustained a fatal stab wound(s). **GRO-B** was a patient **GRO-D** **GRO-D** **GRO-D**

14. The Inquiry has revealed a systemic failure of the Trust to have a functioning or effective EIP service at any point when VC needed such intervention between 2020 and June 2023, and as the evidence has revealed before this time too due to the corporate and managerial failures at the Trust. Emails only disclosed recently⁶ [and significantly after the evidence of Dr Thangavelu and Dr Lloyd raising significant issues of lack of candour by the Trust and clinicians] show the scale of the systemic failures and the impact this has had on public safety. In summary, psychotic patients in the community in Nottingham who were not appropriately managed, supervised, reviewed or treated and failings in timely and necessary reviews, communication and care-coordination issues and systemic inappropriate discharge and differing practices. Some key highlights include:

- A woeful shortage of psychologists.⁷

⁴ Dr Mona Ahmed, 16 April 2026 PM, 126–128 INQ T0000054.

⁵ **GRO-D**

⁶ NHFT0023736, NHFT0020759, NHFT0021432, WITN0206043.

⁷ WITN0478035.

- Not acting in line with best practice guidance, higher than recommended caseloads, delivering generic not specialist EIP work, unable to meet NICE standards for EIP.⁸
- “a very concerning picture” “I am very worried about the expectations of addressing the LMHT waiting times while at the same time increasing the EIP offer, all without the extra resources actually being in place. It seems the impact of this is increased sickness and thereby stretching those staff even further.”⁹
- “EIP pathway needs some immediate managerial focus. We are currently limited in terms of what caseload cover can be offered due to how the EIP pathway is situated currently resulting in EI cases either being unallocated or staff having 2/3 caseloads which is burning staff out.”¹⁰
- 30.4.19 Dr Lloyd to Consultant Dr O’Reagan cc Dr Thangavelu in response to questions asked by Dr O’Reagan on 26.4.19 *Do you guys know how many on your case load currently and the proportion that are EIP and AO and others? Also the number on CTO? I feel my AO numbers are going up a bit and not sure if should be gate keeping more or not. Do you gate keep and decide as an MDT if you accept new ones or do you just take them referred automatically? Should we arrange to meet some time to discuss how it is going for us currently in these pathways as medics?*^{10a}

Hi, yes I would welcome a meeting. Happy to discuss caseloads but have encountered other problems. We are currently under pressure from our team leaders to discharge high risk AO clients on the grounds that they are not engaging! There seems to be a lack of understanding about the nature and ethos of AO model. I would appreciate some thoughts and advice.

- 2.2.22 Dr Lloyd to Consultant; Eileen O’Reagan

Subject: follow up appointments for EIP and AO

“Hi, just on another matter who books your appointments and lets the EIP and AO patients know when they are next due in clinic? My medical secretaries rely on the CCOs to make the next appointment and let the patient know. Often CCOs forget and overlook this and the follow up is not booked in. One patient was not seen by me for over a year which is extremely poor! I have the med secs to take on this responsibility as it is an admin function and they are not happy. Wondered what the standard practice was for patients with CCOs. I have let Karthik know.”^{10b}

- Dr Lloyd to Dr Thangavelu 3.2.22

“Morning Karthik, please see the email trail below. Do you think it is an issue that my medical secretaries don't and are not willing to send out appointment letters to patients? We have no audit trail that appointments are being offered especially if one gets missed and a patient isn't seen for many months and deteriorates. Let me know your thoughts as I do have concerns. There should really be consistent practice across the Trust/AMH on this.”^{10c}

- 8.2.22 Dr Thangavelu to Dr Lloyd:

⁸ NHFT0023070.

⁹ WITN0478033.

¹⁰ WITN0478033.

^{10a} NHFT0021261

^{10b} NHFT0023736

^{10c} NHFT0023736

“Sorry for the lateness in replying, was swamped with few things this week. With regards to booking appointment for patients with CCO , I tend to leave it to the CCOs as sometimes they ask for sooner than planned (I don't do routine 3 months etc for them anyway) and then fail to cancel the original planned or at times the med secs don't let the CCOs know and I end up seeing the patient without CCO or the day of the planned appointment if the CCO is off sick I still end up seeing them without CCO and doubles the work of having to communicate with them the outcomes etc. I feel CCOs should be accountable for booking reviews and is not a big ask as they would only have 20- 30 in their books and should be reviewing the care plans regularly”.^{10d}

Further Live Evidence

15. Throughout this Inquiry process, those who we represent have had but one objective. That objective is to achieve a thorough, fearless and critical examination of all material which can answer the fundamental questions of how, despite the knowledge and information of so many individuals and organisations as to VC's risk, violence and aggression and untreated schizophrenia failed to take actions.
16. The Survivors made clear in their opening that they wanted accountability for failings and demanded that all witnesses act with candour, transparency and frankness. Lessons must be learned. Despite this there has been late disclosure of highly relevant evidence going to the heart of the Inquiry Terms of Reference.
17. Since the Inquiry has ended substantial additional and new evidence has been disclosed such that on behalf of the Survivors, **we submit that a further small number of days should be listed to receive this evidence and to test the same by questioning.** We request that the following be recalled/called namely:
 - a. Dr Seedat¹¹, Dr Thangavelu¹², Dr Lloyd¹³ and Susan Elcock¹⁴ should be **recalled** regarding their additional statements relating to EIP recently served alongside further new statements and highly relevant exhibits to the same regarding the EIP service from **Andrew Latham¹⁵, Michelle Malone¹⁶ and Ann Wright¹⁷**. This is significant evidence as to systemic and individual failings and is relevant to earlier attacks of those discharged from the EIP too before the 13.6.23 and noting the significance of the following email from Dr Lloyd,

*“We are currently under pressure from our team leaders to discharge high risk AO clients on the grounds that they are not engaging! There seems to be a lack of understanding about the nature and ethos of AO model. I would appreciate some thoughts and advice.”*¹⁸ There has been substantial additional relevant documents and emails disclosed in Tranche 211 which should be examined in questioning too.¹⁹ We would urge the Chair before recalling Dr Lloyd, Seedat and Thangavelu to also disclose the audit as to their access of VC's RIO records before 13.6.23. This is highly relevant in light

^{10d} NHFT0023736

¹¹ WITN0163055.

¹² WITN0206015.

¹³ WITN0357004.

¹⁴ WITN0356098.

¹⁵ WITN0466001.

¹⁶ WITN0462001.

¹⁷ WITN0478001.

¹⁸ NHFT0021432, NHFT0023736_0001, NHFT0021261 and all disclosed in Tr 210 as to relevant documents regarding EIP.

¹⁹ WITN0478031, WITN0478032, WITN0478033, WITN0478034, WITN0478035, WITN0478036, WITN0478037.

of the absence of recordings and when clinicians have maintained that they did review VC's notes. The Trust confirmed in evidence this audit of the records can be done and it is clear that was requested by the bereaved at an early stage.²⁰

- b. More evidence on **CCTV** issues in light of all additional statements on this from NOCC and to call James Pykett²¹ and recall Colin Widderspin,²² Kenneth Cromwell,²³ and Brian Bussey²⁴. All of these witnesses to deal with the updated evidence regarding the significant issues relating to CCTV and monitoring on 13.6.23 and the additional late disclosed documents.²⁵ We are highly concerned as to the lack of candour on behalf of NOCC by this late disclosure and save for witness statement and exhibits, the Inquiry has only 198 "NOCC" disclosed documents on Relativity. A recently disclosed document- NHFT0020347 namely a Notification of Assessment from Social Care for VC and making clear that "VC will be needing social care support on discharge" suggests there is further relevant disclosure from NOCC that has not been disclosed and we invite the Chair to call a corporate witness to address disclosure to the Inquiry.
- c. Evidence should be heard as to the incompetent search by NGPF at 165 Burford Road and those officers responsible namely PS Martyn Toombes²⁶, PC Steve Dalton,²⁷ PC Richard Mosley²⁸, PC Daniel Vasper²⁹, Jeffrey Julious³⁰ and Adam Cooper³¹ who each should be called to deal with the failed consideration of the contents of note books and notes, the failure to search and find the phone in the bag and the responses to this new evidence as addressed in the Supplementary statements of Leigh Sanders³² and Alan Murphy³³ who should be recalled. All of this additional late disclosure and the highly relevant content of the note books recently disclosed, as well as the failure to provide the "Redrum" notes into the investigation concern the Survivors who maintain if this material [alongside the missing Bill Monteiro neighbour evidence addressed below] was before the sentencing court, it was relevant to culpability, and a hybrid order pursuant to s45A MHA would have been imposed which is an order they maintain should have been imposed ensuring a penal element to the sentence.
- d. **Data investigations:** We would ask that the Chair recall Dr Manjeet Shehmar regarding the data breach investigation and update as the current approach to their investigation and lack of progress since June 2026 has created huge uncertainty for the survivors. Further NGPF has now commissioned an audit in respect of data access as confirmed in the 3rd statement of Rob Griffin.³⁴ We suggest the Chair should hear evidence as to this and should ensure that the product of the audit is disclosed

²⁰ NHFT0019343_0006-0008 "Dr O'Malley Kumar's concern is that clinicians are not accessing past history when undertaking a risk assessment and each risk assessment is done in silo. He showed escalating violent behaviours. She would also like to ensure that a full audit is carried out in relation to who accessed records, to ensure that they had a legitimate reason for doing so, particularly post-incident."

²¹ WITN0479001.

²² WITN0224038.

²³ WITN0436003.

²⁴ WITN0438004.

²⁵ TISG0000004.

²⁶ WITN0468001.

²⁷ WITN0470001.

²⁸ WITN0463001.

²⁹ WITN0465001.

³⁰ WITN0471001.

³¹ WITN0486001.

³² WITN0359003.

³³ WITN0083004.

³⁴ WITN0074003, para 65-67.

as a matter of urgency so it can be addressed in evidence and in the Inquiry report.

Candour and Compliance Directions

18. After significant delays, the creation of the Hillsborough Law also known as the Public Office Accountability Bill, has been approved by MPs in the House of Commons on the 14.7.26 with a likely implementation in the Spring of 2027 and before the Chair is anticipated to conclude her report.
19. The legislation introduces a statutory duty of candour - requiring all public bodies and officials to cooperate proactively with investigations, reducing the future possibility of institutional cover up and non-disclosure. The late disclosure being received by the Inquiry and the absence of disclosure which would have been expected from NOCC is of real concern to the Survivors. **We ask that the Chair issues Compliance Directions now as envisaged by the Bill and against all State Agents who are Core Participants or Material Providers to ensure that disclosure obligations and candour to this Inquiry have been appropriately discharged.**

Term of Reference 1: Multifactorial Timeline

20. See ToR 4 below and Appendix 1 (timeline).

Term of Reference 2

21. Time must be taken by the Chair to examine with care the command and control of the police response on 13.6.23. Timelines and transcripts from the BWV and from the control room top desk footage are still either not in existence or incomplete. The fact that NGPF has still not provided any transcripts of the Top Desk³⁵ footage which reveals the full extent of the failures of the FIM Officer Mather is unsatisfactory.

#	Failing	Date of Occurrence	Key APP/Policy Breached	Principal Witnesses	Key Hearing Days
1	Low risk threat assessment (copy-paste)	04:05, 13.06.23	APP/NDM (threat assessment)	Mather, Allardice, Dowson, Speeden	Days 13, 14, 15, 16
2	Delay in granting firearms authority	04:08–05:30, 13.06.23	APP Armed Policing	Mather, Speeden, Allardice, Dowson, Shaw, Griffin	Days 13, 14, 15, 16, 19
3	Flawed "robbery gone wrong" assumption	04:05 onwards, 13.06.23	NDM (working strategy review)	Mather, Allardice, Dowson, Shaw, Griffin	Days 13, 14, 15, 19

³⁵ NGPF0008562R, NGPF0008563.

4	No coordinated search for suspect	04:05–05:30, 13.06.23	APP/NDM (FIM coordination duty)	Mather, Reynolds, Shaw, Dowson, Allardice	Days 12, 13, 14, 15
5	No updated threat/risk assessment	04:05 onwards, 13.06.23	APP (continuous review)	Allardice, Mather, Griffin	Days 13, 15, 19
6	Inaccurate/incomplete M/ETHANE	05:36 onwards, 13.06.23	JESIP framework	Allardice, Mather, Griffin, Chief Constable	Days 15, 19, 18
7	Inadequate briefing to armed officers	05:30 and 06:34, 13.06.23	APP (firearms briefing requirements)	Allardice, Mather, Speeden	Days 13, 15, 16
8	Ground Bronze not informed of Plato	05:30 onwards, 13.06.23	Op Plato/JESIP protocols	Shaw, Dowson, Mather	Day 14
9	Failure to convey attack severity to Gold	05:01, 13.06.23	NDM/APP (FIM duties to SFC)	Griffin, Mather	Day 19,
10	Information not shared across channels	Throughout, 13.06.23	NDM/APP (communication)	Mather, Reynolds, Shaw, Chair	Days 13, 14

22. The Survivors rely upon the following matters as being relevant to this/these issues:

- **Green** displays mention of a search.
- **Blue** references St Barnabus Cathedral search.

Chronology³⁶

04:05:10 hours: Firearms dispatched

04:05:49 hours: Taser Team deployed [NGPF0006136].

04:06:10 hours: Call received – identifies suspect travelling towards city centre on foot [NGPF0006111].

04:06:40 hours: Officer 442 (Nicholas Jamieson) agrees to drive from city centre to Ilkeston Road to search for suspect. Not a formalised search [NGPF0005090].

04:07:44 hours: Officers first arrived at the scene for Grace O'Malley Kumar and Barnaby Webber, as confirmed by Talk Group 7 [NGPF0008564R] 04:08:21 hours: Ambulance services engaged [NGPF0005091].

04:09:03 hours: Dog unit dispatched [NGPF0006136].

04:09:11 hours: "I know our priority is the victims at the moment, my only concern is the offender, we have an unknown whereabouts for him and it's unknown if going to be any future potential victims or that the offender might return to the scene". Speeden [NGPF0004732].

04:09:54 hours: Further ambulance assistance requested [NGPF0006136].

³⁶ The Inquiry has created a more comprehensive chronology of the events of 13.6.23 INQY0000011 and INQY0000012.

04:10:41 hours: Firearms arrive on scene [NGPF0006136].

04:11:02 hours: Further discussion on suspect direction of travel “I’ll start doing an area search”. Not a formalised search [NGPF0004734].

04:12:00 hours: PC Speeden arrived at the scene.

04:12:37 hours: Off duty officer has been woken up by a female shouting ‘get off me’ near St Barnabas Roman Catholic Cathedral [NGPF0006112].

04:13:00 hours: Cardiac arrest lead and specialist practitioners arrive at scene [PC Speeden, 18 March, 811 [INQT0000031].

04:13:23 hours: Area search conducted by Dean Reynolds at Ilkeston Road [NGPF0006136].

04:15:09 hours: Checks being done on 316 Ilkeston Road [NGPF0005116].

04:17:00 hours: Inspector Peter Shaw arrives on scene [WITN0411001_0038-0041].

04:17:53 hours: Further update on VC location – believed to have “gone up Ilkeston Road and believed left into the estate” [NGPF0004742].

04:19:00 hours: Cardiac arrest lead and duty commander arrive at scene [PC Speeden, 18 March, 81 INQT0000031].

04:19:02 hours: Access into 316 Ilkeston Road [NGPF0004741].

04:20:00 hours: A second ambulance crew, doctor and air ambulance arrive [PC Speeden, 18 March, 81 INQT0000031].

04:20:04 hours: Suggestion VC has gone up Hopedale Close [NGPF0004743].

04:25:00 hours: Speeden return to police vehicle with equipment used to gain entry to 316 Ilkeston Road [WITN0407001_0031].

04:26:23 hours: Further request to search for offender [NGPF0004751].

04:34:54 hours: Request for anyone free to travel to go to St Barnabus Cathedral [NGPF0004755].

04:41:00 hours: Pamela Dowson arrived at the scene [WITN0404001_0034].

04:41:06 hours: Further search near St Barnabus Cathedral ordered [NGPF0006112].

04:54:57 hours: Taser response dispatched to St Barnabus Cathedral [NGPF0006112].

04:55:24 hours: Response Sergeant dispatched to St Barnabus Cathedral [NGPF0006112].

04:55:24 hours: nothing in immediate vicinity identified at St Barnabus Cathedral [NGPF0006112].

04:59:47 hours: Further discussion re St Barnabus Cathedral incident and search [NGPF0005059].

05:09:57 hours: No trace in park near St Barnabus Cathedral [NGPF0006112].

05:12:35 hours: No trace in surrounding roads near St Barnabus Cathedral [NGPF0006112].

Failings Include:

Unreasonable Balance Between Preservation of Life and Public Safety

23. Armed Response Officers were unduly focused on first aid administration. ARV Officers are trained in more advanced and medically intensive first aid than ordinary Response Officers and carry a higher level of first aid equipment. Mather states on this basis, he did not grant a firearms authority, as his priority was to save the lives of Grace O'Malley Kumar and Barnaby Webber.³⁷
24. PC Speeden noted surprise at this prioritisation: as assisting with medical treatment did not mean AFOs could not be deployed with all their additional equipment.
25. Upon learning that the incident was a double stabbing with multiple wounds, Speeden stressed that the urgency of firearms deployment was even greater.³⁸
26. Mather did not consider armed authority to be necessary due to requiring firearms officers to provide first aid. 04:12- arrival of first ambulance, 04:17- arrival of second ambulance. He is unclear whether firearms should have been authorised at 04:21- arrival of air ambulance- as he was not present at the scene. Mather admits he may consider it appropriate for medical personnel to take over at that point but would expect firearms officers to inform him they were no longer needed for first aid. Mather failed to take a proactive approach to allow PC Speeden to assume control of the armed search nor did he authorise -what was the firmly held view of the officer on the ground who could see the nature of the brutal attack and that the criteria to deploy armed officers was met for officer and public protection.
27. PC Speeden notes that upon exit of 316 Ilkeston Road at 04:20 hours, "*AFOs were still heavily committed with medical treatment*"³⁹.
28. Mather did not accept that armed authority would have provided a more strategic approach.⁴⁰
29. At 04:32 Mather States: "*I think it's probably that he's going to be long gone now, just concentrate on those two people and the scene and stuff*"⁴¹, as from his policing experience suspects tend to "*run-away*".⁴²
30. The Armed Police and Command Protocol⁴³ states that "*Chief Officers must ensure that there is an officer immediately available in their force area to consider and authorise deployment of [and that's authorised firearms officers] ... where one or more of the criteria have been met*".
31. The deployment of AFOs "*where the officer authorising the deployment has reason to suppose*" that officers may have to protect themselves or others from a person who: *is in the possession of, or has immediate access to, a firearm or other potentially lethal weapon, or is otherwise so dangerous that the deployment of armed officers is considered to be appropriate*".
32. Mather therefore concedes that the threshold for authorising the deployment of Armed Firearms Officers had been met. However, he states that given the large number of knife-

³⁷ WIIN0034001_0035.

³⁸ Johnathan Speeden, 18 March 2026 PM, 82/9-25, INQT0000031.

³⁹ Johnathan Speeden, 18 March 2026 PM, 81/19-25, INQT0000031.

⁴⁰ David Mather, 13 March 2026, AM 86/3-7, INQT0000024.

⁴¹ NGPF0007311.

⁴² David Mather, 13 March 2026, 82/10, INQT0000025.

⁴³ NGPF0007966.

related incidents, he would be authorising armed deployment for every knife related incident if this guidance was to be read and applied literally.⁴⁴ Mather does not appear to have given thought to the possibility of VC returning to the scene and so his officers and medical personnel being vulnerable to further attack, nor the threat posed by VC to the broader public.

33. Although Mather authorised the deployment of taser officers, he states this was a “contingency”. The armed criteria however were not met.
34. Mather’s Article 2 obligation to save lives does not just concern the immediate victims but also potential victims (i.e. to take action to protect those who might otherwise be subject to immediate risk of harm). Mather admits at⁴⁵ that he does not think he gave sufficient thought to future potential victims.
35. Mather fundamentally failed to find an appropriate balance between the preservation of life and that of public safety. Specifically, he did not liaise sufficiently with the ambulance service with the appropriate resources and availability on scene to deliver first aid and to preserve life.
36. The top desk footage makes clear that Mather did not in fact have full situational awareness of the nature of the attack at Ilkeston Road. He failed to appropriately utilise the available resources particularly once other resources (by way of trained medical personnel) had arrived. Nor did Officer Mather consider a request for additional resources from other neighbouring Forces (e.g. the provision of further AFOs given his AFOs were providing life support) to assist with the search and public protection.
37. Additionally, Mather failed to implement a structured search plan. This should have been outlined and communicated to all officers, and armed authority should have been given to allow PC Speeden to take control of the armed search for VC.
38. There should also have been a clear channel for all search related information to be shared and communicated.
39. In this process, consideration should have been given (and provision made for) enhanced search strategy such as drones, NPAS and the use of live CCTV imaging to enhance the prospects of quickly determining VC’s position and apprehending him. The need for such action at this time was crucial and central to the preventability of the second wave of attacks - notably upon Ian Coates, Wayne, Sharon and Marcin. This would have pre-empted and prevented the attack on Ian and the attack in the City Centre.
40. It is of note that when the Police attended the scene at Ilkeston Road they were provided with recordings/footage of the murders from multiple resources namely CCTV, door camera footage, mobile phone and dash cam footage. It is rare that officers would attend a scene such as that and be provided with recordings of the attacks, imaging of the assailant and their direction of travel. Despite this evidence, there was no strategic engagement by way of search.

⁴⁴ David Mather, 13 March 2026 PM, 63/20-25 64/1-8, INQT0000024.

⁴⁵ David Mather, 13 March 2026 PM, 92/6-14, INQT0000024.

Disordered Scene

41. There was no factual basis for the initial assumption that the attack was a robbery gone wrong. Mather had formulated this assumption “based on calls”. The available footage demonstrated the attack, that Grace’s expensive jewellery remained as did her purse and car keys. This was clear and immediate evidence of the fact that the attack was not in the nature of a robbery.^{45a}
42. The value to engage with (and act upon) this evidence contributed to the inadequate decision- making by the Police. It resulted in lost time and opportunities in the search for VC.
43. Officers began the search of 316 Ilkeston Road at 04:07 hrs.⁴⁶ At 04:13 hrs the address was confirmed to be empty and a family address.⁴⁷ Officers were still searching at 04:20 hrs⁴⁸, despite the property having been confirmed to be empty.
44. Time was spent (and thus opportunities lost) unnecessarily focusing on 316 Ilkeston Road, despite confirmation the suspect was not inside the property (and the footage of the scene and witness accounts which confirmed that VC had left). This attests to the lack of coordination regarding scene management and search of the suspect, who was still at large and posed significant risk to public safety and wasted time/opportunity to apprehend him.

Talk Groups

45. The evidence confirms the insufficiency of police resources in the Control Room. Mather thus decided that the officers usually on Talk group 6 would move to Talk group 4, which is patched with another Talk group. Ultimately, this mismanagement of Talk groups and airwaves gave rise to further failure. Officers on the ground were left in a position of channel hopping, utilising the wrong talk group and blocking the airwaves. There was no airwave and talk group discipline on the morning of 13.6.23. The impact upon the quality of communication was to introduce chaos and disorder when clarity was needed.
 - a. **Channel 1199** is the National Interoperable Channel for Nottinghamshire; intended for use by their specialist resources. It is also used for pursuit. Local officers are advised to move onto 1199 to coordinate tactical resources. Bordering forces can also easily access 1199⁴⁹.
 - b. **Channel 1205** is the bespoke channel for Nottingham firearms officers. Mather only informed firearms officers to move to channel 1205 once Operation Plato and the firearms authority had been declared.⁵⁰
46. No clarity was given to the correct Talk Group channel to use. Critical information was missed. This lack of clarity undermined both the search for VC and the focused application of resources. Mather confirmed that there was no clear direction given to officers to stay off the interoperable 1199 channel.⁵¹

^{45a} David Mather, 13 March 2026 PM, 89/4-9; 93/2-10, INQT0000024.

⁴⁶ NGPF0005027.

⁴⁷ NGPF0005029.

⁴⁸ NGPF0004744.

⁴⁹ David Mather, 13 March 2026 PM, 38/20-25 39/1-8, INQT0000025.

⁵⁰ David Mather, 13 March 2026 PM, 41/21, INQT0000025.

⁵¹ David Mather, 13 March 2026 PM 39/22, INQT0000025.

47. Mather declared Operation Plato over dedicated Airwaves radio Talk group which could only be accessed by officers in Armed Response Vehicles and declared on Talk Group 1201.⁵²
48. In terms of preventability of the attacks in the City, Talk group allocation and management are of specific importance. The transcription of Talk group 7⁵³ is at 05:17:29 hours, only 5 minutes before the attack on Wayne.
49. The absence of clear instructions regarding the Talk groups compounded the disorder of the search.
- a. **Officer 1:** 39 21 H
 - b. **Officer2:** 39 21
 - c. **Officer 1:** Are we working off 7 still, then is everyone that was on Talk group 6 onto Talk Group 4 just to confirm,
 - d. **Officer 3:** no, the scene, the Ilkeston Road scene is on 6, Talk group 6. And everybody who normally works on talk group 6 at this time in the morning is on 7.
50. Inspector Shaw⁵⁴ stated due to channel hopping they missed integral information; including the declaration of Operation Plato.⁵⁵ The present policy requires that Operation Plato, and similar declarations, would be declared on every channel/ every relevant channel.⁵⁶
51. In relation to VC travelling down Hopedale Close, there would be an expectation of dispatchers on 1199 to update this information on the incident log, and then the Talk group 7 dispatcher to notice that.⁵⁷ He added, however, if you are driving it is unlikely you would see the log, and so would depend on operators to inform you.⁵⁸
52. This lack of clarity lead to poor communication and undermined the circulation of much needed search information.

Lost Calls

53. Further still there has been the failure of NGPF to retain and record all relevant calls received in the Control Room that day. This is yet further evidence of systemic failures at Nottingham Police.

Coordination of Search for VC: Chief Inspector Mather's Role as Force Incident Manager (FIM)

54. The following roles are integral:
- a. Force Incident Manager and Tactical Firearms Commander – CI David Mather.

⁵² NGPF0004795.

⁵³ NGPF0005162.

⁵⁴ Statement of Inspector Shaw, paragraph 78, WITN0411001.

⁵⁵ David Mather, 13 March 2026 PM, 32/23-25 33/1-5, INQT0000025.

⁵⁶ David Mather, 13 March 2026 PM, 33/21-24, INQT0000025.

⁵⁷ David Mather, 13 March PM, 15/21-24, INQT0000025.

⁵⁸ NGPF0004742 followed by NGPF0004743 and 16/4-8, INQT0000025.

- b. Strategic Firearms Commander – Assistant CC Griffin.
 - c. Operational Firearms Commander – PC Speeden.
55. CI Mather as the FIM was responsible for real-time management of incidents across the Force area. This included strategic oversight and the much-needed tactical coordination. His operations and actions from the Control Room was a major contributor to the poor coordination of the search and lack of utilisation of available resources.
 56. Their evidence confirms that there was confusion as to who had oversight of the search. Inspector Shaw presumed “top desk” was coordinating the search⁵⁹. However, Mather thought that Inspector Shaw had oversight of the coordination of the search.
 57. Mather accepts that oversight over coordination could have been better and admits it was clear that Inspector Shaw was “consumed by matters at the scene”.⁶⁰
 58. The delegation of responsibility should have been clear at the outset.

Dog Handlers

59. PC Reynolds stated his search was based upon his “instincts”,^{60a} Mather confirmed that dog handlers are best equipped to search for suspects in this type of incident. All three dog handlers were on duty on 13.06.23 and deployed to this incident.⁶¹ PC Marshall attempted this. The dog officers and drone officers are specifically trained around subject searches also.
60. As per the telematics:
 - a. PC Marshall was at Hopedale with the dog,
 - b. PC Whysall went on a mobile area search in his car around the Hopedale estate
 - c. PC Crabtree was further south.
61. Mather states that there was no structured arrangement in relation to dog units where someone provides oversight and guidance; but confirms that this would be useful for the force.⁶²

Delay in contacting Assistant Chief Constable Griffin (Gold Commander)

62. Mather contacted Griffin at 05:01. He maintains he was not calling Griffin in his capacity as SFC but rather as the on-call Gold or NPCC lead. Griffin should have been informed of the attacks immediately, to assist with a clear command structure given their clear severity and possible threat to others. On any view this was a critical incident.
63. As per the Armed Police and Command Protocol⁶³, “*in spontaneous incidents, where the initial authority is given by a TFC, an SFC should be contacted as soon as practicable and informed that an incident requiring the deployment of armed officers is taking place. Where the SFC is in a position to take a command role, and make command decisions, they should ratify or rescind the initial authority*”.

⁵⁹ WITN0411001_0023 72-73.

⁶⁰ David Mather, 13 March 2026 PM, 21/8-16, INQT0000025.

^{60a} Reynolds 13 March 2026 AM 40/14-20, INQT0000024.

⁶¹ David Mather, 13 March 2026 PM, 13/6-17, INQT0000025.

⁶² David Mather, 13 March 2026 PM, 22/10-19, INQT0000025.

⁶³ NGPF0007966_008.

as agreed by Mather⁶⁴

64. Griffin was called again at 05:53 and informed about the van attacks and the declaration of Operation Plato.
65. Griffin arrived at 06:20 but did not attend the Force Control room until 06:30. He was slow to react. His more focused and much needed intervention would have ensured a better command structure and organised, coordinated search.

St Barnabus Cathedral

66. At 04:10:08 hrs an off-duty police officer reported hearing a woman screaming “get off me”.⁶⁵
67. It is illogical and concerning that more weight was placed on the report by the off-duty police officer, than the evidence to hand via the ring doorbell. Why was Mather so easily swayed by the off-duty police officers report?
68. Mather “*deployed a load of officers to the cathedral*”⁶⁶
69. “*To any uhm one who is free to travel, start making your way to uhm Derby Road to St Barnabas Cathedral on Derby Road*”.⁶⁷ These instructions were given despite the credible information received that VC was heading to the City Centre, and the timings making it impossible for VC to have arrived at the Cathedral from the murder scene by foot. The level of resources directed to St Barnabus Cathedral was disproportionate to the evidence received. The same can only be explained by weight being given to a call from a police officer rather than a member of the public. Mather allowed this to distract him in terms of search focus and resource allocation, leaving VC free to continue roaming the streets.
70. There is one drone officer in the county of Nottinghamshire; they did “*an initial area search around the incident location, and then were tasked to the cathedral, the search there*”.⁶⁸
71. The resources that were deployed (by PS Berry) were: an ARV, dog officer, police drone, a Response Sergeant, and two Resources Officers⁶⁹. Mather later admitted that this could not have been the same attacker due to the distance from the scene and the time passed.^{69a}
72. Mather redeployed further officers to the cathedral following the initial search; as he did not find the initial search was to an adequate standard.⁷⁰
73. The utilisation of zoning paired with drone support would have significantly increased the likelihood of locating VC and thus preventing his attacks upon the survivors.

⁶⁴ David, Mather, 13 March 2026, 62-63/25-3, INQT0000024

⁶⁵ NGPF0006112.

⁶⁶ David Mather, 13 March 2026 PM, 82/17-18, INQT0000025.

⁶⁷ NGPF0004755.

⁶⁸ David Mather, 13 March 2026 PM, 30/19-21, INQT0000025.

⁶⁹ WITN0034001, para 29.

^{69a} WITN0034001_009 para 29 "looking back, the distance between the scene and the Cathedral would have been a challenge for an individual to cover on foot in the short time between calls".

⁷⁰ David Mather, 13 March 2026 PM, 82/17-20, INQT0000025.

PC Speeden Threshold for Authorised Firearms Officers (AFOs):

74. PC Speeden criticised the absence of search coordination. His multiple requests for armed authority were ignored despite stressing his concerns of potential future victims.⁷¹
75. At 04:11 hrs and 04:20 hours- Speeden asked Mather (FIM) whether he would be authorising the deployment of firearms officers; which was not given. PC Speeden confirmed the relevant criteria had been met for Authorised Firearms Officers; necessary to prevent further attacks.
76. PC Speeden remained critical of the decision not to arm at an early point, and the general lack of coordination in the search efforts, as captured in his BWV footage when he sought a debrief later that morning.

Absence of Updates

77. Crucially, Speeden did not know who was coordinating the search.⁷² Given the points concerning lack of coordination, this is hardly surprising.
78. PC Speeden was not updated on relevant information that VC was seen via CCTV footage on Hopedale Close and was a male in all black. Mather states the dispatcher should have informed Speeden, as he was of the understanding that it was still the original information that VC was heading towards the city centre.^{72a}

Decision to Call Armed Officers Back to Headquarters

79. ARV's provide Nottinghamshire with a dual role response capacity for armed incidents and serious and fatal road traffic collisions and therefore are appropriately trained and equipped to deal with the 13.06.23 attacks⁷³.
80. Further, ARVs are equipped to the minimum agreed (national) standard for Operation PLATO response.⁷⁴
81. Map showing the movements of Armed Response vehicles; [FJ72 BHZ, MA72 YMW, YB71 HTN] supports the following:⁷⁵
- a. **Graham and Hallam: FJ72 BHZ** – arrived on scene around 4:10am, leaves around 5:03am and heads to Nottinghamshire Police Headquarters.
 - b. **Yallop and Bower: MA72 YMW** – searches the area surrounding the park. 05:12am leaves scene, travels to Headquarters. 05:28am returns to scene.
 - c. **Goddard and Speeden: YB71 HTN** – arrives on scene around 4:13am, left the scene around 4:53am, brief drive around the park and returns to Nottinghamshire Police Headquarters.

⁷¹ Johnathan Speeden, 18 March 2026 PM, 83/25, INQT0000031.

⁷² Jonathan Speeden, 18 March 2026 PM, 85/3-4, INQT0000031.

^{72a} "the dispatcher ought to have told PC Speeden that the last sighting was Hopedale Close clearly he was under the understanding that it was still the original information which was heading towards the city centre", 17/4-8, INQT0000025.

⁷³ NGPF0007963.

⁷⁴ NGPF0007963.

⁷⁵ Mapped telematics can be accessed at the following link:

<file:///C:/Users/j.walker/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/GXU30F7W/Route%20Map%20-%20Telematics%20-%20Final%20Version.html>

82.05:22 – First van attack on Wayne. At the point of the van attacks on Wayne, all three ARVs were northbound, away from the city centre.

83. Within the Armed Police and Command Protocol it was Mather's responsibility to ensure an "appropriate command structure was instigated as soon as is practicable". If there was a single command structure with someone directing the AFOs then it is highly unlikely that all three vehicles would have been travelling to base at the same time.^{75a}

84. In returning to headquarters the city centre was left exposed to risk by a violent armed offender and in the run up to rush hour. Notably, firearms officers are pursuit-trained and if in the vicinity, would have had the opportunity and knowledge to properly and safely stop VC in the van before hitting our clients.

Poor Search Training

85. Mather agrees that the lack of search training for ordinary officers and armed officers was a failure:

Q: But ordinary response officers, even, I think, armed officers, don't have 'Search for human' specialist training.

A: Correct.

Q: And do you agree with hindsight that that may be seen to be an omission in the police armoury?

A: Yes, potentially".⁷⁶

86. Inspector Shaw had not received any training on how to complete his role as Response Police Inspector. Nor had he received major incident training.

87. PC Reynolds stated in evidence that he used his instincts to search for VC. Mather is later questioned whether there are any policies/ procedures/ training in relation to the search of large areas.

88. Mather confirms that dog handlers are best equipped to search for suspects in this type of incident. All three dog handlers were on duty on 13.06.23 and deployed to this incident.⁷⁷ PC Marshall attempted this. The dog officers and drone officers are specifically trained around subject searches also.

89. However, no actual search strategy was offered or volunteered in oral evidence and/or was entirely lacking from disclosure. It appears that each officer was required to and did resort to use of their own instincts to search for VC. They did so without any coordination, search strategy, and/or communication as to who was searching for which area(s) and so which area(s) were clear. Inevitably such a lack of coordination would result in some areas being searched multiple times and others overlooked altogether; prolonging the time that VC was on the run and contributing to the loss of opportunity to apprehend him before further attacks were carried out. These were attacks which were entirely preventable with a correctly coordinated and resourced search effort.

^{75a} NGPF0007966_0009 "it is the responsibility of the officers deploying AFOs to ensure that an appropriate command structure is instigated as soon as is practicable".

⁷⁶ David Mather, 13 March 2026 PM, 93/14-20, INQT0000025.

⁷⁷ David Mather, 13 March 2026 PM, 13/6-17, INQT0000025.

Inconsistent Description of VC

90. There were various descriptions given of VC across the Talk groups;
 - a. “Male around 6’2, all dark clothing, something brown on his back/bag, holding a knife when running away”.⁷⁸
 - b. “Black male, around 5’9, 5’10 tall all in black, black hood up, uhhh fat build, he’s put the knife into a man bag before leaving”.⁷⁹
 - c. “The male is wearing grey joggers underneath his black trousers and not carrying a man bag”.⁸⁰
 - d. “Dressed all in black, hood up, doesn’t look fat to me”.⁸¹
91. Varying descriptions leading to confusion during the search and uncertainty as to the individual they are looking for, different heights listed and body types, along with slight variations in outfit.
92. Again, early viewing of the footage provided from the scene would have assisted with the correct description of VC.
93. A clear image from the available footage should have been obtained to run through Police databases which would have enabled VC to have been identified early in the incident.

Nottingham Police – Utilisation of CCTV and Responsibility of Search

94. CCTV should have been properly utilised by Mather within the search for VC. Mather’s strategy regarding CCTV was wholly insufficient.
95. As per Mather’s evidence, the first contact to CCTV operators at Woodlands was at 04:09 hours. “Police request to monitor Ilkeston Road for a black male in all black”. Response: “Monitored the area and played back the cameras on Ilkeston Road but could not find the offender. Informed the police control room that the male was not seen.”⁸³ CCTV operators can listen to and participate via Talk Groups and use the technology **“Follow Me”**. The police can only watch the footage in “real time”.and are unable to backtrack or zoom/control the cameras.
96. A coordinated search should have been implemented to interrogate and monitor the local CCTV in the city. Especially given the footage of VC which ought to have allowed him to be easily identified given the conditions. It was early morning of 13.06.23, sunrise was at approximately 04:42 am and the streets were relatively quiet.
97. VC ought to have been easily identifiable. He did not appear to be trying to hide or avoid detection. After he had stolen Ian’s van he drove slowly around the City Centre, performing three-point turns, driving against the proper direction of traffic and ultimately entering into a restricted bus area before he hit Wayne. Effective monitoring of CCTV

⁷⁸ NGPF0005104

⁷⁹ NGPF0004742.

⁸⁰ NGPF0005131.

⁸¹ NGPF0004763.

⁸³ David Mather, 13 March 2026 PM,24/1-6, INQT0000025.

with a functioning system would have resulted in VC being located; if only on account of his suspicious driving.

There were failures of co-ordination between the Police and Nottingham City Council CCTV monitoring:

98. Mather confirmed that the onus to coordinate a search of CCTV is entirely on the council; they should listen to police radio waves and be actively monitoring the city in relation to what they can hear. However, this is inconsistent with the evidence of Brian Bussey. Bussey states he would have expected police officers to be giving ongoing directions to CCTV operators in respect of locating the suspect – given the seriousness of the incident. Albeit dispatch did contact CCTV operators to provide a description of VC.
99. Mather should have immediately requested and/or directed one of the officers in the control room with him to phone the City Council. Failure to do so demonstrates a lack of joined-up thinking. Mather should not have expected the call handlers to merely be listening to the channels; especially when the operators have reported issues with accessing channels. What was required was pro-active and pre-emptive instruction. Only by this means could relevant intelligence be collated and acted upon.
0. Nottingham City Council commenced searching themselves. They do not recall being specifically requested to take any action by the police.⁸⁴.

Limited Access to Talk Groups

100. Jayne Harvey detailed that CCTV operators cannot listen to talk group channels due to sensitive information; therefore, they do not have access to channel 1199.⁸⁵ As they were not on the firearms talk group/airwaves they missed the information “left into the estate”⁸⁶ and ref to “Hopedale Close”⁸⁷. Jayne confirmed that she did not hear this⁸⁸ and states that had they heard this information it would have “slightly” changed their search.⁸⁹
101. Jayne Harvey was completing a form for the police from 04:38 – 04:46. At 04:38 – 04:41 VC walks down Gregory Boulevard, as seen by Council’s CCTV. Harvey admits that due to completing the form, they missed VC at this location – a clear missed opportunity to intercept and apprehend him before he injured our clients. The other CCTV operator at the time was playing back footage to ensure nothing had been missed; and so was not reviewing the direct livestream.
102. Had CCTV been thoroughly monitored and reviewed VC would have been located sooner, and thus the attacks on our clients prevented. Harvey states that due to not being able to know what direction VC was travelling in (as a result of not being on the firearms channel) they had to fill out the incident log, as they could have been looking at any of the cameras in any direction.⁹⁰

⁸⁴ Jayne Harvey, 26 May 2026 AM, 89/10-17, INQT0000095.

⁸⁵ Jayne Harvey, 26 May 2026 AM, 82/15-22, INQT0000095.

⁸⁶ NGPF0004742.

⁸⁷ NGPF0004743.

⁸⁸ Jayne Harvey, 26 May 2026 AM, 90/18-21, INQT0000095.

⁸⁹ Jayne Harvey, 26 May 2026 AM, 93/21, INQT0000095.

⁹⁰ Jayne Harvey, 26 May 2026 AM, 102/19-22, INQT0000095.

CCTV Faults

103. Brian Bussey identifies that there were 9 cameras on the day of the attacks which were affected by the fault with the “PTZs” function- this is a fault with the pan, tilt and zoom functions. Movement (and thus images) could be delayed or erratic. The 9 cameras were recording, and images were capable of being viewed live (i.e. in real time). However, the directional facility of the cameras was not fully functional. It is confirmed by Brian Bussey at that the 9 cameras were in the Radford area which VC was travelling up on the night of the attacks.⁹¹
104. Camera 167 was the erratic camera on the morning of 13.06.23 and therefore CCTV operators’ vision of VC when he was arrested was impaired. Particularly that the Radford CCTV systems still run on an outdated analogue system.

Location of VC

105. VC was first picked up on the Clumber Street camera which runs from Upper Parliament Street to the Theatre Royal. CCTV operators observed Wayne’s collision.
106. There are a significant number of cameras (both CCTV and traffic cameras) in the 7-minute gap between the attack on Wayne and attack on Sharon, yet despite these, VC’s location was not picked up.⁹² The traffic cameras are quite old, and therefore the pictures are pixelated and difficult to move around. Further, they don’t always point in the right direction.⁹³ These defects called for and required a heightened level of scrutiny and monitoring of CCTV footage by clearly instructed personnel. Had the CCTV facilities been properly monitored further attacks could have been prevented notwithstanding the known faults by NOCC of the CCTV system. Proper monitoring of the CCTV would have resulted in VC being located. Specifically:
 - Camera 138 is on Lower Parliament Street. It offers particular insight in tracing VC’s movements – this was not referenced or revealed in evidence but in disclosure uploaded during the evidence.⁹⁴
 - The issues with camera 138 on Lower Parliament Street is a matter that NOCC have not addressed in their witness statements that dealt with the CCTV issues [significantly this is just off Milton Street where Wayne was hit and where VC passed on a number of occasions before striking Sharon on Upper Parliament Street].
 - The lack of functionality but in particular of those cameras in the city centre and this highly relevant camera 138s functionality and the issue of it not **touring** is of significant relevance [see by way of example email from Kenny Cromwell on 06/06/23 to 3 colleagues, including Brian Bussey highlighting that the VS player is not working, but also stating that “Camera 138 does not tour” and “Certain cameras are still not moving properly”].⁹⁵

⁹¹ Brian Bussey, 26 May 2026 AM, 48/23-24, INQT0000095.

⁹² RLIT0000043.

⁹³ Jayne Harvey, 26 May 2026 PM, 16/15-25, INQT0000096.

⁹⁴ NOCC0000258.

⁹⁵ NOCC0000253, NOCC0000255, NOCC0000258.

108. There is no evidence to suggest that these issues of functionality were shared or otherwise accommodated in any search or monitoring strategy. NOCC failed therefore to assist in a proper and effective search.

PC Dean Reynolds – Pursuit of VC

109. Reynolds was not given clear commands regarding search strategy⁹⁶. As with others (see above) he was therefore relying on his “instincts”.
110. Reynolds was a standard driver. He had not completed the training for pursuits course (SIPP Course).⁹⁷ He was unable to follow a vehicle that had not stopped when aware of his presence and so should not have been in pursuit of VC.⁹⁸
111. Reynolds is recorded speaking to control 12 seconds prior to the collision.⁹⁹ He states prior information given to him re Wayne’s collision was a non-stop RTC. He was not aware that this was a deliberate collision and attack. This was a failing by the control room to share.
112. It is clear that VC is aware of Reynolds’ presence; resultant of Reynolds’ manoeuvre and blue lights. Reynolds did not contact the control room at this juncture as he couldn’t get on the airwave as only one person can speak at one time¹⁰⁰. He was on Talk group 1199.
113. Telematics: - justified by Reynolds as attempting to do a traffic stop under S 163 of the Road Traffic Act.
- i. 5:29:09 – blue lights displayed.
 - ii. 5:29:13 – sirens activated for four seconds.
 - iii. 5:29:17 – sirens deactivated.
114. Sharon Miller considers that it was Reynolds’ actions and the pursuit immediately after the audibility of the sirens that she says ‘spooked’ VC and ultimately resulted in VC hitting Sharon. Reynolds should not have continued to pursue VC after he ignored the sirens as it contravenes his training and permitted actions.
115. The IOPC report states that “it was appropriate for [PC Reynolds] ... to follow the white van after an instruction from [CI Mather] in the Control Room who told a Control Room dispatcher to 'keep that unit following and reporting back the location'. This was incorrect as no instruction had been given by Mather.”¹⁰¹
116. Sounding his siren to detain VC was never communicated to Reynolds. Had the ARVs have been closer to the city, and not sent back to base, they could have been deployed

⁹⁶ Dean Reynolds, 13 March 2026 AM 22/10-17, INQT0000024.

⁹⁷ NGPF0005243.

⁹⁸ We encourage the Chair to watch the breakdown of where Officer Reynolds was in the pursuit as dealt with in questioning as there is a clear point where he should not have followed the Van and before the road where Sharon was hit.

⁹⁹ NGPF0004792.

¹⁰⁰ A concrete example of the failings caused by having no clear and strict Airwave procedure in place on the morning.

¹⁰¹ The IOPC had been supplied by NGPF with the incorrect call log to another officer after Sharon had been hit which authorised those officers [and not Reynolds] who followed VC and so there was no justification or authority for Reynold’s pursuit.

directly to Reynolds' location as soon as Reynolds had located the van which control room clearly knew from the moment Wayne was struck, had undertaken a deliberate and targeted attack, Reynolds should not have pursued, and control should have tasked and utilised the ARVs brought to stop VC as per their pursuit training.

117. A central issue is that an **officer trained in pursuit may have been able to box VC in and bring him to a stop** before he attacked Sharon Miller and Marcin Gawronski. Such action, in line with pursuit training, could have prevented the incident.

118. PC Reynold's evidence also addressed his involvement in the earlier search. No structured plan to the search was admitted by Dean Reynolds:

Q. No one commanded you or directed you, which parts of a breakdown of an area to search or look?

A. That's correct¹⁰².

119. As previously noted, there was no search plan or information of what had and had not been searched, confirmed by Dean Reynolds when he gave evidence;

Q. Were you aware of any coordinated search for this man?

A. I wasn't aware of any, no".¹⁰³

"Q. But were you liaising with the Force Control Room to say which alleyways and passageways you were searching?

A. No, I wasn't. The radio was very busy, so I was awaiting direction from anybody on the radio.

Q. So in those circumstances, there'd be nothing to add to the log from you, no shout over the radio or anything of that nature about where was being searched"¹⁰⁴

120. Superintendent Simon Allardice agreed that if it was not for VC stealing Ian Coates's van and driving into the city, he may have never been arrested;

"Q. The reality is that VC was only arrested when he was as a result of him using Ian Coates' van to run those Survivors over; that's the truth, isn't it? A. Yes, I think that's fair".¹⁰⁵

121. Reynolds further agrees to the importance of the 'Golden Hour' principles and the initial response to the scene. The initial response to the scene the following actions were poorly completed and could have meant that VC was never arrested.^{105a}

Incorrect Information Circulated Post Attack – Wayne Birkett

122. The incident log only referenced a broken clavicle, "still unable to speak but is conscious". However, what had been stated on the phone call was a "probable brain injury". This should have been recorded on the log. Allardice agreed that this was important.^{105b}

¹⁰² Dean Reynolds, 13 March 2026 AM, 22/14-17, INQT0000024.

¹⁰³ Dean Reynolds, 13 March 2026 AM, 38/10-11, INQT0000024.

¹⁰⁴ Dean Reynolds, 13 March 2026 AM, 39/13-20, INQT0000024.

¹⁰⁵ Simon Allardice, 17 March 2026 AM, 54/13-16, INQT0000028.

^{105a} 88/4-12, INQT0000025.

^{105b} 17/17-18/15, INQT0000028.

information, also regarding M/ETHANE. Severity of injury important to ensure appropriate and prompt specialist medical attention required to treat a brain injury

123. Allardice admitted that this was a mistake on his behalf not to address this matter in his statement, “Yes, I don't know why I haven't referenced it. I did hear in the clip that we have just heard just now. It wasn't a deliberate omission. I think that's perhaps a mistake on my part”.¹⁰⁶
124. Had the extent of Wayne's injuries been recorded with more accuracy, it might have allowed for ambulance staff to “appropriately prioritise their resources” and so be in a more advantageous position regarding Wayne's initial treatment and assessment. This matter is of great importance to Wayne.

Absence of Threat Assessments

125. The issue of lack of focus upon and/or engagement with ongoing threat and/or the prospect of further attack has already been addressed. Allardice agrees that Officer Mather only recorded one risk assessment in the incident logs, this was at 4:05am and noted the risk as low despite new information and intelligence coming to light; “I haven't seen any evidence of updated threat and risk assessments within the incident box”.¹⁰⁷
126. As new information comes to light, “it is incumbent on the officers on the ground, and particularly the supervisors, to ensure that is relayed back to the Control Room, and for those in the Control Room, particularly the FIM, to review the impact that has on the threat and risk as they perceive it”.¹⁰⁸
127. Mather labelled the risk as “low” in the incident report.¹⁰⁹ He stated that this was a starting point from which officers can change the assessment, further he states that if he took longer to decide the risk it takes away time for him to be expeditious- i.e. deploy tasers. However, labelling the risk as “low” is inconsistent with the decision to deploy tasers and therefore the risk is unclear to officers; as admitted by Mather.¹¹⁰
128. PC Speeden criticised the later 06:34am Tactical Firearm Commander briefing, which omitted key facts and lacked a proper threat assessment. His evidence illustrated gaps in command, communication, and understanding of firearms processes at the crucial stage of preventability when VC remained at large.

In summary, therefore, the Survivors maintain the following failures should be recorded by the Chair:

129. Inadequate Threat and Risk Assessment

Breach of the College of Policing Approved Professional Practice (APP) on armed policing, and the National Decision Model (NDM). APP requires that threat assessments be based on information known at the time, supported by historic information, and take account of the nature of the threat. CI Mather himself acknowledged this was a copy-and-paste entry made “to be expeditious” and did not represent his actual threat assessment. [04.05]^{110a}

¹⁰⁶ Simon Allardice 17.03.2026, 17/4-7, INQT0000028.

^{106a} 18/13-15, INQT0000028.

¹⁰⁷ Simon Allardice, 17.03.2026 AM, 21/6-7, INQT0000028.

¹⁰⁸ Simon Allardice, 17 March 2026 AM, 23/19-24, INQT0000028.

¹⁰⁹ NGPF0006136.

¹¹⁰ David Mather, 13 March 2026 PM, 70/16-25 71/1-25 72/1-23, INQT0000024.

^{110a} 70-71, INQT0000024.

130. Acts or actions which could or should have been taken:

CI Mather should have completed a proper THRIVE threat assessment reflecting the actual circumstances — specifically, that an armed and dangerous individual was at large having committed a frenzied knife attack — and assigned the threat level to the public, responding officers, and potential future victims as "High". This should have been done at 04:05 and should have been continuously reviewed as more information emerged (per APP and NDM requirements). The FIM or a supervisor should have ensured this assessment was updated throughout.¹¹¹

131. As previously noted, there was a failure to Grant Firearms Authority in a Timely Manner:

- CI Mather refused to authorise the deployment of armed firearms officers (AFOs) despite requests from the Operational Firearms Commander, PC Speeden, from approximately 04:08 onwards. Armed authority was not granted until shortly after 05:30 — approximately 90 minutes after the first attacks and only after VC had committed further attacks on Milton Street and Upper Parliament Street.
- Breach of the College of Policing APP on Armed Policing. The APP provides that deployment of AFOs should be authorised where "the officer authorising the deployment has reason to suppose that officers may have to protect themselves or others from a person who is in possession of or has immediate access to ... a potentially lethal weapon or is otherwise so dangerous that the deployment of armed officers is considered to be appropriate." CI Mather himself acknowledged during evidence that the test was met — a knife-enabled double stabbing — but chose not to grant authority because he prioritised the use of AFOs for first aid to the victims.¹¹²
- CI Mather should have granted firearms authority at or very shortly after 04:08 when the criteria were met and when PC Speeden first raised the issue. Had this been done, armed officers would have commenced a structured armed area search for the suspect, coordinated on the dedicated firearms channel (1205), with designated search zones to avoid duplication. In PC Speeden's evidence, this would have resulted in AFOs searching systematically rather than ad hoc. CI Mather should also have consulted the Strategic Firearms Commander (ACC Griffin) in respect of the authority, as required by APP for spontaneous incidents¹¹³.

132. Flawed Working Assumption — "Robbery Gone Wrong"

This has already been touched upon in preceding paragraphs. Its significance is apparent from the following:

- CI Mather's primary working hypothesis was that the attacks on Ilkeston Road were a "robbery gone wrong." This assumption shaped his entire response, including the refusal to grant firearms authority and the absence of a more assertive search posture. The assumption was not revisited as evidence accumulated that contradicted it.

¹¹¹ David Mather, 13 March AM, 70–71, INQT0000024; Pamela Dowson, 16 March 2026 AM, 8–9 INQT0000026; Simon Allardice, 17 March 2026 AM, 20–21 INQT0000028.

¹¹² David Mather, 13 March 2026 AM, 76–7 INQT00000247; PC Speeden, 18 March 2026 PM, 81–82 INQT0000031.

¹¹³ David Mather, 13 March 2026 AM, 57–65, 76–77, 86–91 INQT0000024; PC Speeden, 18 March 2026, 77–78, 93–95, INQT0000031.

- From approximately 04:05 on 13 June 2023 onwards there was breach of the NDM requirement to continuously reassess working strategies as new information and intelligence emerged.
- CI Mather failed to properly "spin the wheel" of the NDM to consider alternative hypotheses and update the threat assessment accordingly.¹¹⁴
- CI Mather should have critically evaluated his working assumption against available evidence, particularly once CCTV footage of the attack became available, showing it was not consistent with a robbery. He should have engaged with the NDM continuously to develop alternative hypotheses, including the possibility of a random or marauding attack, and adjusted the search strategy and firearms posture accordingly.¹¹⁵

133. Failure to Coordinate the Search for the Suspect

As identified in preceding paragraphs, this failure was ongoing. Specifically:

- There was no coordinated search for VC following the first attacks. Officers on the ground were acting on their own initiative without direction from the FIM or the control room. The search lacked strategic oversight, with no single individual coordinating search resources, areas, or CCTV efforts.
- This represented a breach of the responsibilities of the FIM as set out in the College of Policing APP and the NDM. The FIM is responsible for coordination of the response and effective management of incidents. Superintendent Allardice's evidence was that there should have been "greater oversight by a coordinating supervisor." Inspector Shaw presumed that the control room (i.e., CI Mather) was coordinating the search; CI Mather thought that the dispatchers and Inspector Shaw (or a sergeant) were doing so. Something "fell into the gaps." Individual officers, including PS Reynolds, searched on their own initiative without direction.¹¹⁶
- CI Mather, as FIM, should have ensured that a supervisor was designated to coordinate the search for the suspect, with allocated search zones, regular updates, and oversight of officer deployment. He should have directed the dispatchers to manage the search or appointed an inspector or sergeant specifically to that role. A PolSA (Police Search Advisor) could have been called out. CCTV coordination between the police control room and Nottingham City Council operators should have been actively managed and directed by the FIM or under his instruction.¹¹⁷

¹¹⁴ Simon Allardice, 17 March 2026 AM 23/25 24/1-25 INQT0000028; Pamela Dowson, 16 March 2026 AM 8; INQT0000026, TDCC Griffin, 23 March 2026 AM, 7 INQT0000036; David Mather, 13 March 2026 PM, 54–55, 86–92, INQT0000025.

¹¹⁵ David Mather, 13 March 2026 PM, 54–55 INQT0000025 (working strategy discussion); David Mather, 13 March 2026 PM, 86–92 (robbery hypothesis and NDM) INQT0000025; Pamela Dowson, 16 March 2026 AM, 16 INQT0000026 (her view: priority was catching the person); TDCC Griffin, 23 March 2026 AM, 7 INQT0000036 (Mather told him it may be connected to a robbery).

¹¹⁶ David Mather, 13 March 2026 PM, 7–21 INQT0000021; Simon Allardice, 12 March 2026; Simon Allardice, 17 March 2026 AM, 71–72; PS Reynolds, 13 March 2026 AM, 7–11 INQT0000024; Insp Peter Shaw, 16 March 2026 PM, 17, 25, 28 INQT0000027; Pamela Dowson, 16 March 2026, 12, 16 INQT0000026; TDCC Griffin, 23 March 2026, 10–11 INQT0000036.

¹¹⁷ David Mather, 13 March 2026 PM, 17–21; 21/11 INQT0000025 (gap in search oversight, "I will ultimately take responsibility"); Dean Reynolds, 13 March 2026 AM, 7–9 (searched on own initiative without direction); Insp Peter Shaw, 16 March 2026 PM, 17, 25, 28 INQT0000027 (presumed top desk was coordinating); Simon Allardice, 17 March 2026 AM, 71–72 (gap not filled by control room, Chair's intervention); CTI Opening, 23 February 2026 PM, 185–186 INQT0000001 (searches focused too much on area south and east).

- **Absence of search coordination and training.** There was no standard police training for urgent searches of human subjects beyond dog handlers. Search efforts were left to dispatchers under pressure, with no zoning or geographical coordination.

- **Earlier firearms authority and coordinated armed search.**

* PC Speeden, the Operational Firearms Commander, raised concerns about VC's whereabouts as early as 4.11 am, stating: "I know our priority is the victims at the moment, my only concern is the offender, we have unknown whereabouts for him. It's unknown if there will be future victims or that the offender might return to the scene." He and other firearms officers were frustrated that no authority to deploy firearms had been granted, which would have enabled "an armed areas search for the subject" on the firearms channel, with areas designated to avoid duplication. Had firearms authority been granted earlier, armed officers could have been deployed in a structured search rather than remaining at the Ilkeston Road scene.

- **The absence of a coordinated search strategy.**

There was no coordinated or structured search using armed or unarmed officers and resources. Inspector Shaw noted he asked Chief Inspector Mather: "We've got some cops looking for the suspect, haven't we, if not many?" and Mather responded, "He is going to be long gone now". There was no zoning, no proper liaison with CCTV operators, no helicopter request, and no drone in the air in the critical period. Superintendent Allardice conceded there should have been "greater oversight by a coordinating supervisor".

134. Failure to Update Threat and Risk Assessment as Events Unfolded

For the reasons rehearsed previously, this was a recurring and significant failure:

- The only recorded threat and risk assessment by CI Mather is the one at 04:05 (marked "Low"). There is no evidence of any updated or revised threat and risk assessment at any point thereafter in the incident logs, despite multiple further attacks (the stabbing of Ian Coates at approximately 05:20, the van attacks on Milton Street and Upper Parliament Street at approximately 05:23 and 05:29) and the declaration of Operation Plato at approximately 05:30.
- This was in breach of the College of Policing APP which requires that "as an incident progresses, regular review of available information and intelligence is necessary" and that "a threat assessment should be based on a number of matters, including information known at the time, historic information and to whom and under what circumstances the threat may occur." Superintendent Allardice agreed that the failure to update the threat assessment was "a failing" and that good practice required it to be recorded in some way.¹¹⁸
- CI Mather should have conducted and recorded updated threat and risk assessments at each significant development: upon learning of the second victim; upon receiving CCTV footage; upon learning of the stabbing of Ian Coates on Magdala Road; upon the van attacks on Milton Street and Upper Parliament Street; and upon the declaration of Operation Plato. Each updated assessment should have been recorded (in the

¹¹⁸ Simon Allardice, 17 March 2026 AM, 20–21, 24, INQT0000028.

incident log, on paper, by Dictaphone, or on body-worn video) and should have fed into revised working strategies and tactical plans.¹¹⁹

135. Inadequate and Inaccurate M/ETHANE Messages

- The M/ETHANE message added to the incident log at 05:36, following the declaration of Operation Plato, was incomplete and inaccurate. It gave the exact location as only Milton Street (omitting Upper Parliament Street), recorded "at least five units" rather than the number and severity of casualties, directed access routes through a scene location, and was never revisited or updated. CI Mather himself appeared, on top desk footage at approximately 06:41, to be uncertain whether a major incident had even been declared.¹²⁰
- This was in breach of the JESIP (Joint Emergency Services Interoperability Principles) framework which requires M/ETHANE messages to accurately record, inter alia, the exact location, type of incident, hazards, access routes, number and severity of casualties, and emergency services required. The M/ETHANE was never updated as required. At 07:00, CI Mather still lacked clarity as to the number of fatalities and believed there could be 15–20 victims.¹²¹
- CI Mather should have ensured accurate and complete M/ETHANE messages from the start of the critical incident and ensured M/ETHANE message was recorded at the time of the Plato declaration, including both locations (Milton Street and Upper Parliament Street), the accurate number and severity of casualties, and safe access routes that did not direct emergency services through active scenes. The M/ETHANE should have been continuously updated as new information emerged. CI Mather, as the FIM, bore responsibility for ensuring this situational awareness was maintained and communicated to multi-agency partners.¹²²

136. Inadequate Briefing to Armed Officers Following Firearms Authority

The cumulative effect of the various operational deficiencies are graphically demonstrated in relation to ARV/Armed officer deployment:

- When CI Mather eventually granted firearms authority (shortly after 05:30), he did so with no briefing whatsoever to the firearms officers. Top desk footage from approximately 05:48 confirmed he had provided no briefing at the time the authority was given. Subsequently, at approximately 06:34, when he gave a fuller briefing, he omitted the stabbing of Ian Coates on Magdala Road — a significant omission that

¹¹⁹ Simon Allardice, 17 March 2026 AM, 20–21 INQT0000028 (agreed it was a failing, should have taken place); Simon Allardice, 17 March 2026 AM, 24 INQT0000028 (Mather should have been aware of additional information and considered how it might change threat/risk); Survivors' Opening Statement, SUBS0000012 pages 12–13, para 52–53; CTI Opening, 23 February 2026 PM, 177–178 INQT0000001 (APP requirements for threat assessment).

¹²⁰ Top desk footage NGPF0008563 and through questioning of TDCC Griffin, 23 March 2026 PM INQT0000037 63/1-25; Simon Allardice, 17 March 2026 AM, 5 INQT0000028

¹²¹ Simon Allardice, 17 March 2026 AM, 1–12, 18–19 INQT0000028; David Mather Top Desk Footage NGPF0008563; TDCC Griffin, 23 March 2026 PM, 68–69; INQT0000037

¹²² Simon Allardice, 17 March 2026 AM, 1–12 INQT0000028 (M/ETHANE analysis, top desk footage showing lack of situational awareness); Simon Allardice, 17 March 2026 AM, 18–19 INQT0000028 (agreed M/ETHANE recording very important, not revisited), TDCC Griffin, 23 March 2026 PM, 68–69 INQT0000037 (M/ETHANE messages of poor quality, inaccurate later message at 07:07).

meant officers were not aware of the full picture of the attacks. He also inaccurately summarised the van attacks as having occurred only on Milton Street.^{122a}

- This was a Breach of the College of Policing APP which requires that briefings to armed officers include "all relevant intelligence and information as known at that time," including a detailed threat assessment addressing the threat to officers (tasked and untasked, armed and unarmed), the public, and potential future victims. Superintendent Allardice agreed that the omission of Magdala Road from the 06:34 briefing was "a significant omission" and that a fuller briefing should have been expected after the arrest of VC when the armed authority was kept in place.¹²³
- CI Mather should have provided, at minimum, a brief but comprehensive threat and risk briefing at the point of granting firearms authority, covering known information about the suspect, the nature and number of attacks, the weapons involved, and the threat to all relevant groups. After the arrest of VC, when the armed authority was maintained due to the possibility of an unknown further threat, CI Mather should have delivered a full NDM-based briefing covering all incidents including Magdala Road, the correct locations of all attacks, and a clear articulation of the threat he perceived at that time.¹²⁴

137. Failure to Communicate Operation Plato Declaration to Ground Bronze Commander

- When CI Mather declared Operation Plato at approximately 05:30, Inspector Shaw — the Ground Bronze Commander and the officer at the scene — was not informed. Inspector Shaw gave evidence that the first he learned of the Plato declaration was approximately four and a half hours later, when the daytime FIM contacted him. This meant that Inspector Shaw was unable to perform his JESIP role of coordinating with the equivalent commanders in other blue light services (ambulance and fire), and that multi-agency coordination did not take place as it should have.¹²⁵
- This was in Breach of Operation Plato protocols and JESIP principles, which require the Ground Bronze Commander to be informed of the Plato declaration so that multi-agency coordination can take place. Inspector Shaw acknowledged this was "a Plato failure" and that the organisation's execution on the night was deficient, even if the plans existed.¹²⁶
- CI Mather, upon declaring Operation Plato, should have immediately informed Inspector Shaw as Ground Bronze Commander, either directly or through the control room dispatchers. Inspector Shaw should have been told the Plato declaration had been made, briefed on the rendezvous point, forward control point, zone designations

^{122a} NGPF0008562R and NGPF0008561.

¹²³ Simon Allardice, 17 March 2026 AM, 26–29, 35–37, INQT0000028.

¹²⁴ Simon Allardice, 17 March 2026 AM, 26–29, INQT0000028 (no briefing when authority given, Allardice expected fuller briefing post-arrest); Simon Allardice, 17 March AM, 35–37, INQT0000028 (Magdala Road omitted from 06:34 briefing — a significant omission).

¹²⁵ Explored by Ms Langdale KC and others during evidence from Insp Peter Shaw, 16 March 2026 PM 39/1-25 40/1-25 41/1-25, INQT0000027.

¹²⁶ Insp Peter Shaw, 16 March 2026 PM, 41–42, 45–46, INQT0000027; Pamela Dowson, 16 March 2026 AM, 49–55, INQT0000026; David Mather, 13 March 2026 PM, 33/1-25, INQT0000025.

(hot/warm/cold), and his JESIP responsibilities, including liaison with the ambulance and fire service incident commanders.¹²⁷

138. Lack of Situational Awareness and Failure to Convey the Nature of the Attack

- When CI Mather briefed TDCC Griffin at 05:01, he described the events as potentially "connected to a robbery" and did not properly convey the mechanics or severity of the attack. TDCC Griffin's evidence was that "the actual nature or the mechanics of the attack weren't described to me at that time." CI Mather did not ask for advice on whether firearms support should be authorised, did not mention PC Speeden's requests for armed authority, and did not ask for strategic advice on the search.
- This was in breach of the FIM's duty under the NDM and APP to provide accurate, timely, and complete information to senior commanders. As Gold Commander and Strategic Firearms Commander, TDCC Griffin should have been fully apprised of the situation to enable him to make informed strategic decisions and, if appropriate, to take command or provide guidance. The failure also relates to the FIM's responsibility to consult the SFC in respect of firearms authorities in spontaneous incidents.¹²⁸
- CI Mather should have conveyed the full severity and mechanics of the attack to TDCC Griffin, including the extreme violence observed, the weapons used, that there was a lethal attacker at large, and the requests from the OFC for firearms authority. He should have sought strategic guidance from TDCC Griffin, particularly in his capacity as Strategic Firearms Commander, regarding the appropriate response posture.¹²⁹

139. Failure to Ensure Information Was Shared Across Radio Channels

As previously noted:

- Critical information, including updated descriptions of the suspect and intelligence that the van collision with Wayne Birkett on Milton Street may have been deliberate (rather than a road traffic collision), was not effectively communicated across the multiple radio talk groups in use. CI Mather acknowledged in evidence that there was no method to systematically ensure information was passed across channels, and the Chair directly challenged him on this point.
- This was in breach of the FIM's responsibility under the NDM and APP to ensure effective communication and information sharing across all responding units. The use of multiple talk groups without a mechanism to share information between them meant that officers on different channels were operating with incomplete and potentially outdated intelligence.¹³⁰

¹²⁷ Insp Peter Shaw, 16 March 2026 PM, 41–42 INQT0000027 (not told about Plato for 4.5 hours, surprised when told); Insp Peter Shaw, 16 March 2026 PM, 45–46 INQT0000027 (agreed it was a Plato failure; raised it with CI Humphries and CI Mather); Pamela Dowson, 16 March 2026 AM, 49–55, INQT0000026 (not told rendezvous point, forward control point, zones, incident commanders, roles and responsibilities).

¹²⁸ TDCC Griffin, 23 March 2026 AM, pages 7–11 INQT0000036; David Mather, 13 March 2026 AM, 52–53, 62–63, INQT0000024.

¹²⁹ TDCC Griffin, 23 March 2026 AM 7–10, INQT0000036 (nature of attack not described, no request for advice, no mention of Speeden's requests); TDCC Griffin, 23 March 2026 PM, 63–64 INQT0000037 (not informed about firearms authority requests, first became aware when reading Speeden's statement).

¹³⁰ David Mather, 13 March 2026 PM, 109–110 INQT0000025; Dean Reynolds, 13 March 2026 AM, 2–3, 10–11 INQT0000024; Insp Peter Shaw, 16 March 2026 PM, 4–8. INQT0000027.

- CI Mather should have directed dispatchers or control room staff to ensure that critical updates, descriptions, and intelligence were broadcast across all relevant talk groups. He should have considered calling in a tactical airwaves advisor. He should have ensured that a common operating picture was maintained so that all officers, regardless of channel, had the same information.¹³¹

140. Maintaining armed response vehicles (ARVs) in the city centre

- All three ARVs left the city centre and headed north to police headquarters (two to replace medical equipment), leaving the city unprotected. Chief Inspector Mather accepted there should have been an ARV resource left in the city centre. Had an ARV remained in or near the city, it could have been deployed immediately after the 5.23 am attack on Wayne to locate and stop the van before it struck Sharon at 5.29 am. The Chair is aware from the redacted document the exact location within the city as to where the ARV should have been situated in the City centre and it is therefore not speculative to say that had ARVs been there this would have prevented the attacks on Sharon and Marcin.

141. Effective use of and failure to monitor CCTV

The CCTV operators were not recontacted after VC's direction of travel towards Hopedale Close became known at 4.19–4.20 am. Superintendent Allardice conceded that "in an incident of this seriousness, [they] should, in my view, have taken the opportunity to recontact CCTV" to search cameras north of Ilkeston Road.

Additionally, no one was monitoring the city centre CCTV when the stolen van was being driven around the city centre between 5.23 am and 5.29 am, passing the police station twice this was a serious failure.

Mather conceded that if someone had been monitoring the city centre CCTV, "again, there was a real opportunity, again, to have prevented the attack on Sharon Miller," accepting the proposition as "an organisational consideration that there ought to be someone looking at the CCTV all the time".¹³²

While Superintendent Allardice's concession relates to the earlier period, it compounds the later failure: had CCTV been properly tasked, operators might have tracked VC through his route to Magdala Road and into the van, providing real-time intelligence before either van attack.

142. The seven-minute gap between the two van attacks.

Between the attack on Wayne at 5.23 am and the attack on Sharon at 5.29 am, VC drove the van past Nottingham police station twice and around the one-way system.

Superintendent Allardice's concession about the need for "greater oversight by a coordinating supervisor" of the search and the failure to pass critical information across talk groups has direct relevance to the gap between the attacks on Wayne and Sharon. The evidence shows that after VC struck Wayne at 5.23 am, he drove the van around the city

¹³¹ David Mather, 13 March 2026 PM, 109–110, INQT0000025 (Chair's intervention: "So is there not a method within the Control Room to make sure that that's passed on to the other channels?" — "There isn't."); David Mather, 13 March 2026 PM, 34–35 INQT0000025 (communications issues in debrief).

¹³² David Mather, 13 March 2026 PM, 72, INQT0000025.

for approximately seven minutes, passing the police station, before striking Sharon at 5.29 am.

The survivors' position is that the police had sufficient time to have blocked the van or deployed vehicle tactics to stop VC during this 7-minute window, and that firearms officers trained in vehicle tactics could have stopped VC had an ARV remained in the City Centre.

143. Communication failures across talk groups.

Incidents were run on different radio channels, and critical information—such as VC's direction of travel left at Hopedale Close—was not passed to the firearms officers or Bronze Commander. PC Speeden was not updated on a sighting north of Ilkeston Road and consequently directed officers toward the city centre. PC Reynolds, the pursuing officer, was on a different talk group and firearms officers were unable to communicate with him just prior to the attack on Sharon.

144. Lack of preparedness for a Plato/MTA incident.

Inspector Shaw was not even told Operation Plato had been declared, and stated that if he had been, "I do not think I would have known my roles and responsibilities". Nottinghamshire Police appeared not to have followed pertinent recommendations from the Manchester Arena Inquiry regarding command, control, communications, and training.

- The Chair should record that Nottingham Police were fundamentally ill prepared as at 13 June 2023 to deal with and respond to a Marauding or Terrorist Incident. The Home Office should undertake or direct an audit to ensure all Police Forces have undertaken training and have procedures in place that are fit for purpose to respond to spontaneous attacks and have embedded JESIP working within the local force¹³³.

Who Was Responsible for the Missed Opportunities?

Responsible Person/Body	Missed Opportunity
Chief Inspector David Mather (FIM)	Failed to conduct updated threat assessments; assessed risk as "low"; told Inspector Shaw the suspect was "long gone"; failed to grant firearms authority; failed to coordinate the search; failed to ensure CCTV operators were recontacted; failed to ensure ARV coverage in the city centre, failed to implement clear Airwave procedures for proper communication.
Inspector Peter Shaw (Ground Bronze Commander)	Focused on scene preservation rather than the suspect search; conceded he should have requested another inspector to plug the management gap
T/DCC Rob Griffin (Gold Commander)	Was not contacted until 5.01 am, nearly an hour after the first attacks; had no knowledge of or strategic oversight of the search activity; made public statements saying the police "couldn't have changed" the response, later acknowledging they were overly-definitive and lacked empathy. Lack of candour
Nottinghamshire Police (institutionally)	Systemic failures due to lack of training for a. major incidents, b. Plato incidents and Plato protocols, and c. human subject

¹³³ WITN0372004 para 12-25.

	searches; d. failure to follow Manchester Arena Inquiry recommendations
Nottingham City Council CCTV	Widespread failures in respect of City Centre CCTV functionality
PC Reynolds	Should not have pursued the van.

Term of Reference 3

Nottingham University Trust

The below chronology documents key events in respect of data breaches by members of staff of NUH. It is not intended to be an exhaustive list.

13 June – July 2023	Medical records for the deceased and injured victims are created as part of emergency and ongoing care.
July 2024	Dr Manjeet Shehmar is appointed Medical Director and GMC Responsible Officer at NUH.
4 October 2024	NUH receives an audit request from Nottinghamshire Healthcare NHS Foundation Trust following contact from solicitors representing bereaved families.
October-November 2024	NUH conducts limited audits focused on Nottinghamshire Healthcare staff; no inappropriate access by those staff is identified.
9 December 2024	Further information identifies a clinician working across both trusts who may have accessed records.
February 2025 (early)	NUH identifies evidence suggesting wider unauthorised access by NUH staff to the deceased victims' medical records.
12 February 2025	Incident logged internally; potential data breach reported to the Information Commissioner's Office (ICO). Incident Command Group is established, led by Dr Shehmar.
12-14 February 2025	NUH informs senior executives and NHS England; human resources and governance investigations begin.
19-20 February 2025	NUH issues Duty of Candour notifications to bereaved families and formally reports concerns to the GMC, ICB, and other bodies.
February-March 2025	NUH implements a two-stage investigation process (managerial fact-finding followed by independent external investigation).
21 March 2025	Solicitors for surviving victims raise concerns about unauthorised access to their medical records.
Late March 2025	NUH confirms inappropriate access may also affect surviving victims; duty of candour letters issued to them.
March-July 2025	Ongoing investigations continue; regular updates provided to families and survivors; independent investigators and counsel appointed to review decisions.
15 July 2025	Statement reflects the position of NUH investigations at this date.
25 November 2025	The Inquiry issues a further request for documents, seeking updated disclosure on the Trust's ongoing investigation into inappropriate access.
5 December 2025	Dr Shehmar signs and submits her witness statement to the Nottingham Inquiry.
December 2025	The Trust supplies additional investigation documents to the Inquiry, many later exhibited to this statement.
Late 2025	The Trust identifies concerns about audit completeness and carries out full system audits, leading to the creation of Cohort 3.

January–April 2026	Disciplinary hearings for Cohort 1 individuals are scheduled and undertaken, with some cases delayed due to staff absence.
19 February 2025	Dr Shehmar signs and submits this Second Witness Statement, updating the Inquiry on investigations, communications with families, and improvement actions.
18 May 2026	Further update provided in respect of ongoing investigations.
27 May 2026	Dr Shehmar gives evidence to the Inquiry.
24 July 2026	Meeting held with Survivors, legal team and NUH (including Dr Shehmar) to provide updates on data breaches.
30 July 2026	Further correspondence from NUH via Browne Jacobson providing updates to investigation.

Initiation of investigations into unauthorised access to Survivors’ medical records

132. The investigation into unauthorised access of the survivors’ medical records by members of staff at Nottingham University Hospitals Trust did not commence until a letter was sent by their solicitor, Greg Almond (Rothera Bray Solicitors), on 21st March 2025.¹³⁴
133. By email response, Dr Manjeet Shehmar (Medical Director and Responsible Officer to GMC) confirmed that the initial investigation into data breaches relating to the attacks on 13th June 2023 did not initially include an audit into the access of medical records belonging to the three surviving victims of VC.¹³⁵ She confirmed that the investigation had since been expanded to include the surviving victims.
134. Dr Shehmar accepted that until she had received the letter from Greg Almond on 21st March 2025, she had not been aware that there were surviving victims of the attacks on 13th June 2023:
- When asked whether she was aware that there were victims who had survived the attacks by VC prior to the contact from Greg Almond, Dr Shehmar stated that she was not aware.¹³⁶
 - Dr Shehmar stated that “if I had kind of sat and thought about it, I probably would have remembered [that there were surviving victims].”¹³⁷
 - The reason that there had been no audit prior to March 2025 in respect of the surviving victims is that “the focus was on the bereaved families”¹³⁸
 - This was confirmed again in a meeting on 24/07/2026 with surviving victims and legal representatives for NUH, with Dr Shehmar present.
148. NUH have offered limited explanation as to why the surviving victims were not prioritised equally alongside the bereaved families, save that those tasked with overseeing the audit process for unauthorised access were clearly not aware of the existence of surviving victims. This lack of institutional knowledge is inconceivable, given that NUH had

¹³⁴ NUHT0000113.

¹³⁵ NUHT0000114.

¹³⁶ Dr Manjeet Shehmar, 27 May 2026, 76/7-9, INQT0000097.

¹³⁷ Dr Manjeet Shehmar, 27 May 2026, 76/13-14, INQT0000097.

¹³⁸ Dr Manjeet Shehmar, 27 May 2026, 78/6-10, INQT0000097.

provided medical treatment to all three surviving victims in the wake of the attacks on 13th June 2023.

149. NUH hold a statutory responsibility to the victims to ensure that their data would be handled with due confidentiality.
150. Despite being on notice since October 2024 of potential data breaches in respect of the deceased victims of VC, nothing was done by NUH in the interim to investigate whether their statutory duty towards the surviving victims had been breached.
151. The significant delay between unauthorised access and disclosure to survivors is evidence of NUH's failure to comply with the duty of candour towards survivors and to treat them with dignity and transparency.
152. The survivors are concerned that if their solicitor had not raised the question of data breaches relating to their own medical records with NUH directly, it would not have been addressed at all.

Failure to consult Survivors regarding investigation

153. Even since March 2025, when potential unauthorised access into the surviving victims' medical records was identified, they have not been given any opportunity to ask questions or challenge explanations in the same way that the bereaved families have been:
 - Bereaved families were consulted on the terms of reference of different elements of the investigative process.¹³⁹
 - The views of the bereaved families were taken into account when considering an external review by barrister, Robin Hopkins, into the Stage 1 process.¹⁴⁰
 - The survivors were updated on the limited progress of the investigations relevant to them, but were not consulted.¹⁴¹
 - NUH met with the bereaved families in January 2026.¹⁴² No meeting was offered to the survivors until after the evidence was heard at the Inquiry. NUH met with the survivors and their legal representatives on 24/07/2026.
154. This is further evidence of NUH's failure to comply with the duty of candour and afford the surviving victims the dignity, respect and transparency they are entitled to.

Continued delays to investigation

155. As of 18/05/2026, in respect of Cohort 2 data breaches at NUH:
 - 141 fact-finding reviews were completed out of 164 individuals who accessed records without apparent immediate need. Therefore, 23 fact-finding reviews remained outstanding.¹⁴³

¹³⁹ WITN0226001, para 20 and 196.

¹⁴⁰ WITN0226001, para 195-197.

¹⁴¹ WITN0226001, para 208-209.

¹⁴² Dr Manjeet Shehmar, 27 May 2026, 69/15, INQT0000097.

¹⁴³ NUHT0000350.

- Of the 60 individuals who were progressed to Stage 3, 1 individual has had a hearing and received an outcome. 59 hearings and outcomes, therefore, remained outstanding.¹⁴⁴

156. Further potential unauthorised access was identified in late 2025 (cohort 3).

- A further 542 individuals (in addition to Cohort 2) have accessed records of the surviving victims.¹⁴⁵
- Dr Shehmar could not confirm that even a legitimacy test had been conducted on these outstanding cases.¹⁴⁶
- In the meantime, the 542 individuals remain employed and/or working for NUH without knowing whether they accessed records with a legitimate purpose.
- Dr Shehmar suggested that, given the prolonged treatment received by Wayne Birkett, this cohort is especially complex¹⁴⁷ and a significant amount of such access is likely to be legitimate¹⁴⁸. It is extremely unlikely that Wayne Birkett came into contact with 542 individuals in the course of his care with NUH.

157. A further update on the ongoing investigation was provided to the survivors on 30 July 2026.¹⁴⁹

- Cohort 1 – 22 individuals. The Trust expects that the outstanding disciplinary panels will be concluded by September 2026.
- Cohort 2 – 272 individuals. The Trust is committed to completing the investigation and disciplinary processes in relation to these individuals by the end of January 2027.
- Cohort 3b – 542 individuals. The Trust is unable to provide a confirmed timeframe for completion of these investigations.

158. NUH is initially focusing on Cohorts 1 and 3a (those relating to the bereaved families) and will then proceed to consider Cohort 3b alongside Cohort 2 (those relating to the surviving victims).¹⁵⁰ This is further evidence that the surviving victims have not been prioritised equally alongside the bereaved families by NUH in their investigations.

159. The most recent summary of unauthorised access to records is as follows:¹⁵¹

- The total number of individuals who have been identified as part of the Trust's audits as having accessed these records is 836.
- 542 out of 836 individuals have not been reviewed to date.
- Of the remaining 294 individuals, at present, 201 of these individuals have been identified as having legitimately accessed the records, requiring no further action and

¹⁴⁴ NUHT0000350.

¹⁴⁵ WITN0406067, para 27.

¹⁴⁶ Dr Manjeet Shehmar, 27 May 2026, 83/16-84/16, INQT0000097.

¹⁴⁷ Dr Manjeet Shehmar, 27 May 2026, 84/12-16, INQT0000097.

¹⁴⁸ WITN0406067, para 27.

¹⁴⁹ Letter sent by Browne Jacobson to Rothera Bray, 30/07/2026, ROBR0000003.

¹⁵⁰ WITN0406067, para 27.

¹⁵¹ Letter sent by Browne Jacobson to Rothera Bray, 30/07/2026, ROBR0000003.

having no case to answer. Investigations into potentially illegitimate access by 80 individuals are ongoing.

- 13 people were found to have accessed records inappropriately and received disciplinary sanctions following a disciplinary panel. 8 individuals have been dismissed.
- Processes remain ongoing in relation to the remaining individuals, and further updates will be provided in due course.

Continued lack of candour

160. NUH continue to fail to comply with their duty of candour:
161. NUH have repeatedly refused to confirm that the bereaved families and survivors would be provided with factual context of the data breaches.¹⁵² In particular, NUH have repeatedly failed to confirm whether the names of the individuals who are the subject to disciplinary proceedings will be provided to the bereaved families and survivors. The bereaved families and survivors cannot make referrals to regulators or engage in those processes without details about the nature and scope of the illegitimate access.
162. This is a particularly pertinent issue for the survivors and their families. They live in Nottingham and continue to receive care and treatment from staff at NUH. NUH has failed to provide any assurances that those members of staff under investigation will not be involved in the care and treatment of the survivors and their family members while the investigations remain ongoing.
163. This limits transparency and restricts the bereaved families and survivors' knowledge of what information has been shared about themselves and/or their family members.
164. Furthermore, these matters have been referred by NUH to the police for investigation. No further information about the police investigation has been provided by NUH or the police. It is cause for concern to the survivors that the investigating police force is NGPF rather than an independent police force.

NHFT

165. Counsel for NHFT has confirmed that, following investigations, there were no data breaches found by members of NHFT staff. This was due to a system-wide lockdown that prevented members of staff from accessing relevant data without due cause from 13/06/2023 onwards.

Nottinghamshire Police Force

The below chronology documents key events in respect of data breaches by members of staff of NGPF. It is not intended to be an exhaustive list.

14 th June 2023	NGPF first become aware of members of staff accessing the incident on the police system without a "policing purpose". It was decided that there was no time to conduct audit checks, so incidents of inappropriate access should be dealt with on a case-by-case basis by line managers unless the access was "more intrusive". ¹⁵³
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¹⁵² Dr Manjeet Shehmar, 27 May 2026, 58-60, 70/15-25, 71/1-16, 81/2-9, INQT0000097.

¹⁵³ WITN0044001, para 66.

18 th June 2023	Audit conducted of who had accessed Niche records relating to the 13 th June 2023 attacks between 13 th June 2023 and 16 th June 2023. ¹⁵⁴
22 nd June 2023	Email sent to all members of staff reminding them of expectations relating to inappropriate access to the incident file. ¹⁵⁵
13 th July 2023	IOPC referral made regarding Sarah Rutherford (Front Counter staff member) due to allegation of computer misuse.
20 th July 2023	PC Gell misconduct interview.
29 th July 2023	Sarah Rutherford given caution for “causing a computer to perform a function to secure or enable unauthorised access”.
1 st September 2023	SC Skenderaj admits that he viewed BWV footage that was captured in relation to the VC investigation. Further investigations showed that he had accessed footage of Barney and Grace receiving medical assistance and being placed in body bags. He had also accessed the Niche record of VC and the occurrences linked to Sharon and Wayne, as well as other records relating to VC. He accessed the information while at home and admitted he had no policing purpose for doing so.
13 th September 2023	SC Skenderaj resigns.
14 th September 2023	Misconduct investigation finds PC Gell has a case to answer for gross misconduct for sharing operational information without lawful authority and accessing Niche systems in relation to VC without a policing purpose.
20 th September 2023	First discussion between DCI Gould, D/Supt Williams and FLOs in relation to informing the bereaved families about the ongoing PSD investigations. FLOs DC McVey, DC Farrell and DS Kimberley were included in the email chain. DC Johal was not. ¹⁵⁶ ACC Griffin indicates he is keen for the families to find out about the PSD investigations from the police, rather than elsewhere.
22 nd September 2023	Coates family are informed of PC Gell PSD investigations by FLO without authorisation. ¹⁵⁷
12 th October 2023	SC Skenderaj case is referred for an Accelerated Misconduct Hearing.
13 th October 2023	D/Supt Sanders states there should be no dialogue with families in relation to PSD matters. ¹⁵⁸
29 th November 2023	The misconduct investigation against Sarah Rutherford concluded that she had had searched NICHE for the VC and accessed his record as well as records relating to a Nottingham address VC was showing as linked to. She had accessed a NICHE nominal record, viewed SAFE Command and Control incidents relating to the events of 13 th June 2023 and conducted intelligence searches for the subject VC. She did not view any CCTV or Body Worn Video evidence.
11 th December 2023	Accelerated Misconduct Hearing finds that SC Skenderaj would have been dismissed without notice had he still been serving. He was placed on the Barred List.
12 th December 2023	D/Supt Sanders emailed T/Supt Reynolds requesting a list of PSD investigations and noted that the family would ask why they had not been informed of the PSD matters to date.

¹⁵⁴ NGPF0007874.

¹⁵⁵ NGPF0007866.

¹⁵⁶ NGPF0007867.

¹⁵⁷ DCI Gould, 26 March 2026 PM, 19/12-14, INQT0000042.

¹⁵⁸ WITN0044001, para 156.

14 th December 2023	ACC Griffin states he believed that some information had already been disclosed re PSD investigations.
15 th December 2023	It was decided that disclosure of PSD matters at that time was not appropriate.
18 th December 2023	D/Supt Sanders documents in his log that following a meeting with the head of PSD, FLOs should be appraised of the PSD matters so that they could provide a briefing if required. It would need to be delivered a time when they can digest and understand.
19 th January 2024	Misconduct panel finds that PC Gell committed gross misconduct. He is given a 2 year Final Written Warning.
14 th February 2024	Emma Webber is told about PC Gell's misconduct hearing by a source who was present. ¹⁵⁹
20 th February 2024	CC Kate Meynell writes to all families setting out the detail of each PSD investigation and outcome. She apologised that they had not been kept up to date and stated they had not intended to keep matters hidden.
23 rd February 2024	Email from Tracey to CC Kate Meynell – informs that Wayne and Tracey were already aware of PSD investigations and had found out via social media. ¹⁶⁰
5 th April 2024	A Police Misconduct hearing finds that the allegations against Sarah Rutherford were proven to the level of gross misconduct and determined that she would be dismissed with immediate effect. She was placed on the Barred List.

Lack of candour

163. From the outset, NGPF did not take potential data breaches relating to the 13th June attacks seriously. It was stated on 14th June 2023 that “this case is such that it is impactful on the whole force and... if we did an audit this officer wouldn't be the only one” and that there would be a “very high volume” cases of potentially unauthorised access to work through.¹⁶¹ It is alarming that NGPF recognised there was likely a high number of cases but were initially reluctant to investigate further.

164. When discussions did commence about informing the families about the PSD investigations into data breaches, DC Johal (the surviving victims' FLO) was not included in the correspondence. It appears that the police had not considered the need to disclose the PSD investigations to the surviving victims at this stage.

165. Despite knowing about potential data breaches from 14th June 2023 and discussing the need to inform the victims about the ongoing PSD investigations, the surviving victims and bereaved families were not formally told about the PSD investigations and data breaches until 20th February 2024.

166. DCI Gould stated in evidence that the families should have been informed as early as September 2023.¹⁶²

¹⁵⁹ WITN0289001, para 123.

¹⁶⁰ NGPF0007144.

¹⁶¹ NGPF0007863_0002.

¹⁶² DCI Gould, 26 March 2026 PM, 28/12-16, INQT0000042.

167. By the time the information was formally provided to the surviving victims, Wayne and Tracey had already heard about the PSD investigations via social media, which was an entirely inappropriate way for them to find out.
168. The data breaches at NGPF were concerning to Wayne, in particular. Due to his brain injury, Wayne did not recall the accident. He feared opening his phone and seeing leaked CCTV footage of the attacks on social media. Without detailed information about the data breaches from the police, this fear continued.
169. The failure by NGPF to properly communicate information about the data breaches to the bereaved families and survivors until February 2024 shows a lack of candour and disregard for the dignity and rights of the victims.

Ongoing investigations

170. In her witness statement dated 5th December 2025, Superintendent Kathyn Craner accepted that there had been no audit into the viewing of video footage from 13th June 2023 with no policing purpose by members of staff. She could not identify a policy decision for this.¹⁶³
171. In March 2026, NGPF confirmed that an audit would take place.
172. The surviving victims were updated on 14th July 2026 and told that audits are either completed, ongoing, or planned in respect of NICE, DEMS, Video Manager, EPICS, PNC, NICHE, SAFE, Bridgeford Research Drive, EMRN and Big Job Drive.
173. Because the police have failed to conduct these audits within a timely manner, it is likely that individuals who have inappropriately accessed data have remained as serving officers despite potential misconduct. An audit has now been commissioned as confirmed in the 3rd statement of Rob Griffin.¹⁶⁴

The Big Job Drive

174. The Big Job Drive was being used by Nottinghamshire Police as a storage location for sensitive case material, separate from standard police systems.
175. Records relating to the 13th June 2023 attacks were stored on the Big Job Drive, including CCTV footage of the attacks. Hayley Williams stated was “astounded” that this material was being stored on a relatively insecure drive where hundreds of officers and staff could access it.¹⁶⁵
176. On 15th April 2026, the survivors’ legal team formally requested that the audit activity be expanded to include the Big Job Drive.
177. As of 14th July 2026 when an update was provided to the survivors by East Midlands Police in respect of ongoing audits, no audit activity has commenced but data has been secured.
178. As a result, it is not yet clear the extent to which data breaches occurred at NGPF, given the extent of the ongoing audit activity.

¹⁶³ WITN0044001, para 137.

¹⁶⁴ WITN0074003, para 65-67.

¹⁶⁵ WITN0417001, para 26.

Nottingham City Council

14 th July 2023	Three members of Nottingham City Council's Community Protection Service access the Niche occurrence records relating to the 13 th June attacks.
June/July 2023	An audit of police systems identified that council employees had accessed Niche occurrences relating to the attacks on 13 th June 2023, including the occurrence relating specifically to Wayne without authorisation or policing purpose.
6 th July 2023	The police inform the council of the potential data breaches involving their employees.
24 th July 2023	Meetings at NGPF HQ take place with employees and line manager from the council. Employees receive
20 th February 2024	Bereaved families and survivors are informed of "three partner agency staff" being involved in data breaches via correspondence from CC Kate Meynell.
7 th March 2024	Sanjoy Kumar makes further enquiries relating to which "partner agencies" were involved. ¹⁶⁶
8 th March 2024	Emma Webber contacts Nottingham Post stating that she has been made aware that three members of the city council's community protection service have been disciplined after accessing information about the Nottingham attacks. ¹⁶⁷ Nottingham Council provide statement to families detailing their employees' involvement.
18 th March 2024	Letter of apology sent by Leader of the Council Mr David Mellen to the bereaved families. ¹⁶⁸

166. Colin Wilderspin could not recall seeking clarification from the police to establish whether the families had been properly informed of these data breaches.¹⁶⁹

167. Nottingham City Council only reached out to the bereaved families about the data breaches by their own employees when they had no other choice due to the enquiries made by Sanjoy Kumar and Emma Webber.

168. The surviving victims were never contacted by the council to explain the involvement of their own employees or to apologise. This is another example of the surviving victims being treated differently to the bereaved families.

169. As above, this caused particular distress for Wayne, who was concerned about CCTV (which was owned by the council) being released to the public and accidentally viewing it online.

¹⁶⁶ NOCC0000237.

¹⁶⁷ NOCC0000237.

¹⁶⁸ WITN0224016.

¹⁶⁹ Colin Wilderspin, 26 May 2026 PM, 56-57, INQT0000096.

HMPPS / HMCTS

16 th June 2023	Case first received by Nottingham Magistrates Court.
17 th June 2023	Case sent to the Crown Court.
25 th January 2024	Court Senior Probation Officer was contacted by the Delivery Manager at Nottingham Crown Court regarding inappropriate access to files.
1 st February 2024	Counter Fraud team's investigation into the ten HMPPS staff's access of files.
16 th May 2024	Counter Fraud team began investigations into HMCTS staff access of
21 st May 2024	Seven referrals to Nottinghamshire Police following Counter Fraud team's investigation into ten HMPPS staff members.
October 2024	Two HMCTS staff members are dismissed and one resigns following investigations.
19 th December 2024	SEROCU contact Tracey to inform her that they are investigating potential data breaches by HMPPS and HMCTS after a file was sent to them by Nottinghamshire Police.
23 rd April 2025	Incident Panel and Data Protection Team concluded that although the access to the records constituted a data breach, it did not meet the threshold for reporting to the Information commissioner's Office or the victims, victims' families or the offender.
May 2026	File returned to CPS. Decision not to proceed with prosecution made by police/CPS.

179. Despite being aware of potential data breaches from January 2024 onwards, no efforts were made by these organisations to inform the survivors of the data breaches. Amy Holmes stated that this was because the threshold of data protection policies had not been deemed to have been met for notifying the individuals of inappropriate access.

180. Amy Holmes accepted that active consideration should have been given to contacting the bereaved families and survivors to avoid them finding out from the police and/or the media. The MOJ guidance and policies have been updated so that provision of information to impacted parties is actively considered in the future.¹⁷⁰

181. Amy Holmes admitted that there should have been restricted access to the file as it qualified as a "Case of Special Sensitivity" and an invite-only feature should have been implemented from the outset.¹⁷¹ This was not done until 23rd May 2025.

SEROCU investigation

182. Further information relating to data breaches at HMPPS and HMCTS has been provided via Thames Valley Police. It is not clear the extent to which these cases overlap with those outlined above.

183. On 19th December 2024, SEROCU (South-East Regional Organised Crime Unit) wrote to Tracey and informed her that there were ongoing investigations in relation to data breaches at HMPPS and HMCTS.

184. In a letter dated 26th June 2026, SEROCU confirmed that an investigation found that six employees had illegitimately accessed the case file relating to the crime against Wayne.

¹⁷⁰ Amy Holmes, 14 April 2026 AM, 97, INQT0000049.

¹⁷¹ Amy Holmes, 14 April 2026 AM, 83/14-22, INQT0000049.

Interviews were conducted. The police chose not to proceed with prosecution in four out of six cases due to insufficient evidence to request CPS advice. The CPS made the decision not to proceed in the remaining two cases due to insufficient evidence to give a realistic prospect of conviction.

189. Sharon was never contacted by SEROCU in respect of any potential data breach by staff at HMPPS or HMCTS. It is unclear why Tracey was contacted on Wayne's behalf in respect of the data breaches and Sharon has not been directly informed. If there were no data breaches involving Sharon's personal information, then she should have been informed of this.
190. Due to the vague nature of the correspondence provided by SEROCU, the surviving victims are still unaware of the nature and extent of the data breaches involving them.

Key themes for Terms of Reference 3

191. There are three common themes across all agencies in respect of data breaches:
1. A failure to create and/or implement systems to ensure that data is secured and restricted to those with authorised access when an organisation is involved in a high-profile case, thus preventing the data breach from the outset.
 2. A failure to provide appropriate training and enforce policies on data protection within their organisations.
 3. A failure to comply with their duty of candour to victims when a data breach has been identified.
192. These failures have led to the rights of the surviving victims being disregarded in favour of the protection of organisational reputation.

Term of Reference 4

KEY FAILURES

193. **Failures in Information sharing between Agencies**

*"The law does not prevent appropriate information sharing... to the contrary, it permits it and indeed, on occasion may even mandate it"*¹⁷² [Alex Ruck-Keane]

*"...Confidentiality does have limitations; it's not absolute. You can share information when people give their consent. You can share information if it's lawful, if there is thought to be a risk to others, certainly.... You should ideally tell the person that you're going to do this, unless you think that that in of itself is going to create harm"*¹⁷³ [Professor Lade Smith]

*"There needs to be an improved inter-agency briefing network"*¹⁷⁴ [PS Louise Ellis]

194. **Failures in Risk Management**

¹⁷² WITN0288001_0078.

¹⁷³ Professor Lade Smith, 1 June 2026, 15/22-25 and 16/1, INQT0000103.

¹⁷⁴ WITN0038001_0013, para 42.

“The way in which was being documented and formulated was not indicative of a dynamic approach to risk assessment and management. That is to say, risk was not considered to be changeable based on the presence of known hazards and in the context of different settings”¹⁷⁵ [Theemis Report]

195. Police Absence of Knowledge of Policy for Dealing with Persons of Mental Health [NGPF0006002]

“An enormous part of the response officer’s work was attending suicidal risks, mental health...”¹⁷⁶ [PC Jamie Severn]

“There’s just a lot of policies and procedures. You don’t know them all”¹⁷⁷ [PI Sharonjit Powar] “It’s all e-learning... it is all sort of e-learning packages for mental health training”¹⁷⁸ [PC Marsden]

“As a police force, we have a number of policies. I wouldn’t say that I am fully conversant with any particular policy”¹⁷⁹ [PC Johnson]

196. Cumulative NHFT Failures

Whilst VC was under the care of NHFT “there were a series of errors, omissions and misjudgements”¹⁸⁰ [CQC]

197. Overall Failure of the EIP Service

Where EIP “fell short was around the organisational structural governance structure above us”¹⁸¹. “We didn’t feed into the wider LMHTs. We were kind of a standalone team. So, if there were any changes to be made in processes or structures, we wasn’t part of that or to know that”.¹⁸²

FAILINGS OF THE UNIVERSITY

Failure to Proactively Seek Information About VC's Mental Health Upon First Admission (May/June 2020)

198. The University should have proactively sought out full details of the incidents leading to VC's admission, including from the police, and should have considered whether the Withdrawal on the Grounds of Health and Safety policy (then in force) should have been invoked.¹⁸³ The policy permitted withdrawal where "concerns surrounding the health and safety of other students and staff are also central to the decision-making process".

Failure to Require Medical Evidence on Return from Voluntary Interruption of Study (September 2021)

199. VC took a Voluntary Interruption of Study in November 2020 and returned in September 2021. The University did not require any medical evidence that VC was fit to return to

¹⁷⁵ NHNB0018966_0171.

¹⁷⁶ PC Jamie Severn 3 March 2026 AM 35/13-16, INQT0000010.

¹⁷⁷ PI Sharonjit Powar, 2 March 2026 AM, 53/14-15, INQT0000008.

¹⁷⁸ PC Richard Marsden, 26 February 2026, 2/9-14, INQT0000007.

¹⁷⁹ PC Matthew Johnson, 5 March 2026, 56/19-21, INQT0000014.

¹⁸⁰ CQCM0015215_0003.

¹⁸¹ Emma Robinson Interview [NHFT0019593_0003].

¹⁸² Emma Robinson, 5 May 2026, 50/1-4, INQT0000071.

¹⁸³ Professor Katherine Linehan, 9 March 2026 AM, 26/1-15, INQT0000016.

study.¹⁸⁴ The Voluntary Interruption of Study policy in force at the time permitted the university to "require a student to provide medical evidence that they are fit enough to engage with academic study prior to the next period of proposed relation".¹⁸⁵ Because the Fitness to Study policy had not been invoked, the box requiring medical evidence was not ticked. Critically, during his interruption, VC had assaulted a police officer on 3 September 2021, been detained under Section 2 of the Mental Health Act, and assaulted his flatmate Sebastian — none of which was known to the University at the time.

200. Professor Linehan accepted that the Voluntary Interruption of Study form did not have the relevant box ticked because the Fitness to Study policy had not been invoked, and acknowledged this has since been changed.¹⁸⁶ The Chair asked whether the mental health service "should have done really" (had input into such situations), and Claire Thompson responded: "I think in an ideal world, yeah".¹⁸⁷

Failure to Invoke Fitness to Study or Code of Discipline Following the Raleigh Park Incident (January 2022)

201. On 15 January 2022, VC placed his flatmate Christopher in a headlock and prevented him and another flatmate from leaving their flat, prompting Christopher to call the police twice.¹⁸⁸ The University became aware of this incident on 17 January 2022. On 18 January 2022, the University also learned for the first time that VC had been recently sectioned (September/October 2021), had assaulted a police officer, and was currently disengaging from community treatment and had run out of medication.¹⁸⁹ Despite this accumulation of information about VC's risk, no formal Fitness to Study process or Code of Discipline proceedings were commenced.¹⁹⁰
202. The University should have formally invoked the Fitness to Study policy and/or the Code of Discipline.¹⁹¹ The Fitness to Study policy (in force at the time) permitted referral at Stage 2 where "a student's behaviours give cause for significant concern",¹⁹² and at Stage 3 could lead to suspension or exclusion.¹⁹³ The Code of Discipline included as misconduct: "Violent, indecent, disorderly, threatening or offensive behaviour ... affecting or concerning a University student".¹⁹⁴ The University should also have considered whether VC's continued presence at the University posed an unacceptable risk to other students, particularly given what it had by then learned about the September 2021 assault, sectioning, and ongoing disengagement.
203. Claire Thompson accepted that the Fitness to Study policy "potentially could have been" triggered in January 2022, but said "at that point the focus was on his care and treatment".¹⁹⁵ She also accepted the Code of Discipline "potentially" could have been used.¹⁹⁶ She conceded that none of the misconduct or Fitness to Study policies were "acted

¹⁸⁴ Professor Katherine Linehan, 9 March 2026 AM, 33–34, INQT0000016.

¹⁸⁵ Professor Katherine Linehan, 9 March 2026 AM, 32/10–18, INQT0000016.

¹⁸⁶ Professor Katherine Linehan, 9 March 2026 AM, 33/13–25, INQT0000016.

¹⁸⁷ Claire Thompson, 25 February 2026 PM, 101/22–25, INQT0000005.

¹⁸⁸ Claire Thompson, 25 February 2026 PM, 55/1–15, INQT0000005.

¹⁸⁹ Opening Statement University, page 28, SUBS0000002.

¹⁹⁰ Claire Thompson, 25 February 2026 PM, 87/1–15, INQT0000005; Professor Katherine Linehan, 9 March 2026 AM, 53–54, INQT0000016.

¹⁹¹ Claire Thompson, 25 February 2026 PM, 46–56, INQT0000005.

¹⁹² Professor Katherine Linehan, 9 March 2026 AM, 28/1–11, INQT0000016.

¹⁹³ Claire Thompson, 25 February 2026 PM, 50/1–10, INQT0000005.

¹⁹⁴ Claire Thompson, 25 February 2026 PM, 55/5–15, INQT0000005.

¹⁹⁵ Claire Thompson, 25 February 2026 PM, 54/16–21, INQT0000005.

¹⁹⁶ Claire Thompson, 25 February 2026 PM, 55/17–20, INQT0000005.

on".¹⁹⁷ Professor Linehan said that the Code of Discipline and Fitness to Study were "considered" by MHAS, but conceded there was "no documentation to support that or the escalation" and she could not identify who considered them, how they were considered, or what factors were assessed.¹⁹⁸ She accepted that consideration of temporary suspension or exclusion "is not documented".¹⁹⁹

Failure to Involve Academic Staff/Tutors in Monitoring VC After His Discharge (February 2022 Onwards)

204. VC was discharged from hospital on 24 February 2022 and returned to complete his studies. No measures were put in place by the University to involve VC's tutors in identifying signs of deterioration in his mental health or disengagement from academic work.²⁰⁰ The University's MHAS did not establish any monitoring arrangement with the academic staff, despite knowing that academic stress was a potential trigger for VC's psychosis.
205. The University should have established a formal plan involving VC's personal tutor and relevant academic staff to monitor his engagement with studies and identify any signs of deterioration, as part of a coordinated support plan.²⁰¹ Claire Thompson's own email of 19 January 2022 stated she would check with VC's academic department how he was engaging and that "if he is not progressing academically, we may need to consider urgent Fitness to Study",²⁰² but this was not followed through into any formal process.
206. When asked why no measures were put in place to involve tutors in identifying signs of deterioration after discharge, Claire Thompson did not provide a clear answer.²⁰³ Eleanor Turner accepted that her engagement with VC was "reactive rather than proactive".²⁰⁴
207. The University emphasised that VC had transferred to the BEng degree, which required only one final report, and that he liaised with academics to complete this and graduated in July 2022.²⁰⁵
208. It is highly significant that the attacks on 13.6.23 commenced in eyesight of Raleigh Park and with the names of the students he attacked in his backpack. This suggests this was part of the motivation for the attacks on 13 June 2023 and selecting two students as his first victims.

FAILINGS OF NOTTINGHAM CITY COUNCIL

209. Following VC's detention under s.3 MHA, he qualified for s117 aftercare from the Local Authority. It is a significant and systemic failure that there is no evidence that at any stage anyone from NOCC engaged with, spoke to, assessed, undertook a Care Act Assessment for or provided support with accommodation to VC. This is set against the timeline and background of his admissions and discharges.

¹⁹⁷ Claire Thompson, 25 February 2026 PM, 91, INQT00000005.

¹⁹⁸ Professor Katherine Linhean, 9 March 2026 AM, 54/1–25 and 55/1–6, INQT00000016.

¹⁹⁹ Professor Katherine Linhean, 9 March 2026 AM, 53/10–25, INQT00000016.

²⁰⁰ Claire Thompson, 25 February 2026 PM, 67–68, INQT00000005.

²⁰¹ Claire Thompson, 25 February 2026 PM, 68/1–12, INQT00000005.

²⁰² Opening Statement University, page 33, SUBS00000002.

²⁰³ Claire Thompson, 25 February 2026 PM, 67–68, INQT00000005.

²⁰⁴ Eleanor Turner, 25 February 2026 PM, 79/8–10, INQT00000004.

²⁰⁵ Opening Statement University, page 5, SUBS00000002; Counsel for the Bereaved Families, 24 February 2026, page 56, INQT00000002.

210. Christopher Atherton confirmed that local Authorities have aftercare obligations and duties to individuals that are discharged under s.3, which encompasses: healthcare, social care, employment services, and supported accommodation. These services exist to meet the person's wider social, cultural and spiritual needs, if these needs arise or are related to their mental disorder, to help reduce the risk of deterioration in the patient's mental condition. Christopher Atherton agreed that this is a "vital component" in a patient's overall treatment and care.
211. Despite being discharged twice under s.3 MHA, NOCC did not assess whether VC needed aftercare services.²⁰⁶ Christopher Atherton deferred responsibility to the treating hospital, stating that a decision on whether the Local Authority has an obligation to meet a patient's needs upon discharge is made by the discharging hospital or agency.²⁰⁷
212. Further, NOCC AMHPs had seen and assessed VC on numerous occasions and should have also flagged VC as an individual who qualified for and needed support under s117.
213. A recently disclosed document, namely a Notification of Assessment from Social Care for VC, makes clear that "VC will be needing social care support on discharge" in October 2021.²⁰⁸
214. There has been a fundamental failure by NOCC to discharge their s117 duty to VC

TIMELINE OF INTERACTIONS AND FAILURES

24 May 2020

Criminal Damage

215. VC arrested at 00.20 on 24 May 2020 at Brook Court by PC Katie Eustace for criminal damage. At the time of her attendance, VC was "*outside flat 11 and another member of the public within flat 11 preventing him from entering*"²⁰⁹. VC was taken into custody, arriving at 00.47 and underwent a physical examination at hospital, and a subsequent full Mental Health Act assessment (MHAA) at 14.00 on 25 May 2020, which resulted in referral to the crisis team. VC was interviewed by PC Gail Collins and released under investigation back to Brook Court at 19.18.
216. NGPF failure to take heed of the occupants' (of flat 11) concerns when VC was discharged back to Brook Court. Occupants were concerned that "he may try and gain entry or cause further issues for them if he is released"²¹⁰. Failure by Police and Healthcare to consider risk to the public and actions necessary to mitigate that risk.
217. Failure by PC Eustace to arrest VC for attempted burglary rather than criminal damage which she reflected on in her statement.²¹¹
218. Failure by NGPF to retain evidence. Loss of PC Katie Eustace's body worn footage which she had saved. She alerted the Inquiry Team that it could not be found and agreed there

²⁰⁶ Christopher Atherton, 11 May 2026 AM, 19/23, INQT0000079.

²⁰⁷ Christopher Atherton, 11 May 2026 AM, 21/8-12, INQT0000079.

²⁰⁸ NHFT0020347.

²⁰⁹ WITN0007001_0004, para 20.

²¹⁰ NGPF0000068_0010.

²¹¹ WITN0007001_0004-5.

- should have been a log on the Police system, and an audit trail in respect of the footage.²¹² Absence of specific training in relation to mental health for NGPF officers despite mental health being an enormous part of their workload. PS Anthony Wilde, custody sergeant confirmed the absence of such training “I can’t recall any specific training in place during our custody course.”²¹³
219. Inadequate care plan by PS Wilde to consider VC’s mental health. This care plan was completed at 01.03 on 25 May 2026 and PS Wilde recorded for officers to be “cautious” as PS Wilde noted VC’s “*behaviour is a little strange*”.²¹⁴
 220. PS Wilde recorded on the custody record that VC appeared to be having a mental health episode. VC was seen by the Liaison and Diversion Service and subsequently underwent a full MHAA.
 221. Inappropriate delay in MHAA. Referral took place at 09.15 but delay for CRHT gatekeeping until 12.12 (Annette Palmer)²¹⁵. The Mental Health Crisis Care Concordat confirms “*Responses to mental health crises should be on a par with responses to physical health crises. This means that health and social care services should be equipped to deal safely and responsively with emergencies that occur at all times of day and night, every day of the year.*”²¹⁶
 222. Inter-agency failures in information sharing: the MHAA team were not aware of the damage caused by VC to the door (kicked off the hinges) or that VC was continuing to attempt to enter the property when Police arrived and had to be restrained and handcuffed. Dr Gandhi accepted that he was not made aware of information regarding VC’s offending, including the fact that he had caused damage to one flat door, but was still attempting to enter another flat when police arrived, and that the occupants of flat 11 had raised concerns if VC were to be released. He confirmed “*any risk assessment is incomplete without any information that’s not been given to us or withheld from us.*”²¹⁷
 223. Dr Malik, present at both MHA assessments, confirmed that during the first MHAA, he was not aware that VC’s mother had indicated she would travel from Wales. He acknowledged that if concerns are raised by a family, who would like them to wait until discharge, they can make those arrangements. “If someone is raising concerns and she would like for us to wait here... and I’ll give you an example we’re assessing somebody on a 135 or we have done the decision and that, for whatever reason, you know, they can’t go and if they need to stay a bit, we can make those sort of arrangements...”²¹⁸
 224. Failure by Ben Williams to update Dr Malik and Dr Gandhi about VC’s mother’s concerns and her telephone conversation²¹⁹.
 225. Flawed decision making in MHAA: despite conclusion of the assessment that VC lacked capacity to consent to treatment²²⁰, Dr Gandhi states that Annette Palmer persuaded the

²¹² Inspector Katie Eustace, 26 February 2026 AM, 68/3-24, INQT0000006. Highly suspicious loss of this relevant footage to be viewed also in light of the complete absence of investigation by Nottingham Police of the release of VC from his first period of detention and the failings which allowed VC to then attack Feven. For Feven then to be told that on any view a s18 offence GBH offence was being closed down raises the question as to there having been a complete lack of scrutiny of the Police’s failures that allowed the attack on Feven to be carried out.

²¹³ PS Anthony Wilde, 2 March 2026 AM, 2/1-2, INQT0000008.

²¹⁴ PS Anthony Wilde, 2 March 2026 AM, 7/16-17, INQT0000008.

²¹⁵ NOCC0000044, WITN0115001_0012.

²¹⁶ HOMP0000013_0033.

²¹⁷ Dr Gandhi, 21 April 2026 PM, 13/9-11, INQT0000058.

²¹⁸ Dr Malik, 21 April 2026 AM, 75/20-25, INQT0000057.

²¹⁹ WITN0085001_0006, para 21.

²²⁰ NHFT0000168_0002 and NOCC0000044_0005.

team that care at home would be the safe alternative²²¹. Concerns that Annette Palmer may have opted against detention and for release due to the over representation of black males in inpatient settings.

226. Failure by Ben Williams to record the likelihood of risk of aggression as high (recorded as medium).

227. Failure by NGPF following the MHAA to record all relevant information in the custody record. *“A record must be made in the custody record of... any clinical directions and advice, including any further clarifications, given to police by a healthcare professional concerning the care and treatment of the detainee in connection with any of the arrangements made...”*²²² Acceptance by PS Wilde that there had been a failure to record all relevant information in the detention log.²²³

228. Stark failures by PC Collins as the investigating officer:

- a. Did not review the detention log prior to interview.
- b. Did not question VC’s 2 addresses in interview- VC stated his address was 48 Salisbury Street but that he resided at 7 Brook Court.
- c. Failed to consider any risks to other occupants at Brook Court and action required to mitigate such risks.
- d. Investigated the crime in isolation to the crime to Feven which occurred shortly after release from custody. She did not consider the Feven crime because *“it wasn’t in relation to my inquiry”*²²⁴ and *“because he got sectioned. After the incident had occurred after he had been released from custody he then got arrested and then he was sectioned.”*²²⁵
- e. Failed to undertake reasonable lines of inquiry in the investigation: including obtaining information as to VC’s detention. Contact was only made with Highbury Hospital on 22 January 2021 as a result of instruction from Sergeant Palethorpe.
- f. Failed to provide regular updates about the investigation and take proactive steps to investigate this crime.
- g. Inappropriately closed the crime under outcome 12 with no clear rationale.
- h. Failure to add a mental health marker to VC’s record for this crime.

229. Inappropriate release back to Brook Court due to focus on least restrictive option despite reservations from Dr Gandhi *“as a new patient, you do not know how their illness will respond to treatment, how the course of the illness will progress and how this will inform the risk”*²²⁶ and reference to *“blind spots”*.

230. VC was released home with no medication and with no one present, without any family member involved in the MHAA despite his mother’s wish for him to be kept at the police station until she could arrive from Wales. Failure to consider VC’s best interests:

²²¹ WITN0302001, para 120.

²²² RLIT0000005_0040, section 9.15.

²²³ PS Anthony Wilde, 2 March 2026 AM, 24/11-14, INQT0000008.

²²⁴ PC Gail Collins, 26 February 2026, 58/13, INQT0000007.

²²⁵ PC Gail Collins, 26 February 2026, 58/21-24, INQT0000007.

²²⁶ WITN0302001, para 127.

When assessing what is in an individual's best interests, "if it is appropriate and practical to do so, consult other people... in particular try to consult anyone previously named by the person as someone to be consulted, anyone engaged in caring for the person, close relatives, friends or others who take an interest in the person's welfare... For decision about major medical treatment or where the person should live, and where there is no-one who fits into any of the above categories, an Independent Mental Capacity Advocate must be consulted".²²⁷

231. Despite MHAA relying on crisis team follow up as the least restrictive principle, VC was released from custody before administration of medication.
232. Failure by Annette Palmer, Clinical Lead and who had attended the first MHAA, to complete a Datix in accordance with her professional duty when she was informed about Feven jumping out of the window sustaining injury at the time she attended on 25 May 2020 to deliver VC's medication (after VC had been arrested on the second occasion).
233. Ms Palmer accepted that the incident would have triggered an incident reporting investigation, enabled an opportunity for the Trust to have interrogated what records the police had, what the failings were in the assessment and enabled, in May 2020, the most robust assessment of what went wrong on 24 May 2020. "*Q. Do you agree that you personally had a role and you failed in your personal obligations under candour and for Datix incident. There may be other people issues as well, but you personally, with the first-hand knowledge you had, failed? A. Yeah, I admit that I could have tried to put something on...*"²²⁸

25 May 2020

Feven

234. VC was arrested by PS Stephen Swift at 21.14 on 25 May 2020 shortly after he had been released back to Brook Court under investigation. He undertook a risk assessment at 21.41.
235. A clear NGPF failure to recognise and respond appropriately to the extent of Feven's injuries. The PNC record states "*female has fallen approximately 10-12 feet and has suffered back pain from the fall. IP was very scared and in shock. IP in hospital for precautionary scans.*"²²⁹ [METF0000003] which meant that the seriousness of this crime was never accurately recorded. This had a clear ongoing impact when individuals and agencies accessed the PNC.
236. The seriousness of Feven's injuries was apparent immediately. "*Q Why do you think it was very obvious? A Because I was very much in pain. I could not stand or sit right with my back.*"²³⁰ There was no attempt to update or amend this inaccurate record.
237. Failure to treat Feven's injuries as Grievous Bodily Harm. PC Sharonjit Powar accepted that "*looking at the injury level*" the crime on Feven "*should have been treated as Grievous Bodily Harm*"²³¹ and should have been referred to the CPS to take a decision on charge- email from Nicholas Hall to ACC Rob Griffin.²³² Repeated failure by NGPF to explain why this crime was not treated with the utmost seriousness and recorded accurately when NGPF was fully aware of the extent of Feven's injuries: key theme of disregarding victims of crime.

²²⁷ NHFT0015597_0006, 0030.

²²⁸ Annette Palmer, 21 April 2026 PM, 122/8-14, INQT0000058. Dr Mona Ahmed confirmed there would have been great learning arising from a Datix and this failure of Annette Palmer is significant.

²²⁹ METF0000003.

²³⁰ Feven, 26 February 2026 AM, 32/8-11, INQT0000006.

²³¹ PI Sharonjit Power, 2 March 2026 AM, 46/7-8, INQT0000008.

²³² NGPF0007833_0005.

238. Failure to link and treat the crimes together: no explanation by NGPF as to why these crimes were dealt in isolation but acceptance now that they should have been.
239. Absence of knowledge of PC Collins about the details of the Feven crime when she undertook the investigation in the criminal damage crime as she mistakenly believed data protection prevented her from considering it.²³³
240. Failure by PC Marsden to seek CPS advice when an offence of GBH, which was clear from the injuries sustained by Feven: *T12 fracture which required surgery to fix with metalwork and screws and fractures to the L1 and L2 vertebrae and damage to the sacroiliac joint*, is an offence where only the CPS can take a decision on charge.
241. Failure by NGPF to take an account from VC. Failure by PC Marsden due to his assessment of VC *“lacking capacity”* meant that VC was not interviewed and no account was ever taken from him. NGPF policy, Dealing with Persons with Mental Health, indicates that an interview in detention could be conducted with the permission of a clinician²³⁴.
242. Flaw in PC Marsden’s decision-making which relied on an email from Dr Seedat, a medical opinion but not a legal determination as to whether VC had capacity to form criminal intent²³⁵. PS Sparks reflected that relying on an email from Dr Seedat without interviewing VC or obtaining a witness statement was not sufficient and we *“could have gone back and got further details in a more comprehensive way”*.²³⁶
243. Failure by PC Marsden to make any referrals to Victim Services or inform Feven about any available services for complainants.
244. Failure by PC Marsden to offer an interpreter to Feven.
245. Clear failure to undertake any formal assessment of VC’s capacity.
246. Failure by Dr Seedat to respond to PC Marsden on 2 June 2020 by email: he accepted he should have insisted that PC Marsden sent him the form and provided an opinion as to whether VC was fit for interview.
247. PC Marsden and NGPF informed Feven that VC *“might have killed”* ^{236a} her but that VC could not be prosecuted due to his mental health issue. This demonstrates a fundamental lack of knowledge and misunderstanding of NGPF’s own policy Dealing with Persons with Mental Health:
 - a. *“When a substantive offence may have been committed, it is generally more appropriate to arrest for the offence and convey to a custody suite, rather than detain under section 136. In such circumstances, a mental health assessment can be conducted in custody if required”*²³⁷ and,
 - b. *“Public interest issues: under certain circumstances it may be necessary to prosecute an offender to allow Mental Health Treatment Orders, Hospital Orders and/ or other statutory support. This will certainly be the case for serious crimes”*²³⁸. This was a key failure and clearly impacted.

²³³ WITN0036001_0007.

²³⁴ NGPF0006002_0020.

²³⁵ NGPF0000082_0015.

²³⁶ PS Katie Sparks, 2 March 2026 AM, 89/2-4, INQT0000008.

^{236a} Statement of Feven WITN0252001_005 para 21: “You were brave to jump out of the window, if you hadn’t, VC might have killed you.... “We’ve tried everything but since VC has a certificate for schizophrenia, he cannot be imprisoned. He’ll be placed in a psychiatric hospital for six months”.

²³⁷ NGPF0006002_0006.

²³⁸ NGPF0006002_0023.

on the subsequent interactions that VC had with agencies, particularly the Police and Healthcare.

- 249. Failure by PC Marsden to make any attempt to link the 2 crimes at Brook Court on 24 and 25 May 2020 and this could and should have been done.
- 250. At second MHAA at 16.24, Dr Malik was present with Dr Sadraie and Eleanor Cullen. No access to RIO from Eleanor Cullen and no access to the custody records so the assessing team had limited information about the crime.
- 251. Failure by both NGPF and NHFT to inform University accurately and with complete information about these incidents. Eleanor Turner had no knowledge until July 2020 (see below) and raised concerns when she became aware. Failure to share information and work collaboratively: a key theme and an opportunity lost to protect the public.

Outcome 12 Closure

- 252. The clear failures in respect of Feven represented a missed opportunity to escalate VC's mental health and need for long-term treatment. Closure under outcome 12 precluded disposal and treatment in a forensic pathway but also precluded appropriate and accurate recording of this crime. DCI Hall confirmed in his email to ACC Rob Griffin: *"the approach taken via outcome 12 precludes conviction and imposition of a hospital/ treatment provision by way of sentence"*.²³⁹
- 253. The absence of a clear rationale with the closure under outcome 12 by PS Sparks is accepted by NGPF and also set out succinctly by DCI Nicholas Hall:

"The basis for Outcome 12 is not clearly rationalised..."

*This decision is problematic because VC was not interviewed about the offence and no additional, formal MHAA was conducted. Given the seriousness of the injuries, I believe the correct course of action would have been to continue the investigation, interview VC, and consult the CPS for early investigative advice"*²⁴⁰.

- 254. PC Sharonjit Powar accepted that *"looking at the injury level" the crime on Feven "should have been treated as Grievous Bodily Harm"*²⁴¹ and should have been referred to the CPS to take a decision on charge.²⁴²
- 255. Following the conclusion of oral evidence, a statement dated 9 July 2026²⁴³ was disclosed from NGPF to confirm that Paul Cook, Force Crime Registrar (FCR) had updated the Crime Outcomes Procedure Guide²⁴⁴ to introduce a set of 22 new outcome templates, to be completed to justify the particular closure outcome on the occurrence. This was introduced to NGFPPF and communicated to all NGPF sergeants, inspectors and chief inspectors on 16 June 2020, which was 7 days after PS Sparks closed the crime against Feven under outcome therefore the *"appropriate template was neither completed nor included within the occurrence enquiry logs"*.²⁴⁵
- 256. There was a clear failure by PS Sparks to justify closure outcome 12 even before introduction of the new template. Although Paul Cook seeks to justify this failure stating

²³⁹ NGPF0007833_0005.

²⁴⁰ NGPF0007833_0005.

²⁴¹ PI Sharonjit Power, 2 March 2026 AM, 46/7-8, INQT0000008.

²⁴² NGPF0007833_0005.

²⁴³ WITN0469001.

²⁴⁴ NGPF0006054.

²⁴⁵ WITN0469001_0003, para 19.

on 9 June 2020 “new templates had not been communicated to the Force and were not available for selection within NICE RMS until 16 June 2020”²⁴⁶, DCI Nicholas Hall drew ACC Griffin’s attention to incident 2 confirming “the offence of GBH is not police chargeable” and “the decision or not to charge in cases where MH is a factor are complex and for this reason alone referral to the CPS should have been undertaken”.²⁴⁷ There was no justification for closure of this crime under outcome 12.

Admission from 25 May 2020 to 17 June 2020

257. VC was admitted to Rowan 1 ward at 23:30 and a core assessment was completed by Dr Ackroyd. During the admission, VC required restraint on multiple occasions, with one occasion resulting in an incident notification being completed. VC’s responsible clinician was Dr Seedat and VC was discharged after 24 days back to Brook Court.
258. Failure by NHFT to request information from NGPF at the time of this admission so that the treating team had all relevant risk information and this was encapsulated in the core assessments. All entries from the admission and through the various assessments omit “the reasons and aims of admission”.²⁴⁸
259. Failure by Dr Seedat to appraise himself of the Feven incident: he said that if he had known VC had caused injury to an individual, it would have completely changed his risk assessment but, contrary to his evidence, the incident and injury is recorded in the RIO entries on 24 May 2020²⁴⁹ so Dr Seedat failed to consider this. Dr Seedat stated “because the information I had at the time was that VC had damaged the door, but there was no information in the records which suggested that he had gained entry, and that the person in that flat had fled because VC had gained entry into the flat”²⁵⁰ but at the end of his evidence, Dr Seedat confirmed in answer to the Chair that he did know about the incident involving the young female²⁵¹. Professor Lade Smith highlighted the importance of transparency “actually that very first interaction and the first, especially the first admission, is crucial to how the person may engage with you later on. So, transparency is a really important thing”.²⁵²
260. Dr Ludvigsen completed the core assessment on 27 May 2020 and admitted she was “slightly unclear as to the purpose of the core assessment”²⁵³ and was also unaware about Feven jumping out of the window. The core assessment was based on incomplete information.
261. Failure by NHFT to record and consider relevant risk information. Dr Ludvigsen failed to include the incident on 26 May 2020 when VC kicked a glass door and had to be restrained, and an alarm was triggered, in the core assessment, which was clearly relevant to risk to others. Dr Seedat had accepted that information on risk assessments was inadequate and not dynamic in real time for clinicians when reviewing risks.
262. Dr Seedat undertook a review of information provided by VC’s family on 3 June 2020. Dr Seedat failed to add the information provided so other clinicians could not see what VC had written: they had to rely on Dr Seedat’s summary which had a number of omissions. Dr Manzar agreed that the full note should have been shared with other clinicians. “As a

²⁴⁶ WITN0469001_0003-4, para 19.

²⁴⁷ NGPF0007833_0005-6.

²⁴⁸ NHFT0000168_0011.

²⁴⁹ NHFT0000168_0003.

²⁵⁰ Dr Seedat, 23 April 2026 PM, 77/16-20, INQT0000062.

²⁵¹ Dr Seedat, 23 April 2026 PM, 115/6-20, INQT0000062.

²⁵² Professor Lade Smith, 1 June 2026 AM, 17/16-19, INQT0000103.

²⁵³ Dr Ludvigsen, 22 April, AM 51/14, INQT0000059.

general rule, any risk that has been highlighted, I think it's everyone's responsibility to put that one into the notes so that the clinicians are aware of the risks".²⁵⁴ Dr Ludvigsen confirmed that if she had seen the notes, *"it would have confirmed to thoughts I think we, as a clinical team, already had about his risks when unwell"*.²⁵⁵

263. Failure by Dr Seedat to include the dangerous and harmful statements made by VC in his summary in VC's RIO notes. Dr Seedat confirmed that he was unaware that Red Rum was "murder" backward and he failed to record that VC had written "intended to harm permanently" and "break their hand in hands".²⁵⁶
264. Failure by Dr Seedat to discuss the messages with VC as that was something that was requested by VC's family (disputed by VC's family).
265. Key risk information was not captured in any further risk assessment or management/safety plan: Dr Seedat failed to record VC's risk to others *"there have been no incidents of violence yet"*.²⁵⁷ System failure: no routine monitoring what a patient is viewing on social media and devices unless specific concern is raised: reliance on reactive reporting rather than proactive steps.
266. At discharge on 17 June 2020 after just 24 days of assessment, Dr Seedat not only failed to record VC's risk of violence to others but referred to Feven's injuries as *"minor injuries"*.²⁵⁹
267. VC was discharged with only 14 days' worth of medication.
268. Discharge back to Brook Court despite concerns raised by Katherine Linehan and Eleanor Turner. Katherine Linehan stated that the University was constantly having conversations with the NHS and Police about their concerns about the first incidents and Brook Court.²⁶⁰ Eleanor Turner states that there was not persuasion or discussion with VC about him returning to Wales²⁶¹.
269. Inaccurate recording of information: Dr Seedat blamed nursing staff for the record that VC was trying to *"rescue the neighbour"* in the Feven incident.²⁶² stating in evidence it should have been recorded as *"rescue the mother"*.²⁶³
270. Failure to consider VC's risk to others: residents of Brook Court and the broader community.

Discharge from Crisis Team 30 June 2020

271. VC was discharged from the Crisis Team on 30 June 2020. There was reliance on VC's self-report to Claudia Birtles and Daisy Coleman that VC was willing to take medication.

²⁵⁴ Dr Manzar, 27 April 2026 PM, 83/16-19, INQT00000064.

²⁵⁵ Dr Ludvigsen, 22 April 2026 AM, 59/15-17, INQT00000059.

²⁵⁶ Dr Seedat, 23 April 2026 PM, 53 to 55, INQT00000062.

²⁵⁷ NHFT0000168_0017, 0028, 0036

²⁵⁸ NHFT0000168_0036.

²⁵⁹ NHFT0000023.

²⁶⁰ Katherine Linehan, 9 March 2026 AM, 42/10, INQT00000016.

²⁶¹ Eleanor Turner 25 February AM 9/11, INQT00000004.

²⁶² NHFT0000021_0001.

²⁶³ Dr Seedat, 23 April AM, 92/7, INQT00000061.

273. VC was repeatedly trusted to voluntarily take medication despite concerns raised by his mother.
274. VC was referred to the EIP in June 2020 when it was a service in disarray “not uncoupled” and when transformation had not been completed. The Theemis report in January 2025 concluded a number of failures in the EIP service.²⁶⁴ that:
- a. New service model of EIP, dedicated psychologists, social workers and OTs, were not part of the EIP team,
 - b. Restructure of the EIP resulted in isolation from CMHTS,
 - c. Assertive approach EIP could offer was constrained and did not reflect policy.
- VC’s mother raised concern on 11 July 2020 to the Crisis Team that VC may not be taking medication and Claudia Birtles confirmed that VC was ok, but the crime leading to VC’s second inpatient occurred 2 days later.

Luke 13 July 2020

275. This crime took place 14 days after VC was discharged from the Crisis Team, and VC later said he had stopped taking medication when he was released from detention. It was reported that VC had kicked the flat door into another flat at Brook Court, assaulted an occupant, and was being restrained by a neighbour.
276. Incident was dealt with by attending officer, PC Jamie Severn, in the absence of knowledge of the facts and seriousness of the crime on Feven. He said “*I wasn’t aware of the gravity of what happened in May*”²⁶⁵. Officers did not access incident reports where it was logged that VC had previously broken into the property opposite and thrown a lady out of the window.
277. Failure to investigate this crime. VC was detained under S.136 but no criminal investigation ensued²⁶⁶ despite the criminal damage investigation (from 24 May 2020) remaining open but with no contact with PC Collins who was investigating of that offence.²⁶⁷ Fundamental lack of knowledge of NGPF policy, dealing with persons with mental health “*when a substantive offence may have been committed, it is generally more appropriate to arrest for the offence and convey to a custody suite, rather than detain under S.136... Detention under S.136 should be used if necessary, where there are no offences, or where any offences are of a minor nature and do not warrant action within the criminal justice system*”.²⁶⁸
278. Systemic failure by NGPF as there was no formal induction or specialist training for officers attending incidents of complex mental health crisis.
279. Failure to make referrals for multi-agency response including MARAC or MAPPA or safeguarding by PC Severn as he “*didn’t consider I needed to do one in this particular instance because he had been detained, and the mental health services were obviously going to assess him*”.²⁶⁹

²⁶⁴ NHNB0018966.

²⁶⁵ PC Jamie Severn, 3 March 2026 AM, 30/11-12, INQT0000010.

²⁶⁶ WITN0014001_0005.

²⁶⁷ NGPF0000049_0002.

²⁶⁸ NGPF0006002_0006.

²⁶⁹ PC Jamie Severn, 3 March 2025 AM, 33/16-19, INQT0000010.

280. Failure by NGPF to consider information sharing with University despite a record that VC was a full-time student.
281. At the arrest, CPN Nigel Wade recorded his impression that VC was attempting to conceal his symptoms²⁷⁰ and medication was discovered, a 14-table strip²⁷¹ evidencing non-concordance at that early stage.

Admission 14 July 2020 to 31 July 2020

282. Following S.136 detention on 14 July 2020, a MHAA took place. VC had stopped taking medication 2 weeks after his previous discharge. VC was detained under Section 3 MHA.
283. Inaccurate record keeping by Busayo Ajewole who recorded in the Risk and Safety Assessment that VC had “no history of violence or aggression” and “no past history of mental health difficulties”²⁷² in knowledge of the 2 May incidents and the July incident which led to VC’s arrest.
284. Failure to take account of risk of violence to others. During the admission it was recorded in the 72-hour review by Dr Ludvigsen that “Dr Seedat observed that there seems to be no insight or remorse and that the danger is that this will happen and again perhaps [VC] will end up killing someone”.²⁷³ Dr Ludvigsen confirmed that “in fact that level of serious violence that might lead to somebody’s death was something that people were concerned about”.²⁷⁴
285. Inaccurate risk information recorded by Dr Ludvigsen “there have been no incidents of violence yet”.²⁷⁵ Dr Ludvigsen attempted to explain this error as the section is referring to “acts of harm coming to an individual as a direct wilful action of the patient”²⁷⁶ and she did not believe the first incident fitted that criteria. The clinicians justified their failure to properly consider the risk of harm to others by seeking to differentiate between intended and unintended harm.
286. Failure to consider depot medication despite this being raised by VC’s mother.
287. Inaccurate and incomplete information in the referral to Crisis on 29 July 2020²⁷⁷ prior to discharge: omission of Feven’s incident and her injuries, and VC’s history of violence, including the violence VC displayed during his first admission with requirements for restraint.

Discharge 31 July 2020

288. VC was discharged without S.117 care despite an entitlement to this as he had been detained under S.3 MHA.
289. Failure to provide S.117 care following discharge “so in place of Section 3 for Section 117 aftercare, the processes that we kind of worked to is that the hospital will refer somebody to us on discharge

²⁷⁰ NHFT0000168-56.

²⁷¹ WITN0240001, para 34.

²⁷² NHFT0000196_0004.

²⁷³ NHFT0000168_64.

²⁷⁴ Dr Ludvigsen, 22 April 2026 AM 73/16-18, INQT0000059.

²⁷⁵ NHFT0000168_0065.

²⁷⁶ Dr Ludvigsen, 22 April 2026 AM 99/24-25, INQT0000059.

²⁷⁷ NHFT0000030.

*if they believe there's a need for Section 117 to- for somebody to be assessed for their aftercare needs. They didn't do that on this occasion".*²⁷⁸ Failure by Geoff Culpin to raise the issue of S.117 aftercare.

290. Failure to heed the concerns raised by Eleanor Turner "*psychological risk to the female resident and the potential vulnerability of VC*"²⁷⁹ when she advocated for VC to return to Wales. Failure by Dr Seedat to consider the risk to others when discharging VC back to Brook Court "*he is well, he is taking meds, he will have close follow up and not sure what else she wants. You can't just tell people where they should go, he is an adult*".²⁸⁰
291. Reliance on assurance by VC that he understood the importance of taking medication.²⁸¹
292. Failure by Claudia Birtles to raise concerns about VC's non-concordance.
293. Failure by Claudia Birtles to update VC's risk assessment on discharge.²⁸² Claudia Birtles agreed that it was a constant theme that "*record keeping and risk assessments were poor and virtually non-existent*".²⁸³
294. Erroneous entry in the updated "Risk Factors and Safety Plan" that there were "*no incidents of violence*"²⁸⁴. Claudia Birtles accepted that "*no evidence of violence*" contradicted what was then stated about the Feven incident, and the descriptions of both incidents misstated the position of VC in terms of impact on others.²⁸⁵
295. Failure to document and even consider the risk of violence "*there have been no incidents of violence yet, but this would be a potential concern if acutely unwell*"²⁸⁶.
296. Failure by Claudia Birtles to record the diagnosis as likely paranoid schizophrenia on VC's care and summary plan.

Crisis and EIP Teams August 2020 to May 2021

297. VC was visited by Clive Chimbi from the Crisis Team on 1 August 2020 following discharge. He could not find his medication during the visit and there was a failure to escalate potential medication non-concordance when on 3 August 2020 VC resists being observed taking medication.
298. Failure to respond appropriately to VC's non-concordance. It is recorded that VC stopped taking medication 2 weeks after discharge believing he was well, and medication was slowing him down when studying²⁸⁷ yet VC is discharged to EIP after a final visit by the Crisis Team on 15 August 2020 where it is recorded that C had a "*masked expression*".
299. Concerns were raised by Abigail Parsonage that VC may be masking symptoms at her first interaction with him on 21 August 2020²⁸⁸.

²⁷⁸ Geoffrey Culpin, 27 April 2026 AM, 27/17-22, INQT0000063.

²⁷⁹ UNIN0001084.

²⁸⁰ NHFT0018308.

²⁸¹ NHFT0000222_0003.

²⁸² NHFT0000222.

²⁸³ Claudia Birtles, 29 April 2026 AM, 62/13-19, INQT0000067.

²⁸⁴ NHFT0000222_0003.

²⁸⁵ Claudia Birtles 29 April 2026 AM, 63/19-23, INQT0000067.

²⁸⁶ NHFT0000222_0003.

²⁸⁷ NHFT0000168_0129.

²⁸⁸ NHFT0000168_0131.

- a. Failure to heed take appropriate action following concerns from VC's mother in October 2020 who reported she had not spoken to him for 2 months and it was out of character. Abigail Parsonage relied on comment from housemate that VC was okay without considering if the housemates were aware of VC's diagnosis.
 - b. Failure to raise concerns about non-concordance on 6 November 2020 during a visit VC and he indicated he had 10 tablets remaining.
300. Failure by Claudia Birtles to escalate to the Crisis Team in November 2020 when VC sought an earlier appointment with Dr Burri as *"he had something very important to discuss"*.^{288a} No involvement with Crisis team as she did not know what VC's presentation was indicating.
301. Failure to escalate after there is evidence of potential deterioration when VC fails to attend a review with Dr Burri on 5 May 2021, informs Claudia Birtles on 13 May 2021 that he remains unconvinced as to the effect of medication, and VC's mother contacts the Crisis Team that she believes VC is becoming unwell and feels he has not been taking his medication.²⁸⁹ No role for Crisis Team after VC said he is fine, and referral made to LMHT.
302. Failure by Claudia Birtles to arrange a medication review which meant there was a missed opportunity to offer VC Clozapine *"adults with a diagnosis of schizophrenia that has not responded adequately to treatment with at least two antipsychotic drugs will be offered clozapine"*.²⁹⁰

MI5 Thames House 31 May 2021

303. Just 2 days after VC's mother had contacted the Crisis Team to raise concerns about VC, he travelled from Nottingham to London on a bank holiday and attended M15 headquarters.
304. Failure by Metropolitan Police Offices to probe and investigate VC's attendance *"claiming to have information regarding a case"* and that *"he wanted to be arrested but would not give any more information"*. VC did not wish to speak to officers, and PNC checks were done where there were no warning signals, markers or special checks against his name. Report completed by PC Nash that VC *"did not display any unusual behaviour or make any unusual comments to the police and left the location prior to the police"*.²⁹¹ PC Foster stated that he failed to ask VC why he wanted to be arrested as he wanted to build a report *"I wanted to come across as...to build a rapport quite relaxed... so I was trying to be calm and relaxed with VC and to build that rapport to see if he was offering any other information to us"*.²⁹²
305. Officers failed to appreciate that VC had travelled from Nottingham and failed to ask any further questions after VC said yes when they asked if he had booked an uber home.
306. Failure to include in the Intelligence Report sent to the Fixated Threat Assessment Centre (FTAC) that VC had asked to be arrested, or that he had tried multiple entrances over a period of time.²⁹³

^{288a} NHFT0000168_0137.

²⁸⁹ NHFT0000168_0153.

²⁹⁰ NHFT0000460_0007.

²⁹¹ METF00000002.

²⁹² PC Foster, 3 March 2026 AM, 47/11-16, INQT00000010.

²⁹³ METF00000002.

307. Due to NGPF failures to add a mental health marker in May 2020 and record the Feven crime as GBH, these factors were not available for consideration by FTAC, which otherwise would have formed part of their consideration.
308. Relevant NHFT records should have been considered by FTAC. VC's reported auditory hallucinations "consist of people from many different departments including MI6, police, etc..."²⁹⁴
309. Clear failure in information sharing: Claudia Birtles only became aware of the MI5 attendance during the Inquiry.²⁹⁵

Sebastian Assault 5 July 2021

310. No changes are made to VC's risk assessment and care plan in June 2021. Claudia Birtles was not made aware of the MI5 visit. VC failed to attend a review with Dr Burri on 28 June 2021 and VC's care plan is not updated by Claudia Birtles on 29 June 2021. On 1 July 2021 VC unexpectedly travelled to his family's house and refused to go into the house. The family were clearly concerned "it was really worrying for my parents, and I was concerned for them" [Elias's statement]²⁹⁶ but no family member informed Claudia Birtles about this so there was no escalation.
311. Just 4 days later VC assaulted his flat mate, Sebastian.
312. There was a failure by PC Amy Pannell to respond appropriately and take action in respect of the report by Sebastian and further stark failures are identified:
- a. PC Pannell's absence of knowledge of relevant policies including Dealing with Persons with Mental Health²⁹⁷,
 - b. PC Pannell's lack of knowledge in respect of information sharing with other agencies. "*I had no way of contacting the NHS or able to contact those particular people who visited that property*"²⁹⁸ and university "*we get so many calls and if we contacted the university for every enquiry that was made to the police, you know we don't have time to do that*". Communication failures: "*Q. So is your answer really to the question of why you didn't share it with the University of Nottingham is that you didn't have time? A. No, it's just in this particular instance the job was not- we are not going to be arresting VC, we had no supporting victim and as such the job was filed and then no further action was taken*".²⁹⁹
 - c. Failure to carry out essential checks on systems, PNC and NICHE by PC Pannell (and PS Zoey Price).
 - d. Failure to give consideration to VC's previous contact with the Police,
 - e. Failure to give consideration to VC's contact with mental health services,
 - f. Failure to take an account from VC,

²⁹⁴ NHFT0000168_0138.

²⁹⁵ Claudia Birtles, 29 April 2026 AM, 100/8, INQT0000067.

²⁹⁶ WITN0087001, para 55.

²⁹⁷ NGPF0006002.

²⁹⁸ PC Amy Pannell, 4 March 2026 AM, 12/15-19, INQT0000012.

²⁹⁹ PC Amy Pannell 4 March 2025 AM, 34/21-25 and 35/1-2, INQT0000012.

- g. Recorded in error that VC was the victim,
 - h. Closure outcome 16 despite no account having been taken from VC,
 - i. System failure from NGPF that PC Pannell's mobile phone was not in use she was studying, and there was no forwarding system, so no response from NGPF when Sebastian sent a further message to PC Pannell.
313. Supervision failures by PS Price. PS Price reviewed the evidence at 21.26, did not conduct any checks on NICHE or PNC and did not check whether PC Panell had completed this. Inadequate response by NGPF for this crime to be closed as outcome 16 with no consideration of the history and no thought to re-occurrence- accepted by NGPF that VC ought to have been interviewed before finalisation which may have enabled diversion or treatment options³⁰⁰ Neither PS Panell nor PS Price had been appraised of the critical findings of the review by DCI Goucher.
314. Information sharing failure: Claudia Birtles was not made aware of the assault on Sebastian. She visits VC on 8 July 2021 and reported that he was 100% back to his usual self, that voices were barely noticeable and he was taking medication every day.³⁰¹
315. On 14 July 2021 Sebastian heard someone trying to open his door. He received no response when he sent a text message to PC Pannell asking for advice about reporting this further incident.

August 2021

316. There is a clear failure to escalate appropriately throughout August 2021 when it is evident that VC is relapsing.
317. VC fails to attend his clinic appointment, which would have been his first appointment with Dr Lloyd on 9 August 2021. Failure to escalate by Dr Lloyd when Claudia Birtles reported "*concerns that he may be relapsing*".³⁰²
318. Further failure to respond appropriately when VC attended Rowan 1 Ward on 16 August 2021 asking whether staff had heard voices on the ward and had communications with AI. "*At the time I queried whether he was relapsing in terms of his mental health...*".³⁰³ Although there is immediate contact by the nurse to the EIP team, at a further home visit on 19 August 2021 there was more evidence that VC was relapsing as he appeared "*muddled*", "*guarded*" and "*looked more unkempt*"³⁰⁴ it took a further visit on 31 August 2021 to determine that a further MHAA may be required.
319. Failure to escalate urgently following visit on 31 August 2021 when VC was presenting as "psychotic, delusional and suspicious".³⁰⁵ Gary Carter confirmed that VC unnerved him and had not been taking his tablets and that VC was on the verge of a breakdown and he did not feel safe being in the same room as VC. He also recorded that he was "currently relapsing" and "*may require Mental Health Act due to lack of insight*".

³⁰⁰ NGPF0007835.

³⁰¹ NHFT0000168_0156.

³⁰² NHFT0018991.

³⁰³ Amanda Frost, 22 April 2026 PM, 127/18-19, INQT0000060.

³⁰⁴ NHFT0000168_0161.

³⁰⁵ NHFT0000168_0162-163.

PC Pritchard 3 September 2021 and Failure to Execute Warrant

320. After the home visit on 31 August 2021, there were 3 failed attempts for a MHAA by Jen Shaw on 2 September 2021, 11.30, 15.30 and 18.30.
321. On 3 September 2021, VC assaulted PC Barnaby Pritchard and other officers in extreme violence that made PC Rachel Wakefield “*fear for her life*”³⁰⁶ and the use of CS gas and repeated taser discharges were required. 5 officers had to actively restrain VC and a panic alarm was deployed which caused further officers to attend, including PS Zoey Price. VC had to be removed from the property in handcuffs and ankle restraints. PC Wakefield confirmed it was the most violent S.136 warrant she had attended. Amie Staples states “*it was a really serious attack... and caused them significant harm... it’s one of the most distressing Mental Health Act Assessments I’ve ever witnessed*”³⁰⁷. PS Louise Ellis added a warning marker on the PNC “*extremely violent to male officers. Will assault without provocation*”.³⁰⁸
322. Prior to attending VC, there was a failure to ensure there was a clear briefing to the attendees based on an adequate risk assessment with the knowledge of VC’s history of violence and risks.
323. It has been of concern to the Survivors who was present and the lack of detail provided from others present during this incident. During the evidence of PS Zoey Price we wished to address with her the failure to address her involvement in this incident but were unable. The photographs detail who was present and we encourage the Chair to review the BWV again when dealing with this incident:
324. Failure by NGPF to take timely steps in respect of this investigation even though it has significance in light of Operation Hampshire. The file submitted to the CPS was returned incomplete in November 2021 as officers had failed to obtain medical evidence and statements and the investigation was not progressed until 20 March 2022 despite OIC PC Matthew Johnson describing this as a “*very straightforward police assault*”³⁰⁹. PC Pritchard was “*disappointed he was never prosecuted for the assault on myself*”.³¹⁰
325. Following the CPS charging decisions, there was a clear failure to take any proactive steps to search for VC and execute the warrant.
326. Incorrect marking of the warrant as “*low priority*”³¹¹. This allowed the task to be closed on the system without going to a supervisor to check completion. If marked medium/ high priority, would have been sent to a supervisor to confirm task completion.
327. NHFT was unaware that VC had been charged with the offence of assaulting an emergency worker despite the fact that the assault by VC on PC Pritchard occurred when seeking to enforce a S.135 MHA warrant: communication and information sharing failure.
328. Failure to record and heed the seriousness of this assault. Dr Manzar referred to the incident as a “*scuffle*”³¹² and Busayo Ajewole recorded “*no violence has resulted*”³¹³.

³⁰⁶ NGPF0000023_0009.

³⁰⁷ Amie Staples, 5 May 2026 PM, 68/17-19, INQT0000072.

³⁰⁸ NGPF0000027_0012.

³⁰⁹ PC Johnson, 5 March 2026 AM, 45/8, INQT0000014.

³¹⁰ WITN0040001, para 40.

³¹¹ NGPF0010624.

³¹² WITN0350001, para 153.

³¹³ NHFT0000193.

329. Failures in information sharing by NGPF: the University did not know about the assault.³¹⁴ Failures in information sharing by the University: Amie Staples as thought others would do this *“it made sense that the ward would make decisions about what information needed to be shared at the point of discharge”*³¹⁵.
330. Failure to take action about bags of unused medication. Amie Staples and Dr Lomas found boxes that dated back to February³¹⁶
331. Failure in MHAA to appropriately record the risks. Amie Staples knew about the Feven incident but only noted *“serious risk of physical harm to police officers in the context of a MHA assessment”*.³¹⁷ Failure to consider detention under S.3 instead of S.2: *“in terms of considering Section 3, you have to be able to say where available treatment is and we didn’t know where that was at that point”*³¹⁸
332. VC was detained under S.2 and nursed in seclusion until 9 September whilst awaiting a PICU bed and then admitted to an out of area provider, Cygnet in Darlington- clear information sharing failure as set out in the Theemis Report *“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”*.³¹⁹

Social Circumstances Report 17 September 2021

333. Failure by Claudia Birtles to include crucial information that VC had shared with her³²⁰ in the social circumstances report prepared for VC’s appeal to the Tribunal. Significantly, that VC had said to the doctors he would take medication and that he was not hearing voices to get out of hospital.
334. Absence of knowledge by Claudia Birtles about VC’s visit to MI5 or the assault on Sebastian due to failures in information sharing between NGPF and healthcare.
335. Ms Birtles recorded erroneously that VC *“has no prior history of violence and aggression towards others. [VC] is usually a claim, peaceful and law abiding citizen. [VC] initially co-operated with health and social care staff during the MHS assessment appearing calm however escalated to violence when police intervened”*. This is completely inaccurate.
336. On 23 September 2021, the Tribunal recorded that VC should continue to be detained, recording the view of Dr Shoilekova that *“when he is unwell the risks are serious”*³²¹. On this date VC emailed PC Collins to ask if the conditional caution he had been offered in respect of 24 May 2020 criminal damage offence could be re-considered.
337. Yet another missed opportunity to consider a CTO with power of recall and/or a move to depot medication [CYGN0000029]. Dr Lloyd had also considered this when she became aware of medication boxes being found *“yes I think myself and Claudia Birtles had a long conversation about that and it really was at that point where we felt he ought to be on a depot and a CTO”*.³²²

³¹⁴ UNIN0001829_0006.

³¹⁵ Amie Staples, 5 May 2026 PM, 79/10-13, INQT0000072.

³¹⁶ WITN0117001, para 68.

³¹⁷ NHFT0000272_0004.

³¹⁸ Amie Staples, 5 May 2026 PM, 75/24-25 and 76/1, INQT0000072.

³¹⁹ NHNB0018966_0029.

³²⁰ Claudia Birtles, 29 April, AM 110/10-25, INQT0000067.

³²¹ CYGN0000056.

³²² Dr Lloyd, 6 May 2026 AM, 110/4-6, INQT0000073.

338. VC was detained from 24 September 2021 pursuant to S.3 MHA and despite the Tribunal decision that “*given the rapidity and severity of relapses in his condition, it is essential that medication is maintained and optimised*”³²³ and the view expressed by Ms Birtles that this was VC’s third admission and “*concordance remains an issue*”³²⁴ depot was not used. A clear failure.

Transfer from Cygnet PICU to Priory Arnold 1 October 2021

339. Failures in transfer of key risk assessment information, information sharing gaps, and lack of access to RIO by staff were clear issues in the care provided by this second private provider. Was a copy of the Tribunal decision ever shared? Dr Gurusinghe confirmed that “*most of the staff did not have access to RIO. Only a handful of staff members had access to RIO. A few medics, few ward admins, and Mental Health Act administrator*”.^{324a}
340. Failures in respect of medication. No consideration given to CTO and VC’s medication changed from Haloperidol to Aripiprazole on 7 October as the former “*made him salivate a lot*”³²⁵.
341. Discharged from Section 3 detention despite Tribunal decision that “*there is unequivocal evidence that the risks to others when VC is unwell are high*”.³²⁶

Hammer 10 October 2021

342. Failure to take any appropriate action when VC brought a hammer into the ward following unescorted leave, which should have been followed up. No report undertaken.
343. Individual failure by Dr Gurusinghe to amend VC’s risk assessment³²⁷ despite being aware that VC had brought hammer into the hospital. Dr Gurusinghe accepted VC’s explanation that he needed a hammer to hang items in a new property.
344. Failure to share information with CCO: Claudia Birtles could not recall if she was aware of the hammer incident or not but stated she would have documented it (omitted from risk assessment).

Rescinding Section 3 18 October 2021

345. Failure by Dr Gurusinghe to consider the Tribunal Decision and the opinion of Dr Shoilekova by a prematurely considering rescinding the S.3 on 14 October 2021, just 4 days after VC had brought the hammer into the ward and whilst no therapies had commenced.
346. Failure by Dr Gurusinghe to give sufficient weight to VC concealing and bringing a hammer into the ward following leave as “*he didn’t want to link the hammer incident to his general presentation*”³²⁸
347. Failure by Dr Gurusinghe to consider VC’s repeated non-concordance, the concerns of clinicians and CCO: there was no discussion with VC about depot but he stated he was “*expecting the CCO to persuade VC to agree to medication via depot*”³²⁹.

³²³ CYGN0000056.

³²⁴ WITN0348001_0013.

^{324a} Dr Gurusinghe, 11 May 2026 PM, 15/ 19-22, INQT0000080

³²⁵ PAGR0000159_0003.

³²⁶ CYGN0000056.

³²⁷ PAGR0000010.

³²⁸ Dr Gurusinghe, 11 May 2026 PM, 64/5-6, INQT0000080.

³²⁹ Dr Gurusinghe, 11 May 2026 PM, 66/15-19, INQT0000080.

348. Inadequate final risk assessment before discharge on 21 October 2021 records that VC has no support network in Nottingham and has been “*reluctant to discuss anything in detail*”³³⁰ yet decision to discharge is made without addressing issue of non-concordance with medication.
349. Unsafe discharge with failure to check VC’s address and without phone call to Crisis Team. There should have been a CTO with a power of recall implemented prior to discharge from s3 to ensure VC took his antipsychotic medication.

October 2021 to January 2022

350. Following VC’s third discharge, there are multiple missed appointments with Dr Lloyd and Claudia Birtles and there is a clear failure to apply the do not attend policy.³³¹
351. Failure by Dr Lloyd to appreciate the significance of missed appointments and to take action to assess the level of risk.
352. Failure by Claudia Birtles to update risk assessment on 19 November 2021 when VC was “very guarded”, “manner was quite hostile and unfriendly”^{331a} and on 16 December 2021 when VC said he would pick up medication “*some point*”.^{331b} Failure to escalate as a result of non-concordance.
353. On 20 December 2021 there is a further talking incident involving Sebastian when VC tried to telephone Sebastian after blocking him.
354. By 10 January 2022, there is consideration by Emma Williams to discharging VC due to non-engagement after a further failed appointment with Dr Lloyd. Failure to appreciate likely relapse and risks to others.

Christopher 15 January 2022

355. Just 5 days later VC attacks Christopher by putting him into a headlock and then prevents him from leaving his flat. Numerous failures in the handling of this incident by the attending officer.
356. One attending officer, PC Zacharia was unaware of marker for extreme violence from 3 September 2021: failure by NGPF to check records and systems. PC Faulkner was aware of marker for police assault but did not take this marker seriously as lots of people have police assault markers.
357. Failure by NGPF to treat this crime as serious but as a student fight: officers did not take Christopher’s injuries seriously and offered “restorative justice”.
358. Failure by PC Faulkner to view the footage of the attack which may have changed the decision-making.
359. Communication failure: neither officer was aware of the allegation of false imprisonment.
360. Failure by the University to take appropriate action in respect of the victim, Christopher, and VC’s other flatmates in order to mitigate the risks. It was the victim and other students that had to move, not VC. Fitness to study policy³³²

³³⁰ PAGR0000012.

³³¹ NHFT0000417.

^{331a} NHFT0000168_0201.

^{331b} NHFT0000168_0201.

³³² UNIN0001825.

January 2022

- 361. 5th missed appointment with Dr Lloyd on 18 January 2022 causing her to consider discharge due to disengagement despite known risk of violence when non-concordant.
- 362. Failure by EIP to update VC's risk profile.
- 363. On 19 January 2022 VC was assessed in a MHAA as not requiring admission and was placed under the care of the Crisis Team. No imminent risk to self or to others.
- 364. Failure by EIP service to take account of Eleanor Turner's repeated expression of concerns³³³ by telephone and email.
- 365. Further MHAA under S.135
- 366. At time of VC's 4th admission from 28 January 2022, both Dr Manzar and Dr Lomas considered that VC's "*risk to others is high*"³³⁴ and this was an admission under Section 2.
- 367. Failure to detain VC under Section 3 despite when this was a 4th admission and in the knowledge of ongoing medication non-concordance and a further act of violence.

Discharge 24 February 2022

- 368. VC was discharged just prior to the date that the Section 2 detention would have lapsed on oral medication.
- 369. Dr Thangavelu was VC's responsible clinician and to failed to make any entries in VC's RIO notes.
- 370. Failure by Dr Thangavelu to heed that VC was found on site at the university on 21 February 2022 and had to be escorted off after giving a false name when considering discharge.
- 371. Unsafe discharge: failure to check discharge address: discharged to 209 Ilkeston Road, an address VC was not living at.
- 372. Failure to consider the safety of the discharge: who VC would be living with and assess the risk to others.
- 373. Failure to provide a letter of discharge/ summary to the GP with the most up to date information.
- 374. Yet a further failure to consider depot medication despite the repeated non-concordance issues.
- 375. Failure to challenge VC by Dr Thangavelu and consider the evidence of non-concordance in the community contrary to VC's denial of being non-compliant. Dr Thangavelu "*didn't have any reason to believe VC was not being truthful in his statements when he said he intends to continue to comply with treatment*"³³⁵.
- 376. Failure to consider the documented evidence and concerns about non-compliance by Dr Thangavelu "*As far as the Community Team were concerned, even though they suspected non-*

³³³ WITN0054001_0026-0035.

³³⁴ NOCC0000043_0005.

³³⁵ NHFT0004709_0002.

compliance, I don't think there was anything concrete to state that he had become non-compliant until August 2021".^{335a}

377. At the time of discharge back to the EIP team in 2022, the team did not minute its MDT meetings as there was no admin support. Sharon Heath confirmed that in 2020 the EIP did minute MDT meetings.³³⁶

March to August 2022

378. Following discharge, an alert was put on RIO that VC should only be visited in pairs due to his violence on 28 February 2022.
379. VC attended a first appointment with Dr Lloyd on 14 March 2022 who stated *"We had absolutely no powers to get him to come to appointments" ... "so it became really difficult to know how to manage this situation where he could almost immediately disengage again"*^{336a}
380. Further stalking incident of Sebastian on 26 April 2022 which Sebastian reported. The incident was marked as *"stalking grade 3 scheduled"* to be dealt within a 24-hour period but then was graded as low risk³³⁷.
381. Failures by PS Neil Langham who was unaware of relevant information and failed to ask sufficient information of Sebastian *"I don't think I probed Sebastian enough. Yes, potentially, he could have been following him, and on the balance of probabilities, he perhaps was. But we don't know until we've perhaps got some more, I guess, information or disclosure from Sebastian"*³³⁸
382. Missed opportunity to intervene when the University contacted Claudia Birtles.
383. There was a transfer of CCO 28 April 2022 and a failure to provide an appropriate handover. Gary Carter stated *"when I became his CCO, the handover process was inadequate, basically"*³³⁹
384. Failure to update care plan and risk assessment before handover.
385. At time of the transfer, the EIP team *"gave up on public safety"*.^{339a}
386. VC continued to miss appointments. He had missed around 9 appointments by 13 June 2022. Failure by EIP to follow Do Not Attend Policy.³⁴⁰
387. Failure to escalate when VC sent a message to Abigail Parsonage on 18 July 2022 to state he was not in the UK and he still had medication but *"wouldn't make much difference"*³⁴¹ but a call from VC's mother confirmed he is in Nottingham.

August 2022

388. Failure by EIP to ensure they had correct address for VC. A cold call was undertaken by Gary Carter on 4 August 2022 when he was informed that VC did not live there. When asked about the team's lack of knowledge of VC's whereabouts whilst he was a patient

^{335a} Dr Thangavelu, 13 May 2026 AM, 6/6-16, INQT0000083.

³³⁶ Sharon Heath, 5 May 2026 AM, 100/19-21, INQT0000071.

^{336a} Dr Lloyd, 6 May 2026 PM, 48/11-25, INQT0000074.

³³⁷ NGPF0007924_0004.

³³⁸ PS Neil Langham, 10 March 2026 AM, 25/10-14, INQT0000018.

³³⁹ Gary Carter, 30 April 2026 AM, 94/14-15, INQT0000069.

^{339a} Gary Carter, 30 April 2026 PM, 76/22-25, INQT0000070.

³⁴⁰ NHFT0004725.

³⁴¹ NHFT0000168_0268-9.

under the EIP service, she states that “because VC had so many addresses, it was impossible to keep on top of it all”³⁴².

389. Failure by NGPF to carry out any checks before sending a postal summons with a return date of 22 September 2022 at Nottingham Magistrates Court. The summons was sent to Flat 15, Madison Court, Derwent Way. PC Myers accepted no checks were carried out “if the file preparation unit had any concerns that VC didn’t live there, or if it wasn’t verified within a certain period of time, they would come back to me and say ‘can you do some checks’. Is this person still living there?’ But again, I have taken it as read that they have got the address and the summons has gone out as it would do normally”.³⁴³

Discharge 22 September 2022 and Failure to Appear

390. VC was summonsed to appear in respect of the assault on PC Pritchard on 22 September 2022 and failed to attend so a bench warrant was issued. No action was taken by NGPF in respect of this warrant: “a FTA warrant occurrence sits in an inbox, so each policing area for Nottingham has its own inbox”.³⁴⁴ but a draft press release was prepared by NGPF suggesting that the reason for the warrant not being acted upon was due to VC’s “nomadic lifestyle”.³⁴⁵ PC Myers accepted he took no action in respect of the warrant, and he was unaware of anyone taking any action. He stated that Sergeant Westlake was responsible for managing the warrant inbox but couldn’t say what he did in respect of outstanding warrants³⁴⁶.

391. On the same day there was an unsafe discharge of VC from the EIP team due to disengagement and because VC needed a more robust service than EIP could offer. “I think he needed a more robust service than what Early Intervention actually could offer”.³⁴⁷

392. Failure to follow the EIP policy³⁴⁸ which was accepted by Emma Robinson. And at the time of the discharge there was:

- a. A failure to undertake care co-ordinator visits in VC’s home due to his risk,
- b. No properly documented and considered risk assessment.
- c. The discharge took place in the absence of care co-ordinator, Gary Carter, with no clear treatment plan. Gary Carter confirmed he would not have supported VC’s discharge if he had been consulted and confirmed that if the EIP team had been aware of the warrant, they would not have discharged VC and instead have contacted the Police.³⁴⁹

393. Failure by NHFT to undertake any checks with agencies prior to discharge: NHFT were unaware of standing warrant.

394. Wholly Inadequate discharge letter³⁵⁰ with lack of clarity as to treatment, medication and actions required from GP. Accepted by Sharon Heath that it was “a wholly inadequate letter”, it “doesn’t include those documents: care plan or risk assessment”, “fails to record VC’s current or

³⁴² Dr Lloyd, 6 May 2026 PM, 52/5-7, INQT0000074.

³⁴³ PC Myers, 5 March 2026 AM, 86/11-17, INQT0000014.

³⁴⁴ PC Myers, 5 March 2026 AM, 89/12-13, INQT0000014.

³⁴⁵ NGPF0004449_0004.

³⁴⁶ PC Myers, 5 March 2026 AM, 113/19-25, INQT0000014.

³⁴⁷ Emma Robinson, 5 May 2026 AM, 20/7-8, INQT0000071.

³⁴⁸ NHFT0004725.

³⁴⁹ WITN0368001, para 311.

³⁵⁰ NHFT0000123.

historical risk”³⁵¹. And accepted by Emma Robinson that the discharge letter did not describe VC’s diagnosis, did not tell the GP what VC’s medication was, and did not deal with where VC was actually living.

395. The discharge letter failed to append relevant care plans or risk assessments, but an “administrative error” was blamed as reason that letter was sent with no supporting documentation.
396. Failure by consultant to accept responsibility for the discharge and the discharge letter [NHFT0000123]: *“I’m a community consultant working in a team. I’m not someone with ultimate or sole responsibility”*.³⁵² Dr Lloyd assumed the letter would be written by Gary Carter on his return a week late³⁵³ but Sharon Heath confirmed that administrative support generates automatic standard discharge letters which she failed to approve and add to with any of the relevant information.
397. Failure to confirm VC’s address gave address as 15 Madison Court, Derwent Way.
398. Expectation from EIP team that GP would continue to prescribe VC’s medication and oversee the same when it is was said that *“to sign a prescription for aripiprazole, an atypical antipsychotic medication could be irresponsible and unprofessional”*.³⁵⁴ Failure to consider prescribing constraints of primary care or provide any guidance to the GP on how to manage VC.
399. Failure to attend on VC before discharge. Professor Lade Smith *“in my experience somebody who has a severe mental illness that’s relapsing and remitting, that is associated with risk to self or others, if they stop coming, that’s usually a bad sign, not a sign of health.... it can be that person doesn’t realise they’re unwell, and that’s why they’re not coming to see you. So, what we would have done, what we would do is ensure that we’ve gone to see that person to make sure they’re well before we discharge them”*.³⁵⁵

Arvato 5 May 2023

400. Further attack by VC on members of the public, work colleagues, at Arvato warehouse with response officers from Leicestershire, PC Libbie-Mae Taylor and PC Amos-Perkins. There are clear failures of the individual officers and system failures in the actions taken to respond to and investigate these crimes, contrary to LEPF policy in respect of investigation standards.³⁵⁶
401. The following failures have been identified:
 - a. Failure to pursue lines of inquiry on the day: Attending officers were told that VC was heading towards the bus stop but did not check this.
 - b. Failure to take victims’ statements at the scene. PC Amos- Perkins accepted *“that’s my failing not to pass that message on so I accept that’s my mistake... that’s of the best way we could have obtained the evidence quickly, get the statements on scene”*.³⁵⁷

³⁵¹ Sharon Heath 5 May AM 89/3-18, INQT0000071.

³⁵² Dr Lloyd, 6 May 2026 PM, 59/4-6, INQT0000074.

³⁵³ Dr Lloyd, 6 May 2026 PM, 84/7-11, INQT0000074.

³⁵⁴ Tim Baker, 12 May AM 90/5, INQT0000081.

³⁵⁵ Professor Lade Smith, 1 June 25/12-25, INQT0000103.

³⁵⁶ LEPF0000095.

³⁵⁷ PC Connor Amos-Perkins, 11th March 2026, 105/12-17, INQT0000020.

- c. Failure to secure recording of conversations with witnesses on BWV which would have been enough evidence to caution VC.³⁵⁸
- d. Oversight and supervision failures of PC Taylor by PC Amos-Perkins as she did not consider the BWV to be evidential so did not save it, but did not recall any discussion about this with her supervisor.³⁵⁹ PC Amos-Perkins accepted “...that was one of our failures on the scene, was obviously we recorded that on body-worn video but we hadn’t marked it as evidence, so it then unfortunately got deleted which I accept was a failing on our behalf. I should have overseen that that got done”.³⁶⁰
- e. Failure to save CCTV footage by PC Taylor. She accepted “and whether it’s showing anything or no, I should have saved it as well”.³⁶¹
- f. Failure by both officers to record the use or attempted use of the knife as set out by Louise- photographs.³⁶² PC Taylor stated “We were made aware that all employees had, like, box cutter knives. But no one ever made reference to a knife being used in an assault or attempted to be used in an assault... [if] anybody said that to me... I would have noted that down because obviously it’s quite an important aspect”.³⁶³ PC Amos-Perkins agreed the knife would have been an “aggravating factor”.³⁶⁴
- g. Failure by PC Taylor to carry out appropriate and sufficient checks of police systems; admits she did not check NICHE nor PNC.³⁶⁵ PS Amos-Perkins confirms “PNC, PND, NICHE, all of them need checking so we can check that obviously they are outstanding; previous occurrences”,³⁶⁶ “it’s a basic thing that needed to be done, but it wasn’t, and that again is our fault... I needed to tell PC Taylor that it needed to be done”.³⁶⁷
- h. Failure by PC Taylor to identify the outstanding warrant. “I didn’t see that he was wanted on warrant”³⁶⁸ and stated that she was “potentially” distracted as she “had everything else open at the same time, and most likely I was working off one screen when I was on response” and had a number of tabs open.³⁶⁹
- i. Oversight and supervision failure PC Amos-Perkins when failing to ensure sufficient checks of police systems. He accepted “I should have checked that we were looking about who this person was and the context of this person and the background. But not, I hadn’t, so that was my fault”.³⁷⁰
- j. Training failure for new officers and individual failure due to absence of knowledge of policy. Local body worn video policy is clear: “all recordings can be used in evidence, even if it appears to the user at the time of the incident that this is unlikely. All recordings should be treated as evidential until it is confirmed otherwise”.³⁷¹

³⁵⁸ PC Libbie-Mae Taylor, 11 March 2026, 12/13-25, INQT0000020.

³⁵⁹ PC Libbie-Mae Taylor, 11 March 2026, 13/7-12, INQT0000020.

³⁶⁰ PC Connor Amos-Perkins, 11 March 2026, 100/4-9, INQT0000020.

³⁶¹ PC Libbie-Mae Taylor, 11 March 2026, 15/4-5, INQT0000020.

³⁶² WITN0256002 and WITN0256003.

³⁶³ PC Libbie-Mae Taylor, 11 March 2026, 13-23, INQT0000020.

³⁶⁴ PC Connor Amos-Perkins, 11 March 2026, 107/11, INQT0000020.

³⁶⁵ PC Libbie-Mae Taylor, 11 March 2026, 65/4-8, INQT0000020.

³⁶⁶ PC Connor Amos-Perkins, 11 March 2026, 111/20-21, INQT0000020.

³⁶⁷ PC Connor Amos-Perkins, 11 March 2026, 112/1-4, INQT0000020.

³⁶⁸ PC Libbie-Mae Taylor, 11 March 2026, 43/17, INQT0000020.

³⁶⁹ PC Libbie-Mae Taylor, 11 March 2026, 87/24 – 88/20, INQT0000020.

³⁷⁰ PC Connor Amos-Perkins, 11 March 2026, 115/10-12, INQT0000020.

³⁷¹ LEPF0000096_0008.

- k. Supervisory training failures- no minimum experience to be a tutor and training requirement was one day online with yearly refreshers PC Amos-Perkins confirms his *“training was one day and that was actually online... then after that you have yearly refreshers, but I only had two yearly refreshers after that”*;³⁷² PC Amos-Perkins was not aware of a minimum experience requirement.³⁷³ PC Taylor had done 12 operational shifts and PC Amos-Perkins had been an officer for 3 years. PS Amos-Perkins were not aware of the LEPF policy for managing probationary officers.³⁷⁴ PS Mark Read, the supervising sergeant for PC Taylor and PC Amos-Perkins was unaware of the policy requiring review of their work every day 10 days.³⁷⁵
- l. Failure to make arrest attempts. PC Taylor records *“unable to make arrest attempts... 2 prison handovers.... was meant to have an organised protected day...”*.³⁷⁶ PC Amos-Perkins could not recall any consideration given to arresting VC as they were still chasing outstanding inquires and were not aware of the warrant. *“He would have been arrested for the warrant if we’d have come across him in person”*.³⁷⁷
- m. Failure by the officers in compliance LEPF investigation policy which requires *“proactive and urgent steps should be taken to deal with the suspect... investigators and their supervisors will ensure that all focused enquiries are completed unless there is a clear rationale to the contrary”*.³⁷⁸ PC Amos-Perkins accepted he did not do this or follow this policy; *“I take accountability for what sort of failures we’ve had on scene and ... where we’re chasing up inquiries later on that should have been completed on scene”*.³⁷⁹
- n. Acceptance of mistakes by PC Taylor *“unfortunately, it’s... you know, it’s really difficult, and I can only apologise for making those mistakes and the role I played in it”*.³⁸⁰

EVENTS OF 12 JUNE 2023

Elias Calocane – 12 June 2023 Conversations

402. We maintain that when one considers the calls to Elias and VC’s father on 12th June 2023 that there was a failure by the family not to contact the police or mental health services
403. During a 44-minute telephone call at 7:09pm on 12 June 2023, VC spoke extensively to Elias about the "zip files" and his longstanding belief that his experiences were caused by technology rather than mental illness. Elias described this as a familiar and repetitive conversation which mirrored discussions they had been having for years. VC encouraged Elias to read the files and attempted to persuade him that his beliefs were real. There was no discussion of any violence, attack, or incident involving other individuals. Elias did however deduce from a train announcement that VC was in London *“This train will be arriving at Blackfriars”*.³⁸¹

³⁷² PC Connor Amos-Perkins, 11 March 2026, 92/21-24, INQT0000020.

³⁷³ PC Connor Amos-Perkins, 11 March 2026, 91/21-25, INQT0000020.

³⁷⁴ LEPF0000037.

³⁷⁵ LEPF0000095_0021.

³⁷⁶ LEPF0000004_0011.

³⁷⁷ PC Connor Amos-Perkins, 11 March 2026, 121/9-10, INQT0000020.

³⁷⁸ LEPF0000095_0034.

³⁷⁹ PC Connor Amos-Perkins, 11 March 2026, 127/9-13, INQT0000020.

³⁸⁰ PC Libbie-Mae Taylor, 11 March 2026, 55/2-3, INQT0000020.

³⁸¹ Elias Calocane, 13 May 2026 PM, 68/13; 69/1; 67/21.

404. During that call, VC stated that it would be "the last time" he spoke to Elias. Elias did not understand this as a threat or indication that VC intended violence towards others. Instead, he interpreted it as VC saying that if Elias listened to him and read the zip files, he would stop contacting or "bothering" him.³⁸²
405. At approximately 4:52am on 13 June 2023, VC again contacted Elias, asking whether he had received the documents, repeating that it was the last time they would speak and stating that it was "already done". Elias' suggested his immediate concern was that VC had harmed himself or intended to commit suicide. This is not supported by the clinical records where there is no reference to suicide or self-harm.
406. At 4:58am he texted VC saying, "if you do something stupid", attempted to call him back, tried to access the zip files and contacted his mother. Elias has maintained that he had long feared that VC would take his own life and that if he had believed VC was going to harm another person, he would have contacted the police.³⁸³ The family had an awareness of VC's dark thoughts from the notes shared with Dr Seedat and should have made urgent contact with the police or mental health services.

Celeste Calocane [CC]

407. CC's evidence was that when Elias informed her that VC had said it was the last time he would speak to him and that it was "already done", she immediately believed that VC had taken steps to end his own life. She described this as her "worst nightmare".³⁸⁴
408. CC explained that years of dealing with VC's mental health difficulties had led her to associate significant deterioration in his mental state with the risk of suicide rather than violence towards others.³⁸⁵ This is not supported by the clinical history for VC.
409. CC was working a night shift between approximately 7:15pm on 12 June and 7:45am on 13 June 2023 and was therefore unaware of the content of either the 7:09pm call between VC and Elias or the later telephone call between VC and his father.³⁸⁶
410. CC maintained that his family did not understand his illness as presenting a risk of serious violence to members of the public.³⁸⁷ The Chair should treat this evidence with caution as it is clear that even from attending following the arrests in May 2020 the risk of violence was known to the family.

Terms of Reference 5

411. Failures of the Trust to implement changes from relevant Inquiries such as the Christopher Clunis Inquiry Report
412. Failure of the Trust to properly implement changes arising from Coroner Prevention of Future Death Reports
413. Failures of Nottingham Police to Implement the Necessary changes and Training as flagged by the Manchester Inquiry report

³⁸² Elias Calocane, 13 May 2026 PM, 69-70, INQT0000084.

³⁸³ Elias Calocane, 13 May 2026 PM, 75/1; 97/3, INQT0000084.

³⁸⁴ Celeste Calocane, 14 May 2026 PM, 33/12-34/7; 62/1-64/25, INQT0000086.

³⁸⁵ Celeste Calocane, 14 May 2026 PM, 34/8; 62/1-64/25, INQT0000086.

³⁸⁶ Celeste Calocane, 14 May 2026 PM, 42/10; 43-44, INQT0000086.

³⁸⁷ Celeste Calocane 14 May 2026 PM, 33/12-34/7; 34/8, INQT0000086.

414. The Manchester Arena Inquiry Report Volume 2 (published November 2022) addressed the emergency response to the terrorist attack of 22 May 2017. It made detailed recommendations concerning police command and control, interoperability (JESIP) , M/ETHANE messaging, Operation Plato protocols, airwave communications, talk groups, Force Incident Manager responsibilities, and Bronze Commander training. These were designed to be embedded by all police forces and blue light services to ensure preparedness for future critical, major, and Plato incidents.
415. The Nottingham Inquiry has heard extensive evidence that Nottinghamshire Police failed to implement pertinent Manchester Arena Inquiry recommendations prior to the attacks of 13 June 2023, and that those failures directly impacted the emergency response on that date.
416. The evidence demonstrates failures in the following categories drawn from the Manchester Arena Inquiry's findings and recommendations³⁸⁸:
- a. **Operation Plato declaration and communication:** The Ground Bronze Commander (Inspector Shaw) was not informed of the Plato declaration for approximately four and a half hours. The declaration was not announced on all relevant talk groups.
 - b. **M/ETHANE messaging:** The M/ETHANE messages issued on 13 June 2023 were inaccurate, incomplete, and not updated as the situation evolved. They failed to record the number and severity of casualties as required.
 - c. **JESIP principles and multi-agency coordination:** There was a failure to establish a Forward Command Point, Rendezvous Point, or zone designations following Plato declaration. The JESIP huddle did not take place for several hours.
 - d. **Force Incident Manager (FIM) performance:** Chief Inspector Mather failed to conduct proper threat and risk assessments, failed to give an NDM-compliant briefing, and lacked clarity as to whether a major incident had been declared.
 - e. **Search coordination:** There was no clear allocation of responsibility for coordinating the search for the suspect.
 - f. **Training deficiencies:** Inspector Shaw gave evidence that at the time of the incident there was "a complete lack of training for Sergeants and Inspectors in the role in general but more pertinent to this incident, in Major Incident training."
 - g. **Airwaves and talk group management:** Incidents were managed on different channels without a coordinated approach to communication, hindering situational awareness.

Chronological Table of Failures to Learn from the Manchester Arena Inquiry

#	Lesson / Recommendation from	Date Lesson Ought to Have Been	Persons Responsible for Failure	Issue	Witness
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³⁸⁸ See requested recommendation 83 below.

	Manchester Arena Inquiry	Learned/Embedded			
1	Control Rooms as first point of failure: Need for significant exercising of control rooms in major/critical incidents. The FIM role requires proper training and support.	By June 2023 (report published November 2022; forces were briefed prior to publication)	Nottinghamshire Police (Chief Constable / Force leadership); College of Policing (nationally)	The College of Policing introduced a national Force Incident Manager course in 2025 (over 200 delivered). Sir Andrew Marsh confirmed this was "a direct outcome of the Manchester Arena Inquiry." However, this was not in place by June 2023. Locally, Nottinghamshire Police introduced the Proud to Lead Academy with half-day critical incident and major incident training for Sergeants and a full day for Inspectors.	Sir Andrew Marsh (College of Policing), 14 April 2026: accepted there was "an unacceptable long time from flash to bank" (Day 26, p.99). Inspector Shaw, 16 March 2026: confirmed "complete lack of training for Sergeants and Inspectors ... in Major Incident training" (Day 14, p.31)
2	Operation Plato to be declared on every relevant talk group and communicated to all relevant commanders , including the Ground Bronze.	By June 2023 (principles long pre-date 2022 report; Manchester Arena Report reinforced requirement)	Chief Inspector Mather (FIM on the night); Nottinghamshire Police (systemic: absence of procedures requiring broadcast on all channels)	Post-incident, the Operation Plato plan was reviewed and updated (August 2023 guidance). It now includes "clarity of expectation for each talkgroup" so that at the point of Plato	Inspector Shaw, 16 March 2026: "I wasn't told, which is a massive deviation from the plan ... a failure in the Plato procedure" (Day 14, pp.40, 42, 46–47). He also

				declaration "that would be announced on every single talkgroup not just those proximate to the incident site." Also requires confirmation that the ground bronze has heard the declaration and assigns a staff officer for communication.	agreed it was "a Plato failure and a JESIP failure" (Day 14, p.48). T/DCC Griffin, 23 March 2026: confirmed "the activation of the resilience direct response page and the issuing of the M/ETHANE report were delayed, which impacted initial situational awareness for some partners" (Day 19, p.68)
3	M/ETHANE messages must accurately record casualties, severity, and be updated as intelligence evolves to ensure situational awareness across blue light services.	Pre-existing requirement; reinforced by Manchester Arena Report November 2022	Chief Inspector Mather (FIM); Nottinghamshire Police (training and exercising failure)	Training improvements via JESIP divisional training days now delivered. No specific evidence of a standalone M/ETHANE remediation programme.	Superintendent Allardice, 17 March 2026: agreed the M/ETHANE was not recording "what is required" and agreed "accuracy in terms of detail is important" (Day 15, pp.2–5). T/DCC Griffin, 23 March 2026: agreed the M/ETHANE was "inaccurate" (Day 19, p.69)

4	JESIP principles (co-location, communication, coordination) must be established immediately upon declaration of a major incident / Plato. Forward Command Point, Rendezvous Point, and zone designations must be established.	Pre-existing (JESIP dates from 2012/2013 following 7 July 2005 inquests); reinforced November 2022	Nottinghamshire Police (systemic failure of training and exercising); Chief Inspector Mather (FIM)	JESIP and major incident training now included in divisional training days for frontline responders and the Leadership Academy. Home Office initiated a three-year JESIP transformation programme in 2024.	Inspector Shaw, 16 March 2026: confirmed he was told nothing — not the RVP, FCP, or zones (Day 14, pp.40–48). DI Dowson, 16 March 2026: similarly confirmed she was not told the RVP, FCP, zones, or who the incident commanders were (Day 14, pp.49–50)
5	Structured search coordination : Manchester Arena Inquiry identified the need for clear allocation of search responsibility in a major incident.	By June 2023	Chief Inspector Mather (FIM); Nottinghamshire Police (no policy or procedure for allocating search responsibility)	Superintendent Allardice tasked with implementing changes within the contact centre to ensure "a consistent and coordinated approach to search" going forward.	T/DCC Griffin, 23 March 2026: "the search activity should have been coordinated more effectively. There's no question about that" (Day 19, p.11)
6	Bronze Commander training and preparedness for Plato/major incidents: officers must understand their roles and responsibilities.	By June 2023 (long-standing requirement reinforced by Manchester Arena Report)	Nottinghamshire Police (no bespoke training provided to Sergeants/Inspectors in major incident management)	Nottinghamshire Police's Proud to Lead Academy now trains Sergeants (one-week course including half-day critical incident / half-day major incident management) and	Inspector Shaw, 16 March 2026: "At the time of the incident there was a complete lack of training for Sergeants and Inspectors in the role in general but more pertinent to this incident,

				Inspectors (four-day course including full day on critical/major incident management).	in Major Incident training" (Day 14, p.31). He confirmed this "has been remedied" since.
7	Forces must independently consider and implement Manchester Arena Inquiry recommendations regarding their own procedures and ensure they are "fit for purpose."	Immediately following publication (November 2022); forces were briefed prior to publication	Each Chief Constable individually; Nottinghamshire Police	National : Home Office has strengthened tracking of Manchester Arena Inquiry recommendations and is conducting assurance visits to forces between now and 2027. Local : No evidence of a specific pre-June 2023 review by Nottinghamshire Police of Manchester Arena Inquiry recommendations for fitness of purpose.	Sir Andrew Marsh, 14 April 2026: agreed "each individual force should have considered recommendations of the Inquiry report, such as Manchester Arena around major incidents Op Plato, to make sure that the [policies] and procedures in their own force were fit for purpose" and confirmed the time taken was "unacceptable" (Day 26, pp.99, 102). Richard Clarke (Home Office), 1 June 2026: confirmed that JESIP was not subject to formal dissemination or compliance requirements before 2024

					(Day 53, pp.63–64)
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Term of Reference 6

417. The actions, and inaction, of the police following 13th June 2023 reinforced a system-focused attitude in which the survivors have been treated as an afterthought and oftentimes forgotten. The survivors do not feel that they have been treated as rightfully valued participants by the police. This has also highlighted a disparity in treatment between the bereaved families and survivors.

Breaches of the Victims Code by NGPF

418. The Nottinghamshire Police Family Liaison Policy³⁸⁹ and Practice Advice for Family Liaison Deployment³⁹⁰ sets out the requirement to provide a service to victims of crime and their families that delivers the rights set out under the Victims Code.

419. Wayne, Sharon and their families were entitled to the 12 core rights set out under the Victims Code, including:³⁹¹

- a) To be treated with respect, dignity, sensitivity, compassion and courtesy.
- b) To be provided with timely updates.
- c) To be provided with clear explanations of the investigation and prosecution progress.
- d) To be referred to services that support victims and have services and support tailored to their needs.
- e) To be signposted to compensation.
- f) As victims of one of the most serious crimes (attempted murder) and as vulnerable victims, enhanced rights.

420. Victims' Commissioner Claire Waxman frequently speaks to victims who are not receiving their basic rights under the Victims Code.³⁹² The treatment of the survivors by the police exemplifies this problem. The examples from the written and oral evidence below illustrate the failures by the police to provide the survivors with these basic rights under the Code.

421. Failure to sufficiently allocate FLOs:

- DC Johal was allocated as the sole FLO to three surviving victims, despite deployment in pairs being considered best practice³⁹³. DCI Gould accepted that there should have been two FLOs each allocated to Wayne and Sharon respectively³⁹⁴ and the

³⁸⁹ NGPF0007415

³⁹⁰ NGPF0008684_0005.

³⁹¹ WITN0019002; NGPF0008356.

³⁹² Claire Waxman, 5 June 2026 PM, 53/21, INQT0000111.

³⁹³ NGPF0007415, NGPF0008684.

³⁹⁴ DCI Gould, 26 March 2026 PM, 62/2, INQT0000042.

circumstances of DC Johal as a sole FLO for three families was “not an ideal position”.³⁹⁵

- DC Johal stated that she would inform DCI Gould if being the sole FLO to the surviving victims became unmanageable.³⁹⁶ DC Johal did not request additional support, despite admitting in hindsight that she should have and that having a second FLO would have assisted by making it easier to update the survivors.³⁹⁷
- Due to being sole FLO, DC Johal was expected to update the survivors about the PTPH while she was on annual leave.³⁹⁸
- The survivors received no FLO provision from June 2024 onwards after DC Johal went on sick leave.³⁹⁹

422. It is incomprehensible that it was deemed sufficient for one FLO to be deployed between three survivors’ families, particularly in light of Wayne and Sharon’s entitlement to enhanced rights as vulnerable victims of a serious crime. The failure to deploy sufficient family liaison officers to the surviving victims contributed to them being overlooked by the police and CPS throughout the criminal justice process.

423. Failure to include DC Johal in key meetings and provide key information:

- DC Johal describes herself as part of the “outer circle FLO structure in the investigation”.⁴⁰⁰
- DC Johal was not included in any strategic briefings or decision-making discussions with counsel, CPS, senior police officers or the FLOs allocated to the bereaved families.⁴⁰¹
- DC Johal accepted that this further impacted her ability to provide complete and timely updates to the survivors because it was “impossible to say what they needed to know”.⁴⁰²
- DC Johal did not proactively seek to be involved in the relevant meetings or seek comprehensive updates for the clients, despite her knowledge of being left out of these meetings.⁴⁰³
- The exclusion of DC Johal from these forums, alongside her deployment as the sole FLO to the surviving victims, resulted in the survivors not being informed of significant information regarding the investigation and prosecution in a timely manner, or at all.
- This illustrates the treatment of the survivors as secondary victims and an afterthought by the police.

³⁹⁵ DCI Gould, 26 March 2026 AM, 74/6-8, INQT0000041.

³⁹⁶ DC Johal, 26 March 2026 PM, 77/ 3-25 and 77/ 1-15, INQT0000042.

³⁹⁷ DC Johal, 26 March 2026 PM, 78/14, INQT0000042; DC Johal, 26 March 2026 PM, 78/24, INQT0000042.

³⁹⁸ WTTN0360001, para 109.

³⁹⁹ DC Johal, 26 March 2026 PM, 78/6-11, INQT0000042.

⁴⁰⁰ WTTN0360001, para 142.

⁴⁰¹ DC Johal, 26 March 2026 PM, 78/16-25 and 79/1-6, INQT0000042.

⁴⁰² DC Johal, 26 March 2026 PM, 79/ 16-17, INQT0000042.

⁴⁰³ DC Johal, 26 March 2026 PM, 78/21 -79/9, INQT0000042.

424. No or delayed provision of information to the survivors.

- As sole FLO, DC Johal could not update the surviving families simultaneously. This meant that on occasions the survivors received information when the public did (through social media or news broadcasts) rather than in advance from the police.⁴⁰⁴
- It was accepted by the police in their opening statement that the survivors were not provided with information in a consistent, clear or timely manner in respect of the following:⁴⁰⁵
 - i) **VC's history with the police.** Tracey was wrongly informed by DC Johal that VC had no history with the police.⁴⁰⁶ DC Johal admitted that this information should have been checked before any confirmation was given. She made no attempts to find out whether this was true, despite hearing her colleagues discussing that VC had previously been involved with the police. DC Johal was not aware of the extent of VC's prior involvement with the police until the Inquiry. This was described as a "fundamental failing" by ACC Griffin.⁴⁰⁷
 - ii) **The unexecuted warrant out for VC's arrest.**
 - iii) **The misconduct of NGPF staff following the attacks, including the PSD investigations.** Tracey heard this information through social media before being informed formally by the police.

- DCI Gould's reasoning that this information was not provided to the surviving families because the survivors were "deeply affected and deeply traumatised" by the incident and had informed the police that they did not want to be provided with information relating to the investigation is unsatisfactory.⁴⁰⁸ Firstly, Tracey had asked specific questions and was given incorrect information in response. Secondly, the trauma of victims does not absolve the police of their duty under the Victims Code to provide them with information. It is for the police to adapt the manner that information is provided to suit the needs of the victim.

425. Failed communication methods.

- The only information provided to Wayne and Sharon on the issue of VC's mental health, diminished responsibility and the psychiatric reports in the case was a phone call from DC Johal on 24/11/2023 where a "form of words" was read to them.⁴⁰⁹
- Updates to the survivors was provided by email or a phone call at short notice.⁴¹⁰
- Updates were sent to Wayne's email address, despite requests for the police to contact Tracey directly by post due to Wayne's brain injury and the resulting difficulties he had dealing with the correspondence himself.⁴¹¹

⁴⁰⁴ DC Johal, 26 March 2026 PM, 80/21-24, INQT0000042; Wayne and Tracey, 26 March 2026 AM, 17/16-18, INQT0000041; Sharon and Martin, 26 March 2026 AM, 42/4-5, INQT0000041.

⁴⁰⁵ Opening Written Submissions by Nottingham Police, paragraph 19-20, SUBS0000004.

⁴⁰⁶ Wayne and Tracey, 26 March 2026 AM, 4/9-14, INQT0000041.

⁴⁰⁷ Rob Griffin, 23 March 2026 PM, 47/22, INQT0000037.

⁴⁰⁸ DCI Gould, 26 March 2026 PM, 63/16-24, INQT0000042.

⁴⁰⁹ NGPF0007496.

⁴¹⁰ DC Johal, 26 March 2026 PM, 79/21, INQT0000042.

⁴¹¹ NGPF0007144.

- Updates were given to Sharon and Martin over the phone, despite them preferring written or face-to-face communication.⁴¹²
- Information should be given to victims in an individual-specific manner and provided in “plain, simple language”.⁴¹³ Despite this, the survivors often did not fully understand the information that they were being provided by the police.⁴¹⁴

426. Failures to make reasonable adjustments for Wayne and Sharon.

- The police did not know that both Wayne and Sharon should be classed as vulnerable and entitled to enhanced rights under the Victims Code.⁴¹⁵
- DCI Gould admitted that she had not appreciated that Sharon would be eligible for enhanced rights due to PTSD and her physical disability.⁴¹⁶
- The reality is that both Wayne and Sharon should have been considered as vulnerable and entitled to enhanced rights under the Victims Code due to the physical and psychological injuries they suffered, as well as their status as victims of attempted murder (classed as “the most serious crime” under the Victims Code).
- As victims with enhanced rights, Wayne and Sharon were entitled to be provided with updates about the investigation, prosecution and trial process within 1 working day of important decisions being made.⁴¹⁷ As per the examples outlined above, this was not adhered to.
- Furthermore, the police failed to make individual adjustments for Wayne and Sharon to enable them to understand and engage fully in the proceedings:

i) Wayne

The police were aware that Wayne had suffered a brain injury. This was not factored into deployment of FLOs. Wayne required a FLO solely allocated to him so that the provision of information could be tailored to his specific needs and provided in a way that he could fully understand.

DC Johal recognised that Wayne could not fully understand the processes and found it difficult to comprehend the court process⁴¹⁸ and considered he lacked capacity at the early stages of the investigation.⁴¹⁹ There is no evidence of any reasonable adjustments that were made by DC Johal as a result of this.

Wayne was shown a CCTV compilation by DC Johal on 18/01/2024. He was not provided with any warning that it included footage of the attack on him.⁴²⁰ Wayne had to look away as he has no recollection of the impact, and the view of the expert neuropsychologist is that it would be of detriment to his recovery to view the footage.

⁴¹² Sharon and Martin, 26 March 2026 AM, 52/9-15, INQT0000041.

⁴¹³ Claire Waxman, 5 June 2026 AM, 19/6 and 20/17, INQT0000111.

⁴¹⁴ Sharon and Martin, 26 March 2026 AM, 44/4 and 56/3-7, INQT0000041; Wayne and Tracey, 26 March 2026 AM, 23/14-17, INQT0000041.

⁴¹⁵ DCI Gould, 26 March 2026 PM, 57/8-21, INQT0000042.

⁴¹⁶ DCI Gould, 26 March 2026 PM, 57/21, INQT0000042.

⁴¹⁷ WITN0019002_0026 and 0031.

⁴¹⁸ WITN0360001, para 125.

⁴¹⁹ NGPF0009239.

⁴²⁰ WITN0273001, para 88.

There was no advance consideration of the impact that the CCTV could have on Wayne because of his brain injury.

Wayne was not referred by the police to any suitable support services.

ii) Sharon

Sharon had mobility issues and a fear of leaving her home as a result of the injuries she had suffered. There was no consideration of reasonable adjustments to allow her to participate meaningfully in meetings or hearings.

Sharon was not informed of the option to join VC's sentencing hearing remotely. She did not want to see VC, but she would have attended remotely if this had been offered to her.⁴²¹

Other examples of the survivors being treated as secondary victims by the police

427. It is a key theme that the survivors have been treated as secondary victims by all relevant organisations following 13th June 2023. The police are no exception.

428. The use of language that failed to appreciate the severity of the impact of the attacks on the survivors:

- DCI Gould and SIO Sanders labelled the survivors as the “walking wounded”.⁴²²
- DCI Gould called the survivors “RTC victims”.⁴²³
- DCI Gould stated that she “could have made the decision not to deploy FLOs to the RTC victims”.⁴²⁴
- The police issued a press release that informed the media that Wayne was in a stable condition, while he was still in a coma and critical condition.⁴²⁵
- The initial press briefing stated that all of the attacks occurred on Milton Street, when the attack on Sharon had occurred on Parliament Street and Market Street. The survivor's injuries were also reported incorrectly during this briefing.⁴²⁶

429. The use of this insensitive language re-traumatised the survivors by belittling their experience and trauma as a result of the attacks on 13th June 2023.

430. Royal correspondence:

- Buckingham Palace initially wrote to the police to inform them that the King would write letters to the bereaved families. DCI Gould asked that they consider writing to the survivors also.

⁴²¹ Sharon and Martin, 26 March 2026 AM, 38/2-15, INQT0000041.

⁴²² WITN0360001, para 112; NGPF0008749; NGPF0008900

⁴²³ NGPF0009324, NGPF0009313.

⁴²⁴ NGPF0009313.

⁴²⁵ HMCP0000026.

⁴²⁶ Kate Meynell, 20 March 2026 PM, 24/17 -25; 25/20, INQT0000035.

- The representative for the Royal Family asked for the contact details of all six families (bereaved and survivors).⁴²⁷
- The survivors' details were passed on.⁴²⁸
- DC Johal noted in a FLO log⁴²⁹ that she contacted all three victims and told them that the Prince of Wales and King Charles III would be writing to them. In her first witness statement, she states that she passed letters of condolence from the Prince of Wales and King Charles III to all three victims on 03/07/2023.⁴³⁰
- In her second witness statement, she states that she has no recollection of handing letters to Wayne or Sharon, and she believes she has misinterpreted her daybook.⁴³¹
- In oral evidence, she stated that she informed families that there would be letters that would be delivered from the King and the Prince and those letters would come directly to them.⁴³²
- DC Johal made no attempts to follow up the letters on behalf the survivors, despite letters having been received by the bereaved families.
- On 16th July 2026, the survivors were informed by Malcolm Turner of East Midlands Police Legal Services that the King proposed to write to Wayne and Sharon after closing submissions were concluded.

431. The survivors feel let down and disappointed that the police did not do more to ensure this small source of comfort was provided to them when offered and at a time when it would have provided most comfort. They believe it is only because of their involvement in the Inquiry that they will not receive their rightly deserved letters from the King.

432. Sharon's property:

- The Code of Practice for Victims of Crime (Right 10.3) states: "If the police took any of your property you have the right to get it back as soon as it is no longer required."⁴³³
- Sharon made numerous requests for the return of her belongings.⁴³⁴ Sharon's belongings were only returned to her on 20/01/2026 after the Inquiry made a request to the police on her behalf. There was no justification for retaining these belongings after the sentencing hearing.

Term of Reference 7

433. The Crown Prosecution Service also has a duty to deliver the rights outlined under the Victims Code to victims of crime throughout the prosecution, trial and sentencing stages of the criminal justice process.⁴³⁵

⁴²⁷ WITN0284001, para 189.

⁴²⁸ NGPF0009309.

⁴²⁹ NGPF0009946.

⁴³⁰ WITN0360001, para 62.

⁴³¹ WITN0360002, para 6.

⁴³² DC Johal, 26 March 2026 PM, 100/1-9, INQT0000042.

⁴³³ WITN0019002_0036.

⁴³⁴ WITN0279001, para 79.

⁴³⁵ WITN0019002_0012.

434. The consistent failure by the police to properly prioritise the rights and needs of Wayne and Sharon throughout their involvement in the process are similarly reflected in the approach taken by the CPS.

435. There was a stark disparity in the attitude and approach taken by the CPS between the survivors and the bereaved families.

a) Failure to provide sufficient information to the Survivors

436. Support and provision of information was given to the bereaved families by the CPS and prosecution counsel over multiple meetings and extensive correspondence.⁴³⁶

437. The CPS decided enhanced rights would be offered to the survivors in addition to the bereaved families. On 16th July 2023, the CPS were informed that none of the survivors wished to meet them and were content to receive updates from the FLO. The CPS state that the survivors were aware that if their position changed, they could contact their FLO.⁴³⁷

Wayne and Tracey

438. The CPS were informed by the police that Tracey had requested a meeting on Wayne's behalf on 30th August 2023.⁴³⁸ Alan Murphy was actioned with carrying this forward alongside plans for the bereaved families to meet with leading counsel in advance of the PTPH.⁴³⁹ At a meeting on 8th September 2023, Alan Murphy alongside the police was tasked with arranging this meeting at the PTPH and if not, to arrange another time for the meeting to take place prior to the commencement of trial or before a guilty plea was entered.⁴⁴⁰

439. Alan Murphy stated that he asked for the police to arrange this meeting.⁴⁴¹ Wayne and Tracey did not attend the PTPH. No alternative meeting was arranged by the police. Alan Murphy refused to take any responsibility for ensuring that Tracey's request for a meeting was complied with, at all opportunities deferring to the FLO and stating that he relied upon them to arrange the meeting.⁴⁴²

440. The CPS shared the responsibility with the police to follow-up on Tracey's request for a meeting and was in breach of their obligations under the Victims Code to provide timely and detailed updates about the prosecution by failing to do so. This failure was accepted by Sam Shallow in evidence.⁴⁴³

441. Wayne and Tracey did not meet with the CPS until the sentencing hearing. The circumstances of those meetings were inappropriate and did not afford sufficient time to provide the necessary information to them:

⁴³⁶ SUBS0000007, para 37 onwards.

⁴³⁷ SUBS0000007, para 38; CPSE0006150; CPSE0000187.

⁴³⁸ CPSE0000188.

⁴³⁹ Alan Murphy, 31 March 2026 AM, 95/13-17, INQT0000045.

⁴⁴⁰ CPSE0000190.

⁴⁴¹ Alan Murphy, 31 March 2026 AM, 95/23-24, INQT0000045.

⁴⁴² Alan Murphy, 31 March 2026 AM, 98-100, INQT0000045.

⁴⁴³ Sam Shallow, 13 April 2026 AM, 61/3-6, INQT0000047.

442. A short welfare check and update provided prior to the sentencing hearing, alongside Elaine Newton and the Coates brothers. This was the first time that Wayne and Tracey had met anyone from the CPS.⁴⁴⁴
443. A 15-minute meeting with Alan Murphy, Karim Kalil KC, Michelle Mannion, Leigh Sanders and DC Johal at the end of the sentencing hearing. In this meeting Karim Khalil KC explained what had happened in the hearing and what the sentence meant. It is inconceivable that a singular 15-minute meeting was sufficient to properly explain the relevant complex legal issues to Wayne and Tracey, notwithstanding Wayne's brain injury (which is dealt with below). Tracey recalls that the meeting felt rushed and they were left with many unanswered questions.⁴⁴⁵
444. Wayne and Tracey had not fully understood how the case moved so quickly from a trial to sentencing. Wayne had not fully appreciated the gravity of the attacks on the students and was shocked to hear about this on the day of the sentencing. The lack of clear and consistent communication from the CPS and the police made an already difficult process for Wayne and Tracey even harder to navigate.⁴⁴⁶

Sharon and Martin

445. The CPS did not have any contact with Sharon and Martin prior to or after the sentencing hearing and so they were provided with no information about the process or the sentence. This was disappointing to Sharon.
446. Sharon had initially refused the offer of a meeting with the CPS, but this was never followed up by the CPS or by the police. Although she had felt unable to attend the hearings due to her PTSD, she was surprised that the CPS did not update her as a victim as the proceedings progressed and she felt isolated as a result. She did not receive any letters or contact from the CPS in the lead up to the hearing and felt that she was "left in the dark" about the criminal proceedings.⁴⁴⁷

b) Failure to implement reasonable adjustments and special measures for the survivors

Wayne and Tracey

447. The CPS did not accommodate Wayne's brain injury in their communication with him:
- Alan Murphy did not appreciate how significant the cognitive impairments and impact of the attack was on Wayne.⁴⁴⁸
 - Karim Khalil spoke "slowly and carefully" to Wayne and relied on the fact his family members were present and could explain the information provided to him.⁴⁴⁹

⁴⁴⁴ Michelle Mannion, 31 March 2026 PM, 25/16 - 26/18, INQT0000046.

⁴⁴⁵ WITN0274001, paras 148-149.

⁴⁴⁶ WITN0274001, para 150.

⁴⁴⁷ WITN0279001, paras 93-106.

⁴⁴⁸ Alan Murphy, 31 March 2026 AM, 97/8, INQT0000045.

⁴⁴⁹ Karim Khalil, 13 April 2026 PM, 34/19-25, INQT0000048.

- No efforts were made to obtain information from DC Johal, and nor did DC Johal provide any information to the CPS, about Wayne's brain injury and what he might be capable of retaining or understanding.⁴⁵⁰
448. As a result, no special adjustments were made by the CPS to ensure that Wayne received the information provided to him in a tailored manner. This was an important meeting to explain the process of the sentencing hearing and the consequences for VC. Not tailoring the communication to Wayne's needs led to a lack of clarity about the sentence.
449. Furthermore, the CPS and police both failed in their duties to Wayne in the arrangements made for him to attend the hearing:
- DC Johal did not meet with Wayne and Tracey prior to his attendance at the sentencing hearing to prepare him.⁴⁵¹
 - Wayne was not provided with a separate 'breakout' room at the sentencing hearing and instead shared with Elaine Newton and the Coates brothers. This meant that during breaks Wayne had no private or safe space if he needed a 'brain break' or time away from the hearing.
 - The seating arrangements required Wayne to walk past VC at approximately 2 metres away to leave the courtroom. Wayne was suffering from a cough and had to walk past VC in close proximity on a number of occasions so that he could leave the room. He found this extremely uncomfortable.
450. The failure to meet with Wayne and Tracey prior to the sentencing hearing and to accommodate Wayne's needs when a meeting did take place afterwards meant that their engagement in and understanding of the criminal proceedings was limited, despite their desire to participate fully.

Sharon and Martin

451. The CPS believed that Sharon did not want to participate in the hearings at all.⁴⁵² The CPS relied upon the communication between Sharon and DC Johal. Michelle Mannion did not receive any information from DC Johal about Sharon's injuries and does not recall whether she was aware that she had suffered PTSD.⁴⁵³
452. Alan Murphy maintained that the CPS would have attempted to comply with any request by Sharon to attend the sentencing hearing remotely.⁴⁵⁴ The CPS failed by relying upon the FLO to make these enquiries and made insufficient efforts themselves to engage with Sharon themselves to establish the level of participation she desired. This led to Sharon being prevented from having any meaningful engagement in the criminal proceedings.

c) Failure to ensure the survivors understood VC's hospital order sentence

453. The concept of a hospital order was not properly explained to the surviving victims. This resulted in Wayne and Tracey's belief immediately after the sentence was passed down that VC would "be playing pool or snooker as he pleased... in a comfortable

⁴⁵⁰ Michelle Mannion, 31 March 2026 PM, 36/10-14, INQT0000046.

⁴⁵¹ Wayne Birkett, 26 March 2026 AM, 10/11-24, INQT0000041.

⁴⁵² Alan Murphy, 31 March 2026 AM, 103/21, INQT0000045.

⁴⁵³ Michelle Mannion, 31 March 2026 PM, 37/1, INQT0000046.

⁴⁵⁴ Alan Murphy, 31 March 2026 AM, 64/3-6, INQT0000045.

environment”.⁴⁵⁵ Although Karim Khalil KC corrected this belief in the meeting post-sentencing hearing, the initial belief was particularly distressing to Wayne and Tracey.

454. Tracey was extremely disappointed with the hospital order and felt that a hybrid order would have been a better outcome.⁴⁵⁶ Tracey now fully understands how the release decisions would differ between a hospital order and hybrid order. This was never explained to Wayne and Tracey at the time and if it had been, it likely would have made the sentence somewhat easier to accept.⁴⁵⁷
455. Sharon and Martin never had the concept of a hospital or hybrid order fully explained to them by the police or CPS.
456. The survivors collectively are concerned about the possibility of VC being released in the future. Because of the failures in communication from the CPS and the police throughout the process, they are concerned that if VC was considered for release they would not be informed.

Holding organisations to account under the Victims’ Code

457. Claire Waxman, Victims’ Commissioner, agreed that Wayne and Sharon’s basic rights under the Victims’ Code were not delivered by the police or the CPS throughout the proceedings.⁴⁵⁸
458. The evidence shows that the FLO system is fundamentally flawed. NGPF failed to follow best practice in deploying a sole FLO to three families and excluded DC Johal from key updates. As a result, from the outset, the surviving victims were forgotten.
459. The FLO system has been used by the CPS and other agencies to excuse their own failures in communication with the victims. As a result, the CPS has failed to accept accountability for their own failures in providing key information to the surviving victims at key stages of the investigation, prosecution and sentencing hearing.
460. An overhaul of the FLO system is required. As recommended by Claire Waxman, the introduction of independent advocates or “Victims Hubs” is needed to ensure that victims are properly delivered their rights under the Victims Code.⁴⁵⁹
461. Claire Waxman also identifies accountability as a key area for reform of the Victims’ Code. She stated:

“And again, the frustration with this Victims’ Code that comes back to me time and time again from speaking to victims is it feels quite meaningless...because if rights are not delivered – and they were not delivered in these cases – what’s the accountability? Who do we hold to account for failing to deliver basic victims’ rights to victims in this country? Nothing. And that, I have to say, is an outstanding frustration of mine as Victims’ Commissioner.”⁴⁶⁰

⁴⁵⁵ Karim Khalil KC, 13 April 2026 PM, 35/11, INQT0000048.

⁴⁵⁶ WITN0274001, para 148.

⁴⁵⁷ WITN0274001, para 149.

⁴⁵⁸ Claire Waxman, 5 June 2026 AM, 57/7, INQT0000111.

⁴⁵⁹ Claire Waxman, 5 June 2026 AM, 35, 37 and 48, INQT0000111.

⁴⁶⁰ Claire Waxman, 5 June 2026 AM, 57/8-16, INQT0000111.

462. In her submission to the Ministry of Justice’s consultation on a new Victims’ Code, under recommendation 1, she encourages the Government to enforce a Code compliance monitoring framework under the Victims and Prisoners Act.⁴⁶¹

Failures by Nottingham Police and the CPS to investigate the events immediately preceding the attacks on 11-12 June 2023

463. The evidence demonstrates a material deficiency in the investigation of the events immediately preceding the attacks, in particular the London visit, by Nottingham Police and the CPS as to VC’s contact with Bill Monteiro, the alleged incident with a neighbour in London, and the handling of evidence relating to knives or other bladed weapons.
464. Those matters were not peripheral: they went directly to VC’s movements, state of mind, planning, intent, motive, credibility, and the chain of events by which he returned from London to Nottingham shortly before the attacks. **The London visit and Bill Monteiro were a material line of inquiry that was not investigated sufficiently.** VC travelled to London on Sunday 11 June 2023, where he met and stayed with Bill Monteiro.
465. Shortly after 7 pm on 12 June 2023, VC phoned his brother Elias and said, among other things, “this is the last time I will talk to you,” “disassociate yourself from me,” and “if anything happens don’t come and see me in hospital.”
466. VC then arrived back in Nottingham at around 11.20 pm on 12 June 2023 and was seen travelling from Nottingham station toward the Radford and Ilkeston Road area.
467. The significance of Bill Monteiro was expressly recognised by the Senior Investigating Officer, who accepted that Bill Monteiro was a “significant witness.”⁴⁶²
468. The chronology of contact between VC and Mr Monteiro went back to 25 April, and the investigation identified that Mr Monteiro had lived in Nottingham and that VC had asked him whether he was coming back there.
469. The SIO’s evidence was that VC had asked Mr Monteiro, “do you know someone who can accommodate me for a few days?”, which fitted with VC having been evicted shortly beforehand.^{462a}
470. The SIO also accepted that keys taken from VC in custody fitted the address connected with Mr Monteiro, and Mr Monteiro’s message stated: “I trusted you at my home and you took my key and left with it.”^{462b}

The London neighbour incident was not properly investigated

471. The central deficiency is that the police and prosecution had material pointing to a London incident involving Mr Monteiro’s neighbour, but that incident was not followed up in a way capable of testing VC’s account or establishing what had happened.
472. Mr Monteiro’s voicemail left at 1.15 on 14 June 2023 referred to him wanting to go to “that house” to “see what happened and what didn’t happen,” and warned VC that if the matter “turns into a police case” he was “going to hand” VC over.^{462c}

⁴⁶¹ WITN0455008_0004.

⁴⁶² Leigh Sanders, 18 March 2026 PM, 35/12-14, INQT0000031.

^{462a} Leigh Sanders, 18 March 2026 AM, 81/24-25, INQT0000030.

^{462b} Leigh Sanders, 18 March 2026 AM, 82/12-14, INQT0000030.

^{462c} Leigh Sanders, 18 March 2026 PM, 34-35, INQT0000031.

473. In that same voicemail, Mr Monteiro said that VC had got him “into trouble” with his neighbour, and that he had “trusted” VC in his home, but VC had taken his key and left with it.^{462d}
474. The police interview of Mr Monteiro on 17 June 2023 did not address that neighbour incident, and the SIO accepted that the issue was not put to Mr Monteiro.⁴⁶³
475. The SIO’s explanation was that the matter “probably wasn’t known by the attending officers of the Metropolitan Police”, but he accepted that something had happened in London between VC and another person which caused concern in the exchange with Mr Monteiro.⁴⁶⁴
476. The SIO accepted that the London incident was relevant to intent, motive, and what had occurred, and further accepted that the failure to investigate it was something that “clearly would have been missed.”⁴⁶⁵
477. The omission is particularly important because VC later told Professor Blackwood that he had been threatened in the Lewisham building on the morning of 12 June 2023 after knocking on a neighbour’s door, and that the neighbour had threatened him with a “zombie sword,” which VC said amplified his sense of threat.
478. The SIO accepted that the voicemail and VC’s account should have been connected, and that the failure to revisit the voicemail with Mr Monteiro meant the association had “not been picked up.”^{465a}
479. The SIO further accepted that the matter could have been very relevant to testing VC’s account of his mental state that day.
480. The SIO also accepted that, if VC was lying about the London incident, that would be a serious credibility issue.
481. The reviewing lawyer Mr Murphy accepted that the sequence of events, including CCTV stills and phone footage, omitted significant contact from Bill Monteiro referencing an incident on 12 June in which VC had got into an incident with his neighbour.
482. Mr Murphy said that the voicemail had been provided to the CPS as unused material, which appears to have been treated as an explanation for why it was not included in the sequence of events. This was a failure by the CPS.
483. Mr Murphy did not ask for the London incident to be investigated, notwithstanding the suggestion that it was a further incident on 12 June relevant to VC’s behaviour and conduct.
484. When challenged, Mr Murphy said that, if there was an incident, it would “most likely” support the psychiatric evidence already given, but that was rightly put to him as a “complete leap of faith” because the matter had not been investigated.^{465b}
485. Prosecution counsel was aware that WhatsApp exchanges shared by Bill Monteiro referenced VC’s involvement in an incident with his neighbour, but did not consider that the matter should be explored as part of the relevant chronology, or as potentially relevant

^{462d} Leigh Sanders, 18 March 2026 PM, 35/1-9 INQT0000031

⁴⁶³ Leigh Sanders, 18 March 2026 PM, 35/22-24, INQT0000031.

⁴⁶⁴ Leigh Sanders, 18 March 2026 PM, 53/1-3, INQT0000031.

⁴⁶⁵ Leigh Sanders, 18 March 2026 PM, 54/ 2-4, INQT0000031.

^{465a} Leigh Sanders, 18 March 2026 PM, 37/9-10, INQT0000031.

^{465b} Alan Murphy, 31 March 2026 AM, 109/ 19 - 110/1, INQT0000045.

to culpability, retained responsibility, and the chain of events that drove VC back to Nottingham. This was a failure.

486. Prosecution counsel's explanation was that there was already "so much material"^{465c} relating to VC and his behaviour, but the question put to counsel was that this was an incident occurring only hours before VC attacked Grace and Barney.

487. That answer does not answer the evidential point: the closer in time the incident was to the attacks, the stronger the case for treating it as part of the factual chronology to be investigated, tested, and put before those assessing culpability, responsibility, and sentence. The Survivor's maintain this was highly relevant to the Hybrid Order on sentence.

The Bill Monteiro inquiry also intersected with Nottingham addresses and VC's movements

488. The Bill Monteiro material also raised address-related lines of inquiry relevant to VC's movements in Nottingham who had had an address on Mapperley Road, close to the area of Seely Hirst House where VC sought access shortly before killing Ian Coates.

489. The SIO was asked whether locations linked to Mr Monteiro at Mapperley Road and Querneby Road had been investigated, and his evidence was that he would have to check what inquiries had been made and did not know the significance without seeing the document.⁴⁶⁶

490. These were reasonable lines of inquiry because they potentially connected VC's London accommodation, a London altercation, retained keys, Nottingham address links, and VC's post-attack route around Seely Hirst House and Magdala Road.

HMCPSP Inspection did not address the Survivors

491. Anthony Rogers (HM Crown Prosecution Service Inspectorate) accepted that, in hindsight, "I would have done it quite differently", and agreed to amend his statement (paragraph 52) to accept "there is more that the Inspectorate should have done in respect of the remit of the commission"; he further accepted, in relation to the CPS's over-reliance on FLOs as a conduit, "we did miss an opportunity here, I agree, from the survivors, we missed an opportunity."⁴⁶⁷

^{465c} Karim Khalil, 13 April 2026 PM 71/4 INQT0000048.

⁴⁶⁶ Leigh Sanders, 18 March 2026 PM, 55/16-18, INQT0000031.

⁴⁶⁷ Anthony Rogers, 6 May 2026 AM, 61-65 and 65-69, INQT0000073.

Term of Reference 8

The Survivors invite the Chair to make the following recommendations to ensure lessons are learned and to prevent similar attacks in the future:

Policing

1. The College of Policing should conduct an independent review into Nottinghamshire Police's policing response and regarding the events of 13 June 2023 which was said, "*would constitute an exhaustive examination of police process, actions and policy*" and was paused.
2. There should be an investigation in respect of Nottingham Police's candour after the attack with the public and in press briefings and statements made by CC Meynell and Rob Griffin in line with the principles, expectations and obligations soon to be implemented in the Public Office Accountability Bill conducted
3. Improvements to Police Training:
 - a. Minimum level of experience to be a tutor police officer. Currently no minimum experience required to be a tutor for probationary officers.
 - b. Additional training to be a tutor police officer. Currently only one day online training with annual refreshers. This is important when there is an inexperienced police force.
 - c. Mental Health- further training required to ensure knowledge of local and national policies, and a clear pathway for incidents involving mental health.
 - d. Sufficient training on police policies: a clear absence of knowledge of policies by NGPF and LEPF officers that gave evidence to the Inquiry.
 - e. Police Systems- further training required on all Police systems including interrogation and searching systems and storing information.
4. Need for further Compliance Auditing of Police Systems:
 - a. To ensure effective use of existing systems. E.G. LEPT do dip sample of BWV in relation to performance of the officers but do not dip sample BWV to review if the retention decision is correct.
 - b. To ensure "basic checks" are carried out which the Inquiry heard on multiple occasions were not done.
 - c. To ensure correct Closure Outcomes are consistently applied in investigations.
5. Improved alert system on police computers for high-risk individuals:
 - a. Introduction of a bespoke marker on police systems for mental health issues, and one specifically for "Psychosis/ Schizophrenia", to ensure that high risk individuals are marked appropriately on the police database.
6. Police Services and Resources Required:
 - a. Additional Drone Officer for NGPF.
 - b. Ability to use NPAS without restrictions in the event of a major incident.

- c. Overhaul of the warrant system at NGPF.
7. Review of Police and Local Authority Liaison and Work Practices:
- a. Effective working and monitoring arrangements with Local Authority CCTV and Police.
 - b. Joint training following improvements to technology and services.
 - c. Joint access to CCTV monitoring.

Police investigations and CPS

- 8. There should be a national reminder issued to all Police officers and the CPS that certain powers and protections under MHA 1983 can only be instigated by criminal courts. Prosecution will be appropriate when criminal courts are best placed to weigh the full context and circumstances of a particular case and in any offence of seriousness [such as all assaults, s47, s20, s18, Attempted Murder, Burglary, Robbery, Stalking, all Sexual Offences, Coercive and Controlling Behaviour] rather than divergence.
- 9. Courts are best place to consider more serious offences, even where vulnerable suspects are potentially seriously unwell and to consider a defence of insanity or be found unfit to plead. If the offence is one that would require the public to be protected from a serious risk posed by the defendant.
- 10. This should require an investigating officer to attend on the CPS / Court to confirm that all relevant evidence to assess seriousness and culpability is before the court and that full consideration has been given to the range of restriction and hospital orders available under the MHA Part III.
- 11. Before the CPS instructs a psychiatrist to provide a report the SIO should be required to attend on the CPS and provide a list of all relevant used and unused material to ensure no relevant document that touches on the issue in play as to culpability, seriousness, harm and intent is overlooked.

Feven Incident Investigation

- 12. NGPF, NHFT and NOCC should each provide an analysis of their failings to Feven, complete relevant Datix Incident reporting and investigation and provide an apology to Feven. The IOPC and CQC should consider whether there should be separate investigations as to failures to discharge the Duties of candour including under Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20
- 13. The IOPC should issue updated guidance to Forces as to Death and Serious Incident Investigations and when they are required.

Further support for Victims

- 14. Introduce means tested eligibility testing to provide financial provision to victims of crime. Alternatively, and an interest free loan scheme is made available to victims of crime due to the lengthy time period for compensation claims, CICA etc.
- 15. Provision of training to all stakeholders that are required to apply the Victims Code to ensure delivery of victims' rights under the Code.

16. Provision of specific and separate training on reasonable adjustments, vulnerable victims and enhanced rights to all stakeholders and their staff required to deliver rights under the Code.
17. Provision of specific training to the CPS and police, CPS and counsel on compassionate communication with victims and bereaved families involved in murder or attempted murder cases.
18. Provision of specific training to the CPS and police on their shared responsibilities under the Victims' Code and in particular, CPS and counsel's role in providing legal information directly to victims rather than relying on family liaison officers.
19. Introduction of a pro forma onto the CPS filing system that requires staff to confirm victims have been fully informed of important information relating to the case by CPS lawyers and/or counsel (and not FLOs) at key stages.
20. Introduce a statutory time limit for return of property to victims of crime.
21. Introduction of an independent advocate as a "Victims Case Manager" and/or "Victim Care Hub"⁴⁶⁸ that supports victims of crime separately to the police and CPS. We suggest the role is entitled "Birkett-Miller Representative" and that it is:
 - a. Separate to the FLO role.
 - b. An "end-to-end" service that assists victims of crime from the date of crime to the conclusion of proceedings and beyond.
 - c. Independent of police, CPS and any other organisations required to deliver rights under the Code.
 - d. Given access to relevant databases and systems so that information can be provided to victims in a timely manner.
 - e. Works alongside FLOs, CPS and counsel to create a less fragmented criminal justice system for victims.
 - f. An extension to the Independent Public Advocate Scheme ('Birkett-Miller Amendment and Expansion to the IPA Scheme')
22. Implementation of enforcement framework for non-compliance when victims' rights are not delivered. Claire Waxman's evidence highlighted lack of accountability, so suggestions are to:
 - a. Introduce sanctions for organisations that fail to deliver victims' rights under the Code.
 - b. Provide sufficient resources to enable maintain and develop the Victims' Commissioner's Annual Victims' Survey to ensure that data about victims' experience and Code compliance is available for scrutiny.
23. Reassurance that Surviving Victims will be informed of any updates on VC's sentence and consideration for release.

⁴⁶⁸ Claire Waxman, 5 June 2026 AM, 35/4, INQT0000111.

Healthcare

Improved Healthcare Training (Mental Health Services)

24. Need for sufficient training and supervision for all staff

- a. Gary Carter felt that he had not received enough training when it came to identifying people who are a potential risk to the public.

25. Need for face-to-face training and training which is scenario and task-based

- a. EIP staff training is 'limited to e-learning' and how to manage risk is 'almost learnt on the job'.⁴⁶⁹

26. Risk Assessment and Risk Formulation

- a. Abigail Parsonage accepted that prior to June 2023, she had not appreciated elements of risk assessment,⁴⁷⁰ which resulted in her failing to find out all she could when she saw VC. Risk assessment and formulation is such a key aspect of the role of those working in mental health but the failure in risk assessment and risk formulation was one of the starkest failures in this case.
- b. Reports from family of patients must be incorporated into risk assessments. Celeste made many attempts to advocate for VC, including the fact that he was deteriorating, was not taking his medication and should require a depot.⁴⁷¹ Abigail Parsonage flagged that it was not appropriate to take any urgent action and did not see the report from Celeste as meeting the threshold for a Crisis referral.

27. Public Safety

- a. Need for specific training for staff to ensure that public safety is a paramount consideration in assessment of risk. Gary Carter succinctly highlighted that the EIP team had given on VC and by doing so "gave up on public safety".^{471a}

28. Referrals between Healthcare Teams and Services and Private Providers

- a. A clear early opportunity was lost to refer VC to forensic services, and a protocol is necessary to assess risk for the purpose of a forensic pathway at all stages of a patient's treatment. A clear framework is required when a patient is transferred from a team or service, and particularly when a transfer to a private provider occurs.

29. Medication Non-Concordance and Escalation

- a. Need for a pathway to ensure automatic re-assessment and regular review when there is non-concordance and this pathway is clear and embedded for CCOs, clinicians and social workers to follow. Escalation option: CTO and administration of medication by depot.

30. Disengagement Protocol and Pathway

- a. Action required following missed appointments and disengagement which are likely signs of deterioration and the need for increased support and monitoring.

⁴⁶⁹ Abigail Parsonage, 30 April 2026 AM, 4/14, INQT0000069.

⁴⁷⁰ Abigail Parsonage 30 April 2026 AM, 7/10, INQT0000069.

⁴⁷¹ Celeste Calocane, 14 May 2026 AM, 21/1, INQT0000085.

^{471a} Gary Carter, 30 April PM 76/19-25 INQT0000069.

Action is required when there is disengagement, and this was a clear failure by the EIP service in VC's case.

31. Documentation of MDTs and MHAAs

- a. No documentation of MDTs in 2022 which had changed from 2020. Reason given for this failure was lack of admin support. Result was that important information was missed and not available to future risk assessments and clinical decision-makers. Clear templates are required.

32. Discharge Protocols and Safety Plans

- a. The need for sufficient information to be captured in discharge letters. Template to ensure appropriate referrals and consideration of entitlements- e.g. Section 117 aftercare after a detention under Section 3 MHA. Clear direction required to clinicians in primary care including responsibilities for prescribing and monitoring medication and medication reviews.

33. Record keeping and auditing

- a. As required by Good Medical Practice, but sanctions to be imposed by a Trust in the event of failures detected from audits.

34. GDPR Protocols, Consent and Risk

- a. Regular training needed for all staff.

35. Incident Report Obligations

- a. Lack of understanding of incident reporting procedures and the learning from such reports.

36. Mental Health Tribunals

- a. Requirement for decisions to be reviewed and considered by clinical teams.

Required Services essential for public protection to be available nationally

- 37. It is a postcode lottery as to whether services remain available to the public, but the evidence revealed two clear services which are essential for public protection:

- a. Assertive Outreach.
- b. Street Triage.

EIP and Assertive Outreach

- 38. Restoration of dedicated Assertive Outreach Teams as a discrete resource with full fidelity, not merely an assertive approach within CMHTs.⁴⁷²
- 39. 100% Assertive Outreach coverage as committed by Government, meaning the practice called Assertive Outreach, not merely assertive language.⁴⁷³

⁴⁷² Dr Adrian James, 21 May 2026 PM, 29–37; 89–93, INQT0000094; Professor Appleby, 29 May 2026 AM, 45–49, INQT0000101; Susan Elcock, 20 May 2026 AM, 13–17, INQT0000091.

⁴⁷³ Baroness Merron, 4 June 2026 PM, 29–33, INQT0000110.

40. EIP care coordinator caseloads must not exceed 15:1 as per NICE guidance.⁴⁷⁴
41. Adequate CBT provision: sufficient trained therapists to meet NICE standards.⁴⁷⁵
42. Formal training on disengagement and non-concordance for all EIP care coordinators before commencing practice.⁴⁷⁶
43. City-wide dedicated Assertive Outreach Teams for itinerant, homeless, or unstable-housing patients.⁴⁷⁷
44. Ring-fenced investment for EIP and AO services, separate from general CMHT budgets.⁴⁷⁸

Mental Health Act and Code of Practice (Section 2)

45. Removal of any language implying risk of harm must be imminent for detention criteria to be met.⁴⁷⁹
46. Unequivocal support for CTOs in the Code, with guidance on use where non-concordance and risk of violence are present.⁴⁸⁰
47. Requirement for a second clinician on discharge decisions, with care/treatment plans.⁴⁸¹
48. Clearer guidance on information sharing with police, families, and other agencies where relevant to risk; public interest should override confidentiality where necessary.⁴⁸²
49. Clearer MHA guidance for patients with previous violence, requiring staff to document how public protection was considered and acted upon.⁴⁸³
50. For the chair to express her concerns to Government and DHSC that the changes made to the grounds for detention to be implemented complicate the protection of public criteria and will compromise public safety due to this not being included in the Terms of Reference for these reforms. Sir Simon Wesley's evidence that, *"I mean, as I say, public safety was in the room, whether it was in the TORs or not"*⁴⁸⁴ suggests that the major focus of these reforms has been patient autonomy which has compromised public safety.
51. The Chair goes further than ensuring clarity in the Code of Practice anticipated in 2028/2029⁴⁸⁵ and suggests that the Government do not implement the changes to section 2 and section 3 MHA.

⁴⁷⁴ Dr Adamson, 2 June 2026 AM, 5–8; 29–33, INQT0000105; John Brewin, 18 May 2026 AM, 49–61, INQT0000087.

⁴⁷⁵ Julie Attfield, 20 May 2026 PM, 49–65, INQT0000092.

⁴⁷⁶ Abigail Parsonage, 30 April 2026 AM, 12/22-25, 13/1, INQT0000069; Gary Carter, 30 April 2026 AM, 79/23-25 INQT0000069.

⁴⁷⁷ Professor Tim Kendall, 29 May 2026 PM, 21–29, INQT0000102.

⁴⁷⁸ Julie Attfield, 20 May 2026 PM, 49–65, INQT0000092; Amanda Sullivan / ICB, 3 June 2026 PM, 81–83, INQT0000108.

⁴⁷⁹ Baroness Merron, 4 June 2026 PM, 27–29, INQT0000110; Alex Ruck Keene KC, 16 April 2026 AM, 45–49, INQT0000053.

⁴⁸⁰ Professor Appleby, 29 May 2026 AM, 33–37, INQT0000101; Baroness Merron, 4 June 2026 PM, 24–28, INQT0000110.

⁴⁸¹ Baroness Merron, 4 June 2026 PM, 29–32, INQT0000110.

⁴⁸² Counsel to Inquiry, 23 February 2026, 153–157, INQT0000001; Counsel to Leicestershire Police, 24 February 2026 AM, 85–89, INQT0000002; Baroness Merron, 4 June 2026 PM, 67–68, INQT0000110.

⁴⁸³ Julian Hendy, 28 May 2026 PM, 37–43, INQT0000100.

⁴⁸⁴ Sir Simon Wessely, 2 June 2026 PM, 65/24-25, INQT0000106.

⁴⁸⁵ William Vineall, 4 June 2026 AM, 89/1-9; William Vineall, 4 June 2026 AM, 90/6-13, William Vineall, 4 June 2026 AM, 88/ 21-25, INQT0000109.

Mental Health Nursing

52. Introduction of a national five-day competency-based risk assessment/management module using clinical simulation for harm to self and others.⁴⁸⁶
53. Simulation-based modules on advanced communication skills and psychosocial interventions for challenging patients.⁴⁸⁷
54. Mandatory recurrent risk assessment and management training, with content to include risk to others, longitudinal risk, and dynamic risk.⁴⁸⁸
55. Standardised risk assessment templates nationally.⁴⁸⁹
56. Appointment of a national Director of Mental Health Nursing.⁴⁹⁰
57. Specialist post-registration training for forensic, PICU, and highly specialist services.⁴⁹¹
58. Strategic workforce planning treating clinical supervision as necessary practice, not a luxury add-on; a shared understanding of clinical supervision.⁴⁹²
59. Improved retention measures: pay, career opportunities, wellbeing support, flexible working, reflection time, investment specifically in registered mental health nurses, and senior mental health nursing leadership.⁴⁹³
60. Restoration of field-specific pre-registration standards for mental health nursing.⁴⁹⁴

Trust Governance and Leadership

61. Board-level accountability for clinical risk assessment quality, with regular audit and dip sampling.⁴⁹⁵
62. Proactive (not reactive) governance: policies and processes on risk assessment and discharge must be reviewed after serious incidents and PFD reports without delay.⁴⁹⁶
63. Executive oversight of serious incidents, including audit to identify risk-history/disengagement discharges.⁴⁹⁷
64. Increased clinical presence around the Board and senior leadership.⁴⁹⁸
65. Accountability frameworks that hold to account based on KPIs rather than becoming positive-sharing exercises.⁴⁹⁹

⁴⁸⁶ Christopher Hart, 29 May 2026 PM, 69/19-71/13, INQT0000102; WITN0075001, para 235-237; Amber O'Brien, 2 June 2026 AM, 99-108, INQT0000105.

⁴⁸⁷ Christopher Hart, 29 May 2026 PM, 70/3-71/13, INQT0000102.

⁴⁸⁸ Christopher Hart, 29 May 2026 PM, 73-85, INQT0000102; Diane Hull, 21 May 2026 AM, 2529, INQT0000093.

⁴⁸⁹ Christopher Hart, 29 May 2026 PM, 73-85, INQT0000102.

⁴⁹⁰ Christopher Hart, 29 May 2026 PM, 73-85; Amber O'Brien, 2 June 2026 AM, 99-108, INQT0000105.

⁴⁹¹ Christopher Hart, 29 May 2026 PM, 74/18-75/8 and 83/1-17, INQT0000102.

⁴⁹² Amber O'Brien, 2 June 2026 AM, 103, INQT0000105.

⁴⁹³ Amber O'Brien, 2 June 2026 AM, 101-112, INQT0000105.

⁴⁹⁴ Amber O'Brien, 2 June 2026 AM, 57-60, INQT0000105.

⁴⁹⁵ Paul Devlin, 19 May 2026 PM, 13-21, INQT0000090; Jessica Sokolov, 3rd June 2026 AM, 70/22-71/6 and 73/10-21, INQT0000107.

⁴⁹⁶ Paul Devlin, 19 May 2026 PM, 41-45, INQT0000090.

⁴⁹⁷ Paul Devlin, 19 May 2026 PM, 41-45, INQT0000090; John Brewin, 18 May 2026 AM, 61-64, INQT0000087.

⁴⁹⁸ Ifiti Majid, 18 May 2026 PM, 73-77, INQT0000088.

⁴⁹⁹ Ifiti Majid, 18 May 2026 PM, 5-9, INQT0000088.

66. Adoption of discharge standards including face-to-face assessment before discharge and a nine-point discharge plan.⁵⁰⁰

University

67. Improvement to University Protocols and Enforcement Pathways by introducing:
- a. Formalised Risk Assessment Framework needs to be consistently applied.
 - b. Training on Proactive Triggering of Fitness to Study Policy for students with mental health difficulties.
 - c. Improvement to Information Sharing procedures.
 - d. Introduction of a risk assessment process for all University accommodation and approved providers.

Data Breaches

68. Ensure referrals are made to the GMC and NMC for clinicians involved in data breaches, including those clinicians who have since left the employment of NUH.
69. All public bodies to create and/or implement systems to ensure that relevant data is secure and restricted to those with authorised access when that organisation is involved in a high-profile case. NHFT was the only organisation where no data breaches have been identified, which must, in part, be due to the “lockdown” method that was used.
70. Review policies and procedures in place for auditing systems for data breaches following high-profile cases.
71. Review policies and procedures in place, and provide training, for complying with duty of candour to victims of data breaches under GDPR.
72. In relation to the data breaches by NUH staff, request the provision of information to bereaved families and survivors in respect of what data was accessed, reasons given (legitimate or illegitimate) and the sanction imposed. This will enable the families to engage with GMC and/or NMC procedures where appropriate.
73. Ensure referrals to ICO are made in relation to data breaches where they have not already been made.
74. Request confirmation that none of the individuals currently under investigation for data breaches at NUH are involved, or will be involved, in the care and treatment of the surviving victims and their families while the investigations remain ongoing.

Data Collection

Homicide Reviews and Serious Injury

75. Inclusion of attempted homicide and serious injury data alongside homicide data.⁵⁰¹

⁵⁰⁰ Diane Hull, 21 May 2026 AM, 25–29, INQT0000093; Paul Devlin, 19 May 2026 PM, 81–84, INQT0000090.

⁵⁰¹ Baroness Merron, 4 June 2026 PM, 65–69, INQT0000110; Julian Hendy, 28 May 2026 PM, 73–75, INQT0000100.

76. A national repository where mental health homicide and serious injury investigation reports are published by default.⁵⁰²
77. Recommendations must include specific implementation plans, deadlines, and named responsible parties, not repeated generic phrases.⁵⁰³
78. Comprehensive homicide and serious harm data collection reinstated nationally, with ongoing monitoring.⁵⁰⁴
79. Meaningful family/victim engagement throughout the investigation process, with timely information sharing.⁵⁰⁵
80. Common categorisation framework for recording risk incidents across police, health, and other agencies.⁵⁰⁶

Expansion of NCI remit

81. That the National Confidential Inquiry into Suicide, Homicide and Safety in Mental Health [NCI] is expanded to include data collection for serious non-fatal violence with a focus on perpetrators with schizophrenia to ensure robust inclusions by the NCI⁵⁰⁷

Information Sharing between Stakeholders

82. Recommendations for Information Sharing, Inter-Agency and with External Agencies:
 - a. Clear improved information sharing protocols with timeliness and no delay.
 - b. Better training on GDPR.
 - c. Regular refresher training on risk and public protection.
 - d. Designated contact for each service and each agency for information sharing,
 - e. Designated pathway for information sharing in mental health services.

Multi-Agency Processes and Partnerships

83. The MAPPA and MARAC process should be simplified so as to enable quick, simple referrals to be made of individuals with mental health difficulties where there is repeated contact with police [even where no conviction or caution] and mental health services to ensure an effective sharing and recording of risk information by the multi-agency partners [Police, Health, GP, Mental Health hospital and Mental health community team, Local authority] and a multi-agency strategy adopted.⁵⁰⁸
84. For individuals with psychosis or a diagnosis of paranoid schizophrenia coming into contact with the police as a result of offending to members of the public there should be an enhanced and expedited process to MAPPA, MARAC.

⁵⁰² Counsel for NHFT, 24 February 2026 PM, INQT0000003; 7–8; Julian Hendy, 28 May 2026 PM, 57–61, INQT0000100.

⁵⁰³ Professor Appleby, 29 May 2026 AM, 21–27, INQT0000101; Inquiry Legal Team, 28 May AM, 73–77, INQT0000099.

⁵⁰⁴ Professor Appleby, 29 May 2026 AM, 1–4, INQT0000101.

⁵⁰⁵ Inquiry Legal Team, 28 May 2026 AM, INQT0000099, 69–74; Julian Hendy, 28 May 2026 PM, 57–75, INQT0000100.

⁵⁰⁶ Counsel for NHFT, 24 February 2026 PM, 7–8, INQT0000003.

⁵⁰⁷ WITN0069007, para 42.

⁵⁰⁸ Counsel for NHFT questioning of Dr Ahmed, 16 April 2026 PM, 132-139, INQT0000054.

JESIP and Plato Audit/ Review

85. The Home Office should undertake or direct an audit to ensure all Police Forces have undertaken training and have procedures in place that are fit for purpose to respond to spontaneous attacks and Plato / MTA Terror incidents and have embedded JESIP working within the local force⁵⁰⁹. Assurance should also be provided to the Home Office from each of the Police Forces have embedded the recommendations of the MAI report on the ground.

Accountability and Enforceability of Inquiry Recommendations

86. Public Inquiries should be given the power to monitor their own recommendations to ensure implementation of identified changes.

14 August 2026

Sophie Cartwright KC
Deans Court Chambers
Manchester

Leila Benyounes
Parklane Plowden Chambers
Leeds

Georgia Banks
Parklane Plowden Chambers
Leeds

Instructed by **Greg Almond**
of Rothera Bray
Solicitors

⁵⁰⁹ Third witness statement of Richard Clarke, Home Office WITN0372004 para 12-25 deals with the work done by the Home Office to embed the recommendations of the MAI on these issues but it is clear implementation on the ground as highlighted by the Nottingham Attack is not embedded.