

IN THE NOTTINGHAM INQUIRY

BEFORE HER HONOUR DEBORAH TAYLOR

CLOSING SUBMISSIONS ON BEHALF OF CELESTE AND ELIAS CALOCANE

1. The crimes VC committed on 13.6.23 were a terrible tragedy. They ended the lives of Barnaby Webber, Grace O'Malley-Kumar and Ian Coates, caused life changing injuries to Sharon Miller, Wayne Birkett and Marcin Gawronski, and devastated the families and friends of all of the victims. In order to understand how these horrific attacks could have been prevented, and how similar harm can be prevented in future, it is essential to properly understand what led to them. This was VC's schizophrenia, and the failure to properly treat and manage it. His risk to others was exclusively associated with a relapse into acute psychosis, and a relapse would have been prevented if from an early stage he had received a full and assertive package of NICE compliant medication, treatment and management.
2. These submissions are lengthy, due to the number of issues it has been necessary for VC's family to confront. They deal with the Terms of Reference in order, except that for convenience a section about the CPS appears earlier. VC's family would like to commend the impressive work that has gone into this Inquiry by the Chair and the Inquiry Legal Team, not least the very useful analysis in the Mental Health Related Homicides – the Inquiry Legal Team Review report ("the ILT Homicide Review").

1. TIMELINE OF VC'S INTERACTIONS

VC prior to his illness

3. VC was born on 4.9.91 and moved to Portugal when he was aged 3, from Guinea-Bissau. He first lived in Madeira (which is in Portugal), from age 3 to 7, then moved to Lisbon aged 7. He gained Portuguese citizenship, and he and his family moved to Wales just before VC's

16th birthday in 2007.¹ When growing up in Portugal, VC was an ordinary boy. He was sociable, and had a number of friends, who stayed together through from primary school to high school. He spent much of his time playing football with his friends. VC did not have any issues in school in Portugal and received good reports.²

4. VC started at Sir Thomas Picton school in Wales in September 2007. He was put back two years because he did not speak English to start with. VC initially struggled to fit in and make friends because the culture was very different to Portugal, he did not speak English and he was one of the few Black children in school. However, he still played football with people in the local park and went to a youth church group until he was nearly 18. At home VC remained very sociable with his family. He joked around and was generally helpful around the house.³
5. VC had some minor incidents as a child, but nothing unexpected or out of the ordinary. When VC started pre-school in Madeira some children called him names associated with his race. But this lasted not even a few weeks and there were no other issues when VC was in pre-school and middle school. When VC went to middle school in Lisbon, he experienced a one-off initiation ritual, involving slapping, but VC continued in middle school thereafter without difficulties for four years. When he moved to Wales, VC occasionally experienced racism. Celeste may have used the term '*bullying*' when speaking to Ms Doherty, but the specific conduct she was referring to is as set out above, and it might not be described by everyone as '*bullying*'.⁴
6. There is no evidence that this occasional racism is of any significance in terms of diagnosing VC's psychiatric condition. It is worth noting that a survey by the Welsh government in 2010 found that 47% of pupils in year 6 had experienced bullying in the last year: §2.4; and 20% of pupils in year 10 reported seeing others being bullied due to their race or ethnicity.⁵ This does not mean that those children suffer psychiatric conditions.

¹ WITN0085008, p2, §7

² WITN0085008, p3-4, §§11-15

³ WITN0085008, p4-6, §§17-18, 21-23

⁴ WITN0085008, p7-8, §§32-35

⁵ RLIT0000072, p6, §2.11, A Survey into the Prevalence and Incidence of School Bullying in Wales Summary Report, Welsh Assembly Government, www.gov.wales/sites/default/files/statistics-and-research/2019-01/survey-into-the-prevalence-and-incidence-of-school-bullying-in-wales-summary.pdf

7. VC completed his AS Levels around June 2010, receiving three C grades. He then studied for his A-Levels, but did not in the event sit the exams, so was given three E grades in light of his AS Level results.⁶ VC moved out of the family home when he was 19 years old, which was in the second year of doing his A-Levels. This was in either 2010 or 2011. He moved to a house share in Wales, which was only about a mile away from his family, so they would see each other very often. He spent much of his time at the family house and they saw him all the time.⁷ He also worked doing cleaning jobs at night together with his mum, so spent time with her then too.⁸
8. VC moved from Wales in early 2015 aged 24. He was always independent and was not initially clear about his move. He did an access course in Birmingham so that he could go to university, and in September 2017 started at The University of Nottingham (the ‘University’), studying mechanical engineering. After moving away from Wales in 2015, VC continued to come home for special occasions including Christmas, although he did not go home for one Christmas, in 2015, because he could not get time off from work.⁹

Incident when Elias was 13

9. Evidence was given about an incident when Elias was aged 13. He had an argument with his dad. *“Valdo was not in the house at the time... The incident had finished well before he came home, and he was not involved in it”*.¹⁰ This incident is therefore irrelevant to the Terms of Reference of this Inquiry. If the incident had involved VC, it might be relevant, but it did not involve VC at all. It is also sensitive and private: an embarrassing episode involving a 13 year old boy. For both reasons, and in accordance with s.24(1) Inquiries Act 2005 and Article 8 ECHR, it should not be included in the Chair’s report. If that submission is rejected, please see the detailed explanation Elias has given about this episode, in WITN0087008, §§10-17; and 13 May 2026, PM, 85/4-86/24.

⁶ WITN0085008, p6, §29; WITN0085010

⁷ INQT0000084, Mr Calocane, 13 May 2026, PM, 80/19-25

⁸ WITN0085001, p2-3, §§7-8

⁹ WITN0085001, p3-4, §§12-13; WITN0085008, p11-12, §53

¹⁰ WITN0087008, p3, §14

VC's PARANOID SCHIZOPHRENIA

10. VC was diagnosed with schizophrenia on 31.7.20. (The family were not informed of the diagnosis until late 2023.) It is unknown exactly when he first began to suffer symptoms of the illness. VC's family began to notice signs of concern in early 2020,¹¹ but there are indications that it may have begun in late 2019.
11. VC was given the diagnosis of paranoid schizophrenia by a number of psychiatrists who were involved in VC's care, including consultant psychiatrists who had had lengthy periods to assess VC as an inpatient. Dr Seedat first diagnosed VC with paranoid schizophrenia on 31.7.20, with the advantage of having been his responsible clinician in hospital for a number of weeks.¹² He explained that VC was exhibiting "*classic symptoms of schizophrenia*".¹³ Dr Shiolkova gave VC the diagnosis of schizophrenia at the point of transfer to The Priory, again after a significant period of close assessment of his condition. She explained the reasons were that he had displayed several first rank symptoms of schizophrenia for an extended period.¹⁴ The diagnosis was affirmed by the Mental Health Review Tribunal on 24.9.21¹⁵, and by Dr Gurusinghe on 24.10.21¹⁶, and Dr Gibson¹⁷ on 17.2.22. As Professor Blackwood put it, among the psychiatrists involved in VC's care "*there's never any doubt of the diagnosis*" – it was schizophrenia.¹⁸ The four expert psychiatrists who reviewed VC for the purpose of the criminal trial confirmed the diagnosis of schizophrenia.¹⁹ The CQC experts, Dr Dracass and Dr Ahmed, agreed with the diagnosis.²⁰
12. Schizophrenia, once established, is a life-long condition. However it can normally be treated and managed – many people do respond well with treatment.²¹

¹¹ NGPF0001787, p20

¹² NHFT0000222, p3

¹³ INQT0000062, Dr Seedat, 23 April 2026, PM, 86/24-87/2

¹⁴ INQT0000076, Dr Shoilekova, 7 May 2026, PM, 92/11-25

¹⁵ CYGN0000056, p4, §9

¹⁶ NHFT0000062, p1; PAGR0000029, p1

¹⁷ NHFT0000168, p250, and INQT0000082, Dr Gibson, 12 May 2026, PM, 11/18-24

¹⁸ INQT0000044, Professor Blackwood, 30 March 2026, PM, 3/3-9

¹⁹ Professor Blackwood, WITN0308001 p19, §52 and CPSE0000011, p1-2 §5

²⁰ INQT0000054, Dr Dracass, 16 April 2026, PM, 19/5-20

²¹ INQT0000076, Dr Shoilekova, 7 May 2026, PM, 93/1-5; INQT0000055, Professor Fazel, 20 April 2026, AM, 97/13-18

13. VC's current treating psychiatrist, Dr Ross Mirvis explained in his January 2024 report that VC is diagnosed with treatment resistant schizophrenia.²² The key component of treatment resistant schizophrenia is that two anti-psychotic medications have been fully trialled, and the patient still has symptoms.²³ It does not follow from that diagnosis, however, that proper treatment and management of VC's condition, particularly prompt care in 2020 straight after it was first discovered, could not have addressed his risk to others. That is in part because the 'treatment-resistant' diagnosis was not given until 2024, and because "*the longer people are untreated when they have treatment-resistant schizophrenia, the harder it is to treat*".²⁴
14. There was a question mark about whether VC suffered pre-morbid symptoms of schizophrenia. There were possible pre-morbid schizophrenia symptoms: There was a witness statement from a housemate from the flats where VC lived in Milford Road, from 2014-2015.²⁵ She said she observed behaviour she considered to be unusual. This included that VC was often up in the kitchen at night time, he sometimes stood in the garden at night time, and she heard noises she would describe as screaming coming from his room.²⁶ There is also a vague reference in an East Midlands Ambulance Service document dated 23.5.20, which recorded VC saying he had "*mental health problems in past but would not say what*".²⁷ This could have referred to the symptoms he experienced in early 2020 and late 2019: it does not show he had symptoms before that.
15. It is worth noting that the behaviour the housemate described may have had a non-pathological explanation. For example, it is not surprising that she saw VC up at night time, given that he worked night shifts and was "*a bit of a night owl*".²⁸ The screams she heard at night might have been from television or films: there is evidence VC liked to watch movies from the 1950s and 1960s.²⁹ The housemate did not give oral evidence, and there was no opportunity to better understand these contextual points. But if the behaviour was

²² CPSE0000484, p27, §10.1; WITN0073002, p10, §5.1

²³ INQT0000044, Dr Mirvis, 30 March 2026, PM, 77/5-78/4

²⁴ INQT0000044, Dr Mirvis, 30 March 2026, PM, 79/4-79/7

²⁵ WITN0428001, p1

²⁶ She also described finding mud and something that seemed to be the spine of a small animal within it, in the bath. However, there is no evidence VC left the mud/possible small animal spine there. There were a number of housemates, and often many people coming and going, including friends and other visitors. It could have been any of them, and there is nothing to demonstrate it was VC: WITN0428001, p3, §11-12.

²⁷ EMAS0000002, p2

²⁸ INQT0000084, Mr Calocane, 13 May 2026, PM, 41/13-41/22

²⁹ NHFT0000168, p139, 147, 152, 159

pathological, then this supports the diagnosis of schizophrenia, rather than personality disorder. Professor Blackwood said in oral evidence that the above would suggest “*pre-morbid features of psychosis ... a longer timeline for the development of his psychotic illness rather than any separable evidence of personality difficulties*”.³⁰ Likewise, Dr Seedat’s evidence was that this would not make any difference to his diagnosis of paranoid schizophrenia.³¹

Not personality disorder

16. VC does not suffer from a personality disorder:

- a. Dr Mirvis has been VC’s responsible clinician since late 2023, so has been able to assess VC closely for more than 2 ½ years. He stated that VC has only been diagnosed with schizophrenia, and the team in charge of his care have not observed any features suggestive of personality disorder.³²
- b. Professor Blackwood assessed VC for personality disorder and concluded he did not have one. He explained the complex process of diagnosing personality disorder in someone with schizophrenia. One element of this is that there must be evidence of “*conduct disordered behaviours in childhood*” (e.g. persistent violence or impulsivity). He explained that there was no such evidence for VC.³³
- c. Dr Seedat also considered VC did not have a personality disorder.³⁴ He explained the type of factors appearing in childhood that may indicate a personality disorder (inherent criminal behaviour, abuse, fighting at school etc) and explained that VC had no history of those factors.

17. It was suggested in questioning to Professor Blackwood and Dr Latham that there were gaps in the data they had been provided with.³⁵ Professor Blackwood said “*we had a very full dataset*”. Similarly, Dr Latham said that the missing information would not have made a

³⁰ INQT0000043, Professor Blackwood, 30 March 2026, AM, 45/16-46/13

³¹ INQT0000062, Dr Seedat, 23 April 2026, PM, 90/5-91/11

³² WITN0073003, p2, §4

³³ INQT0000043, Professor Blackwood, 30 March 2026 AM, 10/4-11/12; INQT0000044, Professor Blackwood, 30 March 2026, PM, 2/24-3/3

³⁴ INQT0000062, Dr Seedat, 23 April 2026, PM, 87/25-88/21; WITN0163001, p100, 141-142 and 163, §248, 376 and 433

³⁵ INQT0000043, Professor Blackwood, 30 March 2026, AM, 89/20-90/7; INQT0000044, Dr Latham, 30 March 2026, PM, 46/20-48/13

difference to his conclusions because they had full information for the period of three years prior to the index offences and for the time after the offences.³⁶

18. The missing evidence has now been obtained, and it points very firmly away from personality disorder. The new evidence contains no suggestion of any conduct disordered behaviours in childhood. For example:

- a. Celeste, who spent a great deal of time with VC from his birth until about 2015 had no concerns about his mental health.³⁷ Her evidence about VC's early life is set out in WITN0085001, p1-4, §4-15 and WITN0085008, p2-7, §6-47. He was an ordinary boy: there was nothing out of the ordinary in his childhood behaviour.
- b. Elias, who spent a lot of time with VC from his birth until 2015 also states there was nothing out of the ordinary in VC's childhood behaviour. There were no issues between VC and his father or mother that were unusual for a child or adolescent.³⁸
- c. Ms Hutchinson from Birmingham Metropolitan College, where VC was enrolled from 2015-2016, explained that his student records do not identify any behavioural concerns or any other concerns relating to him.³⁹ Nigel Thomas, who worked closely with VC at Sir Thomas Picton School, described him as "*a model student... never sanctioned for poor behaviour*".⁴⁰ Similarly, Rebecca Pritchard from the same school does not recall him being involved in any bullying, and states his peers described him as "*always charming*".⁴¹
- d. Dr Charlotte Lisa John, a GP from VC's old surgery in Wales states that during his time as a patient (between September 2007 and September 2017), VC never presented to her or any other GP at the practice with mental health related issues. No concerns that VC was or might be suffering mental health related symptoms has been documented in VC's electronic notes held by them.⁴²
- e. VC was employed by SSG from August 2012 to March 2015 when he was working as a cleaner at Pembrokeshire College. The employer confirmed they hold no record

³⁶ INQT0000084, Dr Lantham, 30 March 2026, PM, 48/10-13

³⁷ INQT0000086, Ms Calocane, 14 May 2026, PM, 19/21-25

³⁸ INQT0000084, Mr Calocane, 13 May 2026, PM, 41/23-42/3; WITN0087001, pp1-3, §§4, 7, 9

³⁹ WITN0431001, p3, §§12-14

⁴⁰ WITN0476001, p3-4, §§6-7

⁴¹ WITN0475001, p2-3, §5

⁴² WITN0449001, p2, §3

of any incidents or disciplinary action or complaints made against VC from his period of employment.⁴³

19. In short, before VC's illness caused him to break into neighbour's apartments on 24.5.20, he was a law-abiding, peaceful and well-behaved young man. Before he was ill, there is no evidence whatsoever that he posed a risk of harm to others. He was never alleged to have been involved in crime. The only possible signs of concern (by the neighbour in 2015) were, at worst, pre-morbid signs of schizophrenia. Dr Shoilekova was right to state: "*before coming ill, he was a kind and caring person who would not be physically violent*".⁴⁴

What caused VC's schizophrenia?

20. The original cause is unclear. The doctors thought the most likely trigger for his psychotic episode in spring 2020 was stress from university work and lack of sleep.⁴⁵ It is possible that VC's grandfather had some mental health difficulties, but he was never given a diagnosis, and there is nothing to show it was psychosis.⁴⁶
21. The schizophrenia was not caused by drugs. VC used cannabis on one occasion, when he had an unusual reaction, thinking his arm would drop off and he might die. However, there is no evidence he ever used drugs apart from that. In fact, there is considerable evidence showing he did not use drugs otherwise.
- a. His family had never seen evidence that he used drugs, and understood he was anti-drugs.⁴⁷
 - b. Sebastian, who lived with VC for about 1 ½ years, said "*I never saw Valdo smoking cannabis and never smelt cannabis on or around him. I was never told by anyone else or had reported to me that VC smoked cannabis*".⁴⁸
 - c. VC voluntarily provided a urine sample, which was screened for illicit substances on 28.5.20, and it came back negative for all of them (except benzodiazepines which he had been prescribed).⁴⁹ Detection periods for drugs in urine samples are

⁴³ WITN0432001, p2, §8-9

⁴⁴ INQT0000076, Dr Shoilekova, 7 May 2026, PM, 10/16-17

⁴⁵ E.g. Dr Gandhi and Dr Malik, NHFT0000168, p2; Dr Sadraei, NHFT0000168, p5; INQT0000061, Dr Seedat, 23 April 2026, AM, 20/17-23 and PM, 91/14-92/21; NHFT0000168, p11; Annette Palmer, NHFT0000006, p2

⁴⁶ WITN0086001, p4, §21; WITN0086004, p1-2, §§3-7; NHFT0000168, p24

⁴⁷ WITN0085001, p3, §10; INQT0000084, Mr Calocane, 13 May PM, 44/9-12

⁴⁸ WITN0151001, p2, §5

⁴⁹ WITN0166001, p76-77, §159; INQT0000059, Dr Ludvigsen, 22 April 2026, AM, 84/6-86/3; NHFT0000168, p13

set out in a table in Professor Wolff's report.⁵⁰ For example, moderate use for cannabinoids is detectable for 4-5 days in urine.

- d. It appears VC also had his blood tested on 24.5.20, and it came back clear of any illicit drugs. The RiOs,⁵¹ p1 on 24.5.20 at 09:54 contain a note by Dominic Lloyd (nursing) which says: *"he had bloods taken there which came back clear of substances"*. (A much earlier entry – at 04:01 on that day – apparently by a police officer, in the custody record,⁵² said that blood tests had not been taken. It therefore appears that the blood results did not become available to everyone until after 04:01).
- e. Extensive records have been obtained about VC, including school, work, police, GP and medical records, and there is no suggestion anywhere within those records that he took drugs.

22. Similarly, there was considerable evidence that VC had not taken drugs around the time of the 13.6.23 offences. For example, PC Matthew Bower got hold of VC to arrest him just after the offences on 13.6.23. He did not smell any alcohol or drugs on VC's person or when he was in the van.⁵³ The security guard at Seely Hirst House was in close proximity with VC for a few seconds. He did not recall that VC smelt of cannabis.⁵⁴ There is no evidence in the police investigation of drugs being found on VC's person or in his belongings.⁵⁵ There was no evidence of a smell of drugs by anyone. No drugs paraphernalia were found in any of the searches of the properties relating to him. There were no drug-related messages on his phone. There was no evidence from any university student that he took drugs.⁵⁶

23. Similarly, Professor Blackwood did not consider that VC's illness at the time of the offences was caused by drug use. That is in part because:

"his mental state abnormalities continued to obtain many months after any such substances would have left his system: that is, even if substance misuse had obtained in the weeks before or on the day in question, his illness was not/ is not reducible to a drug-induced psychosis."

⁵⁰ WITN0394002, p10

⁵¹ In these submissions 'RiO' refers to the RiO Patient Record Summary, NHFT0000168

⁵² NGPF0000077, p7

⁵³ INQT0000026, PC Bower, 16 March 2026, AM, 101/16-20

⁵⁴ WITN0191001, p3, §19

⁵⁵ NGPF0008791 (decision 102)

⁵⁶ INQT0000045, Mr Murphy, 31 March 2026, AM, 115/1-23; INQT0000030, DSI Saunders, 18 March 2026, AM, 114/6-9

*The clinical picture is of a major mental illness (paranoid schizophrenia) with an onset and course unrelated to substance misuse.”.*⁵⁷

24. He explained that one bad experience with cannabis, even if it was dramatic, would not cause psychosis. It is necessary for there to be consistent use of cannabis for it to be a precipitating factor in psychosis. There is no evidence that VC used cannabis more than once. Professor Blackwood also indicated that the extreme reaction VC experienced may reflect a pre-existing vulnerability to psychosis.⁵⁸ That is, the psychosis caused the cannabis reaction rather than vice-versa. Dr Mirvis agreed. He “*was quite satisfied that cannabis in this instance wasn’t a significant precipitant or perpetuating factor*”. He confirmed VC’s symptoms continued in high security hospital, where VC did not have access to illicit substances. Dr Mirvis explained that a number of measures were put in place aimed at ensuring patients including VC did not take illicit drugs. For example, he regularly gave urine samples which were found not to contain any illicit drugs, and drug dogs did not detect anything.⁵⁹
25. VC should have been tested for drugs when he was brought into custody on 13.6.23. However, had he been tested, there are two reasons why that would not have made any difference to subsequent decisions relating to the prosecution. Firstly, it is highly unlikely VC was intoxicated to a significant degree, as explained above. Secondly, even if he was intoxicated, this would have made no difference to the conclusion of diminished responsibility. Diminished responsibility arises even if the Defendant is intoxicated at the time of the offence, provided the test in s.2 of the Homicide Act 1957 is met.⁶⁰ The experts were clear that it was satisfied.

The symptoms of VC’s schizophrenia

1. Delusions and hallucinations which led to dangerous acts of violence

26. VC suffered distressing hallucinations and delusions, which led him to commit aggressive or dangerous acts.

⁵⁷ WITN0308001, p20 §43; INQT0000044, Professor Blackwood, 30 March 2026, PM, 12/4-13/24

⁵⁸ INQT0000043, Professor Blackwood, 30 March 2026, AM, 30/14-31/19

⁵⁹ INQT0000044, Dr Mirvis, 30 March 2026, PM, 73/5-7; WITN0073001, p2-3, §§8-9; WITN0073002, p5, §3.7; Dr Mirvis, 30 March 2026, PM, 96/18-98/1

⁶⁰ RLIT0000074, *Tandy* [1988] 87 Cr. App. R. 45, CA; and RLIT0000070, *R v Kay (Robert)* [2017] 4 WLR 121

27. On 24.5.20 he kicked down the door of a neighbour's flat. He told medics what led to this was he heard his mother screaming, and heard people telling him that his mother was being raped in the upstairs flat and was in pain. He genuinely thought this was happening, and this was the reason for trying to break the door down in that flat. When he saw the Mental Health Act 1983 ('MHA') assessors, he asked them if his mother was OK *"at which point he became tearful"*.⁶¹
28. One hour after VC returned home on 24.5.20 he tried to break down the door of another neighbour's flat. Fearful for her life, she jumped out of a first floor window, resulting in serious back injury requiring surgery.⁶² Dr Seedat and Dr Malik explained that VC broke into this flat for similar reasons to the first incident: he was acting in response to *"hallucinations that he could hear his mum screaming in pain and in danger"* and *"hearing voices talking about his mum being raped"* and he wanted to save her.⁶³
29. The experts explained that VC genuinely believed the hallucinations were real: that his mum was in fact screaming, in pain and being raped. Professor Blackwood said this would have been a horrific experience, and VC was tormented by his experiences.⁶⁴ Dr Ahmed explained: *"how distressing these paranoid delusions were. He felt he was taking these actions to save members of his family"*.⁶⁵
30. VC was taken into hospital, given sedatives and an antipsychotic. His condition settled. He then had a trial of not taking anti-psychotics from 28.5.20 to 5.6.20. On 5.6.20 he reported he could hear a woman in distress and screaming from inside a linen cupboard: *"He said he was hearing a woman in distress and wanted to save her"*: NHFT0000168, p23. *"He was surprised when the cupboard was opened and his mother was not there"*.⁶⁶ Ms Frost

⁶¹ INQT0000057, Dr Malik, 21 April 2026, AM 83/24-84/14, cf NHFT0000168, p1-2; INQT0000058, Ben Williams, 21 April 2026, PM, 66/6-16; WITN0115001, p20-21, §63; cf NOCC0000044, p3; NHFT0000006, p2 (Ms Palmer, 24.5.20)

⁶² NHFT0000168, p3 (Mr Todd, 24.5.20); CYGN0000047, p2; WITN0252001, p4 §16

⁶³ INQT0000057, Dr Malik, 21 April 2026, PM, 85/10-21; WITN0163001, pp66, 71-72 and 126, §§160, 176-177 and 334; INQT0000062, Dr Seedat, 23 April 2026, PM, 94/16-95/3

⁶⁴ INQT0000044, Professor Blackwood, 30 March 2026, PM, 3/21-4/5; WITN0308001, p25, §52; and to the same effect Dr Ahmed CQCM0010416, p1

⁶⁵ INQT0000054, Dr Ahmed, 16 April 2026, PM, 78/17-20, 81/21-24

⁶⁶ WITN0163001, p59-60, 90-91, §§144 and 222; see also WITN0196002: nursing team update

explained VC was “*perplexed as he was convinced there was someone in there screaming*”.⁶⁷ At this point, Dr Seedat considered the psychotic symptoms had returned and VC needed anti-psychotic medication.⁶⁸ His condition then improved.

31. On 14.7.20 VC tried to force his way into a neighbour’s flat. He was restrained on the floor by a number of residents. Again, his hallucinations led him to act in this way. VC appeared to be experiencing delusions that his mum was at risk.⁶⁹ He also heard unpleasant voices inside his head, discussing him, which were coming from his neighbour’s flat. He went into the flat trying to confront them as to why they were affecting his mind.⁷⁰ Dr Manzar said that “*VC had become aggressive and violent due to the relapsing of his mental disorder and a re-emergence of his psychotic symptoms. These symptoms were characterised by auditory hallucinations*”.⁷¹
32. After discharge from the second admission, VC’s schizophrenia symptoms continued. For example, Dr Burri recorded voices and delusions on 10.11.20.⁷² On 24.11.20 VC told Ms Birtles that he heard the voices “*pretty much all day without a break*”, and on 21.12.20 it was noted he continued to hear voices on a daily basis: NHFT0000168 p142. The voices and delusions continued into May and July 2021.⁷³
33. On 16.8.21 Ms Frost said “*it appeared to me that he was experiencing delusions about whether he was hearing voices or not and about artificial intelligence*” and he was experiencing symptoms of psychosis.⁷⁴ The 31.8.21 visit by Ms Birtles made clear he was relapsing. On 3.9.21 VC seriously assaulted a police officer, in the midst of acute psychosis. The Mental Health Tribunal on 24.9.21 concluded that “*Valdo’s delusions were sufficiently severe and distressing so as to cause him to seriously assault a police officer*”.⁷⁵ Dr

⁶⁷ WITN0196001, p21, §69; INQT0000060, Ms Frost, 22 April 2026, PM, 124/21-125/11

⁶⁸ INQT0000061, Dr Seedat, 23 April 2026, AM, 72/16-23

⁶⁹ NHFT0000168, p56; INQT0000067, Ms Birtles, 29 April 2026, PM, 75/2-18

⁷⁰ INQT0000062, Dr Seedat, 23 April 2026, PM, 95/4-12; cf NHFT0000037, p3-4

⁷¹ WITN0350001, p15, §72

⁷² “*the voices consist of people from many different departments including MI6, Police, etc... He believes that voices are real experience and not the result of mental illness*”, NHFT0000168, p138

⁷³ NHFT0000168, p152; and see evidence of Celeste and Elias, below

⁷⁴ INQT0000060, Ms Frost, 22 April 2026, PM, 127/1-128/4, cf WITN0163001, p187, §500

⁷⁵ CYGN0000056, p5 §12(iii)

Shoilekova agreed with that.⁷⁶ Dr Manzar explained that VC's psychotic processes led him to cause harm in this incident: his actions '*were dominated by psychotic processes*'.⁷⁷

2. He genuinely believed the hallucinations and delusions were real: lacked insight

34. An important symptom of VC's illness was that he lacked insight – he genuinely believed the delusions and hallucinations he suffered were real, and that he was not unwell.⁷⁸ Dr Shoilekova and Professor Blackwood explained that VC's lack of insight – his delusion that his experiences were real - was itself a symptom; an "*integral feature*" of his schizophrenia.⁷⁹ It is a common symptom of schizophrenia that those suffering from it genuinely believe their delusions are real.⁸⁰ Earlier in the progress of his illness, at times, it appears VC exhibited partial insight.⁸¹ But this deteriorated and later on, medical staff generally considered he lacked any insight.⁸²

3. Delusion of conspiracy by medical services and others

35. The symptoms of VC's schizophrenia also included persecutory delusions that medical professionals (with other agencies) were conspiring against him and harassing him: they had used a technology called 'neural remote mapping' to scan and manipulate his thoughts.
36. VC's delusions of a conspiracy began at an early stage. They were apparent in his communications with Elias, and in the 24.5.20 MHA assessments (e.g. NHFT0000168, p2, Dr Gandhi: "*he started talking about being observed and bugged*"). When in hospital on 9.6.20 he was noted to be suspicious of clinicians: he was "*suspicious of all activities that were offered to him... suspicious of the equipment*".⁸³
37. However, VC's delusion that medical staff were part of the conspiracy against him crystallised more clearly later - in 2021. Ms Birtles noted on 31.8.21 that VC:

⁷⁶ INQT0000076, Dr Shoilekova, 7 May 2026, PM, 55/2-22

⁷⁷ INQT0000064, Dr Manzar, 27 April 2026, PM, 91/17-92/12

⁷⁸ INQT0000054, Dr Ahmed, 16 April 2026 PM, 81/22-24

⁷⁹ INQT0000076, Dr Shoilekova 7 May 2026 PM, 87/11-17; Professor Blackwood, CPSE0000011, p24, §106

⁸⁰ CQCM0016518, p11

⁸¹ A possible example is 25.7.20: NHFT0000168, p93

⁸² See, for example, Dr Shoilekova: "*Completely lacks insight*" 21.9.21, CYGN0000061, p4; Mr Waldron "*Nil insight, does not believe he has ever been unwell*" : 3.11.21 NHFT0000168, p197; "*does not believe he has ever been unwell... doesn't appear to have any insight into his MHC and mistrusts his CCO...*". Ms Birtles, 28.2.22: NHFT0000190, p5

⁸³ WITN0196002 'Nursing Team Update'

*“believes we are working in collaboration with the judicial system and the hospital (highbury) and we’ve created a technology to cause his voice experiences / monitor him... appears paranoid/suspicious and is not trusting of services... believes technology has been developed to deliberately cause him harm... Refusal to engage... knows we will have to ‘feedback to the higher powers’ but [he is] not willing to engage any further with treatment... Appears to believe he is more at risk by engaging with us... didn’t trust are [sic] intentions so remained very guarded in his responses”.*⁸⁴

38. In September, Dr Shoilekova agreed: *“systematised delusions of conspiracy and persecution persist – subject to psychotronic harassment orchestrated by NHS and Judiciary...”*.⁸⁵ Ms Jacques explained on 24.9.21 that VC believes *“that the voices he hears have been manufactured using technology set up by the health professionals to make him believe that he is ill. He was clear that he believed that his CPN was actively involved in this conspiracy”*.⁸⁶

4. Those symptoms led VC to stop taking medication

39. The symptoms of VC’s illness led him to stop taking medication. The first symptom was VC’s genuine belief that the delusions and hallucinations were real (the lack of insight). This meant he believed he did not need treatment or medication. Dr Shoilekova explained that: *“He believed ‘voices’ are transmitted to his mind by the authorities, and were not a symptom of mental disorder, hence no treatment was required... does not believe these experiences are [at]tributable to mental illness, hence he stopped taking his antipsychotic medication”*.⁸⁷
40. Dr Ahmed agreed that the fact VC genuinely thought the hallucinations and delusions were real impacted on his compliance with medication. He did not recognise medication had a role in managing these experiences.⁸⁸
41. The delusion of a conspiracy by medical staff – i.e. the very people who were prescribing the medication - was a second symptom of VC’s illness that led him to stop taking medication. That is apparent from the 31.8.21 entry by Ms Birtles, and her oral evidence.⁸⁹

⁸⁴ NHFT0000168, p162, p197 (Ms Birtles, 31.8.21); NHFT0014619, p7 (Ms Birtles, 17.9.21); NHFT0000190, p4-5 (Ms Birtles, 28.2.22)

⁸⁵ INQT0000076, Dr Shoilekova, 7 May 2026, PM, 87/6-10; CYGN0000061, p3-4

⁸⁶ CYGN0000052, p13

⁸⁷ INQT0000076, Dr Shoilekova, 7 May 2026, PM, 88/2-7; and CYGN0000047, p3-4 (17.9.21). Cf Dr Seedat CHCA0000028, p3; and Ms Birtles NHFT0000168, p162

⁸⁸ INQT0000054, Dr Ahmed, 16 April 2026, PM, 127/18-22

⁸⁹ INQT0000067, Ms Birtles, 29 April 2026, PM, 77/23-78/7

Dr Ahmed agreed that VC's delusions that medical staff were involved in a conspiracy against him was a factor which impacted on his compliance with medication.⁹⁰ Professor Blackwood gave similar evidence.⁹¹

42. Thus, the symptoms of VC's illness drove him to stop taking his medication. VC's decision to stop his medication was not a culpable omission by a mentally well individual: it was founded on the illness he had been struck down by. Professor Blackwood explained VC's *"failure to comply with anti-psychotic medication and wider aspects of community psychiatric treatment were determined by his lack of insight into his condition rather than a culpable omission on his part"*.⁹² Similarly, Dr Ahmed explained that *"lack of insight is... symptomatic of what's going on, the decision to disengage from services, that's not being made by a rational capacitous choice"*.⁹³

5. Symptoms also led VC to be guarded, mask symptoms, and disengage

43. The delusion of conspiracy also led VC to be guarded with medical professionals, to mask his symptoms, and to disengage. Again, that is evident from the 31.8.21 entry from Ms Birtles (above), in which she explained that VC's delusions made him believe he was at risk of harm if he engaged with medical staff. She expanded on this in oral evidence.⁹⁴ Dr Ahmed said these conspiracy delusions *"made it very difficult for him to open up to the team and be more clear about his psychotic experiences"* and *"those factors led him to be more guarded, disengage from the team"*.⁹⁵ Dr Manzar agreed the conspiracy delusion was part of VC's illness and it caused him to disengage and be guarded.⁹⁶ The Tribunal recorded: *"he is guarded about sharing information - he was worried that Ms Birtles and the NHS were part of causing the voices"*.⁹⁷
44. Another reason why VC was guarded and masked his symptoms was the voices indicated he should not reveal those symptoms. For example, on 1.12.20 VC said the voices were *"quite*

⁹⁰ INQT0000054, Dr Ahmed, 16 April 2026, PM, 127/23-128/1

⁹¹ INQT0000044, Professor Blackwood, 30 March 2026, PM, 9/25-11/7; and CPSE0000011, pp8 and 24, §28 and 106

⁹² INQT0000043, Professor Blackwood, 30 March 2026, AM, 61/15-19, 65/12-15, and 66/9-67/3

⁹³ INQT0000054, Dr Ahmed, 16 April 2026, PM, 114/1-18

⁹⁴ INQT0000068, Ms Birtles, 29 April 2026, PM, 77/23-78/14

⁹⁵ INQT0000054, Dr Ahmed, 16 April 2026, PM, 128/1-6

⁹⁶ INQT0000064, Dr Manzar, 27 April 2026, PM, 89/18-20

⁹⁷ CYGN0000056, p2, §7

powerful ... [they] don't particularly like it when he speaks about what they are saying": NHFT0000168 p140.

45. Again, it is wrong to portray VC's masking of his symptoms as a culpable decision by a rational individual and that he was blameworthy for masking or lying about his symptoms. This misunderstands the medical evidence that it was the schizophrenia, and the symptoms of it, that led him to be guarded and to mask or lie about what he was experiencing. This is common in patients with schizophrenia.⁹⁸
46. Clinicians were well aware that VC tried to mask his symptoms.⁹⁹ For example, on 10.11.20 VC admitted that, when he told Dr Seedat in July that he no longer heard voices, that was not the case and he only said it to get discharged: NHFT0000168 p138. He became increasingly guarded over time, particularly from about September 2021. On 21.9.21 Ms Birtles said: "*he believed I continued to be involved with the hospital in a cover up*" and "*he was likely to be more guarded with me going forward*": NHFT0000168, p191. Then on 3.2.22 Ms Birtles explained that "*He is very guarded*": NHFT0000168 p225.
47. This meant clinicians could not expect VC to disclose his symptoms or be overtly psychotic, even when he was very unwell just before an incident of aggression. He was not overtly psychotic on 15.7.20, at a time when he was suffering from an acute psychotic relapse: NHFT0000168, p59. On 19.8.21 he was said to be "*likely relapsing*" but on 24.8.21 he stated he was "*fine there is nothing to worry about*": NHFT0000168 p161. He was calm at the time just prior to the 3.9.21 attack, when he was in fact acutely psychotic: NHFT0000168, p215.

Need for a longitudinal approach

48. For those reasons, it was clear, particularly from late 2021 onwards, that clinicians could not simply rely on what VC told them about his condition. They had to take collateral information, a longitudinal view, and look for non-overt signs that he was psychotic.

⁹⁸ INQT0000055, Professor Fazel, 20 April 2026, AM, 98/13-99/1; INQT0000044, Professor Blackwood, 30 March 2026, PM, 11/16-12/3

⁹⁹ NHFT0000168, p52 (Ms Baker), 56 (Mr Wade), 138 (Dr Burri), 162 (Ms Birtles), 191 (Ms Birtles), 205 (Dr Skelton); CHCA0000012, p5 (Dr Gurusinghe, 21.10.21); CYGN0000054, p23 (Ms Staples, 04.09.21).

49. A number of experts emphasised that, especially for someone who was guarded and masked their symptoms, it was important to take a ‘longitudinal approach’ to risk assessment. That is, in basic terms, analyse how VC presented at the time of his previous relapses, and identify ‘relapse warning signs’. This approach is very well-established. It was identified as far back as The Ritchie Inquiry. It is particularly important for someone who is guarded and masks their symptoms.¹⁰⁰ Dr Dissanayaka gave an example of a patient scratching cars, which would be innocuous for a healthy person, but for that particular patient was known to be associated with a sharp escalation of risk.¹⁰¹

Relapse leading to 28 January 2022 admission

50. When the above points are taken into account, it is evident that VC remained psychotic in 2022. The starting point is that VC had been reliably and consistently diagnosed with schizophrenia by a number of clinicians since July 2020. This is a life-long condition so VC would have continued to suffer from it in 2022. Moreover, in early 2022 there were a number of signs he was psychotic despite his attempts to hide his illness.

- a. On 17.12.21 he was “*fixed in his staring*”: NHFT0000168 p202. On 15.1.22 VC assaulted and took his flatmates hostage. Most significantly: “*After this, Chris explained Valdo was “acting strangely” and refused to let them leave the flat.*”: NHFT0000168 p228. Dr Gibson said that this was unusual and indicated VC was suffering from psychosis.¹⁰² Ms Birtles said this “*altercation suggested he was relapsing*”.¹⁰³ Dr Lomas described this incident as “*highly concerning*”: NHFT0000168 p215. Chris also told Dr Gibson (NHFT0000168 p228) that:

“there had been some concerns about Valdo’s presentation for about a month. Short screams were heard intermittently from his room, which were thought to be from him. He also reportedly entered another flatmate’s bedroom in the middle of the night and asked “can you hear that screaming” (referring to a different scream, potentially hallucinatory)”.

- b. This was “*a clear sign of psychosis*”.¹⁰⁴ It is particularly significant when a longitudinal view is taken: The two incidents on 24.5.20, and that on 13.7.20, concerned VC breaking into flats having heard screaming or voices, and VC heard

¹⁰⁰ See INQY0000033, p36, §11.1; and INQT0000082, Dr Gibson, 12 May 2026, PM, 81/3-25

¹⁰¹ INQT0000051, Dr Dissanayaka, 15 April 2026, AM, 67/16-68/7

¹⁰² WITN0205001, p24, §64; and INQT0000082, Dr Gibson, 12 May 2026, PM, 85/4-7 and 85/16-19

¹⁰³ WITN0348001, p134-135, §408

¹⁰⁴ INQT0000075, Dr Skelton, 7 May 2026, AM, 80/15-22

screaming on 4.6.20 coming from a linen cupboard, judged to be a psychotic relapse. Dr Gibson accepted that, particularly in that context, VC entering a flatmate's bedroom because he was hearing hallucinations of screaming, was *"pretty significant"*.¹⁰⁵

- c. On 4.2.22 Ms Turner spoke to Dr Gibson and said VC's *"pattern of behaviour had been typical during episodes of mental illness for him in the past"*: NHFT0000168 p228. Dr Gibson accepted this was another factor which weighed towards relapse.¹⁰⁶
- d. VC was repeatedly noted to be very suspicious and paranoid, very guarded, and felt persecuted by health services.¹⁰⁷ These factors were particularly significant when a longitudinal view is taken. VC became especially paranoid and expressed persecutory delusions about the health services in the context of previous relapses: §41 above. Dr Gibson accepted that when VC's expressions of paranoia and persecution are put in that context, they were a sign that he may be relapsing.¹⁰⁸ Similarly, Dr Malik said these were signs of psychosis, because they indicate paranoia.¹⁰⁹
- e. On 3.2.22, while on s.17 leave, VC trespassed at his old accommodation at Raleigh Park. He gave false information about this: Dr Gibson, NHFT0000168 p228. Trespass was a clear sign of relapse, as the incidents in May and July 2020 show.
- f. On 10.2.22 VC said to Dr Thangavelu that the second and third admissions were *"not rational"*: NHFT0000168 p238. That demonstrates a manifest lack of insight on 10.2.22, which is itself a sign VC was unwell.

51. In summary, as Dr Dracass explained, VC's schizophrenic symptoms continued throughout his contact with the services, including during 2022.¹¹⁰ Dr Lloyd was therefore plainly wrong to say VC *"was well at that point in March"* 2022 when she saw him and *"there was*

¹⁰⁵ INQT0000082, Dr Gibson, 12 May 2026, PM, 82/5-10

¹⁰⁶ INQT0000082, Dr Gibson, 12 May 2026, PM, 84/1-13

¹⁰⁷ E.g. 28.1.22, Dr Manzar: *"very suspicious and paranoid"*: NHFT0000070, p8; 31.1.22 Dr Miles-Marsh: *"On the ward [VC] appears paranoid and wide-eyed"*: NHFT0000168, p220; 2.2.22, Celeste: VC *"feels persecuted by [MH services]"*: NHFT0000168, p223; 3.2.22, Dr Thangavelu: *"very guarded... feels persecuted by mental health services"*: NHFT0000168, p225 and 28.2.22: *"very paranoid and suspicious"* NHFT0000190, p5

¹⁰⁸ INQT0000082, Dr Gibson, 12 May 2026, PM, 83/1-8

¹⁰⁹ INQT0000057, Dr Malik, 21 April 2026, AM, 86/3-10

¹¹⁰ INQT0000054, Dr Dracass, 16 April 2026, PM, 58/5-59/2

nothing to suggest that he was psychotic".¹¹¹ There were many suggestions he was psychotic as set out above. A competent psychiatrist taking a longitudinal view would have recognised these non-overt relapse indicators. A demonstration of how poor Dr Lloyd's analysis was, is that around the time of her appointment with VC, he was describing a series of deeply psychotic delusions within his May 2022 Investigatory Powers Tribunal ('IPT') complaint, yet she failed to spot any sign of this.

52. Celeste told Dr Gibson on 2.2.22 she was worried about VC and that he feels persecuted by the health services¹¹². Celeste was not, however, in a position to judge VC's mental state at this point. She had not seen VC face-to-face since July 2021, but this was important for assessing his mental state, because he "*will give the impression that all is well*" and did not admit his symptoms.¹¹³ By 2022 VC was very guarded and stopped telling Celeste about his mental health. She had also been given little to no information about him recently by the health services, because he had objected to them doing so.

VC's risk arose exclusively from his illness

53. VC's risk to others was entirely attributable to his schizophrenia. This is a critical point, because it demonstrates how important it was to properly treat and manage VC's illness. If these attacks were going to be prevented, it was by properly treating and managing the schizophrenia.
54. The CQC experts said VC's: "*Risk of violence was only associated with a deterioration of his mental state and active symptoms of psychosis*"; it was "*exclusively driven by a deterioration in his psychotic symptoms*".¹¹⁴ Dr Ahmed said: "*the principal driver of those violent assaults were very distressing paranoid psychotic symptoms*".¹¹⁵ Professor Blackwood concluded: "*His risk to others is driven by his psychotic illness*".¹¹⁶ Dr Seedat said his risk "*was dependent on the presence of acute psychotic symptoms*", and in each of

¹¹¹ INQT0000074, Dr Lloyd, 6 May 2026, PM, 56/14-21

¹¹² NHFT0000168, p223

¹¹³ NHFT0018562, p2; NHFT0000168, p51

¹¹⁴ CQCM0013648, p9-10 §100-101; and INQT0000054, Dr Dracass, 16 April 2026, PM, 59/20-25

¹¹⁵ INQT0000054, Dr Ahmed, 16 April 2026, PM, 126/22-24, and CQCM0010417, p1; and CQCM0010416, p1-2

¹¹⁶ CPSE0000011, 24-25 §107; INQT0000043, Professor Blackwood, 30 March 2026, AM, 11/1-4

the incidents where he had acted aggressively in 2020: *“his actions were driven by the psychotic experiences he had been having”*.¹¹⁷

55. When VC was unwell, he posed a high risk of harm to others. The Mental Health Tribunal and clinicians concluded that *“There is unequivocal evidence that the risks to others when Valdo is unwell are high”*.¹¹⁸ As Dr Shoilekova put it: *“When he is unwell the risks are serious”*.¹¹⁹ VC caused serious harm in both May 2020 and September 2021, when he was described as using *“extreme levels of violence”*.¹²⁰ It follows that it was of great importance to properly treat and manage his illness.

The experts/CPS cannot be criticised for concluding that the assaults on 13 June 2023 were entirely attributable to VC’s illness

56. This issue is more relevant to item 7 of the Terms of Reference, but is dealt with here as it flows from the matters set out above. The experts decided that the assaults on 13.6.23 were attributable to VC’s schizophrenia and that VC was mentally unwell at the time of the offences. The key experts (Professor Blackwood, Dr Mirvis and Dr Latham) took into account all relevant evidence, and there is no basis to criticise them.¹²¹
57. Professor Blackwood said: *“... the assaults [on the 13th June] would not have occurred but for [VC’s] ... psychotic symptoms. The offending was in my view entirely attributable to his mental illness”*.¹²² Dr Latham concluded mental illness was *“a very compelling dominant explanation for these offences”*. The evidence to support that conclusion - that VC’s schizophrenic symptoms were the cause of the offences on 13.6.23 – was compelling. What VC told the psychiatrists in late 2023 was only one element of the evidence that led them to this conclusion. It was triangulated by a wide range of other sources, that were consistent

¹¹⁷ WITN0163001, pp65, 77, 79 and 95, §158, 194, 196, 233

¹¹⁸ CYGN0000056, p5 §13(i) (MHT, 24.9.21). See also CYGN0000085, p2 (Dr Lomas, 3.9.21); CHCA0000019, p3 (Ms Modern and Ms Parker, 28.1.22)

¹¹⁹ CYGN0000056, p3 §3

¹²⁰ CYGN0000001, p182 (MDT, 21.9.21)

¹²¹ INQT0000044, Professor Blackwood, 30 March 2026, PM, 52/15-20

¹²² INQT0000044, Professor Blackwood, 30 March 2026, PM, 1/10-15; CPSE0000011, p23-25, §§101-102, 106-107; and WITN0308001, p21, §44-45

with the account VC gave to the psychiatrists after arrest¹²³ and with the notes he wrote in prison on 21.7.23.¹²⁴ The triangulation included:

- a. The communications between Elias and VC in early 2020. VC said he heard voices in his head, that there were people in the apartment above or next to him, who were monitoring him, and that the people were using a technology to monitor him.
- b. There were numerous reports in the extensive medical records between May 2020 and August 2022, by a wide range of clinicians, and the Mental Health Review Tribunal, which were consistent with the account VC gave in late 2023 and which demonstrated VC suffered from classic symptoms of schizophrenia.¹²⁵ There can be no suggestion that VC was concocting these ‘*classic symptoms of psychosis*’ that he had displayed for a long-time prior to his offences.
- c. In the IPT complaints VC made on 21.5.22 and 27.5.22 he expressed similar delusions, such as that the police and MI6 use an AI system/program to monitor his thoughts, to harass and misinform him; the technology “*responds to thoughts and content that is only available in the complainant’s mind*”; and it causes “*constant 24/7 malign and hostile inner ear communication*”.¹²⁶
- d. It is clear VC was guarded during 2022 – he sought to disguise his symptoms from medics. For example, he did not reveal the delusionary contents of the IPT complaint. Nevertheless, as explained in §50 above, there remained a considerable number of indications that VC continued to suffer psychotic symptoms.
- e. VC sent zip files to his parents on 24.12.22, and amended versions to Elias late on 12.6.23 at 23:52.¹²⁷ In this, VC explained his belief that technology was being used as surveillance and to put voices into his head: “*The brain can be read and edited*”¹²⁸; and he had some information about who the operators were. This was significant for the expert psychiatrists.¹²⁹

¹²³ VC’s description of the hallucinations he suffered at the time of the offences, given to Professor Blackwood is CPSE0000011, p18-19, §78-84

¹²⁴ NGPF0003167, p173 to 178; INQT0000044, Professor Blackwood, 30 March 2026, PM, 8/24-9/5; Dr Latham, 30 March 2026, PM, 52/15-56/9; and Dr Mirvis 30 March 2026, PM, 93/3-95/5

¹²⁵ INQT0000044, Professor Blackwood, 30 March 2026, PM, 2/11-3/20, and 4/6-13; INQT0000044, Dr Latham, 30 March 2026, PM, 53/4-54/9

¹²⁶ INQY0000003, p2-5, §5-19

¹²⁷ INQY0000003, p6, §21 and 23

¹²⁸ INQY0000003, p7

¹²⁹ See, e.g. INQT0000044, Dr Latham, 30 March 2026, PM, 54/23-25

- f. On 12.6.23 VC phoned Elias at 19:09, for 44 minutes. VC expressed similar delusions to those he had been expressing for years. They included that: *“I am not ill but there is 2-way communication and 24/7 voices in my head... The majority of the call was him talking about his delusional beliefs and trying to persuade me that some research he had done would prove everything he believed. He talked about his mind being controlled ... there [was] ... [a] connection issue during the call ... [and] [VC] was adamant that it was the technology he was referring to interfering and that he was being monitored”*.¹³⁰
- g. Professor Blackwood explained that this evidence was *“incredibly important”* in demonstrating that VC’s offences were motivated by his psychosis.¹³¹ Likewise Dr Latham considered it was *“really important information about the fact that he was likely to have still been psychotic at that time”*.¹³²
- h. When he was first taken into custody on 13.6.23 VC continued to be guarded, as he had been previously. For example, on 13.6.23 in police custody VC was asked by Rosie Draper: *“if he was experiencing any voices or hallucinations”*, he responded *“I do not want to discuss that with you”*.¹³³ And on 17.6.23 in prison VC was asked *“if he had any mental health problems”* and responded *“It’s not for you to know”*.¹³⁴ It was recognised by 15.6.23 that he was *“very good at masking symptoms of mental illness”*.¹³⁵ It is no surprise that some ordinary police or prison officers, who did not have specialist training in how to recognise symptoms of psychosis in a schizophrenic patient who was guarded and well-practiced in disguising his symptoms, did not recognise symptoms in VC. However, it is wrong to say that VC displayed no symptoms of psychosis at this point. There were a number of indications he was mentally unwell.
- i. They included 13.6.23 RiOs p272, Health Care Professionals Rosie Draper and Holly Bramley, who saw VC in police custody, said: *“[VC’s] responses were delayed. Based on history and current presentation HCPs believe VC is mentally unwell...”*. Ms Bramley said she had concerns about VC’s mental health on 13.6.23

¹³⁰ WITN0087001, p23-25, §85 and 87

¹³¹ INQT0000044, Professor Blackwood, 30 March 2026, PM, 18/8-16 and Professor Blackwood, 30 March 2026, PM, 4/14-5/21

¹³² INQT0000044, Dr Latham, 30 March 2026, PM, 54/10-22

¹³³ NGPF0002379, p2

¹³⁴ NHFT0002546, p8, §60

¹³⁵ NHFT0002476, p2

because he was unusually calm despite the grave offences; and the possibility of drugs was low as this calmness continued after a significant rest period.¹³⁶ On 13.6.23 at 12:53 a police officer noted *“possible mental health”*.¹³⁷ VC was distracted and there were long pauses when he spoke, which is a sign of psychosis.¹³⁸ On 14.6.23 at 21:19 an officer noted: *“DP likely to have mental health issues”*¹³⁹, and at 23:53 another officer said: *“Concerns re his mental state”*.¹⁴⁰ On 17.6.23 in prison VC was described as *“bizarre in his presentation, appeared mentally acutely unwell”*.¹⁴¹

- j. Professor Blackwood explained: *“his psychosis comes from symptoms of reality distortion which he hides from others and has done for years before that, and then there are suggestions of that, his guardedness, his suspiciousness, the delayed responses the lack of emotional resonance when he looks at all the terrible events in police interviews, and then further evidence emerges in prison. They pick it up very early on, but then there are better descriptions as he begins to engage with psychiatrists”*.¹⁴²
- k. Dr McSweeney assessed VC on 10.7.23.¹⁴³ He concluded VC *“remains actively psychotic in custody... It is my opinion that he requires urgent transfer to a psychiatric inpatient unit under s.48/49 of the MHA 1983... he will require transfer to a high secure psychiatric unit”*.¹⁴⁴
- l. Dr Ullal saw VC on 11.7.23, and stated that, given VC’s current presentation, risk and symptomology, an admission to high security hospital was indicated. Dr Ullal asked that an urgent assessment be made for admission of VC to psychiatric hospital for further assessment and treatment.¹⁴⁵
- m. Dr Milton saw VC on 8.8.23. He concluded VC met the criteria under the MHA for transfer to a high security hospital for further assessment and treatment; VC had a

¹³⁶ INQT0000029, Ms Bramley, 17 March 2026, PM, 98/7-16

¹³⁷ NGPF0002195, p15

¹³⁸ INQT0000057, Dr Malik, 21 April 2026, AM, 85/22-86/6

¹³⁹ NGPF0002195, p107

¹⁴⁰ NGPF0002195, p33

¹⁴¹ NHFT0002009, p4

¹⁴² INQT0000044, Professor Blackwood, 30 March 2026, PM, 8/1-9

¹⁴³ CPSE0000003, p3-4, §3.1

¹⁴⁴ CPSE0000003, p18 §16.33-16.34

¹⁴⁵ NHFT0001214

mental disorder which was a psychotic illness, probably schizophrenia; and he should be transferred for “*urgent treatment*” to hospital.¹⁴⁶

58. Taking a step back, the overall course of VC’s illness, as demonstrated by the long-term and comprehensive independent evidence set out above, “*fortified by years of psychiatric investigations pre-dating, and then post-dating the offence*” was “*entirely consistent*” with schizophrenia at the time of the offence.¹⁴⁷ Likewise, Dr Latham explained, by reference to the symptoms VC displayed from early 2020 onwards: “*this is such a classic case of schizophrenia, the symptoms are so classic and so consistent, and the progression of his illness is so typical... the schizophrenia itself is so typical*”.¹⁴⁸
59. Professor Blackwood stood by his conclusion that VC’s offending was entirely attributable to his mental illness, notwithstanding some evidence he had not previously seen, such as the CCTV of the assault on PC Pritchard, that was shown to him in oral evidence. Similarly, it was suggested to him that he could have asked further questions of VC. He said that this would not have made any difference: he was secure in his conclusions, regardless.¹⁴⁹ Similarly, Dr Latham was provided with further information prior to giving evidence, including audio of Sebastian’s call to 999 and the CCTV of PC Pritchard. He said this would not have made any difference to his conclusions. Nor would the fact that further questions could have been asked of VC.¹⁵⁰
60. As Dr Latham and others accepted, it would have been better if psychiatric assessments had taken place earlier – soon after VC came into custody. One reason for that is it would have led to VC being transferred to hospital sooner, where his schizophrenia would have been properly treated and managed, and the risk he posed to those around him in detention would have reduced. However, the psychiatrists were unanimous that earlier assessment would have made no difference to their conclusions that VC’s offending was entirely attributable to his illness, and that the partial defence of diminished responsibility was available.¹⁵¹ As can be seen from §57 above, those conclusions were founded on detailed evidence about the

¹⁴⁶ NHFT0002546, p23, §159-164

¹⁴⁷ INQT0000044, Professor Blackwood, 30 March 2026, PM, 20/23-21/24

¹⁴⁸ INQT0000044, Dr Latham, 30 March 2026, PM, 53/9-54/9

¹⁴⁹ INQT0000044, Professor Blackwood, 30 March 2026, PM, 14/7-13 and 16/3-25

¹⁵⁰ INQT0000044, Dr Latham, 30 March 2026, PM, 31/18-33/11, 45/25-46/5, 52/15-53/3

¹⁵¹ WITN0308001, p18-19, §41, and see CPSE0000011, p2, §6-8

course of VC's illness over a period of some 3 years prior to the offending, and evidence of his mental state at the time of the offences themselves. That founding evidence was not tarnished by the delay in psychiatric interview.

61. VC acted rationally and/or exercised self-control in some respects. For example, he slowed down when he went over a speed bump, and gave a 'no comment' interview. But that did not undermine the conclusion that his offences were entirely attributed to his schizophrenia. The experts properly took these factors into account and explained why they did not show that VC was mentally well. In short, VC's schizophrenia caused him to suffer hallucinations, delusions and reality distortion. But in 2023 it did not prevent him from being able to behave rationally in some other respects.¹⁵² Likewise, the fact VC was calm at the time of the index offence, does not show he was not acutely psychotic. VC was also calm at other times when he was very unwell, such as on 3.9.21. VC was emotionally blunted at this point, which is why he appeared calm.¹⁵³
62. In the .zip files that VC sent to his parents at Christmas 2022, and to Elias on 12.6.23, VC sought to present evidence that his experiences of having thoughts inserted into his mind and his thoughts controlled by a technology, were in fact real. He had been searching online for proof that his schizophrenic hallucinations and delusions were real, for years.¹⁵⁴ There were 3700 individual files in the .zip files VC sent to his parents. One of those individual files, Bott.pdf¹⁵⁵, mentioned the Navy Yard Shootings, together with the claim that "*Nanotechnology was used to harass*" the shooter. The date VC obtained the file is unclear. There were also images extracted from VC's mobile phone and videos of weapons and shootings, apparently added to his phone in 2022 and 2023: INQY0000001. These images post-date rather than pre-date his schizophrenia, so it appears the interest in them is a result of his deteriorating condition. There is certainly no basis for saying VC was an extremist, or viewed violent content, before he developed schizophrenia.

¹⁵² INQT0000044, Professor Blackwood, 30 March 2026, PM, 9/6-15 and 18/24-19/9; and CPSE0000011, p2, §103

¹⁵³ INQT0000044, Professor Blackwood, 30 March 2026, PM, 9/19-23; and Dr Latham, 30 March 2026, PM, 58/9-59/4

¹⁵⁴ INQT0000044, Dr Mirvis, 30 March 2026, PM, 73/16-74/6; Mr Calocane (below); Ms Jacques CYGN0000052, p14, 24.9.21

¹⁵⁵ ECAL00002360

THE INVOLVEMENT OF VC's FAMILY

i. Communications between Elias and VC

63. Elias produced NGPF0001787 - a 20-page transcript showing communications between the two brothers from 12.4.20 to 23.5.20 - shortly after he learned that his brother had been detained in a psychiatric hospital for the first time, suffering from a psychotic episode, as a result of the two incidents on 24.5.20. The majority of the original messages were in Portuguese, and Elias translated them himself. It took him about 2 ½ to 3 days to produce it. The document was then emailed by Celeste to Dr Seedat on 28.5.20.¹⁵⁶
64. Elias prepared this *“because I thought it would be helpful in showing the medical professionals what had been happening with Valdo and to help them come up with some sort of diagnosis”*.¹⁵⁷ De Seedat's witness statement for this inquiry describes the messages as *“extremely important and useful”* and said the messages informed his diagnosis of schizophrenia.¹⁵⁸
65. The family did not at any stage suggest the messages should not be revealed to VC or anyone else. As Celeste explains: *“To the contrary, we shared the messages with Dr Seedat to assist the medical team in understanding what was happening with Valdo and we assumed it would be used for that purpose. I did not suggest in my email to Dr Seedat that he should withhold the messages [NHFT0017802...]. I explained to Miss Thwaites on 26 May 2020 that I was happy for the messages to be passed on... I also outlined some of the messages to the ward round (by phone) on 28 May 2020, which Valdo attended”*.¹⁵⁹ The RiOs confirm at p8: *“[Celeste] is happy for these to be passed on”*. And at p11 they note that Celeste outlined some of the contents of the communications in the ward round when VC was present: see ‘Family/Carer’s involvement’.

¹⁵⁶ NHFT0017802 and INQT0000025, Mr Calocane, 13 May 2026, PM, 45/13-17

¹⁵⁷ WITN0087001, p4, §16

¹⁵⁸ WITN0163001, p66-67, §213

¹⁵⁹ WITN0085008, p13, §58

Elias' understanding of what VC said

66. Elias was asked what he understood VC to be saying to him in the NGPF0001787 communications. Elias' evidence about the document is footnoted.¹⁶⁰ As that evidence makes clear, when faced with this alarming series of messages and calls from his brother, Elias did not have a clear or simple understanding of what VC was saying. In considering what Elias took from the messages at the time, two points are important.
67. Firstly, context is critical. Anyone reading the communications in the context of knowing in hindsight about VC's terrible crimes, will naturally interpret them as malign. But Elias was reading them in an entirely different context. Elias was speaking to his brother, who he loved and had never known to be violent, and who he knew to be a "*very calm and peaceful person*".¹⁶¹ It is important to stand in Elias' shoes, and ask: what would I think if my own brother started speaking like this?
68. Secondly, it is easy now to pick out single lines in the messages, to abstract and isolate them from the context, and to take time to focus on what the meaning of those particular words may be. But Elias was facing a barrage of information coming in quick succession from VC. The information was bizarre, jumbled and complex. This sudden onset of a psychotic breakdown was, for VC's family, highly alarming and caused them real distress. (Elias explained that this "*worried me hugely*"¹⁶².) Neither Elias nor Celeste was a psychiatrist with the expertise and responsibility to come up with a diagnosis or to provide treatment to VC. Elias had no understanding of VC's illness.¹⁶³ He was a concerned family member trying his best to help the clinical team. In that context, it is understandable that Elias was: "*so confused and thrown by it all and I had no idea what was going on*".¹⁶⁴
69. One example is the calls and messages on 12.4.20¹⁶⁵, shortly before 15:00. In a relatively short space of time, VC told Elias that "the person" has been controlling his router and is able to see "exactly" his laptop and phone screen. He asked Elias questions about reconciling

¹⁶⁰ WITN0087001, p4-9, §15-29; WITN0087008, p4-8, §18-32, and INQT0000084, Mr Calocane, 13 May 2026, PM, particularly 4/16-39/10 and 45/2-17

¹⁶¹ INQT0000084, Mr Calocane, 13 May 2026, PM, 15/22-23

¹⁶² WITN0087001, p8-9, §28

¹⁶³ INQT0000084, Mr Calocane, 13 May 2026, PM, 48/22-50/2

¹⁶⁴ WITN0087001, p7, §26

¹⁶⁵ NGPF0001787, p17

faith and intelligence. He then explained the events of the night before when VC had texted Elias saying he loved him, by the following messages:

[14:52, 12/04/2020] Valdo: That previous night I felt immense anguish, paranoia, anger, hatred

[14:53, 12/04/2020] Valdo: Because of this spying/monetering thing

[14:54, 12/04/2020] Valdo: Couldn't sleep, had the darkest thoughts of could imagine

[14:54, 12/04/2020] Valdo: Wanted to hurt... permanently...

[14:56, 12/04/2020] Valdo: It was overwhelming, so at some point something in me begged "take it away, nothing else, just take it away"

[14:57, 12/04/2020] Valdo: I didn't say it, I'm not sure I even thought it

~~[14:57, 12/04/2020] Valdo: Finally dozed off for a couple hours about 7 am~~

[14:58, 12/04/2020] Valdo: When I woke up close to 9am, I felt the greatest peace I've ever felt in my life

[14:59, 12/04/2020] Valdo: Something I can't quite put into words

70. Elias interpreted these messages as indicating VC wanted to hurt himself (rather than someone else). This was partly due to the contents of the messages, such as VC saying "something in me begged "take it away nothing else, just take it away". It was partly due to other comments relating to suicide that VC had made when speaking to Elias on the phone. It was in part because Elias had never known VC to be a violent person, but rather to be a loving and peaceful brother. When preparing the document and summary of the phone calls, Elias did not think it was necessary to include everything VC said, and thought it was already apparent that VC was talking about suicide.¹⁶⁶

71. Another example is from 18.5.20. VC had called Elias, and was crying uncontrollably and screaming.¹⁶⁷ There was then a series of messages which included the following:¹⁶⁸

"I know that I am being watched by the room next to me. But if it is that other people are also watching. I don't know what happened. Just that I cried like a mother who had lost a son and there was no reason...If this was God, and I say this being one against the idea of God. Would it not be better if it had happened in front of family or friends or people I know? But in front of strangers to be mocked even more? ... Because I think they are watching I know that I can break their heads with my hands. Give me a reason to be mocked? ... I have to decrease for Him to increase..."

¹⁶⁶ WITN0087001, p5-6, §19 and INQT0000084, Mr Calocane, 13 May 2026, PM, 14/15-16/10

¹⁶⁷ NGPF0001787, p12 and WITN0087001, p6-7 §22

¹⁶⁸ NGPF0001787, p13-14

72. Elias thinks he was concerned but can't remember exactly how he took those words at the time.¹⁶⁹ Attention has been focused on *"break their heads with my hands"*.¹⁷⁰ But when that is put in the context of the jumble of bizarre thoughts that VC was rapidly expressing, rather than being abstracted and isolated, it is understandable that Elias was not clear what the words referred to or meant.
73. The *"red rum"* comment¹⁷¹ is similar. It falls within a barrage of bizarre and apparently unconnected thoughts. For example, it was immediately followed by *"Not only do I not care I feel appreciation. I want people to know I love them and want to be there for them"*. Elias said *"the whole conversation is about that experience of praying or asking something to take that away, and coming into, like, a new sense of peace that he can't quite explain."* Elias was not sure he noticed *"red rum"* at the time. He did not associate it with murder.¹⁷² On 20.5.20 VC said he had watched a video about the ethics of capital punishment. The video did not show capital punishment itself.¹⁷³
74. For an expert psychiatrist, the comments, taken together, should have raised concerns about VC's potential risk to others.¹⁷⁴ But the question of what Elias understood from these at the time is different from how an expert psychiatrist should have interpreted them. It is understandable that a stunned family member took from this that the brother he knew to be entirely non-violent, was a risk to himself.
75. Celeste did not read the document.¹⁷⁵ Elias went to a great effort to transcribe the calls and texts in detail, in order to try to help the medical services by giving them as full and clear a picture as he was able to at that difficult time about what VC had been saying.¹⁷⁶ He should not be criticised for leaving details out, or for not giving a more detailed overview of his personal interpretation of the messages.

¹⁶⁹ INQT0000084, Mr Calocane, 13 May 2026, PM, 21/9-12

¹⁷⁰ NGPF0001787, p14

¹⁷¹ NGPF0001787, p18

¹⁷² WITN0087008, p6-7, §28; and INQT0000084, Mr Calocane, 13 May 2026, PM, 33/15-35/3

¹⁷³ INQT0000084, Mr Calocane, 13 May 2026, PM, 22/14-22; WITN0087008, p7, §29

¹⁷⁴ Dr Seedat accepted as much: INQT0000061, Dr Seedat, 23 April 2026, AM, 42/20-43/2

¹⁷⁵ INQT0000085, Ms Calocane, 14 May 2026, AM, 21/15-23

¹⁷⁶ INQT0000084, Mr Calocane, 13 May 2026, PM, 37/7-39/10

ii. The family's contact with VC and Nottinghamshire Healthcare NHS Foundation Trust

76. After VC left Wales in early 2015, he would see his family for some special occasions including Christmas.¹⁷⁷ He did not however go home for Christmas in 2015. However, they were all in frequent contact by phone. Elias, Celeste and VC were in close contact until VC became ill.
77. VC's family were alerted to his illness in early 2020. From the outset, VC's family, particularly Celeste, were rightly recognised by doctors to be an important protective factor in VC's care. Dr Seedat considered the family provided valuable and important input, and said "*I would like to commend [Celeste] for the time and effort she made to be involved in his care and treatment*".¹⁷⁸ Dr Shoilekova listed "*positive factors*" including "*he has family support – parents*".¹⁷⁹ Ms Birtles agreed that Celeste was "*heavily involved in [VC's] care, provided valuable information about him, and was a positive factor*".¹⁸⁰ A schedule is attached which shows the recorded contacts the family had, or attempted, with health services – that is, the visits, phone calls, or messages, that are evident from the documents or witness statements¹⁸¹. They show Celeste had 133 recorded contacts. There are likely to be considerably more, of which there remains no record. For example, in her statement, Ms Birtles states she does not believe she documented all her contact with Celeste. She remembers frequent contact with Celeste during the period of mid-November 2020 and late December 2020, but this is not recorded.¹⁸²
78. On 24.5.20 Celeste asked Mr Williams if VC could be kept at the police station so she could come and pick him up, noting it would take her 5 hours to get there. She travelled straight to Nottingham, despite covid restrictions on travel.¹⁸³ No effort was made to keep VC at the police station until Celeste arrived. There does not appear to be any reason why someone did not simply ask VC to stay there until she got there. Mr Williams accepted he could have done this.¹⁸⁴ There were good reasons to do so: she would have been a safeguard, and would have

¹⁷⁷ WITN0085001, p3-4, §§12 and 15

¹⁷⁸ WITN0163001, p95-96, §§236-237

¹⁷⁹ CYGN0000124, p5

¹⁸⁰ INQT0000068, Ms Birtles, 29 April 2026, PM, 74/9-12

¹⁸¹ SUBS0000029

¹⁸² WITN0348001, pp81-82 and 85-86, §§240, §242 and §253

¹⁸³ WITN0085001, p6-7, §21

¹⁸⁴ INQT0000058, Mr Williams, 21 April 2026, PM, 68/5-14

reassured him she was not coming to harm. Indeed, there was a sufficient basis to detain VC after the first incident, or at least to do so until Celeste was there to look after him.

79. On the night of 24.5.20 Celeste slept in her car because of the covid restrictions. On 26.5.20 she dropped VC's belongings off at the hospital, but was not permitted to enter for the same reason. She then stayed near the hospital so that she could visit, even though there remained stringent covid restrictions in place. She took VC back to his flat at the end of the admission, and slept there for 2 or 3 nights.¹⁸⁵ This was a particularly difficult time for Celeste, given that she was facing death every day working on an acute ward at the height of covid.¹⁸⁶ The schedule shows Celeste saw VC a number of times in hospital during his first and second admissions, including at ward rounds, and also after discharge such as on 31.7.20.
80. Dr Seedat first mentioned a depot to Celeste during the first admission. He had said that VC should be compliant with medication for 6-9 months. She asked what happens if VC is not compliant with the oral medication. Dr Seedat responded that they can sometimes give an injection.¹⁸⁷ Later, in the second admission, on 16.7.20 Dr Seedat explained the pros and cons of a depot to VC. Then on 21.7.20 Celeste "*queried about starting VC on a depot*": NHFT0000168, p79. She did this because she remembered that Dr Seedat had mentioned a depot during the first admission.¹⁸⁸
81. Celeste had roughly daily phone contact with VC in the few weeks between his first two admissions, and then after the second admission until about October 2020. She did so in part to prompt him to take his medication.¹⁸⁹ In October 2020 VC told his mum: "*Don't speak to me for 2 months*" then cut off contact with her: NHFT0000168 p135. He resumed contact later in November 2020, but they did not see each other at Christmas due to the covid lockdown.¹⁹⁰ Celeste saw VC a few times in 2021, the last of which was on 11.7.21. Celeste was away in August and shortly after she returned VC was taken into hospital for the third admission.

¹⁸⁵ WITN0085001, p11, §32; INQT0000085, Ms Calocane, 14 May 2026, AM, 50/8-17

¹⁸⁶ INQT0000085, Ms Calocane, 14 May 2026, AM, 8/7-9/5 and 18/23-20/7

¹⁸⁷ INQT0000085, Ms Calocane, 14 May 2026, AM, 58/3-58/11; WITN0085001, p13, §39

¹⁸⁸ WITN0085001, p13, §39

¹⁸⁹ INQT0000085, Ms Calocane, 14 May 2026, AM, 54/25-55/10, 72/12-72/25; NHFT0000168, p126 and p131

¹⁹⁰ INQT0000085, Ms Calocane, 14 May 2026, AM, 77/3-77/9; WITN0085001, p16, §53

82. At around this time, VC began to disengage from his family, and distanced himself from them. It is notable that this coincides with his psychotic breakdown in August 2021, and the deterioration in his psychotic conspiracy theories and relationship with the health services. VC refused consent to allow the medical team to contact his mum on 7.9.21: NHFT0000168, p185.¹⁹¹ During the third admission, Celeste contacted the hospital to try to arrange a visit to VC, but was unable to do so.¹⁹² She found it hard to speak to people from the Cygnet and Priory – when she did get through she was given little information.¹⁹³ Dr Shoilekova accepted that communication by Cygnet with Celeste was not as good as it should have been.¹⁹⁴ Celeste was also unable to speak to Dr Gurusinghe.¹⁹⁵ Dr Gurusinghe’s evidence on this was unclear. He said VC refused him consent to contact Celeste, he made no note of any contact but would have made a note if he had contacted her, and said: “*you can corroborate that with VC's mother whether I have contacted her or not*”.¹⁹⁶
83. Despite being unable to arrange a visit with the hospital, Celeste went to Nottingham and cleared out VC’s flat.¹⁹⁷ VC was discharged on 22.10.21. Celeste was not informed: NHFT0000168, p194. Dr Gurusinghe had no reason why not.¹⁹⁸ After VC was discharged from hospital, Celeste continued to speak to him every week or so.¹⁹⁹ For example, on 29.11.21 she reminded him of the importance of attending his appointments: NHFT0000168, p199. She also spoke to him to try to arrange to go and visit him. But he refused to allow her to visit him and refused to give her his new address. Celeste explained: “*It doesn't matter how much I tried, he would not give me his address, because he didn't think I was safe to be – go and see him. He wouldn't give it to me.*”²⁰⁰ This is why she did not visit him more after October 2021.
84. Ms Birtles texted Celeste on 16.12.21 to tell her that VC had said Ms Birtles should not have any contact with Celeste. Celeste understood this meant she would not receive any

¹⁹¹ He repeated this on 9, 7.10.21 (PAGR0000159, p3), and 21.10.21 (NHFT0014635, p1)

¹⁹² INQT0000086, Ms Calocane, 14 May 2026, PM, 56/18-57/13

¹⁹³ WITN0085001, p19-20, §§63 and 67

¹⁹⁴ INQT0000076, Dr Shoilekova, 7 May 2026, PM, 93/6-10

¹⁹⁵ WITN0085001, p20, §67

¹⁹⁶ INQT0000080, Dr Gurusinghe, 11 May 2026, PM, 84/20-85/8

¹⁹⁷ WITN0085001, p19, §64

¹⁹⁸ INQT0000080, Dr Gurusinghe, 11 May 2026, PM, 87/13-18 and 89/17-25

¹⁹⁹ WITN0085001, p21, §70

²⁰⁰ INQT0000086, Ms Calocane, 14 May 2026, PM 57/22-58/1; 14 May 2026, AM, 92/24-93/2 and 104/19-24

information about how VC was doing, going forwards. She found VC's decision to cut off contact with her upsetting.²⁰¹ Elias thinks, in hindsight, that the reason for this was VC was becoming more paranoid that his family would come to harm if he had contact with them.²⁰² Likewise, Ms Birtles said "*I always felt... that VC's behaviour was driven by a strong belief that he needed to protect those close to him; by a fear that... his family were at risk of harm*"; and that this may have been the reason why he withdrew consent.²⁰³ That is consistent with what VC had said a number of times to the family previously. For example, Elias explains that VC became fixated on his family's safety, "*saying that we were all in danger and we were not safe in this country... when he was acutely unwell ... before he was admitted to hospital such as in May and July 2020*".²⁰⁴ And on 11.7.21, VC believed that if he went into his parents' home, the people inside his head would be able to see inside this and would put his parents in danger. On 10.11.20, he said to Dr Burri: "*the voices that I hear can see other people as well and he don't want that other people to get into the trouble*" [sic]: NHFT0000168, p138.

85. In 2022 VC stopped telling Celeste anything: "*Valdo stopped then telling me anything. By this point everything was just broken down, the communication and the engagement. All was just broken down*". If she asked him about his mental health, he would just say he was OK, and would not tell her what was going on. If she asked about medication he would say he was taking it, he's fine.²⁰⁵ For example, on 19.1.22 VC told Celeste he was taking medication, when in fact he was not. Ms Crane explained: "*I also sensed she [Celeste] was despairing because VC would not let her be involved*".²⁰⁶ He did not even give her his address.
86. VC maintained his refusal for medical staff to contact Celeste. For example, Dr Gibson noted at a ward review on 31.1.22: "*[VC] continued to request I did not speak to [his parents] even to gain information*".²⁰⁷ Although she was told about both of the mental health assessments in January 2022, she was not told that he had been detained after the second one, for his

²⁰¹ INQT0000085, Ms Calocane, 14 May 2026, AM, 93/19-24, 94/23-95/18; NHFT0000168, p201

²⁰² INQT0000084, Mr Calocane, 13 May 2026, PM, 52/1-4

²⁰³ INQT0000068, Ms Birtles, 29 April 2026, PM, 75/20-76/3

²⁰⁴ WITN0087001, p13, §§42-43

²⁰⁵ INQT0000085, Ms Calocane, 14 May 2026, AM, 111/8-11; and PM, 60/11-21

²⁰⁶ INQT0000079, Ms Crane, 11 May 2026, AM, 97/23-25 and 99/21-100/14

²⁰⁷ INQT0000085, Ms Calocane, 14 May 2026, AM, 102/4-6

fourth admission. She was not invited to any of the ward reviews and not given any notice of discharge.²⁰⁸

87. Celeste went to Nottingham in August 2022 to try to see VC. She explained: *“I didn’t have an address for him at that time as he had not told me where he was living so I just drove to the university campus. I rang him when I arrived and said I was in Nottingham and wanted to see him. He said that he was too busy. I tried to find out where he was and convince him to see me but he wouldn’t and told me that I shouldn’t have just turned up.”*²⁰⁹ In or around early autumn 2022 VC told Celeste that he had moved to Coventry.²¹⁰ However, he refused to tell her his address there. Celeste thought he refused to tell her to keep her safe.²¹¹ The last time the family saw VC before the 13.6.23 attacks was on 5.11.22. They were in Birmingham for a concert, and he came to join them. He suggested he thought it wasn’t safe.²¹² Celeste said VC seemed empty: *“he was just empty. There was nothing there”*.²¹³ Thereafter, Celeste continued to have phone contact with VC every week or every few weeks.²¹⁴

88. In summary, during the period of VC’s illness, Celeste tried her best to look after VC. But he shut his family out from his care: they were completely in the dark. As he was an adult, they were powerless and could not force him to engage with them.

Elias’ contact with VC

89. As seen from NGPF0001787 Elias had a lot of contact with his brother until 24.5.20. After he went into hospital, there was little contact initially. After that, they continued to have contact by text message and occasional phone calls. However, particularly from mid 2021 most of the interactions were about VC’s paranoia around technology monitoring his thoughts and inserting thoughts into his mind, and VC seeking to prove that this was really happening. Their contact reduced significantly after summer 2021, and Elias and VC did not

²⁰⁸ INQT0000085, Ms Calocane, 14 May 2026, AM, 102/11-14, 107/22-25; and WITN0085001, p23, §77

²⁰⁹ WITN0085001, p24 §81; INQT0000085, Ms Calocane, 14 May 2026, AM, 109/14-110/4; and see NHFT0000168 31.8.22, p270

²¹⁰ WITN0085001, p24 §82

²¹¹ CPSE0000019, p1 (21.6.23 email from Ms Calocane), p1; and INQT0000086, Ms Calocane, 14 May 2026, PM, 64/3-10

²¹² WITN0085001, p25, §85

²¹³ INQT0000086, Ms Calocane, 14 May 2026, PM, 2/21-22

²¹⁴ WITN0085001, p25, §86

really talk between September 2022 and June 2023. Elias saw VC face-to-face in October 2020 and November 2022.²¹⁵

90. The reasons for the reduction in contact between Elias and VC were as follows. Firstly, Elias was not given sufficient information by the health services about VC's illness to properly understand it. For example, he was not told of the schizophrenia diagnosis. He did not understand that VC's paranoid delusions, to him, were completely real; or that his refusal to take medication was part of the psychosis; or that VC believed that those giving him medication were conspiring against him. As a consequence, Elias mistakenly (albeit understandably) thought he could reason with VC and persuade him he was ill and that his beliefs were not rational. He thought VC was being stubborn and selfish. He felt VC's behaviour was causing real worry for their parents, and Elias became really angry with VC as a result of all this. This "*hugely informed*" Elias' response, undermined their relationship, and was one reason the brothers stopped having much contact.²¹⁶ Now that Elias better understands psychosis (and has more details of VC's illness, including his diagnosis of schizophrenia) he realises this was mistaken and VC could not help his behaviour: he cannot be held responsible for behaviour that was determined by schizophrenia.
91. As Elias explains "*At no time, as a family, were we offered any support from the mental health professionals to educate us on what psychosis meant either generally or for Valdo*".²¹⁷ This is very unfortunate. Had the family been given better information by health services, that may have led to Elias having more contact with VC and being more receptive or responsive to him, especially later on. The difficulties that VC's schizophrenia caused to his relationship with his family are not unusual. Professor Smith agreed that schizophrenia can "*lead a patient to have difficulties in their relationships with family members. For example, if it causes them to disengage or distance themselves from family members... it's not uncommon... - There can often be a lot of paranoia. Oftentimes people will direct it around to the people who are closest to them ... usually it's the case that it's people that are closest to each other who have the problems*".²¹⁸

²¹⁵ INQT0000084, Mr Calocane, 13 May 2026, PM, 48/21-50/2; WITN0087001, pp12 and 13-16, §§39-41,48-55

²¹⁶ INQT0000084, Mr Calocane, 13 May 2026, PM, 48/21-50/2; WITN0087001, p12-16, §§39-4,1 48-55;

INQT0000086, Ms Calocane, 14 May 2026, PM, 5/3-9

²¹⁷ WITN0087001, p13, §41

²¹⁸ INQT0000104, Professor Smith, 1 June 2026, AM, 92/17-22, 93/21--95/3

92. The decreasing contact between Elias and VC was partly because, as VC's illness got worse, VC disengaged from his family: he wanted them to be around him less and less.²¹⁹ *"It became much more apparent how much he didn't want any of us to visit him and I remember times when my parents were trying to arrange to see him and he was refusing. I would often get frustrated with this as I thought it was him being thoughtless about my parents and I didn't understand at the time that it was his attempt to protect them from the danger he perceived they were in."*²²⁰
93. As time went on, Elias began to feel hopeless about VC's situation. The family had repeatedly raised their concerns to health services, but there seemed to be no remedy. After the third admission in late 2021, now more than one and a half years after VC first became ill, VC was just discharged back into the community without significant support. Elias said: *"By that point, I felt more and more defeatist about it all but also because of my lack of understanding about his illness, I also felt frustrated. I genuinely felt pretty hopeless and that it would all end by Valdo eventually taking his own life"*.²²¹

Family not told about schizophrenia

94. The family were not told that VC had been diagnosed with schizophrenia until they were informed of this on 9.10.23 following the first forensic psychiatric report.²²² That is their clear and consistent evidence. It is not contradicted by any other evidence.
95. On 15.6.20 Dr Seedat told Celeste: *"this presentation is not isolated, appears to be going towards an illness"*.²²³ Celeste later explained that Dr Seedat *"told us that Valdo had an acute psychotic episode but he didn't want to make a formal diagnosis because it was the first time that it had happened... He said that if it happened again, then it was maybe an ongoing thing like schizophrenia, bipolar disorder or something of the sort but they didn't want to put a label on it then"*.²²⁴ At this early stage, Dr Seedat had not diagnosed VC with schizophrenia

²¹⁹ INQT0000084, Mr Calocane, 13 May 2026, PM, 52/15-53/7

²²⁰ WITN0087001, p15, §50

²²¹ WITN0087001, p18, §60; and INQT0000084, Mr Calocane, 13 May 2026, PM, 62/19-25

²²² INQT0000085, Ms Calocane, 14 May 2026, AM, 46/25-47/10; INQT0000084, Mr Calocane, 13 May 2026, PM, 50/3-5

²²³ NHFT0000168, p45; INQT0000085, Ms Calocane, 14 May 2026, AM, 46/15-48/7

²²⁴ CPSE0000019, p2; WITN0085001, p10-11, §31

– that did not occur until much later. Shortly after the above comment, on 17.6.20 Dr Seedat made clear he had not come to any specific diagnosis. He told Celeste: “*diagnosis of first episode psychosis and explaining why no specific label used and how this was not useful at this time*”: NHFT0000168, p49.

96. Dr Seedat ultimately diagnosed VC with schizophrenia on 31.7.20. He did not tell VC’s family of this. His oral evidence was that he did not recall and was not certain what he told Celeste.²²⁵ He made no note, anywhere, that he told them that VC had schizophrenia. Likewise, VC’s CCO, Ms Birtles, did not tell the family about schizophrenia.²²⁶ The box on the discharge letter that demonstrated it had been sent to Celeste was not ticked – it was left blank, and Ms Danson was not aware that the letter had been sent to the family.²²⁷

Family not told important information about the level of VC’s risk

97. Celeste was aware of some information to show VC was a risk to others. For example, she was made aware that VC had twice broken into neighbours’ apartments on 24.5.20, and on the second occasion, this led the occupant (Feven) to jump out of the window and be taken to hospital. She understood the risk to arise from “*him reacting to voices or delusions rather than him being at risk of randomly attacking somebody*”.²²⁸ She felt that he was a risk to others at that point and that he should be detained in hospital.²²⁹ Celeste was aware of the incident in July 2020.²³⁰ On 6.8.20 she told Ms Birtles that there is a risk VC would stop his medication again in the community, and medical staff should be mindful of the previous risks to others when he was unwell: NHFT0000168, p126. She was also aware that on 3.9.21 he had resisted arrest and assaulted a police officer. She was shocked by this, and understood it was due to him being unwell.²³¹
98. However, she was not told important information about the level of VC’s risk to others, prior to 13.6.23. For example, in respect of the second incident on 24.5.20, she was not told the extent of the injuries that Feven had suffered. As to the 3.9.21 assault, she knew no more

²²⁵ INQT0000062, Dr Seedat, 23 April 2026, PM, 89/25-90/4

²²⁶ INQT0000067, Ms Birtles, 29 April 2026, AM, 70/21-24

²²⁷ NHFT0000222, p6; INQT0000060, Ms Danson, 22 April 2026, PM, 83/5-84/9

²²⁸ INQT0000086, Ms Calocane, 14 May 2026, PM, 6/8-12, 61/2-21

²²⁹ INQT0000085, Ms Calocane, 14 May 2026, AM, 16/10-17/7; see also NHFT0000168, p3

²³⁰ INQT0000086, Ms Calocane, 14 May 2026, PM, 6/8-12

²³¹ WITN0085001, p18, §60

than he assaulted a police officer while resisting arrest. She was not given any detail about the assault and not told how serious it was. She was not told the extent to which VC was non-compliant and aggressive after being detained on 3.9.21. In respect of the incident with the flatmate on 15.1.22, Celeste was told that there had been “*an altercation*”. But was not told that VC had held his flatmate in a headlock, stopped the two flatmates from leaving, or been intimidating to them. She was not told that a decision had been made in February 2022 that VC was so dangerous that home visits should not happen unless absolutely necessary and that in such circumstances, two members of staff should visit. She knew nothing about the assault VC committed on two of his colleagues in May 2023, the incidents involving Sebastian, the MI5 visit, or that a warrant for VC’s arrest had been issued. No professional explained to her what level his risk was assessed to be.²³²

99. There was a range of other information Celeste was not given about VC’s care, which is described elsewhere in these submissions: §§82-83, 94-96, 98, 111-112, 128. Celeste repeatedly expressed frustration to medical staff about the lack of information, and explained that it meant she did not have a proper understanding of VC’s difficulties. As time went on she told staff this made her feel “*hopeless in [VC’s] care*”.²³³ On 2.2.22 she spoke to Dr Gibson. He made a contemporaneous note in the RiOs: “*She also expressed some frustration about our lack of ability to share information based on confidentiality, but accepted explanations*”: NHFT0000168, p223. VC’s withdrawal of consent meant Dr Gibson withheld the circumstances of VC’s detention and information about the current admission, such as the fact he’d been admitted, where he was admitted to, what Dr Gibson’s role was etc. He fairly accepted that, in that context, it was understandable Celeste was frustrated about their inability to share information.²³⁴

100. Mr Majid accepted the Trust should have told VC’s family about VC’s diagnosis, his risk and how to recognise it, and what to do if he relapsed including what services they can access, and Ms Attfield accepted the communication with VC’s family was inadequate.²³⁵

²³² WITN0085001, pp16-17 and 19, §§50, 57, 61; INQT0000085, Ms Calocane, 14 May 2026, AM, 87/1-21, 99/11-15; INQT0000086, Ms Calocane, 14 May 2026, PM, 5/11-18, 6/24-7/8

²³³ NHFT0000168, p192, 23.9.21; NOCC0000040, p4, 19.1.22; INQT0000085, Ms Calocane, 14 May 2026, AM, 97/16-24

²³⁴ INQT0000082, Dr Gibson, 12 May 2026, PM, 78/22-81/1, 13/14-16/24 (See, likewise, Dr Gibson’s second note of that conversation, the next day, NHFT0000168, p225

²³⁵ NHFT0000168, Mr Majid, 18 May 2026, PM, 105/21-106/20; INQT0000092, Ms Attfield, 20 May 2026, PM, 85/8-21

This lack of information about VC's condition meant his family were unable to properly understand his illness or risk, and to respond. Celeste explains that if she had known about the true picture, she would have been much more vigilant.

Concerns raised by family to health services

101. The family (Celeste in particular) raised their concerns with the Trust about VC's mental health on a number of occasions. Celeste reported VC's paranoid delusions multiple times, including that a technology was being used to monitor his thoughts and implant voices into his mind. However, the message which came back from the Trust in response was that VC was fine. The family were not told that their concerns led to any substantive difference in the care or treatment VC received.²³⁶

102. For example, on 28.5.20 Celeste passed on the document Elias created containing his communications with VC. Elias explained that VC was "*paranoid about my safety*", that "*he was worried that somebody had come and got me*". VC said he heard voices in his head. There were people in the apartment above or next to him, who were monitoring him. There were people who were using a technology to monitor him. He asked "*if there's any technology/AI that could map his thoughts accurately enough to know them in real time*".²³⁷ The family received no feedback about the document, and in consequence Elias "*assumed the document was not useful in helping them come up with a diagnosis or in helping with Valdo's treatment... this made me think that the document... was a bit of a waste of time*".²³⁸

103. On 11.7.20 Celeste phoned and spoke to Mr Jackson. She said she thought VC's mental state may be deteriorating, and he may not be taking his medication. He was not making much sense, and his speech was similar to prior to 24.5.20 – slow and not lucid.²³⁹ She asked if he was getting any support from services and asked for an update on VC's care.²⁴⁰ Mr Jackson said he could not discuss VC's care without his consent: NHFT0000168, p55. Celeste spoke

²³⁶ INQT0000086, Ms Calocane, 14 May 2026, PM, 54/3-56/2; INQT0000086, Mr Calocane, 13 May 2026, PM, 57/3-8, 58/1-4

²³⁷ NGPF0001787, pp1-4, 6, 7, 14, 19, 20

²³⁸ WITN0087008, p7-8, §31

²³⁹ INQT0000085, Ms Calocane, 14 May 2026, AM, 52/1-24, 54/10-24

²⁴⁰ This was the only occasion when Celeste asked staff not to make VC aware she was asking about his care. She did not do so on any other occasion. The reason for doing so on 11 July 2020 was because she had spoken to VC shortly beforehand, he said he did not want her to speak to the services about him. She thought he was very paranoid at that point and she did not want to make that worse: WITN0085001, p11-12, §34; WITN0085008, p13, §59; and WITN0087008, p8 §33

to Ms Birtles again about the same issues on 14.7.20. No-one from the Trust contacted or visited VC, in response to Celeste's concerns, prior to him barging into the flat late on 13.7.20.²⁴¹ Dr Seedat accepted the crisis team should have carried out a face-to-face assessment in response to Celeste's concerns.²⁴²

104. On 9.10.20 Celeste tried to speak to Ms Birtles, leaving several answerphone messages, and ultimately spoke to Ms Parsonage. She said she was concerned about VC because he said *"don't speak to me for 2 months"* and she had since been unable to contact him. She asked that someone from the team goes to see him: NHFT0000168, p135. She phoned again on 15.10.20 and 24.10.20 to reiterate her concerns and ask if someone had made contact with VC: NHFT0000168, p135. She also had concerns that VC's memory was poor, and emailed Dr Seedat about this on 21.10.20.²⁴³ No-one called her back to say VC had been visited in response to her concerns, or how he was, so she assumed VC was OK.²⁴⁴ Dr Seedat told her he could not help.²⁴⁵ The community team accepted they should have phoned her back.²⁴⁶
105. On 29.5.21 Celeste phoned and spoke to Ms Lopez from the CRHT, since Ms Birtles was on leave. Celeste said she believed her son was becoming unwell, and he wasn't making sense. There were long pauses when he replied and his thoughts were disorganised. VC had told Elias that he had not been taking his medication for 2-3 weeks.²⁴⁷ Celeste was told that VC had been assessed and the team thought he was *"okay, it's fine, nothing is wrong. I [thought] maybe I just need to adjust to this new life now"*.²⁴⁸
106. Celeste and Ms Birtles communicated again on 14.6.21 and 17.6.21, when Celeste explained she had been worried, but *"the team assessed him over the phone and thought he was fine also went to see him which put my mind at rest"*: NHFT0000168, p154. Very shortly afterwards, VC visited his parents on 11.7.21. He reiterated the same type of thoughts that had led Celeste to raise her concerns with the Trust before. He said the people behind this

²⁴¹ INQT0000068, Ms Birtles, 29 April 2026, PM, 74/13-75/1

²⁴² INQT0000062, Dr Seedat, 23 April 2026, PM, 85/4-86/12

²⁴³ WITN0085001, p15-16, §49; see also INQT0000085, Ms Calocane, 14 May 2026, AM, 83/18-23

²⁴⁴ WITN0085001, p16, §50

²⁴⁵ WITN0085001, p15-16, §49

²⁴⁶ See, e.g. INQT0000069, Mr Carter, 30 April 2026, AM, 102/9-15

²⁴⁷ NHFT0000168, p153; WITN0085001, p17, §55; INQT0000085, Ms Calocane, 14 May 2026, AM, 78/6-25

²⁴⁸ NHFT0000168, p154, INQT0000085, Ms Calocane, 14 May 2026, AM, 81/22-82/4

could use a technology to read his mind, and he refused to come inside the house because that may put his family at risk.²⁴⁹

107. It was suggested by Ms Carwright KC that the family should have contacted the health services again on 11.7.21 to tell them what VC had said, and that VC was driving while he was unwell. Celeste explained why she didn't do this. VC had said similar things multiple times previously and she had reported her concerns numerous times to the health services, most recently on 29.5.21. She knew the health services were well aware by this point that VC thought there were people using a technology to read his mind, and that his family were in danger.²⁵⁰ When she raised her concerns, the message she got back from the health services was that VC was fine, and that had occurred very recently in May/June 2021. So far as she was aware, her concerns made no difference to his care. As a consequence, she was made to feel that there was no point doing this again. The situation ultimately left Celeste feeling hopeless about VC's care.²⁵¹ On 11.7.21 she did not think there was any point in telling them what they had been told just weeks beforehand.
108. Elias gave similar evidence, noting that the family had just contacted the services on 29.5.2021 raising their concerns yet again, and had been told he was OK.²⁵² Ms Parsonage accepted that if family members are repeatedly phoning up raising their concerns about VC, and then they are not given any information about what happened in response, that's not a good way to encourage them to continue to raise their concerns.²⁵³ VC's family had no psychiatric expertise: they cannot be expected to gainsay the advice they got from the medical professionals.
109. Further, something that had particularly concerned Celeste about VC's mental state on previous occasions was when his speech and thoughts were disordered. That was the case on 29.5.21 for example. On 11.7.21 when VC visited her, his speech and thoughts were not

²⁴⁹ INQT0000085, Ms Calocane, 14 May 2026, AM, 81/4-18; INQT0000086, Ms Calocane, 14 May 2026, PM, 48/10-49/18

²⁵⁰ See §101 above; and also INQT0000085, Ms Calocane, 14 May 2026, AM, 25/12-16, 71/11-13, 78/8-82/4; and INQT0000086, Ms Calocane, 14 May 2026, PM, 49/3-51/15, 54/3-56/11

²⁵¹ INQT0000086, Ms Calocane, 14 May 2026, PM, 56/8-11, 97/18-20

²⁵² INQT0000084, Mr Calocane, 13 May 2026, PM, 116/23-25

²⁵³ INQT0000069, Ms Parsonage, 30 April 2026, AM, 76/3-8

disordered – he sounded calm and coherent.²⁵⁴ There is no evidence that VC was legally prohibited from driving on 11.7.21, still less that Celeste knew or ought to have known of any such legal prohibition.²⁵⁵

110. In this context, Ms Cartwright KC mentioned the email that Celeste sent to Dr Seedat on 29.7.20 in which she said “*I was wondering if the police have got back to you regarding Valdo’s detention and whether it would come up on the record in the future*”.²⁵⁶ Ms Cartwright suggested the reason Celeste did not tell health services about the 11.7.21 visit, was that she wanted to keep from the services that he was driving when he was unwell. That is totally misplaced. Celeste had contact with health services on well over 130 occasions and passed on detailed sensitive information about his mental state. That makes crystal clear that she had no reluctance in doing so because of fear of repercussions for VC. Moreover, Celeste did not say (either in the 29.7.20 email or otherwise) that she did not want any particular information on VC’s police record. She just wanted to know what was going to happen.²⁵⁷
111. On 23.8.21 Celeste texted Ms Birtles and said VC was showing signs of paranoia and had not taken his medication in a while.²⁵⁸ On 2.9.21 Celeste told Ms Shaw that VC had not responded to her phone call, which she felt to be very unusual and concerned her. She later spoke to VC, who “*spent much of the call talking about the Government monitoring him and it was difficult for her to challenge these beliefs as Valdo appeared quite fixated on them*”: NHFT0000168, p164. On 22.10.21 VC was discharged from hospital. There was a failure to inform Celeste about this in advance,²⁵⁹ and no-one called Celeste thereafter to tell her what the plan in the community was.²⁶⁰

²⁵⁴ INQT0000085, Ms Calocane, 14 May 2026, AM, 54/16-24, 78/8-25 and 81/24; cf INQT0000084, Mr Calocane, 13 May 2026, PM, 116/16-17

²⁵⁵ Dr Burri said patients with psychosis are not prohibited from driving. There are DVLA guidelines that they should not drive for 3 months after the first diagnosis (i.e. in mid 2020): INQT0000066, Dr Burri, 28 April 2026, PM, 45/2-8; and NHFT0000168, p133

²⁵⁶ WITN0163015

²⁵⁷ INQT0000050, Ms Calocane, 14 May 2026, PM, 52/3

²⁵⁸ WITN0085003, p5

²⁵⁹ NHFT0000168, p194 and INQT0000085, Ms Calocane, 14 May 2026, AM, 91/10-14; and INQT0000054, Dr Dracass, 16 April 2026, PM, 55/23-56/2

²⁶⁰ INQT0000069, Ms Parsonage 30 April 2026, AM, 74/24-75/25

112. After the fourth admission, as Dr Dracass put it, “*attempts to liaise with VC’s family petered out*”.²⁶¹ He was discharged to his GP in Sept 2022 but his family were not told.
113. When Celeste received the .zip file on 24.12.22, she read the ‘ReadMeFirst’ document, but did not read the rest of the .zip file.²⁶² There was, rightly, no suggestion in evidence that Celeste ought to have passed on the .zip file to VC’s GP. VC had repeatedly expressed similar delusions over the previous years, as those which he set out in the ‘ReadMeFirst’ document: about there being a technology which was putting voices in his head. She explained that the .zip file contained “*just a repeat of things he had been saying before so there wasn’t anything new in there. The whole thing made me feel hopeless*”.²⁶³
114. VC later sent the file to Elias, at 23:52 on 12.6.23. Elias was asleep at the time and could not open it when he first accessed it as it was corrupted. He did not open it until some time after 05:00 on 13.6.23.²⁶⁴ By this time, Nottinghamshire Police had already been alerted to VC’s attacks and had been at the scene for over an hour.²⁶⁵ Elias explains that the delusions VC expresses “*were the most present symptom throughout the whole time that he was unwell... these beliefs always seemed to be present*”.²⁶⁶ They were the same nature as the communications Elias and VC had been having more than 3 years earlier, in April and May 2020.²⁶⁷

2. TIMELINE OF EVENTS PRIOR TO ARREST ON 13 JUNE 2023

Elias 12 June 2023 - 13 June 2023

115. On 13.6.23, after he learned about the attacks, Elias contacted the police. He voluntarily explained the contents of the calls he had had with VC on 12 and 13 June. VC phoned Elias at 19:09 on 12.6.23 and they spoke for about 44 minutes, as described above §57(f). Elias explained: “*The content of our conversation was similar to previous conversations that I had had with him*”. That is “*the same circular sort of conversations that we’d been having*

²⁶¹ INQT0000054, Dr Dracass, 16 April 2026, PM, 55/14-22

²⁶² INQT0000086, Ms Calocane, 14 May 2026, PM, 4/2-5; and INQY0000003

²⁶³ WITN0085001, p26, §88

²⁶⁴ WITN0087001, p24-25, §87

²⁶⁵ NGPF0004340, p21

²⁶⁶ WITN0087001, p16-17, §52; cf p14, §48

²⁶⁷ NGPF0001787. Elias sent the zip file to the police on 13.6.23: NGPF0004119

for the previous years”.²⁶⁸ VC explained his delusional beliefs that people including the government were monitoring him. He tried to persuade Elias, as he had many times before, that this was all real. However, VC’s manner was significant: *“He sounded calm and fine. He has had psychotic incidents in 2020 and he sounded different then but yesterday he was calm.”* There were none of the hallmarks that Elias associated with a crisis, as there had been in May and July 2020, or May 2021.²⁶⁹

116. At one point in the call VC said *“this is the last time I will talk to you. After this I will leave you alone.”* This was an offhand comment, and the tone was significant. Elias understood this to mean that VC would not bother him again with these issues: *“I will tell you about this stuff and then you can - I will leave you alone.”*²⁷⁰ VC also said: *“just dissociate yourself from me, if anything happens don’t come and see me in hospital”*. Again, VC had said a number of times before that his family should stay away from him because they would be in danger due to the monitoring. Elias did not interpret this as meaning VC was in hospital at that time, and he is not sure he gave much thought to that statement at the time.²⁷¹
117. VC phoned Elias again at 04:52, for 1 minute 5 seconds. Elias was asleep and the call woke him up. VC asked Elias *“Did you get the documents...”*²⁷² He subsequently told Elias *“that he loved me and that this would be the last time we would speak and I should take the family out of the country... I asked him, ‘are you going to do something stupid?’ and he replied ‘its already done’ and then he hung up.”*²⁷³ Elias’ interpretation of this at the time was: *“I thought it was relating to suicide. I remember speaking to the detectives that I was a little bit confused after a while, in terms of, you know, him saying, you know, “It’s already done”, and me thinking maybe he took something, maybe, maybe it’s something else, and not really knowing how to square that. But yeah, I was just worried in general and trying to figure out what happened”*.²⁷⁴ As Elias explained, he was worried about the call so immediately took steps to respond.

²⁶⁸ INQT0000084, Mr Calocane, 13 May 2026, PM, 71/11-20; and WITN0087001, p23-24, §85

²⁶⁹ INQT0000084, Mr Calocane, 13 May 2026, PM, 76/21-77/7; WITN0087001, p23-24, §85, and 13.6.23 statement NGPF0008987, p113

²⁷⁰ WITN0087001, p23, §84 and INQT0000084, Mr Calocane, 13 May 2026, PM, 69/17-70/13

²⁷¹ WITN0087001, p23-24, §85 and INQT0000084, Mr Calocane, 13 May 2026, PM, 117/7-21

²⁷² INQT0000084, Mr Calocane, 13 May 2026, PM, 72/23-73/5

²⁷³ WITN0087001, p24-25, §87

²⁷⁴ INQT0000084, Mr Calocane, 13 May 2026, PM, 74/13-20; cf Mr Calocane 13 May 2026, PM, 107/13-22; WITN0087001, p24-26, §§87-91 and NGPF0008987, p4

118. He sent a series of messages to VC, but got no response. At some stage shortly after this he tried to open the .zip file. It was corrupted, so he used a software which allowed him to partially recover some of the contents. The bits he saw were “*the same sort of content that we had been discussing many times over the years.*”.²⁷⁵ He did not read the article about a shooting.²⁷⁶ He called VC a number of times, but got no response. He called Celeste at 04:52. She was not able to speak at the time but they did speak at 06:47 (see below). He considered reporting the matter to the police. He googled Coventry Police station, as he understood VC was living in Coventry at the time. He considered filling the missing person form, but he did not do so because he had very limited information. For example, he did not have VC’s address. Further, the website indicated the form was not suitable as you should not complete the form if you have heard from the person in the last 24 hours (which Elias had). Elias did not know what else to do. He thought if VC had harmed himself, it may be on the news so he kept an eye on Twitter. At 09:40 he saw ‘Nottingham’ trending and clicked on it out of curiosity. This ultimately led him to discover VC had committed the attacks.

Celeste: 13 June 2023

119. On 12.6.23 Celeste began work on the ICU at 19:15. She did not speak to her husband after VC phoned him that evening, and did not speak to VC at all. Elias phoned Celeste at 04:52 but she “*was not able to speak at that time as I was at work so I said I would call him back.*”.²⁷⁷ Elias then sent a text to Celeste.²⁷⁸ The text was timed 04:55, but it is not clear exactly what time Celeste read it. It may be that she read it just before she responded at 05:55. The text said VC had called Elias and told him “*This is the last time I’ll speak to you... I [Elias] asked him if he was going to be stupid and he said it had already been done.*”.²⁷⁹ Celeste thought this indicated VC had taken something to end his life.²⁸⁰

120. In her 05:55 response when she had read the text, Celeste said “*I’ll call you later*” and she phoned Elias shortly afterwards at 06:45.²⁸¹ This was about 50 minutes after she texted Elias.

²⁷⁵ WITN0087001, p24-25, §87

²⁷⁶ INQT0000084, Mr Calocane, 13 May 2026, PM, 66/18-67/7

²⁷⁷ WITN0085001, p28-29, §101

²⁷⁸ WITN0085005, p28-29, §101

²⁷⁹ INQT0000086, Ms Calocane, 14 May 2026, PM, 8/1-15

²⁸⁰ INQT0000086, Ms Calocane, 14 May 2026, PM, 9/12-22 and 62/15-21

²⁸¹ WITN0085001, p29, §102

There was this short delay between when she read VC's text and when she called Elias because she was working on the ICU. Celeste is not sure what she did in this period, but noted that she is not supposed to have her phone during work time. (An ICU is for people with acute, life-threatening conditions.) She did not phone the police at this point because she did not have an address for VC.²⁸²

Ms Doherty

121. Mr Doherty's report is very helpful, but she appears to have misunderstood some of what Celeste told her having spoken to Celeste at a greatly distressing time. Her son had very recently killed three people and seriously injured three others, and Ms Doherty was the first person from the health services / any state institution (other than the police) who she had been able to speak to since the attacks.²⁸³ Ms Doherty's report needs some clarification, in the following respects:

- a. §6.2 *"Mrs Calocane explained that, to her knowledge, her son was still living in Nottingham at the time of the offences..."* Celeste did not say this to Ms Doherty. The family believed VC was living in Coventry on 13 June 2023, as they told the police at that time.²⁸⁴
- b. §6.4, *concerning bullying*. The correct position as to bullying is as set out in §5 above.
- c. §6.5 *"He had completed his GCSE's and his A-Levels"*. This is correct in the sense described in §7 above, and in more detail in Celeste's statement.²⁸⁵ Celeste was only very briefly asked about this issue, so it is not surprising that Ms Doherty did not fully understand it.
- d. §7.2: This is correct in noting that the family moved to Lisbon Portugal when VC was 7 years old, but misses out that they had moved to Madeira Portugal when VC was 3 years old.
- e. §8.1: VC did not attend school in Guinea-Bissau.

²⁸² INQT0000086, Ms Calocane, 14 May 2026, PM, 62/22-64/1

²⁸³ INQT0000086, Ms Calocane, 14 May 2026, PM, 15/1-16/1; WITN0085008, p1-2, §§3-4

²⁸⁴ WITN0085008, p12, §55; NGPF0008987, p3; and CPSE0000019, p4

²⁸⁵ WITN0085008, p6, §§28-30

3. UNAUTHORISED ACCESS AND DISCLOSURE FOLLOWING VC'S ARREST

Nottinghamshire Police: Leaking of information to the media

122. The leaking of sensitive and confidential information to the media started very early in the Nottinghamshire Police investigation and was known to be a problem.²⁸⁶ As noted by DI Claire Gould on 20.9.23 *"I am certain there was one"*.²⁸⁷
123. On 13.6.23 Elias was visited by police officers, DC De Waele and DC Davis, and gave a statement. The same detectives attended on the family again on 14.6.23 and asked further questions about VC, his background and the family history.²⁸⁸ During this meeting VC's family explained the relevant family history, including that VC was born in Guinea- Bissau, when the family moved from Guinea-Bissau to Madeira and then to Lisbon, and when the family were granted Portuguese citizenship. On 15.6.23 the press arrived outside the family home in Wales and the houses of extended family members whose addresses had been provided to the police the previous day. Elias emailed the two detectives at around 5pm that day stating that he was concerned that information had been leaked.²⁸⁹
124. On 15.6.23 at 21:33 the Telegraph published an article which reported some of the information that VC's family had given to the police the previous day, in particular the date that VC's father had gained Portuguese citizenship. On 16.6.23 Elias spoke to Josette Davis, a Detective Constable from the Major Crime Team, about his concerns that the police had leaked this personal information to the press. On 19.6.23 at 14:40 DSI Saunders recorded on his investigation log that *"there appear to be details of investigation appearing in the press, for example suspect identity, family location. This could be through investigative interviewing or through conscious or unconscious leaks to media outlets. DS Buxton to liaise with DI Gareth Harding at CCU"*.²⁹⁰ The lack of reference to Elias' concern suggests that by this stage DSI Sanders had not been informed of it. DSI Sanders did not task Buxton and

²⁸⁶ NGPF0004863, p4

²⁸⁷ NGPF0007813, p3

²⁸⁸ WITN0087001, p27 §93

²⁸⁹ WITN0087001, p27 §95

²⁹⁰ NGPF0008791, decision 63

Harding to investigate the concern.²⁹¹ It also does not appear in the Lawful Business Monitoring activity of 16.6.23 as recorded on Clue reference 1557.²⁹²

125. There is no evidence that Nottinghamshire Police Professional Standards Department ('PSD') were tasked to investigate the leak concerns raised by Elias to Ms Davis. On 27.2.24 Elias made a formal request to DC Beddoe for copies of the notes taken by the officers of the information given by VC's family on 13.6.23 and 14.6.23. DCI Garth Harding then contacted Elias on 12.3.24 and 14.3.24 and it was agreed that the concern would be treated as a complaint to the police.²⁹³ This represents an unacceptable delay and an unjustified difference in approach by the police and PSD to that taken to other suspected leaks (e.g. PC Gell and separately that VC was wanted on a warrant and had attended MI5).²⁹⁴
126. On 5.7.24 the finding made by the PSD was that there was no evidence of misconduct or criminality by a police officer or police staff from Nottinghamshire Police (i.e. no police leaking) but that information was passed to the media by members of the public, primarily from a former flatmate based on information in the public domain, and research was then conducted by the media.²⁹⁵ That does not seem to be correct. There is no evidence that the former flatmate was aware of all of the information leaked, such as the date of grant of Portuguese citizenship to VC's father. It did not appear in her interview to the Daily Mail (published 15.6.23 15:11) and the flatmate is not referenced as a source in the key Telegraph article. This information was not in the public domain prior to publication.
127. The disclosure before the Inquiry shows that there were early discussions between the Home Office and the former CC Meynell. CC Meynell records in her log on 13.6.23 "*bio details to run through immigration systems agreed for [?] to be done*" and then on 15.6.23 CC Meynell records the date on which VC was granted EU settlement status.²⁹⁶ Separately there were discussions between the Home Office and Nottinghamshire Police press office about VC²⁹⁷ with a decision taken on 15.6.23 by the police (and mentioned in the Op Hendrix Gold Group

²⁹¹ INQT0000031, DSI Sanders, 18 March 2026, PM, 64/1-16

²⁹² NGPF0005639; WITN0044001, p24-25, §87

²⁹³ WITN0087001, p28-31, §§101-104

²⁹⁴ WITN0044001, p24-25, §87

²⁹⁵ WITN0087003, p13, §51

²⁹⁶ NGPF0011120, p4, 8

²⁹⁷ WITN0087006, p6, WITN0087004, p9, §27

on the same date) not to “*mention that he [VC] was not an illegal immigrant or asylum seeker on advice from Home Office Comms*”.²⁹⁸ The PSD did not investigate whether other individuals had direct knowledge from the Home Office and related searches about the immigration history of VC’s family and whether this was the source of the leak in ‘Allegation 1’ – which related to VC’s father’s immigration history.²⁹⁹ The above inadequacies in the PSD investigation were not identified and addressed by the IOPC.³⁰⁰

4. ASSESSMENT AND MANAGEMENT OF VC’S RISK

Engagement with VC’s family, and assessment of VC’s capacity

128. Various failures to communicate with or respond to the family have been identified in §82-105 above. More broadly, there was a failure to comply with long established principles of support to carers embedded in the ‘triangle of care’ approach and to recognise the essential role that a carer/family has in mental health care.³⁰¹ This includes psycho-education, developing co-produced care plans and risk management plans, and informing the family of key information, listening to them and responding.³⁰² Ms Attfield accepted that VC and his family “*would have benefitted a great deal from carer support*” and that they did not receive “*an adequate standard of provision*”.³⁰³ Mr Majid accepted engagement with VC’s family was inadequate, and that VC’s family should have been told about diagnosis, giving them enough information to understand risk.³⁰⁴ VC’s refusal to consent that his confidential information can be passed on to his family, did not justify those failures. Some of the failures occurred before he refused consent. And as the CQC note, “*the trust could have continued to engage with the family while still maintaining [VC’s] confidentiality*”.³⁰⁵

129. Moreover, there was reason to think VC may not have had capacity to refuse consent in this respect, so there should have been an assessment of his capacity. He suffered delusions that

²⁹⁸ NGPF0011115, p2

²⁹⁹ WITN0087006

³⁰⁰ WITN0087006

³⁰¹ INQT0000091, Dr Elcock, 20 May 2026, AM, 114/5-22; INQT0000098, Mr Johnston, 27 May 2026, PM, 48/17-23; INQT0000092, Ms Attfield, 20 May 2026, PM, 18/1-8; INQT0000088, Mr Majid, 18 May 2026, PM, 105/21-107/10

³⁰² INQT0000093, Ms Hull, 21 May 2026, AM, 79/10-24

³⁰³ INQT0000092, Ms Attfield, 20 May 2026, PM, 85/8-21

³⁰⁴ INQT0000088, Mr Majid, 18 May 2026, PM, 103/4-106/23

³⁰⁵ CQCM0016518, p28

there was a conspiracy by the medical services against him, and that his family were at risk if he came into close contact with them. Those delusions would appear to mean he was unable to understand or weigh up the risks of communication between those medical services and his family. However, it appears that no assessment of his capacity in this respect was conducted. After VC had told Ms Birtles that he did not consent to information sharing, Ms Birtles said she discussed this with her manager, Ms Robinson. But Ms Robinson said that she would not have advised Ms Birtles to conduct an assessment of VC's capacity.³⁰⁶ There was no subsequent revisiting of VC's refusal to consent to share information, but it ought to have been kept under review.

130. There is a systemic issue regarding capacity: often when CQC does inspections it raises concern about the assessment of capacity.³⁰⁷ Mr Ruck-Keene recommends the Chair consider whether there should be a legal duty on professionals to consider capacity where there is 'reason to do so'.³⁰⁸ VC's family agree there should be that duty. That duty may have made an important difference in this case: information sharing could have continued with Celeste, helping her to continue to play a role. Instead she was left in the dark about VC's illness and risk.

131. There are broader systemic failures relating to family involvement. There were a number of other reports, including pre-dating June 2023, of families and carers not being engaged in care provided by NHFT.³⁰⁹ Ms Hull accepted that this was "*a systemic and chronic problem*"; and that at the time of VC's care, there was a failure to involve carers in risk formulation and safety plans, contrary to DHSC guidance.³¹⁰ Several inquests in 2021 and 2022 had identified inadequate involvement of families,³¹¹ and the Trust recognised (and the Board was aware) that it was "*quite a distance from carers and families*".³¹² The action taken to bring families

³⁰⁶ INQT0000077, Ms Robinson, 5 May 2026, AM, 63/17-66/8. If it had been determined VC did not have capacity, there should then have been a decision about whether sharing was in his best interests. Again, there were good chances that it was, since that Celeste was well-recognised to be an important protective factor. See also WITN0288001, p74, §163

³⁰⁷ INQT0000104, Professor Smith, 1 June 2026, AM, 45/9-16

³⁰⁸ WITN0288001, p79-80, §177

³⁰⁹ INQT0000088, Mr Majid, 18 May 2026, PM, 107/18-108/17; this was a wider problem identified by the CQC: CQCM0016518, p26

³¹⁰ INQT0000093, Ms Hull, 21 May 2026, AM, 38/14-39/1, 79/8-83/9; DHSC Guidance, March 2009 "Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services" (DHSC0000038)

³¹¹ WITN0356017, p1; NHNB0012321, p3

³¹² INQT0000092, Ms Attfield, 20 May 2026, PM, 18/1-8, WITN0356017, p1, NHNB0012321, p3

back to the centre “*wasn’t sufficient*”.³¹³ This is a national issue. Professor Smith said the number of families who had not been told what illness their relative suffered from was “*striking*”.³¹⁴ MIND state “*information sharing failures... between services and families or carers, are a recurrent and well-evidenced source of harm*”.³¹⁵ The ILT Homicide Review found concerns regarding communication with carers/family arising in 65% of cases.³¹⁶ The Warren Review³¹⁷ found lack of family engagement in many homicide cases, and the RCPsych 2015 report ‘Old Problems, New Solutions’ estimated that greater contact with families would significantly reduce the incidence of homicide by mentally ill patients.³¹⁸ Mr Fathers accepted “*the important need for carers and families to be considered much more greatly in all of our considerations*”.³¹⁹ There is a need for better training and guidance about this: see below.

Failure to ensure VC received a depot

132. During his third admission, when he was detained under s.3 MHA, VC should have been placed on a community treatment order (‘CTO’) with a condition that he take depot anti-psychotic medication. He should have been detained under s.3 MHA in his fourth admission and then placed on a CTO with a condition that he take a depot.³²⁰ If necessary, the depot should have commenced while he was in hospital. The basic reasons for this were that it was highly likely VC would be non-compliant in the community if he did not have a depot, and if he was non-compliant he would suffer an acute relapse and as a consequence pose a high risk of serious harm to the public.
133. Dr Seedat considered that antipsychotic medication was “*crucial*” to prevent relapse into psychosis.³²¹ Dr Ahmed said “*medication was vital in preventing a relapse*”; and “*On the basis that his violence was motivated by his paranoid psychosis, the crucial intervention for minimising the risk he posed was ensuring assertive and consistent medical treatment of his psychotic illness...*”.³²²

³¹³ INQT0000092, Ms Attfield, 20 May 2026, PM, 84/16- 85/4, 85/22-86/2

³¹⁴ INQT0000103, Professor Smith, 1 June 2026, AM 96/11-17

³¹⁵ WITN0433001, p19, §71

³¹⁶ INQY0000033, p43

³¹⁷ NHFT0000518, p3

³¹⁸ WITN0263130, p78

³¹⁹ INQT0000089, Mr Fathers, 19 May 2026, AM, 41/18-23

³²⁰ CQCM0013649, p24

³²¹ WITN0163001, p144-145 §384, cf p102-103, §256-7; and see NHFT0000168, p79

³²² INQT0000054, Dr Ahmed, 16 April 2026, PM, 128/15-20 and CQCM0010417, p1

134. VC plainly could not be relied on to take oral medication in the community. It was evident from his recognised symptoms, including his delusions that he was not ill and did not need medication; and his paranoia that drove him to think those prescribing the medication were conspiring against him. It was also evident from his history, whereby his relapses in July 2020, September 2021 and January 2022 were preceded by him stopping medication.³²³ In consequence, as Dr Ahmed said, “*he was almost certain by that stage to be non-concordant with medication in the community*”.³²⁴
135. Similarly, VC’s assurances that he would take medication could not be relied on. On 24.9.21 VC said he was only taking anti-psychotic because he had to in order to get discharged from hospital: “*he said he would make a sacrifice if it meant he could be discharged. VC said he feels like he doesn’t have a choice but is not taking it because he needs it*”.³²⁵
136. VC repeatedly told professionals that he was taking, or would take, his medication but then did not do so. Upon being discharged from his first and second admissions, VC accepted the need to take medication.³²⁶ On 14.7.20 VC asserted he was taking his medication, but he later admitted he had not been doing so since the start of July: NHFT0000168, p56 and 58. On 24.9.21 VC told the Tribunal he had consistently taken medication for 13 months up to August 2021.³²⁷ However, it was evident he had not been taking medication at least on occasion since as far back as February 2021.³²⁸ On 28.1.22 VC was “*adamant that he was taking medication and that he had never spat it out*”.³²⁹ That was clearly false: the last date VC picked up his medication before the 19.1.22 assessment was 17.12.21, so VC would have been non-concordant by early January 2022.³³⁰ The RiO progress notes made clear he was “*No longer concordant with his medication*” by 18.1.22: NHFT0000168, p204, and as Dr Manzar noted in his 28.1.22 assessment, VC was non-concordant on most occasions after

³²³ See §42 above, and WITN0425001, p17-18, §72-77

³²⁴ INQT0000054, Dr Ahmed, 16 April 2026, PM, 128/11-14

³²⁵ CYGN0000016, p7 §19; cf NOCC0000038, p3-4, and INQT0000083, Dr Thangavelu, 13 May 2026, AM, 40/16-42/19

³²⁶ WITN0166001, p67 §138; and NHFT0000222, p3

³²⁷ CYGN0000056, p4 §8

³²⁸ NHFT0000272, p3. It is unclear whether the bag contained medication from Feb 2021 only; from Feb to Sept 2021; or somewhere in between: INQT0000076, Dr Shiolekova 7 May 2026, PM, 13/2-12

³²⁹ Dr Manzar and Dr Lomas, NHFT0000168, p215; WITN0357001, p54, §154

³³⁰ INQT0000083, Dr Thangavelu, 13 May 2026, AM, 20/9-24/25

19.1.22.³³¹ Dr Shoilekova accepted that there was a repeating pattern of VC providing assurances to professionals that he was taking medication, then he did not do so.³³²

137. Dr Ahmed was right to conclude that *“inappropriate emphasis was placed on VC’s autonomy”*... *“by those third and fourth admissions, it was evident that the reassurances that he was giving to inpatient teams that he was going to adhere to medication in the community, that that wasn’t reliable, based on a more longitudinal view of his presentation...”*.³³³

138. The community team repeatedly told the inpatient teams that they considered VC should be on a depot, and a CTO should be put in place with a depot as a condition. They even emailed Dr Thangavelu directly about this.³³⁴ This should have been given real weight by the hospitals, because the community team were best placed to know the extent to which VC would comply with oral medication in the community. The conditions in hospital were completely different to those in the community: there was much closer monitoring of compliance and compulsion to comply (i.e. VC would not be released unless he did so).

139. Thus, Dr Ahmed considered a depot in conjunction with a CTO was *“clearly necessary”*.³³⁵ Dr Gibson accepted the wrong decision was made and VC should have been on a CTO with depot as a condition.³³⁶ Celeste,³³⁷ and Dr Shoilekova³³⁸ thought that VC should have been on a depot. Professor Blackwood was right to say that, for those such as VC, depot was essential,³³⁹ and that this should have been established by longer periods of inpatient care.

³³¹ NHFT0000286, p8; NHFT0000168 pp206, 212, 215, 219, 225

³³² NHFT0000286, p8, cf NHFT0000168, pp206, 212, 215, 219

³³³ INQT0000054, Dr Ahmed, 16 April 2026, PM, 128/21-23, and 129/7-22. Incidentally, the ‘least restrictive option’ principle can be misunderstood and misused. It does not require clinicians to choose the least restrictive option in any circumstance. Rather, they should choose the least restrictive means of treating and managing the patient (1) safely, and (2) which achieves the warranted assessment or treatment. Thus, if one option is less safe, or it is less effective, then it should not be chosen merely because it is less restrictive. The correct approach is apparent within the MHA Code of Practice

³³⁴ NHFT0000168, p226 and 250; WITN0348001, pp113-114, 119 and 137-140, §341, 343, 363, 416-421; and NHFT0018527

³³⁵ INQT0000054, Dr Ahmed, 16 April 2026, PM, 107/17-22; and 128/7-10; WITN0425001, pp10 and 17-18, §§39, 72, 77

³³⁶ WITN0205001, p35-36, §92, 94 and 95

³³⁷ CYGN0000016, p7 §20

³³⁸ CYGN0000047, p5, §15

³³⁹ WITN0308001, p27-28, §55(ii)

Dr Manzar said depot was “*an essential component of his discharge and relapse prevention plan*”.³⁴⁰

140. Dr Thangavelu’s reasons for not applying a CTO with depot as a condition were deeply flawed.³⁴¹ For example, Dr Thangavelu initially claimed VC was “*generally concordant*”³⁴² with medication, and there was nothing concrete to show he was non-compliant until August 2021 or between the third and fourth admissions; and he claimed that VC had “*reasonable levels of insight*”³⁴³ at the time of the fourth admission. Both claims were plainly wrong for the reasons explored by Mr Carr. Dr Thangavelu said he did not have any reason to disbelieve VC when he said he would comply with medication in the community, but was later forced to admit that was wrong.
141. Another of Dr Thangavelu’s reasons was that “*This would have required taking blood tests... under restraint*”.³⁴⁴ It was also suggested that it would be necessary to restrain VC with a team of 6 people in order to force him to have the depot. Without at least trying depot, it was far from certain this would be necessary. VC had repeatedly given blood tests in hospital during 2020 to 2022 without any resistance. Moreover, it was known that he would take medication in order to be released from hospital. There is no reason to think that his “*desperation to get out of hospital*”,³⁴⁵ would not have been a sufficient motivation to accept the depot.
142. VC should have been detained under s.3 MHA before the end of the fourth admission, which would have enabled a CTO to be imposed. That is for the reasons given by Dr Dracass and Dr Ahmed.³⁴⁶ VC met all the criteria for admission under s.3 MHA. By that stage, the nature of his mental disorder was already well-known and admission was not necessary for assessment under s.2 MHA. Dr Manzar accepted this.³⁴⁷

³⁴⁰ WITN0350001, p75 §320

³⁴¹ INQT0000083, Dr Thangavelu, 13 May 2026, AM, 5/5-64/1

³⁴² WITN0206001, p117, §393

³⁴³ WITN0206001, p68, §217

³⁴⁴ WITN0206001, p117, §395

³⁴⁵ INQT0000083, Dr Thangavelu, 13 May 2026, AM, 41/23-24

³⁴⁶ INQT0000054, Dr Dracass, 16 April 2026, PM, 23/14-24/18; CQCM0013649, p15-16; and WITN0155033, p32-33

³⁴⁷ INQT0000064, Dr Manzar, 27 April 2026, PM, 65/18-66/17; and WITN0350001, p67 §286, and p75 §322

143. Had depot been administered to VC, he would have been properly medicated. This was a really important failing. That is because there is cogent evidence that antipsychotics have around a 63% reduction in violent outcomes.³⁴⁸ Depot is substantially more effective than oral anti-psychotic, including in treating psychosis, reducing the risk of re-hospitalisation and of preventing treatment failure. This is "*not controversial*", and supported by various studies.³⁴⁹ Depot was especially likely to help in VC's case: it would have given certainty that he had taken anti-psychotic medication, whereas it was clear he would not take the oral medication. There was also a failure to give VC sufficient oral antipsychotic medication, for the reasons given by Dr Ahmed.³⁵⁰
144. The benefit of a CTO with receiving depot as a condition, is that if VC failed to comply with that condition he could be recalled, pursuant to s.17E MHA.³⁵¹ There is every reason to think this would have been an effective means of motivating VC to accept the depot in the community, since it was known he would accept medication in order to avoid being in hospital: §135 above. Professor Appleby said case histories provide "*absolutely compelling*" evidence of the efficacy of CTOs.³⁵²

Failure to provide EIP treatment in accordance with NICE Guidelines

145. There was a failure to provide a robust package of care and monitoring, including appropriate care and treatment for first episode psychosis and schizophrenia, as required by NICE Guidelines. This is an important issue because it had the potential to manage or remove VC's risk to others.
146. NICE Guidelines and Standards indicate that within 2 weeks of referral to the Early Intervention in Psychosis ('EIP') team, the patient should be provided with a full range of treatment, including psychological and educational interventions, and Cognitive Behavioural Therapy for Psychosis ('CBTp').³⁵³ VC was on the first episode psychosis

³⁴⁸ WITN0401001, p6 (b); and INQT0000055, Professor Fazel, 20 April 2026, AM, 30/4-9

³⁴⁹ INQT0000094, Dr James, 21 May 2026, PM, 23/14-24/11 and others

³⁵⁰ WITN0425001, pp10, 13 and 19-21, §§38, 52-53 and 81-88

³⁵¹ And see CQCM0013649, p24

³⁵² INQT0000101, Professor Appleby, 29 May 2026, AM, 40/11-12

³⁵³ NICE0000020, p15, 17, 19; NICE0000015, p17 §1.3.1.3, p25, §1.4.4.1

pathway from 17.6.20 when he was discharged after the first admission, so that full package of care should have been provided by the start of July 2020.³⁵⁴

147. VC was not provided with the full package of care within 2 weeks. While CBTp was discussed with him on 8.8.20 and 17.11.20: NHFT0000168, p127 and 139, it was not actually provided to him. Similarly, the only time psychoeducation was formally provided to him in the community was on 7.9.20. As the CQC explained, this “*goes against NICE guidelines on first-episode psychosis*”.³⁵⁵
148. This failing was significant to the outcome. Dr Dracass stated: “*VC required a much more robust package of care that included consistent and assertive interventions. More assertive engagement and restrictive measures were crucial to managing his illness and the risk he posed to others when unwell*”.³⁵⁶ Professor Appleby explained that, for patients with schizophrenia, “*it was exceptionally rare for patient homicide to occur without comorbidity or problems in delivering standard care*”.³⁵⁷ Dr Shoilekova said: “*It is essential that treatment is given early*”.³⁵⁸ Dr Seedat said “*There are lots of studies which have shown that the longer the period of untreated psychosis, the poorer the long-term prognosis*”.³⁵⁹ Professor Kendall gave equivalent evidence, and said 70% of patients with schizophrenia given the full treatment and support recommended by NICE (including medication) “*do very well*”.³⁶⁰ Professor Smith said: “*the longer you’re not treated for, the worse the outcome. The most effective way of reducing the likelihood of serious harm is timely and guideline concordant treatment of psychosis*”.³⁶¹ Like treatment for cancer, treatment for psychosis must start early.
149. One reason why it was important for this full package of treatment to begin early was that VC was more receptive and open to discussing his illness and receptive to treatment at an earlier stage.³⁶² For example, on 17.11.20 he said he would be open to CBTp:

³⁵⁴ NHFT0017906, p2-3

³⁵⁵ CQCM0016518, p21

³⁵⁶ INQT0000054, Dr Dracass, 16 April 2026, PM, 57/4-12

³⁵⁷ INQT0000101, Professor Appleby, 29 May 2026, AM, 19/14-20/2

³⁵⁸ INQT0000076, Dr Shoilekova, 7 May 2026, PM, 89/23-90/7

³⁵⁹ WITN0163001, p86-87, §213

³⁶⁰ INQT0000102, Professor Kendall, 29 May 2026, PM, 43/21-45/18

³⁶¹ INQT0000103, Professor Smith, 1 June 2026, AM, 34/17-35/20 and 25/15-23

³⁶² INQT0000068, Ms Birtles, 29 April 2026, PM, 49/18-20; and 79/12-80/9; NHFT0000168, p115, 133, 142-6

NHFT0000168, p139. It was only on 7.12.20 – over 5 months after CBTp should have started - that VC said he was “*not keen at the moment*”.³⁶³ As time went on, particularly from August 2021, he became sicker and sicker, had less insight, engaged less, and was more guarded. Another reason was that, if a patient is not given medication and other treatment in the community for an extended period, their illness may become treatment resistant.³⁶⁴ This appears to be what happened to VC later on.

150. It appears resources were a reason for this failing. Dr Seedat recognised psychoeducation and CBTp were important. But he said they were not provided to VC in hospital, in part because the hospital did not have the relevant psychologists on the ward.³⁶⁵ Similarly, there were inadequate resources in the community. Ms Parsonage’s evidence was that, at that time, there was no clinical psychologist and only one CBTp therapist for the whole of the city and county teams, her job was more difficult as a result, and there was a wait of a year to access the therapy.³⁶⁶ Ms Robinson said she raised both problems in supervisions with her managers,³⁶⁷ as did the RCPych in its 2018/2019 audit. Ms Adamson stated that efforts were made from September 2019 to bring in CBTp therapists.³⁶⁸ But the problem persisted. The 2021/2022 RCPsych audit identified continuing problems with CBTp³⁶⁹ in the EIP team (and some other NHFT teams), and all psychology posts were vacant at the time of the 2024 CQC review.³⁷⁰ It is not understood why several years after 2019 the necessary therapists were not in place. Moreover, they should have been in place well before 2019: the NICE Guidelines requiring CBTp and psychoeducation had existed for several years before that.

Failure to provide proper care and treatment in hospital

151. VC should have been kept in hospital for longer, properly established on medication including (latterly) depot, and should have been provided with assertive psychotherapeutic interventions to improve his insight. Professor Blackwood said: “*longer periods of inpatient*

³⁶³ NHFT0000168, p140-141; and INQT0000066, Dr Burri, 28 April 2026, PM, 92/10-93/5. Another concern is that steps were not taken to encourage him to accept CBTp/psychoeducation after he expressed reluctance in December 2020

³⁶⁴ WITN0188001, p12-13, §36

³⁶⁵ INQT0000062, Dr Seedat, 23 April 2026, PM, 11/1-12/8 and 82/7-10

³⁶⁶ INQT0000069, Ms Parsonage, 30 April 2026, AM, 11/4-15; and see INQT0000071, Ms Robinson, 5 May 2026, AM, 58/8-21

³⁶⁷ INQT0000071, Ms Robinson, 5 May 2026, AM, 58/22-59/1 and 61/25-62/11.

³⁶⁸ INQT0000106, Ms Adamson, 2 June 2026, AM, 10/15-23

³⁶⁹ RCPS0000011, p1-2 and p9.

³⁷⁰ CQCM0016518, p21; CQCM0016517, p42

*care were required to establish medication compliance (using depot anti-psychotic medication) and (after s.3 detention) the use of the CTO framework”.*³⁷¹

152. There were a series of failings by The Priory, under the care of Dr Gurusinghe. They failed to engage VC on the ward with any therapeutic activities. There was only one substantive 1:1 nursing session in which VC was engaged, on 13.10.21.³⁷² Otherwise, he was just left to his own devices.³⁷³ This was typical of The Priory at the time.³⁷⁴ VC stayed there for only 3 weeks in total. Dr Shoilekova expected the inpatient admission to be at least 2-3 months, in part to give VC psychological therapy and develop some insight.³⁷⁵ The Priory was in special measures because of serious concerns raised by the CQC in June 2021 that the assessment and management of patient risk was inadequate. It appears no concrete steps were taken to remedy those concerns by the time VC arrived in October 2021.³⁷⁶

Community monitoring and engagement

153. There were insufficient face-to-face assessments of VC when he was in the community. For example, as early as 19.6.20, Celeste had to raise her concern with Dr Seedat that VC was only being spoken to by phone, not face-to-face.³⁷⁷ The community monitoring was far from robust – it was incapable of recognising VC was relapsing until he had reached a point of crisis on 14.7.20, 3.9.21 and 15.1.22. One problem was the *frequency* of monitoring: there were often long gaps, such as a 3 week delay in a face to face assessment after Celeste raised concerns on 9.10.20.³⁷⁸ Another problem was *the quality* of monitoring. The telephone assessment in response to Celeste’s concerns on 29.5.21 concluded VC was fine and Celeste’s concerns were misplaced. This was inadequate in that it failed to recognise that, at that time, VC was suffering a psychotic relapse. That is now apparent from his visit to Thames House on 31.5.21 and assault on Sebastian on 5.7.21.

³⁷¹ WITN0308001, p26-27, §55(ii)

³⁷² INQT0000080, Dr Gurusinghe, 11 May 2026, PM, 44/15-45/23

³⁷³ INQT0000079, Ms Foster, 11 May 2026, AM, 137/21-25 and 145/6/9; and INQT0000080, Dr Gurusinghe, 11 May 2026, PM, 49/3-24

³⁷⁴ INQT0000080, Dr Gurusinghe, 11 May 2026, PM, 7/4-17

³⁷⁵ INQT0000076, Dr Shoilekova, 7 May 2026, PM, 48/15-49/1

³⁷⁶ INQT0000080, Dr Gurusinghe, 11 May 2026, PM, 3/6-6/14 and 8/4-9/23

³⁷⁷ NHFT0018562, p2

³⁷⁸ INQT0000069, Mr Carter, 30 April 2026, AM, 100/12-18

154. Mr Carter failed to conduct adequate monitoring or assessment of VC's mental state. For example, Mr Carter visited VC on 26.10.20, in response to Celeste's concerns. Mr Carter merely said to VC that his mum was concerned and he should ring her, and left it at that.³⁷⁹ This was nothing like a full attempt at a mental state examination. There was no attempt to ask VC questions which might delve into his mental state (e.g. why he stopped talking to his mum); no effort to look for non-verbal signs of psychosis (even though Mr Carter had been trained about them) to develop a therapeutic relationship, or to obtain proof VC had been taking medication. During the time he was VC's care co-ordinator for about 4 months in 2022, Mr Carter only had face-to-face contact with VC once, when he came for his medication on 27.5.22: NHFT0000168, p267. Ms Heath accepted this was inadequate, and that Mr Carter should have seen VC at least weekly.³⁸⁰ Mr Carter admitted that, on that date, he did not conduct any sort of assessment of VC: VC "*accepted his medication and promptly left*".³⁸¹

155. There was also inadequate psychiatric engagement. Dr Lloyd was the responsible community consultant for VC throughout the period that he was under the care of the EIP team. From when Dr Lloyd became more directly involved in VC's care in July 2021 when Dr Burri handed it over to her, she saw VC only once. At least after the third admission (i.e. from October 2021) it was clear that much more robust and assertive engagement was necessary in the community: VC posed a high risk when unwell, and close supervision was necessary due to previous non-compliance and disengagement.

Risk assessment

156. There were a number of relapse warning signs: signs that VC's illness was or may have been relapsing and therefore he posed a risk of harm to others.

157. First, **not taking medication** was a critical relapse warning sign. As explained above, the clinicians repeatedly emphasised the importance of VC taking medication: §133. The Tribunal said "*Given the rapidity and severity of his relapses in his condition, it is essential*

³⁷⁹ INQT0000069, Mr Carter, 30 April 2026, AM, 101/19-102/12; and INQT0000070, Mr Carter, 30 April 2026, PM, 80/6-25

³⁸⁰ INQT0000071, Ms Heath, 5 May 2026, AM, 113/24-114/8

³⁸¹ INQT0000070, Mr Carter, 30 April 2026, PM, 37/1-19; and 83/11-16

that medication is maintained and optimised".³⁸² Dr Shoilekova agreed with that, and also that a key warning sign of relapse would be if VC was not taking medication.³⁸³ The CQC observed that the evidence "*indicated beyond any real doubt that Valdo would relapse into distressing symptoms and potentially aggressive and/or intrusive behaviour if he was not treated with antipsychotic medicine...*".³⁸⁴ This reflected the NICE Guideline on Psychosis which said that there was a "*high risk of relapse if people [with psychosis] stop medication*".³⁸⁵

158. It is clear that non-concordance caused each of VC's three relapses: §134 above. On 14.7.20 Dr Seedat recorded VC suffered an "*acute relapse due to non-concordance with medication*": NHFT0000168, p81. He said that VC stopped taking medication around the start of July because he believed he was well, and he then started to hear voices.³⁸⁶ The same was true of VC's relapse prior to his 3.9.21 and January 2022 admissions.³⁸⁷ Dr Manzar said relapse was highly likely due to medication non-compliance, and "*stopping medication was a clear relapse warning sign*".³⁸⁸ Mr Carter was aware that concordance was "*key*" and "*vital*" and non-concordance would lead to a relapse and to VC posing a risk to others.³⁸⁹

159. A second sign of relapse was **disengagement**. That was apparent from VC's relapses, and also because it was a sign that VC's persecutory delusions and paranoia about medical services was increasing.³⁹⁰ There was little engagement with VC in the two weeks prior to the violent incident and admission to hospital on 14.07.20: only one brief face-to-face meeting in a car park.³⁹¹ He also disengaged prior to each of the violent incidents which led

³⁸² CYGN0000056, p5 §12(v)

³⁸³ INQT0000076, Dr Shoilekova, 7 May 2026, PM, 90/8-25.

³⁸⁴ CQCM0013649, p25; CQCM0016518, p8, 39. Similarly, see: NHFT0008712, p15 §45 (Dr Craissati)

³⁸⁵ NICE0000015, p27 §1.4.6.3

³⁸⁶ NHFT0000037, p6; CHCA0000028, p3. See also: NHFT0017906, p1-2 (Ms Birtles)

³⁸⁷ See §136 above. NHFT0000272, p3. Similarly, see NHFT0000168, p162-3, 181, 185 (Dr Mambro); CYGN0000029, p2 (Psychologist 'EG', 22.9.21); CYGN0000054, p21 (AMHP Ms Staples)

³⁸⁸ INQT0000064, Dr Manzar, 27 April 2026, PM, 86/21-87/14; and WITN0350001, p14, §65

³⁸⁹ WITN0368001, pp46, 55, 76, 88-89, §196, 238, 253, 315, 317, 359, 362

³⁹⁰ INQT0000064, Dr Manzar, 27 April 2026, PM, 90/19-91/4; INQT0000068, Ms Birtles, 29 April 2026, PM, 80/16-81/8; WITN0368001, p67-68, §289

³⁹¹ NHFT0000168, p54-56 (3.7.20 to 14.7.20 entries)

to his admission to hospital in September 2021³⁹² and January 2022.³⁹³ A third relapse factor was that VC was **particularly guarded and suspicious** prior to previous relapses.³⁹⁴ For example, he was relatively open and welcoming after discharge on 31.7.20³⁹⁵ until spring 2021. From 19.8.21 until his admission, he was noted to be increasingly guarded and suspicious.³⁹⁶ Similarly, he was ever more guarded from mid-December 2021 until his admission in January 2022.³⁹⁷

160. A fourth relapse sign was **trespass and/or violent behaviour**.³⁹⁸ This was associated with all of VC's known acute psychotic episodes.³⁹⁹ For example, on 24.5.20 he was released shortly after the first violent incident, and almost immediately committed a second, this time resulting in serious injury. A **fifth relapse factor** was strange or unusual behaviour, including being deceptive.⁴⁰⁰ Shortly before the 14.7.20 incident, Celeste raised concern that VC "*wasn't making much sense*" and medics noted he was distracted, with delay in his answers.⁴⁰¹ Before the September 2021 incident VC walked into the Rowan Ward, asking to speak to Dr Seedat about the voices he was hearing, and asking whether staff on the ward could hear the voices and whether they communicate with Artificial Intelligence.⁴⁰² In the month before the 15.1.22 admission, VC was heard to be emitting short screams, and entered a flatmate's bedroom in the middle of the night and asked "*can you hear that screaming*".⁴⁰³ He also provided a false address to the team.

161. There was a failure to have a risk assessment for the community which clearly identified the relapse warning signs.⁴⁰⁴ The risk assessments failed to identify how the risks would be

³⁹² NHFT0000168, p163 (Ms Masterton, Ms Van Ham); CYGN0000016, p5 §16 (Ms Birtles: "*marked disengagement*"); and he missed some appointments: NHFT0000211, p5 and NHFT0000168, p161 (Ms Parsonage, 24.8.21)

³⁹³ NHFT0000190, p5 ("*VC has disengaged*"); NHFT0000168, p197-203 (Ms Birtles, Dr Lloyd, Ms Pinder), 210-211 (Mr Mahachi), 215 (Dr Lomas and Dr Manzar); and he missed numerous appointments: NHFT0000211, p7

³⁹⁴ INQT0000068, Ms Birtles, 29 April 2026, PM, 81/9-12.

³⁹⁵ NHFT0000168, p130 (Mr Chimbi)

³⁹⁶ NHFT0000168, p161-2 (Ms Parsonage and Ms Birtles); NHFT0000190, p4-5; and NHFT0000275, p5 §13 (prior to 3.9.21: "*more guarded... likely due to a deterioration in his mental state*")

³⁹⁷ NHFT0000168, p202 (Ms Parsonage), 205 (Dr Skelton), 207 (Ms McPherson), 208 (Ms Matikiti); NHFT0000190, p5

³⁹⁸ INQT0000068, Ms Birtles, 29 April 2026, PM, 81/13-82/16

³⁹⁹ CQCM0013649, p26-27

⁴⁰⁰ INQT0000068, Ms Birtles, 29 April 2026, PM, 82/24-83/14

⁴⁰¹ NHFT0000168, p54-55 (Ms Coleman and Mr Jackson)

⁴⁰² NHFT0000168, p160 (Ms Smillie)

⁴⁰³ NHFT0000168, p201 (Ms Birtles), 228 (Dr Gibson)

⁴⁰⁴ CQCM0010414, p1; CQCM0013648 §75 and 79 CQCM0013649, p16; and NHFT0000190.

managed and what to do if VC disengaged.⁴⁰⁵ As the CQC noted, the risk assessments minimised or omitted key details relevant to risk.⁴⁰⁶ There was a failure to review the risk assessment and care plan in July 2022 or before discharge to the GP.⁴⁰⁷ The CQC considered this review “*would have been crucial*” at that time in highlighting the risk of relapse.⁴⁰⁸ There were other significant failures in the documentation, including in respect of the care plans and discharge summaries. Those failures were covered in detail by CTI in the evidence so are not repeated here.⁴⁰⁹

162. Some of the clinicians responsible for VC’s care in 2022 failed to take a longitudinal approach to risk assessment, and to look for relapse warning signs and other indications that did not rely on VC revealing his symptoms. They placed too much weight on VC’s immediate presentation and what he told them about his symptoms, which was wrong because he was well known to mask symptoms. Examples are Dr Thangavelu, Dr Lloyd, Mr Carter and Ms Parsonage. This failure was a recurrent theme in the ILT Review: §11.2. Dr Gibson accepted there was ‘*undue focus on VC’s snapshot presentation rather than the longer term pattern*’.⁴¹⁰

163. There are a number of systemic problems linked to risk assessment.

- a. The ILT Homicide Review report found concerns about risk assessment arose in 88% of cases, and a number of the concerns were similar to those identified here.⁴¹¹
- b. Risk assessment policy was inadequate. There was no dedicated NHFT risk management policy.⁴¹² Mr Devlin accepted “*the practices and processes as regards risk assessment and discharge were not fit for purpose*”.⁴¹³ There should be a dedicated risk assessment policy that was clear, simple but which met best practice.
- c. Likewise, there was no national guidance, which nurses are trained and expected to follow, on the assessment of risk to others. NHSE has failed – contrary to advice

⁴⁰⁵ CQCM0010414, p1

⁴⁰⁶ CQCM0010414, p1-3; and CQCM0013649, p16-19

⁴⁰⁷ The last assessment, dated 28.2.22, stated there should be a review on 28.7.22: NHFT0000190, p5. That did not happen. See also CQCM0010414, p4-5; CQCM0013648, p4; CQCM0016518, p18

⁴⁰⁸ CQCM0010414, p5; CQCM0013649, p19

⁴⁰⁹ See also WITN0163001, pp51, 53-54, 101, 133 and 148, §126, 133, 250, 353-355, 391-392

⁴¹⁰ INQT0000082, Dr Gibson, 12 May 2026, PM, 81/3-18

⁴¹¹ INQY0000033, p36, §11.1-11.2. See also CQC review: CQCM0016517, p30

⁴¹² INQT0000105, Ms Adamson, 2 June 2026, AM, 24/22-24; and Theemis, NHNB0018966, p134

⁴¹³ INQT0000090, Mr Devlin, 19 May 2026, PM, 45/7-16

from the CQC and Theemmis - to produce guidance on risk to others. Its guidance on risk only concerns risk to self.⁴¹⁴ The NHSE should produce unified guidance on this.⁴¹⁵ Professor Smith states that the view of the Royal College of Psychiatrists is that “*the principles of best practice set out in*” their 2016 RCPsych “*Guide and Report [CR201] are not well integrated into psychiatric clinical practice*”.⁴¹⁶ Those principles need some updating.

- d. The NHFT risk assessment tools were ineffective. That was Ms Birtles’ view.⁴¹⁷ Professor Smith and Professor Fazel (among others) considered there is a need for a national, standardised tool for risk assessment, together with minimum training and documentation.⁴¹⁸
- e. There is no national training for nurses on risk assessment.⁴¹⁹ The local position was also inadequate. Ms Robinson said there was no specific training for the EIP service, and no training on concordance or discharge.⁴²⁰ Ms Parsonage said there was only e-learning on risk assessment.⁴²¹

Failure to recognise signs of relapse and respond appropriately in 2022 and/or 2023. Discharge to GP was wrong

164. There were glaring signs that VC was relapsing from early summer 2022. As to the crucial risk factor, VC stopped taking his medication. On 18.8.22 Mr Carter noted VC “*has not been supplied with medication now for several weeks*”: NHFT0000168, p270. It was clear that he had run out of medication by mid-July. As a result Mr Carter was “*very concerned*”; he considered VC was a serious risk unmedicated in the community; and said he considered it was of “*paramount importance*” that the team find VC. He claimed he told the MDT about this, and that he was very worried.⁴²²

⁴¹⁴ INQT0000094, Dr James, 21 May 2026, PM, 51/14-65/7; NHSE0000046, p7 and WITN0433011

⁴¹⁵ INQT0000104, Professor Smith, 1 June 2026, AM, 21/13-17

⁴¹⁶ WITN0320001, p15-16, §49 and WITN0058002

⁴¹⁷ WITN0348001, p161-162, §491(ii)

⁴¹⁸ Professor Fazel, 20 April 2026, AM, 76/21-77/20; WITN0320001, §§54, 119-120; Professor Smith, 1 June 2026, AM, 81/15-21

⁴¹⁹ WITN0320001, p69-70, §217-220

⁴²⁰ INQT0000071, E.g. Ms Robinson, 5 May 2026, AM, 2/20-3/7

⁴²¹ INQT0000069, Ms Parsonage, 30 April 2026, AM, 4/14-20

⁴²² INQT0000070, Mr Carter, 30 April 2026, PM, 54/21-24; and 83/25-85/19

165. All of the other relapse indicators that have been identified above were also present. As to the second relapse indicator, VC had disengaged from the community team.⁴²³ As to the third relapse indicator, VC was particularly guarded and suspicious.⁴²⁴ For example, on 1.6.22, VC *“looked suspicious [and] was looking around”*.⁴²⁵ This was a sign of psychosis.⁴²⁶ It was particularly significant since it is the last observation of VC prior to discharge to the GP. Fourth, as to trespass/violent incidents, on 21.4.22 VC trespassed at his old Raleigh Park accommodation, remained on site for an hour, and had to be escorted off site: NHFT0000168, p266. Ms Birtles agreed this was *“deeply troubling”* and Mr Carter accepted this demonstrated *“He’s very poorly”*.⁴²⁷ And the fifth indicator: there was strange or unusual behaviour including an odd call to Ms Birtles on 19.4.22;⁴²⁸ on 29.4.22 he gave a false account in two respects and said he was *“spending time preparing ... for whatever is next”*.⁴²⁹ In July he falsely claimed he was not in the UK and gave a false address: NHFT0000168, p269-270.

166. On 31.8.22 Mr Carter spoke to Celeste. She explained she had not seen VC for several months. She tried to visit him in Nottingham but he was not at the address she was familiar with. Mr Carter was right to be *“very concerned at this point”* in part due to *“non-engagement with... his family”*.⁴³⁰ Celeste certainly gave Mr Carter no reason to think VC was well. By this stage, Celeste was not able to judge VC’s mental state: medical services had stopped providing her with any information about him; VC had stopped telling Celeste anything about his mental state; and she had not seen him face-to-face since July 2021.

167. For those reasons, it was highly likely that VC was relapsing by August 2022.⁴³¹ As Dr Ahmed explained, it *“was highly likely that he would discontinue treatment and experience further psychotic episodes”* and therefore *“present again with violence to others in the*

⁴²³ NHFT0000211, p9, showing numerous DNAs from 10.6.22 until discharge; and NHFT0000168, p269-271

⁴²⁴ NHFT0000168, p267-270 (Ms Birtles, Mr Carter, Dr Lloyd)

⁴²⁵ NHFT0000168, p268 (Ms Parsonage, 15.6.22)

⁴²⁶ INQT0000068, Ms Birtles, 29 April 2026, PM, 84/23-85/13; and INQT0000057, Dr Malik, 21 April 2026, AM, 85/25-86/6

⁴²⁷ INQT0000068, Ms Birtles, 29 April 2026, PM, 29/14-25; INQT0000070, Mr Carter, 30 April 2026, PM, 34/6-35/4

⁴²⁸ NHFT0000168, p264-265 *“doing some research”* didn’t want to discuss it over the phone. These, for VC, were signs of delusions and paranoia. See INQT0000068, Ms Birtles, 29 April 2026, PM, 84/23-85/13

⁴²⁹ WITN0348001, p151, §462

⁴³⁰ WITN0368001, p69 §294

⁴³¹ CQCM0013649, p25-27

context of untreated psychosis".⁴³² In consequence, there should have been a face-to-face assessment, and if the team could not be satisfied that he was well and genuinely taking his medication, he should have been assessed for detention in hospital.⁴³³

168. Mr Carter accepted that there should have been a full face-to-face assessment including for admission to hospital.⁴³⁴ On 31.8.22 Mr Carter had identified the need for a face-to-face assessment of VC's mental state: NHFT0000168, p270. This was conveyed to the team by email on 8.9.22.⁴³⁵ There was a failure by the MDT, including managers Ms Heath and Ms Robinson, to ensure that the visit took place.⁴³⁶ A linked problem is that on 8.9.22 Ms Parsonage emailed Ms Heath and others to ask for a covering CCO for Mr Carter's patients while he was away.⁴³⁷ There was a failure by Ms Heath and Ms Robinson to ensure that a CCO took over VC's case while Mr Carter was away.⁴³⁸
169. Staff were not sure what VC's current address was. But there were a number of potential means of finding him. Mr Carter accepted he should have – but failed to – contact the police. This had every chance of locating VC. Mr Carter explained the police had helped him find other clients before. For example, one client went off the radar, and the police found him within 24 hours.⁴³⁹ Professor Kendall noted that police were commonly able to help him find a patient who did not have a fixed abode.⁴⁴⁰ It is most unlikely that the police would have declined to help the team try to find an unmedicated schizophrenic patient who was known to be a serious risk of harm to the public when unmedicated. That is made even less likely by the fact that VC had been charged on about 4.6.22 in respect of the assault on the police officer on 3.9.21, and on 24.8.22 summonsed to appear at the Magistrates Court. The police had every reason to want to find him.⁴⁴¹

⁴³² INQT0000054, Dr Ahmed, 16 April 2026, PM, 130/24-131/5; WITN0425001, p11, §43

⁴³³ INQT0000054, Dr Ahmed, 16 April 2026, PM, 131/6-132/4; CQCM0013649, p25; CQCM0016518, p8,39

⁴³⁴ NHFT0000168, p270, and INQT0000070, Mr Carter, 30 April 2026, PM, 85/23-86/4

⁴³⁵ NHFT0018724

⁴³⁶ INQT0000071, Ms Heath, 5 May 2026, AM, 114/23-115/21

⁴³⁷ WITN0292006

⁴³⁸ INQT0000071, Ms Heath, 5 May 2026, AM, 114/23-115/21

⁴³⁹ INQT0000070, Mr Carter, 30 April 2026, PM, 48/17-49/14

⁴⁴⁰ INQT0000102, Professor Kendall, 29 May 2026, PM, 42/20-43/2

⁴⁴¹ NGPF0007829, p2, p89

170. Mr Carter accepted he should have done more to try to find VC. Someone should have visited Madison Court.⁴⁴² VC had provided the Madison Court address to obtain his medical records, so it was likely he had at least some link to that address at the time (even if he was not living there).⁴⁴³ The Crisis Team should have been contacted.⁴⁴⁴
171. One reason given for discharging VC to his GP was the claim that the MDT had done all they possibly could to try to find and engage him. The failure to contact the police, to use the Madison Court address, or to contact the Crisis Team show that reason is baseless. Moreover, the ‘Do Not Attends’ policy identifies a number of other means of re-engaging the patient, and it was not clear that any were complied with.⁴⁴⁵ For example, the CCO (Gary Carter) or other nominated team member did not (i) call all recorded contacts to ascertain the patient’s whereabouts; (ii) contact other agencies, e.g. GP, housing departments, work and pensions department, family members; (iii) involve the police; and (iv) consider a Mental Health Act assessment.⁴⁴⁶ Far from exhausting the available means of re-engaging VC, as Mr Carter accepted, the team simply “*gave up on VC*” and “*gave up on public safety*”.⁴⁴⁷
172. It is inexplicable why a schizophrenic patient who was unmedicated, and well-known to be a serious risk to the public when unmedicated, was discharged to his GP. It meant the assertive monitoring and treatment which VC clearly needed, was entirely absent. The GP would have no proactive role whatsoever in managing VC’s mental illness and risk, whether by monitoring, encouraging him to take medication or otherwise. Mr Carter said “*I cannot understand why he was discharged for the life of me*”, and accepted it was “*disastrous*”.⁴⁴⁸ Ms Birtles accepted it was frankly absurd to discharge in these circumstances.⁴⁴⁹
173. There is a conflict of evidence about whether or not Mr Carter failed to make sufficiently clear to the remainder of the MDT his serious concerns about VC and that it was of

⁴⁴² INQT0000070, Mr Carter, 30 April 2026, PM, 86/12-22

⁴⁴³ INQT0000068, Ms Birtles, 29 April 2026, PM, 85/14-88/14

⁴⁴⁴ Ms Parsonage also appears to have accepted that: WITN0317001, p60, §231

⁴⁴⁵ Which is NHFT0004725, p7-8

⁴⁴⁶ See, e.g. INQT0000071, Ms Robinson, 5 May 2026, AM, 39/25-43/6; and INQT0000069, Ms Parsonage, 30 April 2026, AM, 53/12-54/22

⁴⁴⁷ INQT0000070, Mr Carter, 30 April 2026, PM, 76/19-25

⁴⁴⁸ INQT0000070, Mr Carter, 30 April 2026, PM, 87/4-8

⁴⁴⁹ INQT0000068, Ms Birtles, 29 April 2026, PM, 33/20-23

paramount importance to find and assess him. In any event, the team which decided to discharge VC on 22.9.22 failed to make sufficient efforts to get input from Mr Carter, for example by delaying the decision until he had returned. They should have done this, because he was more familiar with VC than they were. Ms Birtles was not at the meeting: she had gone on maternity leave in August. Ms Parsonage had little knowledge of VC's case, she had read few of the records, and she was not sure if she attended the part of the 22.9.22 meeting when the decision was made to discharge.⁴⁵⁰

174. Ms Heath and Ms Robinson failed to properly supervise their team, including Mr Carter and Ms Parsonage: §168 above. Further examples are that Ms Robinson did not consider she needed to audit or scrutinise the quality of the records produced by her team, including the RiOs, risk assessments, or care plans. This meant she was unable to audit the quality of that documentation.⁴⁵¹ Ms Heath was not aware that Mr Carter was not seeing VC “*at least weekly*”.⁴⁵² She claimed Mr Carter reported he was seeing VC more regularly, but it was clear from the face of the RiOs that Mr Carter was not. Ms Heath did nothing to ensure the appropriate people were consulted prior to VC's discharge.

175. There were a number of other failings linked to the discharge to the GP. There was a failure to inform or liaise with VC's family, whether to consult them about the wisdom of discharge or to inform them that this had occurred.⁴⁵³ There was a failure to consult any other agencies, including the GP, university or police.⁴⁵⁴ This appears to have been systemic.⁴⁵⁵ The GP should have been given a formal and detailed discharge letter.⁴⁵⁶ Instead the GP was given barely any information about VC, and nothing informative about his risk, the risk associated with non-concordance with medication, or any crisis plan. This was rightly described as “*appalling*”⁴⁵⁷, and was admitted to be “*wholly inadequate*”.⁴⁵⁸ There was also a failure to document the 22.9.22 meeting at which the discharge decision was made.

⁴⁵⁰ WITN0317001, pp27, 59 and 62, §§106, 224 and 238

⁴⁵¹ INQT0000071, Ms Robinson, 5 May 2026, AM, 11/9-12/14

⁴⁵² INQT0000071, Ms Heath, 5 May 2026, AM, 114/1-10

⁴⁵³ CQCM0016518, p6; CQCM0013649, p25; CQCM0013648, p7 §81

⁴⁵⁴ WITN0425001, p16, §66; INQT0000071, Ms Robinson, 5 May 2026, AM, 41/2-41/18; INQT0000069, Ms Parsonage, 30 April 2026, AM, 51/24- 52/3; WITN0317001, p56, §212; Ms Heath, 5 May 2026, AM, 115/22-116/10

⁴⁵⁵ INQT0000073, Ms Robinson 6 May 2026, AM, 68/7-68/18; 69/15-70/1

⁴⁵⁶ See, e.g. Dr Burri, WITN0337001, p20, §50

⁴⁵⁷ INQT0000074, Dr Lloyd, 6 May 2026, PM, 60/2-6

⁴⁵⁸ INQT0000071, Ms Heath, 5 May 2026, AM, 89/3-4; Ms Robinson, 5 May 2026, AM, 55/9-56/20; CQCM0013648, p7 §81; WITN0084002, pp12,14 §§65,75 (Dr Baker)

176. Overall, the team led by Dr Lloyd took a slapdash and reckless approach to discharge of a schizophrenic patient who was highly likely to be relapsing and therefore to pose a serious risk to members of the public. Insofar as those who were involved in the decision to discharge to the GP sought to justify it, their reasons were plainly flawed.⁴⁵⁹ The flaws were exposed very effectively in questioning so are not repeated here. There was also evidence that the Trust had a policy that said, if you did not attend on two occasions, staff should look to discharge the patient. That is obviously inappropriate, because for patients like VC, disengagement can be a sign of high risk.⁴⁶⁰

Dr Lloyd

177. Dr Lloyd was ultimately responsible for the discharge decision. Her decision was wrong for the reasons set out above. Her evidence was as flawed as her decision to discharge. To pick a few examples:

- a. Dr Lloyd claimed that Celeste “*felt that that fourth admission had perhaps not been necessary.*”⁴⁶¹ That is wrong. Celeste always consented to VC being detained, if that was what doctors thought appropriate.⁴⁶² Dr Lloyd’s claim is inconsistent with the records, e.g. the AMHP report on 19.1.22 states “*Celeste advised that she accepts if Valdo needs to go to hospital, stating what needs to be done should be done.*”⁴⁶³ And the AMHP report of 28.1.22, noted that Celeste “*Does not object to admission if we think he needs this.*”⁴⁶⁴
- b. Dr Lloyd claimed that, surrounding the fourth admission, Celeste “*hadn’t raised any concerns*” about VC.⁴⁶⁵ That is inconsistent with the RiOs, which show Celeste said she “*was worried about him. She thinks he is scared of mental health services and feels persecuted by them*”: NHFT0000168, p223. Moreover, as noted above, Celeste was not in a position to judge his mental state.

⁴⁵⁹ See, for example, INQT0000069, Ms Parsonage, 30 April 2026, AM, 49/11-52/19

⁴⁶⁰ INQT0000094, Dr James, 21 May 2026, PM, 20/9-23

⁴⁶¹ INQT0000074, Dr Lloyd, 6 May 2026, PM, 48/17-18

⁴⁶² E.g. INQT0000085, Ms Calocane, 14 May 2026, AM, 89/14-18; NHFT0000168, p192 (re. 23.9.21); Ms Calocane, 14 May 2026, AM, 97/22-24 (re. 19.1.22); and Ms Calocane, 14 May 2026, AM, 98/13-17 (“*every time they ask and say he needs to be detained... I agree with it*”)

⁴⁶³ NOCC0000040, p4

⁴⁶⁴ NOCC0000043, p4

⁴⁶⁵ INQT0000074, Dr Lloyd, 6 May 2026, PM, 92/24-93/7

- c. Dr Lloyd said in oral evidence that the “*decision to discharge VC was made well before [the 22 September] meeting, when Gary Carter was present. It was made in August.*” She could not remember the date and said it was made “*some time in August*”; and the reason for it was that Mr Carter said “*he had done everything that he possibly could*”.⁴⁶⁶ That is inconsistent with Dr Lloyd’s witness statement, which says the decision was made “*at an MDT meeting on 22 September 2022*”.⁴⁶⁷ It is also inconsistent with the note by Mr Carter on 31.8.22 in the RiOs that, in light of concerns raised by Celeste, “*I will arrange a visit with a colleague to go out and see Valdo to determine his mental state*”: NHFT0000168, p270. Mr Carter plainly did not think, in August, they had done everything they could for VC. On 8.9.22 this was emailed to most of the MDT “*for discussion with the MDT*”, with no suggestion VC was about to be discharged.⁴⁶⁸

178. There are further indications that Dr Lloyd sought to concoct the evidence to try to justify her deeply flawed discharge decision. Mr Carter said that, after the 13.6.23 attacks, Dr Lloyd was present with Ms Birtles and Mr Carter in a car park, and Dr Lloyd said “*we’ve got to get together and have a meeting because we’ve got to be singing from the same hymn sheet here*”.⁴⁶⁹ Dr Lloyd was asked whether she recalled these events afterwards and denied it saying “*we were told very clearly... that we should not be talking to any member of the team whatsoever... and I stuck to that very much... There was nobody [I discussed it with]*”. That conflicts with her 27.2.25 email to Ms Birtles and Ms Heath: “*I have been asked to answer a set of questions in relation to a complaint made against the Trust by the [families of VC’s victims] ... I would appreciate meeting up so we can tackle some of these questions together and formulate a response.*”⁴⁷⁰

179. Dr Lloyd stated VC did not have schizophrenia.⁴⁷¹ Her reasons included: “*During periods of remission VC was able to maintain independent living skills, work part time and eventually complete a degree in mechanical engineering from a good university... [which] would be*

⁴⁶⁶ INQT0000074, Dr Lloyd, 6 May 2026, PM, 55/9-17, 81/7-9 and 100/12-101/11

⁴⁶⁷ WITN0357001, p125 §346

⁴⁶⁸ NHFT0018724

⁴⁶⁹ INQT0000070, Mr Carter, 30 April 2026, PM, 77/25-78/4

⁴⁷⁰ NHFT0004821; INQT0000073, Dr Lloyd, 6 May 2026, AM, 77/18-80/16; and INQT0000074, Dr Lloyd, 6 May 2026, PM, 60/23-61/16

⁴⁷¹ WITN0357001, p59-60, §169

very unusual for an individual with schizophrenia".⁴⁷² Further: VC *"was coping well with"* his masters degree.⁴⁷³ That analysis was profoundly flawed. For example, she was wrong to say VC was coping well with his masters degree. His symptoms caused him to struggle with his studies, suspend his course for a year prior to October 2021, and thereafter fail his courses. He graduated with only a bachelors, on the basis of his marks from before he became unwell in early 2020.⁴⁷⁴ VC had only basic jobs as a warehouse sorter.⁴⁷⁵ He did not live independently when he was detained four times in psychiatric hospital. Dr Lloyd was wrong to say it is unusual for a person with schizophrenia to work in a basic job and to live independently at times.⁴⁷⁶

Other systemic failures involving the health services

Training and supervision

180. There appears to have been no formal training for the CCO role, or supervision to ensure a CCO was competent.⁴⁷⁷ The CCO role was an important one, to keep the public and patient safe. It also required specific knowledge, since a CCO had a range of specific duties. There should be specific training and supervision for CCOs, given their importance.⁴⁷⁸ Supervision *"is absolutely integral to continuous learning and good practice."*⁴⁷⁹

Resources and staffing

181. There is a chronic under-funding of psychiatric services.⁴⁸⁰ Many witnesses to the Inquiry gave evidence that resources for mental health services are far too low; and that this has an adverse impact on the care and management of patients like VC. This is dangerous: it increases the risk that those patients will cause serious harm to the public and themselves.⁴⁸¹ There were resource concerns linked to 46% of the homicides in the ILT Review.⁴⁸² In the last 10 years, demand for mental health services has increased by 109%, it accounts for approximately 20% of NHS care yet the proportion of NHS funding allocated to mental

⁴⁷² WITN0357001, p59-61, §§169 and 171

⁴⁷³ WITN0357001, p49-50, §143

⁴⁷⁴ NHFT0000168, p138, p210, p228; NHFT0000286, p8; and UNIN0000258

⁴⁷⁵ BRGR0000003; NGPF0002082 and WITN0426001

⁴⁷⁶ INQT0000062, Dr Seedat, 23 April 2026, PM, 87/3-23; and WITN0196001, p38, §124

⁴⁷⁷ See, for example, INQT0000071, Ms Robinson, 5 May 2026, AM, 14/17-24

⁴⁷⁸ See, for example, INQT0000105, Ms Adamson, 2 June 2026, AM, 46/18-47/17

⁴⁷⁹ INQT0000105, Ms O'Brien, 2 June 2026, AM, 55/15-16

⁴⁸⁰ WITN0308001, p26-27 §55(i); WITN0320001, p15-16 §49

⁴⁸¹ See, for example, WITN0433001, p4, §15

⁴⁸² INQY0000033, p43

health has reduced to only 8.4%. It will not be ring-fenced from next year so it is likely to reduce even more.⁴⁸³

182. The lack of resources has also caused dangerous workforce shortages. There was a huge deficit in mental health nurses, particularly experienced nurses.⁴⁸⁴ Ms O'Brien explained that *"the vast majority of [community mental health nurse] respondents said that they didn't feel that they were able to keep their patients safe, based on -- because of workforce shortages"*. This led to *"lack of clinical supervision, which is a major risk"*.⁴⁸⁵ Mr Devlin said: *"Staffing issues are a major concern, I would suggest, not just for Nottinghamshire Healthcare, but for the bulk of other mental health providers throughout the country as well."* He said: *"there should be national guidance on those expected [staffing] levels"*.⁴⁸⁶
183. EIP staff had caseloads well above the recommended level. That is, there were insufficient care co-ordinators to cover the caseload, and insufficient staff to meet the demands of the EIP team.⁴⁸⁷ This problem was identified in the 2018 review of Nottingham EIP.⁴⁸⁸ National guidance stipulates a ratio of 15:1 patients to CCO is required to achieve compliance with the timely access and effective treatment requirements in the NICE Guidelines for EIP Services.⁴⁸⁹ The Nottingham City EIP ratio was 27:1 - nearly double the stipulated level. This lack of staff caused *"a serious risk to patient safety"*. Getting additional funding to reduce the ratio was *"critically important"*. This was well-recognised and reported to managers since at least as early as 2020⁴⁹⁰, but nothing was done to fix it over the next few years. Ms Adamson raised this concern with her superiors.⁴⁹¹

⁴⁸³ See, for example, WITN0320001, p15-16, §49; INQT0000103, Professor Smith, 1 June 2026, AM, 23/21-24/6, 73/20-74/10; INQT0000105, Ms O'Brien, 2 June 2026, AM, 64/14-18; INQT0000058, Mr Williams, 21 April 2026, PM, 70/20-71/5

⁴⁸⁴ WITN0270001, p18. §§61-3

⁴⁸⁵ INQT0000105, Ms O'Brien, 2 June 2026, AM, 55/1-19

⁴⁸⁶ INQT0000090, Mr Devlin, 19 May 2026, PM, 58/14-59/17

⁴⁸⁷ WITN0348001, p162, §491(vii); and INQT0000105, Ms Adamson, 2 June 2026, AM, 33/20-25

⁴⁸⁸ WITN0319003, p3 and 58

⁴⁸⁹ NHFT0020008, p3

⁴⁹⁰ See email from Ms O'Reagan to EIP managers, 3.7.20 WITN0462005; WITN0466003, 28.1.21; Ms Adamson raised this with her superiors: INQT0000105, Ms Adamson, 2 June AM, 5/3-21, 8/3-9, 9/2-17 and 33/23-34/15

⁴⁹¹ INQT0000105, Ms Adamson, 2 June 2026, AM, 5/2-21, 8/3-9, 9/2-17 and 33/23-17

184. Mr Carter's caseload was 24.⁴⁹² He indicated this undermined his management of VC's case: it was a reason why he did not take further steps to find VC in August 2022.⁴⁹³ Mr Carter said he told his manager Ms Heath that he had a caseload of 24, but she took no steps to reduce that.
185. From July 2021 the only psychiatrist for the EIP Team was Dr Lloyd.⁴⁹⁴ She worked only 12 hours per week. There were about 150 patients on her caseload.⁴⁹⁵ Some of her colleagues had more than 300 people on their caseloads. This was raised repeatedly with managers. Ms Robinson accepted there were inadequate psychiatric resources, and her managers were aware of this.⁴⁹⁶ Ms Adamson said there should have been 4.5 dedicated medics.⁴⁹⁷
186. Dr Brewin sent an email in October 2021 about the lack of staff at Highbury Hospital, referring to serious concerns raised in June 2021, noted "*services are not safe and we need an immediate response to help support them*". It was accepted in evidence that these issues should have been spotted and addressed sooner.⁴⁹⁸ Dr Brewin accepted that insufficient staff numbers was evident "*since 2019, and was an increasing concern, not just in our Trust but in peer trusts and across different hospitals in the county*". However, the Trust did not appear to put in place effective measures to ensure sufficient staff.⁴⁹⁹ Vacancy rates for nurses nationally was 15-20%, and one in six psychiatry posts unfilled.⁵⁰⁰ Ms O'Brien explained that 13,300 mental health nursing posts were unfilled nationally. She, and others, explained that recruitment is a problem. The reasons for difficulty in recruitment included funding and that pay is far too low. Ms O'Brien identified a number of other factors which would assist recruitment.⁵⁰¹

⁴⁹² INQT0000070, Mr Carter, 30 April 2026, PM, 88/13-15; and INQT0000071, Ms Robinson, 5 May 2026, AM, 17/5-7

⁴⁹³ INQT0000070, Mr Carter, 30 April 2026, PM, 61/2-7 and 86/15-18

⁴⁹⁴ Dr Burri left the EIP team in July 2021: WITN0337001, p53 §131

⁴⁹⁵ INQT0000073, Dr Lloyd, 6 May 2026, AM, 81/5-6 and 102/13-14

⁴⁹⁶ INQT0000071, Ms Robinson, 5 May 2026, AM, 62/12-63/12

⁴⁹⁷ INQT0000105, Ms Adamson, 2 June 2026, AM, 11/21-25

⁴⁹⁸ INQT0000087, Dr Brewin, 18 May 2026, AM, 25/2-15; INQT0000088, Mr Majid, 18 May 2026, PM, 16/10-17/11; and INQT0000090, Mr Devlin, 19 May 2026, PM, 49/13-53/24

⁴⁹⁹ INQT0000087, Dr Brewin, 18 May 2026, AM, 28/2-33/6

⁵⁰⁰ INQT0000087, Dr Brewin, 18 May 2026, AM, 25/2-15 and 28/5-18

⁵⁰¹ INQT0000105, Ms O'Brien, 2 June 2026, AM, 109/13-110/6. See also INQT0000090, Dr Devlin, 19 May 2026, PM, 51/17-52/4; and INQT0000092, Ms Attfield, 20 May 2026, PM, 29/1-5

187. There was widespread evidence that there are insufficient inpatient beds in psychiatric hospitals, which could obstruct access to hospital for patients who need it, increasing the risk of harm to the patient and public.⁵⁰² Unavailability of inpatient beds impacted on VC's case.⁵⁰³
188. A fundamental reason to increase resources for mental health care is this will reduce harm: harm to the public from patients who are dangerous; and harm to the patient because their illness is poorly treated or because they harm themselves. It would also have a positive impact on productivity and the economy. There is also good evidence that it is cost-effective to properly fund mental health care: costs are fully offset by savings elsewhere.⁵⁰⁴ For example, Professor Fazel's study explained the annual cost of violence perpetrated by people with severe mental illness was about £2.5 billion in England and Wales.⁵⁰⁵

Assertive Outreach

189. A full Assertive Outreach service should be reinstated nationally, and be sufficiently resourced, to cater for patients in VC's cohort (schizophrenic patients, who are high risk when unwell, and whose illness leads them to disengage with medical services). There was evidence from many witnesses⁵⁰⁶ that there needed to be a far more assertive approach to VC in the community. This is a broader problem. The ILT Homicide Review concluded that in 90% of cases there was non-concordance with medication prior to the attack, and in 86% there were general concerns with compliance.⁵⁰⁷
190. Assertive Outreach would have remedied this. It is a tried and tested means of engaging difficult patients and helping ensure compliance. As Dr Dissanayaka explained, there is "*a wealth of*" evidence that a properly resourced Assertive Outreach approach works and indeed is "*enormously successful*"; it is an effective means of ensuring sustained engagement for patients with severe mental illness, and of managing and reducing the risk

⁵⁰² See, for example, INQT0000103, Professor Smith, 1 June 2026, AM, 52/5-53/7; CQCM0016517, p27; WITN0308001, p26-27 §55(i); INQT0000087, Dr Brewin, 18 May 2026, AM, 36/1-37/21; INQT0000082, Dr Gibson, 12 May 2026, PM, 45/25-46/9; WITN0112001, p21-22 §§76-77; and RLIT0000031

⁵⁰³ INQT0000069, Ms Parsonage, 30 April 2026, AM, 44/18-45/8

⁵⁰⁴ E.g. WITN0075001, p56-57, §192-193; INQT0000103, Professor Smith, 1 June 2026, AM, 83/24-84/14

⁵⁰⁵ WITN0075014, p2

⁵⁰⁶ E.g. WITN0115001, p25-26 §80; WITN0348001, pp160, 162, §490(iii), 491(ix)

⁵⁰⁷ Section 10. See, similarly, the 2017 figures for the NCIH: INQT0000094, Dr James, 21 May 2026, PM, 107/3-8

of this cohort.⁵⁰⁸ Professor Appleby agreed. However, it is important that the ‘*high fidelity*’ or dedicated Assertive Outreach model is used, not a watered down version, and they must have extra resources that are ringfenced.⁵⁰⁹ As Ms Birtles put it: “*Until this changes further incidents will happen: services need to move nationally to proactive rather than reactive models*”.⁵¹⁰

191. Assertive Outreach was one of the key recommendations of the Ritchie Report.⁵¹¹ Yet resources were reduced for Assertive Outreach in the UK in 2010, and the Nottinghamshire team was disbanded in 2015. One reason was that a small number of UK studies were not clear as to whether it reduced inpatient bed days. As Dr Dissanayaka explains, there is evidence to show it does reduce bed days. But in any event there are other important reasons why Assertive Outreach should be properly funded so that it can cater for VC’s cohort. The first one is the reduction in killings and violent attacks, and suicides. This is a hugely important factor. The main impetus for Assertive Outreach had been to reduce the risk of violence from those who were severely mentally ill.

192. The second reason is the reduction in costs elsewhere in society, which result from Assertive Outreach properly managing these patients, including costs to the criminal justice system, of physical healthcare, homelessness, drug use and even lost employment.⁵¹²

Failure of senior management oversight, and failure to learn

193. Senior managers were aware, or should have been aware, of many of the systemic problems identified above, yet failed to do enough to resolve them. For example, Ms Adamson told regional providers and senior staff her concerns about lack of resources, the dangers that this led to, and that the EIP services was “*struggling, failing*” in 2020⁵¹³, yet those problems persisted in late 2022 and after. The Trust failed to gather data necessary to identify whether

⁵⁰⁸ WITN0412001, e.g. pp7-12, 21-22, §§17-23 and 39; and INQT0000051, Dr Dissayanaka, 15 April 2026, AM, 111/20-25; and INQT0000094, Dr James, 21 May 2026, PM, 32/3-22

⁵⁰⁹ INQT0000101, Professor Appleby, 29 May 2026, AM, 45/11-49/19. See also INQT0000094, Dr James, 21 May 2026, PM, 36/3-37/1 and 89/1-93/20; and WITN0412001, p2, §5

⁵¹⁰ WITN0348001, p160-161 §490(iv)

⁵¹¹ INQT0000094, Dr James, 21 May 2026, PM, 86/17-21

⁵¹² INQT0000051, Dr Dissanayaka, 15 April 2026, AM, 116/17-25; WITN0412001, §20-21, 34

⁵¹³ INQT0000105, Ms Adamson, 2 June 2026, AM, 7/24-17/19

its services were meeting the NICE Standards (apart from the two week wait) which was “critically important”.⁵¹⁴

194. A number of reviews identified systemic failings at NHFT that are relevant to this case. There was an extended failure to put them right. For example, the 2018 review of Nottingham EIP noted CCOs had caseloads that were too high, and EIP training and supervision were inadequate. Those matters remained inadequate in September 2022.⁵¹⁵ The RCPsych audit of the EIP team in 2019 found that the team was below national standards in many respects, yet standards remained low in several areas into 2021 and 2022.⁵¹⁶ The CQC’s 2019 report identified a number of problems including unsafe levels of staffing, and poor leadership. The next full report was in 2022, and there was little improvement in relevant areas.⁵¹⁷ The CQC’s Part 1 review in 2024 noted for 5 years it had identified persistent problems that are relevant to this case.⁵¹⁸ The CQC put The Priory in special measures in 2019, and it had a ward devoted to NHFT patients. Dr Brewin was unable to identify any measures that had been put in place to ensure patient safety there.⁵¹⁹ The ICB’s Feb 2020 ‘Long Term Plan’ concluded that EIP “*Services in Nottinghamshire do not currently meet the required NICE standards*”.⁵²⁰ That was not addressed. Conclusions at a number of different inquests in 2019 to 2022 repeatedly raised similar concerns to those relevant to this case.⁵²¹ Trust witnesses accepted there was a serious failure to respond to the various concerns that had been identified.⁵²² The Collins Review in 2024 and the CQC both concluded that the Trust did not adequately address repetitive problems: it did not learn from serious incidents.⁵²³ Corporate governance was poor.⁵²⁴

195. There ought to be a more effective oversight mechanism to ensure that the appropriate changes are made in response to Public Inquiries, inquests, and other authoritative and

⁵¹⁴ INQT0000105, Ms Adamson, 2 June 2026, AM, 15/2-22

⁵¹⁵ WITN0319003, p3 and 58 and INQT0000087, Dr Brewin, 18 May 2026, AM, 50/1-51/3.

⁵¹⁶ RCPS0000011, p1-9

⁵¹⁷ INQT0000087, Dr Brewin, 18 May 2026, AM, 10/3-13/23, and 19/4-24

⁵¹⁸ CQCM0016517, p2-4, 24

⁵¹⁹ INQT0000087, Dr Brewin, 18 May 2026, AM, 33/7-34/24

⁵²⁰ NHNB0004596, p4; and INQT0000087, Dr Brewin, 18 May 2026, AM, 51/4-13

⁵²¹ NHFT0009667, p2-3; NHNB0019232, p5; NHNB0012044; NHNB0012321, p3. See also the Trust’s own reviews: NHFT0003541.

⁵²² INQT0000092, Ms Attfield, 20 May 2026, PM, 79/19-80/6; and INQT0000090, Dr Devlin, 19 May 2026, PM, 33/4-37/24, esp 37/19-24

⁵²³ NHFT0000423; and CQCM0016517, p53-55

⁵²⁴ INQT0000089, Dr Devlin, 19 May 2026, AM, 80/20-81/6

respected investigations. Professor Appleby, Minister Jones and Baroness Merriman supported this.⁵²⁵

Race: Inquiry question 22(e)

196. There is widespread and cogent evidence to show that Black patients are discriminated against in the mental health system.⁵²⁶ The primary causes of this include barriers by the BME community in accessing mental health services⁵²⁷, and also “*stereotyped assumptions not backed up by evidence*”.⁵²⁸
197. It is important at the outset to distinguish between two different forms of treatment.
- a. The first is for clinicians to be aware of systemic or unconscious discrimination against Black patients, and try to reduce the incidence of that. This approach is commendable and consistent with the duties in the Equality Act 2020, e.g. s.149 of that Act: the Public Sector Equality Duty. The aim is to avoid unconscious bias.
 - b. A second, different form of treatment, is positive discrimination in favour of Black patients. That is normally unlawful and contrary to the Equality Act 2010.
198. There is no evidence that VC was treated in either of the ways identified above. NHFT0004927 is non-verbatim note of an interview of Dr Gandhi on 13.6.25. It is not a full transcript and is not an accurate record of the question that was put to Dr Gandhi or his answers. The interview was 5 years after the incident in question, and Dr Gandhi had no recollection of his thought process on 24.5.20 at the time of the interview.⁵²⁹ However, he (and the other three responsible staff) made clear that the 24.5.20 decision was made solely on the basis that the criteria in s.2 MHA were not met: race “*doesn’t come into the picture at all.*”.⁵³⁰ Those staff included Dr Malik, who in fact shortly afterwards decided to detain VC.

⁵²⁵ INQT0000101, Professor Appleby, 29 May 2026, AM, 53/7-25; INQT0000104, Minister Jones, 1 June 2026, PM, 95/25-97/1; INQT0000110, Baroness Merriman, 4 June 2026, PM, 63/7-21

⁵²⁶ WITN0322001, pp25-26, 46 §§61-2, 98; the Final Report of the Independent Review of the Mental Health Act 1983, dated December 2018: WITN0155008, p11-12, 164 and 296; ‘Pursuing Racial Justice in Mental Health’ 2024 report: MIND WITN0433001, §15 and 20; Race Equality Foundations, *Racial disparities in mental health: literature and evidence review* (2020) pp5-6, 23-24; NHS Race and Health Observatory, *Ethnic Inequalities in Healthcare: A Rapid Evidence Review* (2022) pp11, 88-89

⁵²⁷ WITN0320001, p73-74 §233; and the Independent Review: WITN0155008, p107, 167

⁵²⁸ WITN0155008, p171

⁵²⁹ INQT0000057, Dr Gandhi, 21 April 2026, AM, 104/5-108/22

⁵³⁰ INQT0000058, Dr Gandhi: 21 April 2026, PM, 16/17-17/11; cf Mr Williams, 21 April 2026, PM, 70/2-18.

199. Separately, Dr Gibson said there was a discourse that psychiatrists were overly coercive, and he speculated that that discourse had a bearing on VC's care. However, he did not have any evidence that it did in fact have any specific impact on VC's care. His evidence was that VC's race did not have any impact on the care he himself provided to VC.⁵³¹ He did not give any evidence that even the first form of treatment in §197 above had been applied to VC (lawful attempt to avoid unconscious bias), let alone the second.

Statistics

200. It is to be welcomed that the National Confidential Inquiry will again be funded to resume its analysis of homicide by people with mental illness. It was a very useful means of obtaining reliable data about mental health homicides, and it was a mistake to end funding for it. It assessed the number of victims and offenders; all deaths as identified in court determinations including inquests (so not only criminal convictions); and all patients who had been in contact with specialist mental health services at any time (albeit in separate groups).⁵³² So it would have picked up VC.

5. MULTI-AGENCY WORKING AND INFORMATION SHARING

201. From 24.5.20 to the attacks of 13.6.23 agencies failed to act in a collaborative way to ensure that information about VC was shared. Important information about VC remained fragmented between, and within, agencies. This was often because the systems in place for information sharing were either inadequate or simply non-existent. Sadly, this is not a new issue.⁵³³ In 1994 The Ritchie Inquiry identified a "*catalogue of failure*" in part because there was a failure of agencies to share information. The Ritchie Inquiry Report made clear that "*without proper communication and liaison, there cannot be effective care either in hospital or in the community*".⁵³⁴

⁵³¹ INQT0000082, Dr Gibson, 12 May 2026, PM, 71/11-22; 86/22-87/18

⁵³² See INQT0000101, Professor Appleby, 29 May 2026, AM, 5/9-10/2; and INQT0000094, Dr James, 21 May 2026, PM, 14/12-15/13, 94/8-12, 118/22-119/9

⁵³³ INQT0000092, Ms Attfield, 20 May 2026, PM, 79/19-80/6

⁵³⁴ WITN0075001, p17-18, §59; DHSC0000160, p105-106, §42.2.1

202. There was widespread recognition in this Inquiry that information sharing within and between services was deficient and this undermines safety.⁵³⁵ The ILT Homicide Review concluded that communication and information sharing failures are an overwhelming feature of the cases it analysed, arising in 92% of those cases.⁵³⁶

Lack of clarity

203. The legal rules as to when information can, and cannot, be shared are widely misunderstood. If information is not confidential, it can be shared. Even if the subject does not consent to their own confidential information being shared, that does not prevent staff asking others (such as family members) for information about the subject.⁵³⁷

204. Confidential information can be shared if the subject consents. In the absence of consent, it can be shared for a medical purpose or for the purpose of another public function, in one or more of the following circumstances:⁵³⁸

- a. The subject lacks capacity to decide whether to consent to information sharing, and sharing is in their best interests.
- b. Sharing is justified in the public interest. This includes where sharing is in the interest of preventing risk to others, and that outweighs the interest in confidentiality.
- c. Sharing is permitted by law.

205. It was evident that many witnesses did not fully understand the rules. There is an obvious need for better guidance and training for public servants on data sharing.⁵³⁹ The guidance should be as clear, concise and simple as possible. Busy front-line staff (nurses, police officers, etc) do not have the time to learn complicated policy documents. As Mr Ruck-Keene put it, guidance must be appropriate *“for someone who is under a huge amount of stress and doesn't have time to think about this properly”*.⁵⁴⁰

⁵³⁵ WITN0320001, p36, §112-113

⁵³⁶ INQY0000033, p41, §12.1-12.2

⁵³⁷ WITN0288001, p73, §161

⁵³⁸ WITN0288001, p64-71, §142-156

⁵³⁹ E.g. the NMC lacks clear guidance: INQT0000105, Ms O'Brien, 2 June 2026, AM, 80/19-81/3

⁵⁴⁰ INQT0000053, Mr Ruck Keene KC, 16 April 2026, AM, 93/18-20

206. Mr Ruck-Keene discussed⁵⁴¹ various guidance documents that already exist, including the GMC Guidance, the MHA Code of Practice and the Consensus Statement on information sharing and suicide prevention.⁵⁴² There are problems with each document. For example, the MHA Code of Practice (457 pages long) is evidently neither clear nor simple. The Consensus Statement is focused on risk to self, not others, and there should be guidelines about risk to others. Two flow charts⁵⁴³ are useful models for a clear and simple guidance sheet.

Communication within the Health Services about VC

207. In VC's case there were problems in sharing information within the health services. Dr Brewin accepted that the Trust "*had become disconnected from the system more broadly and had become insular in the way it worked*".⁵⁴⁴ For example, inpatient teams, AMHPs and community teams did not fully share information about VC.⁵⁴⁵ GP practices could not access RiO (a problem that persists).⁵⁴⁶ Professor Smith explained: "*the College has repeatedly asked the UK Government to support the interoperability of digital patient records*" but this has not been progressed.⁵⁴⁷ Any technology obviously needs to prevent inappropriate or unlawful sharing of sensitive data (as happened with the bereaved's data in this case). Baroness Merron accepted that the interoperability of digital patient records was important for patient and public safety and suggested that this was being addressed by the Health Bill 2026 through the creation of an electronic patient record.⁵⁴⁸

Communication between the Police and Health Services

208. Poor communication between the Trust and the police also featured in VC's case.⁵⁴⁹ There were important incidents which the Trust did not become aware of: VC was found ringing the doorbell of MI5 on 31.5.21; he apparently assaulted, followed or stalked his former flat

⁵⁴¹ INQT0000053, Mr Ruck Keene KC, 16 April 2026, AM, 83/22 onwards

⁵⁴² DHSC0000007, DHSC0000108

⁵⁴³ WITN0288006, p69 and RLIT0000026

⁵⁴⁴ INQT0000087, Dr Brewin, 18 May 2026, AM, 64/18-24

⁵⁴⁵ See, for example WITN0112001, p8 §§27-28; and CYGN0000047, p2; and INQT0000088, Mr Majid, 18 May 2026, PM, 73/10-74/19

⁵⁴⁶ INQT0000081, Dr Baker, 12 May 2026, AM, 117/19-24

⁵⁴⁷ INQT0000104, Professor Smith, 1 June 2026, AM, 70/3-18

⁵⁴⁸ INQT0000110, Baroness Merron, 4 June 2026, PM, 67/3-23, 68/1-18 (see recommendations)

⁵⁴⁹ See, e.g. INQT0000069, Ms Parsonage, 30 April 2026, AM, 51/17-20, and WITN0396001, p57, §188; INQT0000051, Dr Dissanayaka, 15 April 2026, AM, 53/11-20; WITN0166001, p52-53, §108

mate Sebastian on 5.7.21, 14.7.21,⁵⁵⁰ 26.4.22 and 28.7.22;⁵⁵¹ he committed serious violence at work in May 2023; as well as the application for a warrant, and the warrant granted on 22.9.22.

VC's attendance at MI5

209. VC turned up at MI5 on 31.5.21, asking to be arrested. The mental health services ought to have become aware of this important information.⁵⁵² In the context of VC's symptoms, and of the concerns raised by Celeste shortly before on 29.5.21, it is an indication of ongoing paranoia and delusions. There was a failure to have a clear system to ensure information of this nature was passed on to the mental health services responsible for his care.
210. The officers who spoke to VC arguably did not inquire enough as to why he wanted to be arrested. But even if they could not be expected to recognise his mental illness (not having psychiatric expertise or training), the system should have ensured this information was passed back to the Trust. It appears that the MPS's Fixated Threat Assessment Centre ('FTAC') had some information about VC's mental health difficulties.⁵⁵³ But they did not either seek further information about VC's mental illness or inform the Trust about this incident. The MPS passed on a dissemination report about the incident to Nottinghamshire Police on 1.6.21 by e-mail.⁵⁵⁴ But there is no evidence that this matter resulted in any further action. As a force, Nottinghamshire Police were aware of VC's mental health difficulties. There should have been a clear system which ensured, as a result, they told NHFT about VC's visit to Thames House.

Sebastian

211. The incidents that Sebastian reported to Nottinghamshire Police were not shared with the Trust or other agencies by the police. This was in part because incidents were often viewed

⁵⁵⁰ VC was not seen on this occasion but Sebastian's evidence is that he suspected that this was VC; WITN0151001, p6 §37

⁵⁵¹ CPSE0007848, p6

⁵⁵² INQT0000067, Ms Birtles, 29 April 2026, AM, 100/16-23; and INQT0000066, Dr Burri, 28 April 2026, PM, 71/7

⁵⁵³ INQT0000010, Superintendent Busby-McVey, 3 March 2026, AM, 88/17-24; INQT0000011, Superintendent Busby-McVey, 3 March 2026, PM, 7/4-5, 17/13-18/18; METF0000003, p15

⁵⁵⁴ INQT0000010, PC Foster, 3 March 2026, AM, 58/7-59/9; METF0000006, p3; METF0000004; WITN0012003

in isolation, not always linked⁵⁵⁵ and when they were linked the significance of events recurring was not appreciated by officers.⁵⁵⁶ Police systems were often not properly interrogated or checked⁵⁵⁷ and some police officers suggested they did not have time to conduct these basic checks⁵⁵⁸ or assumed someone else had checked.⁵⁵⁹ Incidents were also downplayed with overreliance being placed by police officers on Sebastian not wanting the police to take further action. There was a lack of critical thinking in a context where Sebastian was a victim who lived with VC, and there were suspected mental health concerns for VC.⁵⁶⁰ Concerns were at times missed by police officers.⁵⁶¹ There were examples of poor or no supervision,⁵⁶² a lack of training,⁵⁶³ a lack of awareness of relevant policies,⁵⁶⁴ and no contact being made with the Street Triage Team.⁵⁶⁵ VC was not visited by police in July 2021, and he should have been (had checks been made about his history).⁵⁶⁶ It is difficult to understand how the incidents involving Sebastian do not appear in the report compiled after the events of 13.6.23 by the Detective Superintendent interrogating police systems.⁵⁶⁷

212. In terms of multi-agency communication, VC's potential vulnerability was not really considered⁵⁶⁸ and a Public Protection Notice ('PPN') was not submitted.⁵⁶⁹ PS Langham told the Inquiry that if a more thorough job had been done by the officers, he would expect either an intelligence report being placed on the system to be used as part of a further risk

⁵⁵⁵ INQT0000012, PC Pannell, 4 March 2026, AM, 30/24-31/6; E.g. INQT0000006, PC Eustace, 26 February 2026, AM, 55/2-15; INQT0000007, PC Marsden, 26 February 2026, PM, 49/17-24; INQT0000007, PC Collins, 26 February 2026, PM, 60/6-8; INQT0000017, PS Faulkner, 9 March 2026, PM, 81/4-20

⁵⁵⁶ NGPF0000004, p1; INQT0000018, PS Langham, 10 March 2026, AM, 6/12-22, 32/11-23; On 9.5.22, Sergeant Langham rang Sebastian and explained that the interaction may be coincidental (NGPF0000004, p5)

⁵⁵⁷ INQT0000012, PC Pannell, 4 March 2026, AM, 32/2-33/3; INQT0000012, PS Price, 4 March 2026, AM, 74/1-12; INQT0000033, PS Small, 19 March 2026, PM, 32/1-9

⁵⁵⁸ WITN0043001, p7-8, §37; WITN0028001, p7-8, §27; INQT0000018, PC Barnes, 10 March 2026, AM, 61/6-12

⁵⁵⁹ INQT0000012, PS Price, 4 March 2026, AM, 74/1-12

⁵⁶⁰ INQT0000011, Sebastian, 3 March 2026, PM, 39/3-14; INQT0000012, PC Pannell, 4 March 2026, AM, 9/14-18; NGPF0000044, p3

⁵⁶¹ WITN0043001, p5-6 §§27-28

⁵⁶² INQT0000018, PC Barnes, 10 March 2026, AM, 47/21-48/1

⁵⁶³ WITN0015001, p8-9 §§31-32

⁵⁶⁴ INQT0000012, PC Pannell, 4 March 2026, AM, 14/4-6

⁵⁶⁵ INQT0000012, PC Pannell, 4 March 2026, AM, 14/23-15/2; INQT0000012, PC Price, 4 March 2026, AM, 95/1-6

⁵⁶⁶ WITN0074001, p242 §1036

⁵⁶⁷ INQT0000036, ACC Griffin, 23 March 2026, AM, 35/11-20; NGPF0007820

⁵⁶⁸ INQT0000012, PS Price, 4 March 2026, AM, 90/6-13, 94/17-21

⁵⁶⁹ INQT0000012, PC Pannell, 4 March 2026, AM, 15/17-16/20

assessment or a PPN being issued and sent to a multi-agency safeguarding hub to be discussed with officials from social care, police and mental health.⁵⁷⁰

Warrant: September 2021

213. Nottinghamshire Police did not tell the Trust that on about 4.6.22 VC was charged in respect of the assault on the police officer on 3.9.21, summonsed to appear at a Magistrates Court, or that a warrant for his arrest was issued on 22.9.22. Mr Carter said that if the team had been aware of this “*I cannot see how the EIP team could have possibly discharged VC on 22.9.22*”.⁵⁷¹ Of course, the team should not have discharged VC anyway, even without this information. But it would have given even greater weight to the reasons why they should not have done so.

Events of 2022 and 2023

214. Nottinghamshire Police failed to share information about the incident with Christopher in 2022 with any other agency, including the Trust.⁵⁷² Full information about the incident should have been passed on to the Trust, given police were “*aware of his [VC’s] previous mental health issues*”.⁵⁷³ The Trust only found out about the incident three days later on 18.1.22 when Ms Turner informed Ms Pinder.⁵⁷⁴ Ms Pinder was then unable to obtain information from the police on 18.1.22 when she contacted them via 101.⁵⁷⁵

215. When Dr Manzar and Dr Skeleton carried out the s.135 assessment on 19.1.22, they were not given full information and so did not know about the nature of the assault on Christopher (e.g. ‘hostage situation’).⁵⁷⁶ On 28.1.22 when VC was admitted following a subsequent s.2 assessment, it is recorded in the risk assessment (which has been variously updated) that details of the assault are unclear as the police have refused to share information.⁵⁷⁷ By 3.2.22 the notes of the ward round record that the police ‘*couldn’t share any further information with Claudia*’: NHFT0000168, p225.

⁵⁷⁰ INQT0000018, PS Langham, 10 March 2026, AM 32/11-23; 33/2-17

⁵⁷¹ WITN0368001, p74 §311

⁵⁷² WITN0024001, p6-7 §30

⁵⁷³ NGPF0000055, p7; and see INQT0000015, Christopher, 5 March 2026, PM, 16/6-21; WITN0059001, p9-10 §70

⁵⁷⁴ WITN0348001, p133, §404; NHFT0000168, p203

⁵⁷⁵ WITN0396001, p53 §170; NHFT0000168, p204; Dr Skelton, 7 May 2026, AM, 17/11-21; NHFT0000191, p2, 5

⁵⁷⁶ INQT0000063, Dr Manzar, 27 April PM, 50/3-22; INQT0000065, Dr Lomas, 28 April 2026, AM, 72/16-25

⁵⁷⁷ NHFT0000191, p2, 5

216. Poor communication in relation to VC was not limited to the police. There is also evidence before the Inquiry of the Trust not seeking relevant information or initiating communication with the police. Further attempts were not made to obtain information from the police before the MDT about the incident involving Christopher. The MDT (including Dr Gibson) did not contact the police when considering VC's return to his accommodation when he was granted s.17 leave on 3.2.22.⁵⁷⁸ Dr Thangavelu requested a PNC check, but this was not actioned.⁵⁷⁹
217. The 5.5.23 serious incident at the Arvato Warehouse and information relating to it was not shared with any agency by Leicestershire Police. Police officers from Leicestershire did not identify there was an outstanding warrant for VC, even when they belatedly obtained his real name. This was apparently because police systems were not properly interrogated.⁵⁸⁰ Had these simple checks been conducted then Nottinghamshire Police would have been notified.⁵⁸¹ The Trust should also have become aware of this incident, and an urgent assessment performed to consider VC's detention in a psychiatric hospital.

Systemic issues: Police and Health Services

218. A health witness described the system for sharing information between the Trust and police as ineffective.⁵⁸² A police officer described there being no mechanism in place for police to share information with mental health services,⁵⁸³ with another police officer stating that they "*wouldn't even know where to start*" in finding out who VC's mental health workers were.⁵⁸⁴ Dr Dissayanaka produced WITN0412015: a template information sharing document between Leeds and York Partnership NHS and West Yorkshire Police. Dr James accepted that it was "*really useful*".⁵⁸⁵

⁵⁷⁸ INQT0000082, Dr Gibson, 12 May 2026, PM, 67/2-10 – considered at MDT on 7.2.22 (NHFT0000168, p233)

⁵⁷⁹ INQT0000083, Dr Thangavelu, 13 May AM, 90/7-13; 101/7-9; 102/6-11

⁵⁸⁰ WITN0011001, p5 §16

⁵⁸¹ WITN0010001, p9 §28; INQT0000021, PS Read, 11 March 2026, PM, 9/5-10

⁵⁸² WITN0206001, p17, §52

⁵⁸³ INQT0000012, PS Price, 4 March 2026, AM, 82/15-22

⁵⁸⁴ INQT0000013, PC Wakefield, 4 March 2026, PM, 81/10-24

⁵⁸⁵ INQT0000094, Dr James, 21 May 2026, PM, 72/12-19

219. Police have several computer systems, which means that information is siloed in parallel databases, and this inhibits proper sharing of information.⁵⁸⁶ The pace of change within policing in response to these challenges continues to be slow and fragmented.⁵⁸⁷ The involvement of Leicestershire Police and the Metropolitan Police Service provide further examples of the limitations of multiple electronic regional policing systems.⁵⁸⁸
220. Disconnect between police and the Trust systems for recording data was also evident. Medical witnesses described experiencing situations where flags on police systems showed incorrect diagnoses when compared to RiO, or flags on police systems were missing from RiO.⁵⁸⁹ There was also evidence of a joint health/police spreadsheet that sat outside national systems (RiO/PNC). Curiously the spreadsheet was locally stored on a police-owned share drive which was used to log incidents of s.136 attendances and associated police checks, and medical intervention (but not a patient's name or details). It was described as an auditable tool for the police with the Street Triage Team CPN having oversight but no access. The spreadsheet was also not directly accessible to other police forces and probably of limited value.⁵⁹⁰ This again suggests a fragmented, technologically inept and siloed approach to data collection.
221. Trust staff would face barriers when requesting information from the police in relation to incidents involving patients, even where information may be crucial to risk formulation and care planning.⁵⁹¹ Many medical witnesses also described the slow wait of a month for the results of PNC check (which must be done by a manager)⁵⁹² and then it “*would only show basic information about arrests, charges, convictions, bail status, wanted or missing persons markers, MAPPA*”.⁵⁹³
222. Conversely there was also evidence indicating that clinicians often did not seek information from the police where, for example, a patient had been assessed for admission as a result of

⁵⁸⁶ INQT0000021, T/CC Sandall 11 March 2026, PM, 74/14-20; INQT0000050, Sir Marsh, 14 April 2026, PM, 57/12-58/14

⁵⁸⁷ See evidence of INQT0000050, Sir Marsh, 14 April 2026, PM, 61/20-62/14

⁵⁸⁸ INQT0000010, Superintendent Busby-McVey 3 March 2026, AM, 105/17-25, 106/1-7

⁵⁸⁹ INQT0000014, Ms Symcox, 5 March 2026, AM, 21/22-25; 22/13-19

⁵⁹⁰ INQT0000014, Ms Symcox, 5 March 2026, AM, 30/19-32/13

⁵⁹¹ WITN0396001, p57, §188

⁵⁹² WITN0163001, p24, §55

⁵⁹³ WITN0317001, p21, §81

or in connection with an arrest or alleged criminal behaviour “*as this information was usually provided by the professionals who carry out the initial assessment*” and because there is no standard practice for seeking information from the police by the Trust.⁵⁹⁴ This theme was repeated by medical professionals from The Priory.⁵⁹⁵

Communication between health services and The University of Nottingham

223. From May 2020 to June 2022 (with the exception of November 2020 – September 2021), VC was a student at university. This was also at a time when he was under the care of the Trust. It was therefore important that once VC became unwell, the University and the Trust worked together collaboratively and shared information in the interests of VC but also to ensure students (and the public) were protected. This did not happen as well as it should have done and important information relevant to VC’s wellbeing and his risk was not shared. Rather, communication between the two bodies was at best limited and sporadic. Communication within the University about VC was also inadequate, as were attempts to engage VC, which further limited the University’s ability to gather and share important information about VC with the Trust.

224. When VC first became unwell in May 2020 the University did not become aware that he was detained in hospital until they were contacted by Celeste on 1.6.20.⁵⁹⁶ Even at this early stage there were indications of barriers to communication between the Trust and the University, which Celeste was seeking to rectify. Information sharing by the Trust with the University continued to be inadequate during the summer of 2020. The University was not told that there had been more than one incident at Brooke Court in May 2020 or that VC was discharged on 17.6.20, and the University was not given a risk assessment or discharge summary.⁵⁹⁷

225. It is a particular concern that the view of several doctors that VC’s psychosis was triggered by stress and lack of sleep connected to his university work, was not passed on to the

⁵⁹⁴ WITN0166001, p21-22 & p52-53, §35 & §108

⁵⁹⁵ WITN0186001, p7, §18

⁵⁹⁶ UNIN0000140; INQT0000058, Mr Williams, 21 April 2026, PM, 34/20-24

⁵⁹⁷ INQT0000004, Ms Turner, 25 February 2026, AM, 16/22-18/18; INQT0000005, Ms Thompson, 25 February 2026, PM, 23/8-11; INQT0000061, Dr Seedat, 23 April 2026, AM, 71/23-72/9

University in clear terms.⁵⁹⁸ Given that the University were in the best position to manage and limit that stress, this clearly should have been passed on. If they had known about it, they could have been expected to monitor the stress VC suffered,⁵⁹⁹ and take steps to reduce that stress. As it was, they placed him under considerable pressure.⁶⁰⁰

226. Despite VC remaining under the care of the Trust, there was no contact between the University's Mental Health Advisory Service ('MHAS') or the Trust about VC after 30.7.20 until 18.1.22.⁶⁰¹ There was also no shared understanding or plan as to how the University, MHAS and the Trust would update each other about relevant information relating to VC's risk to others and engagement in study, what the University should look out for or do in relation to VC and risk, or what assistance MHAS could offer VC to assist him. VC stated that he did not want involvement from MHAS in August 2020,⁶⁰² but he did not object to their involvement and copied Ms Turner into his communication with academic staff.⁶⁰³ VC also did not object to MHAS communicating with the Trust about "*concerns/risks*".⁶⁰⁴ Despite this, MHAS did not consistently and proactively seek out relevant information about VC from the Trust.⁶⁰⁵ There was no collaborative working during this period. This was despite the fact that "*CRHT were planning to remain in place as he has upcoming stressors with university*".⁶⁰⁶

September 2021 – assault of PC Pritchard and MHA detention

227. In an "*astonishing failure of information sharing*"⁶⁰⁷ the University was not made aware of the 3.9.21 assault or subsequent detention until 2022.⁶⁰⁸ Academic staff had the impression that VC was well and ready to recommence his studies.⁶⁰⁹ The discharge plan was not shared with the University despite recording that VC would move to his new flat near the

⁵⁹⁸ INQT0000061, Dr Seedat, 23 April 2026, AM, 68/18-23; INQT0000062, Dr Seedat, 23 April 2026, PM, 92/1-93/4; cf NHFT0018629, p1, INQT0000004, Ms Turner, 25 February 2026, AM, 73/7-11; 74/4-24; 77/9-17

⁵⁹⁹ INQT0000005, Ms Thompson, 25 February 2026, PM, 103/1-15

⁶⁰⁰ For example, UNIN0000521, WITN0053001, p22-27 §§83-98

⁶⁰¹ UNIN0000734, p4; WITN0054001, p24-25 §§64-68

⁶⁰² VC agreed to a call from MHAS '*during the first week of term*', WITN0054001, p23, §62

⁶⁰³ INQT0000004, Ms Turner, 25 February 2026, AM, 38/3-7, UNIN0000067

⁶⁰⁴ UNIN0000734, p15

⁶⁰⁵ INQT0000004, Ms Turner, 25 February 2026, AM, 79/4-10, 89/13-90/4

⁶⁰⁶ WITN0348001, p64 §190

⁶⁰⁷ INQT0000000, CTI, 23 February 2026, 104/6; INQT0000034, Chief Constable Meynell, 20 March 2026, AM, 38/19-39/9

⁶⁰⁸ WITN0054001, p26 §71; UNIN0000734, p8

⁶⁰⁹ WITN0047001, p10-11 §32; UNIN0001012; WITN0053001, p14 §§54-55, UNIN0001357

University.⁶¹⁰ When asked about whose responsibility it would have been to share such information Ms Birtles stated, “*I don’t know*”.⁶¹¹ VC’s care plan included as an action “*liaise with university support services with VC’s consent to do so*”⁶¹² and hence it was Ms Birtles’s responsibility to inform the University about the events in September 2021.⁶¹³

228. If the September 2021 incident and hospital admission had been known about the University ‘*certainly might well have taken action*’.⁶¹⁴ Ms Turner would have liaised with the ward and tried to be part of discharge planning.⁶¹⁵ It could have triggered the University Fitness to Study (‘FTS’) process, or consideration of a conduct policy⁶¹⁶, or withdrawal from studies on the grounds of health and safety.⁶¹⁷ FTS assessments included a multi-disciplinary process which brought together academic and mental health professionals,⁶¹⁸ something clearly required in VC’s case.

229. It was only when the incident involving Christopher in January 2022 occurred that contact between MHAS and the Trust resumed. But it appears that poor communication by the Trust with the University continued after this incident. On 31.1.22, the University was told that VC had been detained on 28.1.22.⁶¹⁹ The University were not told that VC had been granted unrestricted s.17 leave at a ward review on 3.2.22, just weeks after he had assaulted a student⁶²⁰, or that he was granted a second period of s.17 leave (even though VC had returned to his former flat during his first period of leave). The University was also not told about VC’s discharge on 24.2.22 and Dr Thangavelu accepted “*in hindsight, we should have got that better*”.⁶²¹ The University witnesses expressed clear frustration about their perception

⁶¹⁰ WITN0102001, p41 §144, p47 §183

⁶¹¹ INQT0000067, Ms Birtles, 29 April 2026, AM, 77/25-78/5

⁶¹² NHFT0000202, p4

⁶¹³ NHFT0000201, p5

⁶¹⁴ INQT0000005, Ms Thompson, 25 February 2026, PM, 31/20-32/8

⁶¹⁵ WITN0054001, p24-25, §67

⁶¹⁶ UNIN0001825

⁶¹⁷ Withdrawal on Grounds of Health and Safety policy; UNIN0001828, WITN0066007

⁶¹⁸ UNIN0001824

⁶¹⁹ WITN0066001, p104-106, §334

⁶²⁰ WITN0032001, p17, §56

⁶²¹ INQT0000083, Dr Thangavelu, 13 May 2026, AM, 113/18-19

at the time that Trust staff were not responsive to their concerns about VC being discharged, the risk posed by VC and VC returning to his accommodation.⁶²²

230. The University was not told that a decision had been taken on 28.2.22 that professionals should only see VC in pairs, something which Ms Birtles accepted should have been shared to allow other professionals to make their own assessments.⁶²³ There is no evidence of the Trust sharing with the University documented risk assessments, discharge plans or care plans. Ms Turner and Claire Thompson expressed frustration about this.⁶²⁴

231. Poor information sharing between the University and the Trust was exacerbated by the lack of an information sharing agreement between them (something that Ms Thompson was told to stop developing⁶²⁵). The University also had no formal and regular communication with the Trust (or the police) about students.⁶²⁶ There was no structured multi-disciplinary meeting forum in the University at the time for ‘*student cases of concern*’ to be discussed,⁶²⁷ a lack of clarity and training on how to use FTS to manage a risk posed by a student,⁶²⁸ and no formal system for recording risk.⁶²⁹ There was no evidence to suggest that the Manager for Off-Campus Student Affairs looked into the incidents with Feven and Brooke Court, which remains unexplained.⁶³⁰ There was no standardised approach as to what information could be shared by MHAS with VC’s tutors.⁶³¹

⁶²² INQT0000004, Ms Turner, 25 February 2026, AM, 35/16-20; INQT0000004, Ms Turner, 25 February 2026, AM, 47/8-13; INQT0000004, Ms Turner, 25 February 2026, AM, 49/5-8; INQT0000005, Ms Thompson, 25 February 2026, PM, 16/19-17/3

⁶²³ INQT0000067, Ms Birtles, 29 April 2026, PM, 27/12-28/20

⁶²⁴ INQT0000004, Ms Turner, 25 February 2026, AM, 47/8-13; INQT0000005, Ms Thompson, 25 February 2026, PM, 28/16-20

⁶²⁵ INQT0000005, Ms Thompson, 25 February 2026, PM, 61/12-14

⁶²⁶ INQT0000005, Ms Thompson, 25 February 2026, PM, 58/21-25

⁶²⁷ WITN0033001, p17, §56

⁶²⁸ WITN0054001, p8-9, §23

⁶²⁹ INQT0000005, Ms Thompson, 25 February 2026, PM, 41/16-23; WITN0054001, p8, §22; WITN0050001, p5, §13, WITN0066001, p67, §206

⁶³⁰ INQT0000005, Ms Thompson, 25 February 2026, PM, 73/16-75/3

⁶³¹ INQT0000004, Ms Turner, 25 February 2026, AM, 38/8-18

Risk assessment and communication of relevant information within the University and the University's engagement of VC

232. The University was not responsible for assessing VC's risk, but they still needed to understand risk and other information relevant to VC and his illness so that they could support VC, make any reasonable adjustments, safeguard students and staff and share relevant information with other agencies.⁶³² When this information was not forthcoming from the Trust, more effort could have been made to engage VC directly. However, Ms Turner did not make persistent efforts to re-engage VC between 4.8.20 and 18.1.22, with the exception of calls allegedly made to VC in the first week of term in 2020 that were not answered and not documented and one e-mail on 6.11.20 to which there was no response.⁶³³
233. When VC interrupted his studies in November 2020 Ms Turner did not attempt to speak to VC.⁶³⁴ At this stage Ms Turner should have spoken to VC and told him that medical information of fitness to return to study would be required when VC returned as she understood that VC was interrupting his studies for reasons connected to his mental ill-health.⁶³⁵ This was also in line with University policy in place at the time on voluntary interruption of study.⁶³⁶ It was suggested that the system used at the time was not '*robust*'.⁶³⁷
234. The fact that Ms Turner thought that VC had completed his course in April 2022 (it was June 2022) and gave incorrect information to Ms Birtles about this⁶³⁸ is an indication of just how ill-informed and disengaged Ms Turner was about what VC was doing in the University. It is another example of poor communication.
235. Ms Turner lack of proactivity is concerning because when she spoke to VC on 4.8.20 she noted that he appeared to lack "*insight into the fact that he had been unwell*".⁶³⁹ Ms Turner also knew that in 2020 VC had suffered a serious psychotic episode and a relapse which had resulted in two detentions under the MHA and threatening conduct towards members of the

⁶³² WITN0066001, p6, §20; WITN0066001, p9, §28; WITN0066003, p35

⁶³³ WITN0054001, p23-24, §§62-65; INQT0000004, Ms Turner, 25 February 2026, AM, 37/8-21

⁶³⁴ WITN0054001, p24, §65; UNIN0001317

⁶³⁵ UNIN0000067, UNIN0001317

⁶³⁶ WITN0066029, p4; INQT0000016, Ms Linehan 9 March 2026, AM, 32/11-33/5

⁶³⁷ INQT0000004, Ms Turner, 25 February 2026, AM, 43/6-21; 82/4-22

⁶³⁸ UNIN0000633; INQT0000004, Ms Turner, 25 February 2026, AM, 78/3-79/3

⁶³⁹ WITN0054001, p14-15 §42

public. This should have warranted MHAS taking a proactive approach at every available opportunity and regularly seeking to engage VC, even if those attempts were not successful. This information could have then been shared with the Trust.

236. There was also no consideration by Ms Turner, in late 2021 or during the remainder of VC's course in 2022, that continuing to study may be stressful, isolating and therefore harmful to VC's mental health.⁶⁴⁰ These were all matters that should have been considered in tandem by the University/MHAS and the Trust.
237. It is also of note that Ms Turner refused an invitation from the Trust to conduct a joint visit to VC for 26.1.22 because she did not have a therapeutic relationship with VC. Ms Turner was clearly advocating for VC to be assessed under the MHA, but this was another missed opportunity for Ms Turner to meet VC in person and to try to establish a connection with him,⁶⁴¹ and to engage in multi-agency working and communication.
238. The University's ability to gather together and share important information about VC with the Trust was further limited by poor internal information sharing within the University which left VC's tutors left largely in the dark about VC's illness and risk.⁶⁴² When information about VC was passed to VC's tutor by Ms Turner there was confusion.⁶⁴³ As a result, the tutors were not in a position to understand the significance of VC reporting that he was struggling with his studies⁶⁴⁴ and similar reports from his Professors.⁶⁴⁵ The tutors were also not given any guidance on the circumstances in which they could or should feedback information about VC to MHAS and the first check from Student Wellbeing of whether VC was struggling in his academic work was on 19.1.22.⁶⁴⁶ VC's tutors had no information at all about whether VC posed a risk to staff.⁶⁴⁷

⁶⁴⁰ INQT0000004, Ms Turner, 25 February 2026, AM, 77/9-24

⁶⁴¹ NHFT0000168, p211

⁶⁴² WITN0053001, p11, §44

⁶⁴³ WITN0053001, p18-19, §71

⁶⁴⁴ WITN0053001, p10 §40, see also e-mail from Dr McWilliam to Dr Barney UNIN0001685; WITN0053001, p10 §§41, 44

⁶⁴⁵ UNIN0001779, UNIN0001250, UNIN0000380, UNIN0001075, UNIN0000942, UNIN0001153, UNIN0001588

⁶⁴⁶ UNIN0000152

⁶⁴⁷ INQT0000004, Ms Turner, 25 February 2026, AM, 16/25-17/13; INQT0000005, Ms Thompson, 25 February 2026, PM, 11/17-22

Systemic issues: University of Nottingham

239. On 5.7.21 another student, Sebastian, reported to police aggressive behaviour by VC, which he experienced again in August 2021. The University could have learnt contemporaneously about these events if it had had better systems in place to safeguard students. Report and Support was a system introduced by the University for the academic year 2021/22 for students to report harassment and abuse or other misconduct off-campus, with reports going to MHAS if appropriate.⁶⁴⁸ Academic staff could use this service, but the safeguarding policies disclosed to the Inquiry by the University in respect of this system all relate to 2022 and later suggesting that academic staff may not have been aware of Report and Support in 2021.⁶⁴⁹
240. Sebastian did not know where to report the events of July 2021 because they occurred in off-site accommodation and so he reported them only to his supervisor at the University who “*wasn’t very helpful*”.⁶⁵⁰ He was clearly very worried when he reported these incidents to the police although he did not want police to speak to VC because he wanted the incidents to stop.⁶⁵¹ Had the University been aware of these incidents it would have triggered them “*to be asking quite a lot of questions*” and to consider if VC was ‘*well enough to return to their study*’ as stalking of a student would have been a ‘*big red flag*’.⁶⁵² Christopher also did not know he could use Report and Support in January 2022.⁶⁵³ This all suggests the system was not sufficiently publicised to students and others.

Communication between the Police and the University of Nottingham

241. The police did not tell the University important information about VC. This was in part due to poor decision-making by some individual police officers; failures to identify that there was a risk, or pattern of risk, relating to VC or to check police records; a lack of awareness of information sharing agreements⁶⁵⁴ policies, and resources; and training issues.⁶⁵⁵

⁶⁴⁸ WITN0066001, p29-31, §§96 -101

⁶⁴⁹ WITN0066008; WITN0066009

⁶⁵⁰ INQT0000011, Sebastian, 3 March 2026, PM, 36/18

⁶⁵¹ INQT0000011, Sebastian 3 March 2026, PM, 40/2-19, 43/12-16

⁶⁵² INQT0000005, Ms Thompson, 25 February 2026, PM, 31/8-13, 32/3-8

⁶⁵³ INQT0000015, Christopher, 5 March 2026, PM, 37/6-14

⁶⁵⁴ INQT0000012, PC Price, 4 March 2026, AM, 77/4-78/14

⁶⁵⁵ INQT0000018, PC Barnes, 10 March 2026, AM, 78/8-79/9

242. From the start of their involvement with VC the police did not pass on relevant information to the University, despite being aware that VC was a student.⁶⁵⁶ This included information about incidents on 24.5.20⁶⁵⁷ and the 13.7.20 incident.⁶⁵⁸ PC Severn accepted that notifying the University was not something that was considered at the time or as matter of course.⁶⁵⁹
243. The University was not informed of any of the matters reported to the police by Sebastian. PC Pannell did not share information about the 5.7.21 incident.⁶⁶⁰ PS Price accepted that in hindsight it would have been better if the police had contacted the University about the incident because they might have information about VC's mental health.⁶⁶¹ PS Langham suggested that incidents wouldn't be reported to the University "*unless there is an immediate threat to the University...or I guess over-prioritised data protection*".⁶⁶²
244. The police failed to notify the University about the assault on PC Pritchard in September 2021 by VC.⁶⁶³ They did not tell the University that they considered VC was capable of being '*extremely violent*'.⁶⁶⁴ Both DS Sanders and former CC Meynell accepted that information relating to this incident should have been shared by the police with the University.⁶⁶⁵

System failure: University of Nottingham and Nottinghamshire Police

245. At the heart of the repeated poor communication between the police and the University was a serious systemic deficiency: the information sharing agreement between the two bodies was inadequate,⁶⁶⁶ and many officers were not even aware of it.⁶⁶⁷ It was an information

⁶⁵⁶ University learnt that VC was in hospital from Celeste (UNIN0000140, NGPF0000068)

⁶⁵⁷ WITN0066001, p72-73 §228, NHFT0000168, p2

⁶⁵⁸ NGPF0000048, p3; PC Plant agreed enquiries could have been made: INQT0000009, PC Plant, 2 March 2026, PM, 73/5-10

⁶⁵⁹ INQT0000010, PC Severn, 3 March 2026, AM, 26/1-17

⁶⁶⁰ WITN0015001, p5 §19; INQT0000012, PC Pannell 4 March AM, 33/13-35/2

⁶⁶¹ INQT0000012, PC Price, 4 March 2026, AM, 77/4-78/14

⁶⁶² INQT0000018, PS Langham, 10 March 2026, AM, 32/11-15

⁶⁶³ INQT0000034, CC Meynell, 20 March 2026, AM, 38/7-39/6; INQT0000030, DS Sanders, 18 March 2026, AM, 31/16-25; INQT0000017, PC Zacharia, 9 March 2026, PM, 1/4-10; WITN0033001, p10, §32

⁶⁶⁴ NGPF0000054, p5

⁶⁶⁵ INQT0000030, DS Sanders, 18 March 2026, AM, 32/5-7; INQT0000034, CC Meynell, 20 March 2026, AM, 39/2-6

⁶⁶⁶ INQT0000005, Ms Thompson, 25 February 2026, PM, 64/2-10; INQT0000016, Ms Linehan, 9 March 2026, AM, 19/15-23

⁶⁶⁷ The following were not aware of it: INQT0000014, PC Myers, 5 March 2026, AM, 83/10-11; INQT0000030, DS Sanders, 18 March 2026, AM, 31/12-15; INQT0000013, PS Ellis 4 March 2026, PM, 44/6-20; INQT0000013, PC

sharing agreement that was limited to the sharing of information by police where it related to crime and anti-social behaviour on campuses or areas frequented by students and where students receive cautions or convictions. Those who otherwise posed a significant risk to students or staff fell outside the agreement.⁶⁶⁸ The Inquiry heard that the agreement did not cover most of the concerning incidents involving VC.⁶⁶⁹ This may in part explain why it simply never occurred to many front-line officers that information about VC could or should be shared with the University.

246. The University relied on their Security Team (Mr Croy) to liaise with the police and direct contact from the police to MHAS was described as ‘rare’.⁶⁷⁰ In VC’s case Mr Croy’s involvement was limited⁶⁷¹ and relying on security personnel is clearly no substitute for a more formalised system for regular direct communication between the police and the University. Curiously Mr Croy was nervous about information sharing “*because I am not involved in a pastoral or disciplinary role, I did not think it appropriate for me to be the conduit for personal information, and so now others in the University can ask the Police directly for information. I am not aware of any information sharing agreement with the NHS*”.⁶⁷²

Nottingham City Council

247. A number of issues arise in relation to Nottingham City Council (‘NCC’) as VC was not assessed for consideration of his care and support needs under the Care Act 2014 or in respect of his aftercare needs under s.117 MHA. No consideration was given to whether VC needed a social worker. VC was entitled to s.117 MHA aftercare given he had been in hospital under s.3 MHA. In respect of the Care Act 2014, VC also met various eligibility criteria which meant that his care and support needs should have been considered. VC had a mental impairment, was unable to use his home safely, was isolated from the community around

Wakefield, 4 March 2026; PM, 76/24-25; INQT0000012, PC Price, 4 March 2026, AM, 77/4-78/14; INQT0000018, PC Barnes, 10 March 2026, AM, 78/8-79/9

⁶⁶⁸ UNIN0001829, p6 §4.1

⁶⁶⁹ INQT0000016, Ms Linehan, 9 March 2026, AM, 58/19-60/12

⁶⁷⁰ WITN0066001, p22-23 §72

⁶⁷¹ WITN0054001, p14-15 §42

⁶⁷² WITN0052001, p5-6 §14

him because of his mental health and was isolated and did not engage with mental health services when he was unwell which was detrimental to his well-being.⁶⁷³

248. VC's care and support needs should have been considered by the Trust, as clinical teams would usually decide whether adult social care needed to be involved at the point of discharge.⁶⁷⁴ This should have been considered when VC was discharged on 31.7.20, 22.10.21 and on 24.2.22. There was another missed opportunity for the Trust to refer VC to adult social care and for a social worker to be allocated at the point of VC's discharge back to the GP in September 2022.⁶⁷⁵ Some of these missed opportunities could also have been considered or picked up by the AMHP service⁶⁷⁶ or if there had been social work expertise sitting within the clinical-decision making team – something that was not in place at the time.⁶⁷⁷ Systemic inadequacies have also been identified as existing at the time within NCC around s.117.⁶⁷⁸
249. VC's family consider that patients with severe mental illness are vulnerable and so in addition to the main treating team they should have an advocate from the beginning of their illness to support them in their journey. Not referring VC to adult social care or advocating for him to be allocated a social worker meant that he did not have the extra layer of support that he clearly needed, particularly around medication concordance and accommodation needs. Celeste was not referred for a carer's assessment and there is no evidence before the Inquiry to suggest that this was considered.
250. Since the attacks there has been updated DHSC statutory guidance on discharge from mental health inpatient settings which requires NHS bodies and local authorities to have information sharing principles in place to ensure there is a clear process and that information is shared in a timely way.⁶⁷⁹ It is a concern that Mr Atherton was not aware that NCC had implemented an information sharing agreement.⁶⁸⁰

⁶⁷³ INQT0000079, Mr Atherton, 11 May 2026, AM, 12/1-17/24; The Care and Support (Eligibility Criteria) Regulations 2015

⁶⁷⁴ INQT0000079, Mr Atherton, 11 May 2026, AM, 21/2-16; 30/12-23

⁶⁷⁵ INQT0000081, Dr Baker, 12 May 2026, AM, 128/5-20

⁶⁷⁶ INQT0000079, Mr Atherton, 11 May 2026, AM, 4/10-25; 17/1-13

⁶⁷⁷ INQT0000079, Mr Atherton, 11 May 2026, AM, 24/1-16

⁶⁷⁸ NOCC0000192, p20-21; INQT0000079, Mr Atherton, 11 May 2026, AM, 57/11-24

⁶⁷⁹ PHSO0000010

⁶⁸⁰ INQT0000079, Mr Atherton, 11 May 2026, AM, 54/19-21

251. There was evidence to indicate continuing systemic concerns. AMHPs do not have access to RiO and so cannot make notes on it with some having restricted access.⁶⁸¹ AMHPs do not appear to know which GP a patient is registered with and in respect of VC AMHP forms recorded “*GP practice unregistered or unknown*”.⁶⁸² The Trust has no access to information from local social care.⁶⁸³ Ms Crane suggested that she did not obtain further information from the police in relation to the incident with Christopher ahead of executing the warrant on 19.1.22 due to a lack of time, noting also that she wouldn’t have high confidence that such information would be available.⁶⁸⁴

6. CARE AND MONITORING 13 June 2023 – 17 June 2023

252. The narrative above addresses failings in care and monitoring from 13.6.23-17.6.23. For example, VC should have had mental health support from psychiatric experts from 13.6.23: §57(h) above. There was a confusion between Ms Bramley, Ms Draper and Dr Mark Taylor as to the system for how a mental health assessment should be arranged, and in particular whether HCPs should ask the AMHP or Liaison & Diversion Team.

7. THE CROWN PROSECUTION SERVICE

253. The question of whether the CPS psychiatrists made a proper assessment of VC’s mental state at the time of the offences has been considered in §60 above. Another issue that has been raised, was the availability of a hybrid order or prison sentence, in place of a hospital order under Part III of the MHA. It is unclear whether this falls within the Terms of Reference. If it does, then the key point is that hospital is a *far better* way of protecting the public than prison. If the aim is to prevent violent attacks, then there can be no doubt that hospital should be used, not prison.

254. As Professor Fazel explained, the reoffending rate of someone released from hospital under Part III MHA, is “*hugely lower*” than for an equivalent person released from prison: “*It’s*

⁶⁸¹ INQT0000072, Ms Staples, 5 May 2026, PM, 55/16-56/7; INQT0000079, Mr Atherton, 11 May 2026, AM, 48/14-49/13

⁶⁸² INQT0000081, Mr Baker, 12 May 2026, AM, 119/13-25; NOCC0000044; NOCC0000045; NOCC0000046

⁶⁸³ WITN0396001, p42, §130

⁶⁸⁴ INQT0000079, Ms Crane, 11 May 2026, AM, 70/18-71/16

really quite stark”: a 0.079% reoffending rate after hospital (“*almost the lowest rate of re-offending that I’ve ever seen*”) as compared to a 40-50% rate after prison. The evidence to show hospital is a much better way of protecting the public includes Professor Fazel and Professor Blackwood.⁶⁸⁵ The reasons include firstly that the necessary treatment for someone like VC is available in hospital and not in prison. Secondly, detention in hospital is not normally shorter than in prison. VC will remain in hospital for many years or indefinitely if he does not respond properly to treatment.⁶⁸⁶ Thirdly, upon release from hospital, the supervisory and recall framework is much more effective and more likely to protect the public.

8. RECOMMENDATIONS

255. The family invite the Chair to make the following recommendations.

256. **Additional resources** should be allocated to mental health services generally, and for Assertive Outreach specifically. The DHSC should significantly increase resources for relevant mental health services. Those resources should be ringfenced, both in their general and specific provision. This is foundational in the ability of services to protect the public, but are likely to be offset by savings elsewhere: §188 above.

257. National guidance on minimum **staffing levels** for relevant roles, including in EIP and AO teams, for psychiatrists, nurses, CCOs and psychologists.⁶⁸⁷ The minimum staffing levels should be resource-linked: for example, ringfenced resources are provided (funded by DHSC) to ensure those staff can be employed. Measures such as those recommended by Ms O’Brien should be implemented to aid recruitment.

258. A dedicated **Assertive Outreach service**, nationally, with proper and ring-fenced resources, sufficient to cater for VC’s cohort: see in more detail, §189-192 above. The government

⁶⁸⁵ INQT0000055, Professor Fazel, 20 April 2026, AM, 91/16-97/12. See similarly, Professor Blackwood, CPSE0000011, §108-110

⁶⁸⁶ See the previous footnote. Mr Hendy suggested that the 2017 National Institute of Health Research study found that 87% of patients given a s.37/41 hospital order stayed in hospital less than 10 years. That is incorrect. The table relied on by Mr Hendy concerned length of stay in current unit. The length of stay in hospital overall was much longer: RLIT0000042, p79: only 36% stayed less than 10 years. Moreover, the 36% included patients with a range of offences, minor to major, and 17% having no offending history (p136 & 215- 6 & Scientific Summary §xxvii). So for patients with serious offences, the proportion staying less than 10 years would be very much less than 36%.

⁶⁸⁷ Dr Devlin agreed this would be useful: INQT0000090, Dr Devlin, 19 May 2026, PM, 58/18-21.

intends to bring it in nationally, but VC's family invites the Chair to make a detailed recommendation emphasising the importance of this.

259. **Mental health lead in ICBs.** NHSE is being abolished and the majority of commissioning will be delivered at ICB level. There should be someone in each ICB who is responsible for mental health care delivery and who has mental health care and nursing expertise. This is really important. Without it, nothing will change.⁶⁸⁸ Many of the systemic problems identified above including resourcing, have their root in decisions taken at the senior level. If there is no mental health representative there, those root-cause problems will remain.
260. **Families and carers:** there should be a mandatory requirement to offer family/carers a carer support worker to provide support, advice and assistance in liaising with services.⁶⁸⁹ There should also be mandatory national training and guidelines for mental health services, requiring (i) relevant information (such as diagnosis) to be passed on to the family/carer where lawful, (ii) the family/carer be involved in the patient's care and formulation of the care and crisis plans where appropriate, and (iii) staff to properly respond to concerns raised by the family/carer.⁶⁹⁰ The training and guidelines should make clear the importance of the family's input, the requirement to involve the family/carer and to provide a carer support worker.
261. **'Martha's Rule'** should be introduced in mental health care. This is a right to a second opinion. Professor Appleby⁶⁹¹ and Mr Hendy supported it.⁶⁹² It would have solved significant problems in this case. There were a number of occasions on which the family raised their concerns, but were told that VC was fine. This had two problems. First, it discouraged the family from raising concerns about VC's mental state as time went on. Second, it may have led to VC's deterioration being recognised, addressed, and prevented harm. One example is that after the family raised their concerns on 29.5.21, they were told VC was fine – there was nothing to worry about: NHFT0000168, p153. In fact, he was far

⁶⁸⁸ INQT0000103, Professor Smith, 1 June 2026, AM, 49/17-50/17; and INQT0000105, Ms O'Brien, 2 June 2026, AM, 102/12-18, 110/15-23.

⁶⁸⁹ Support comes from Dr James, WITN0365001, p9 §§16-17, and Ms Attfield, WITN0329001, p44 §175 "*Their role is very powerful in supporting cultural change and broader connections between the individual teams and their local carers' support networks*" [p53-54, §211]; INQT0000092, Ms Attfield, 20 May 2026, PM, 83/2 – 85/21

⁶⁹⁰ Support comes from Dr Sokolov, WITN0364001, p6 §14, and Ms Taylor-Hall, WITN0088001, p14-16 §42.

⁶⁹¹ INQT0000101, Professor Appleby, 29 May 2026, AM, 52/5-15

⁶⁹² INQT0000100, Mr Hendy, 28 May 2026, PM, 50/1-12

from fine - on 31.5.21 he attended Thames House, and on 5.7.21 he assaulted Sebastian. A second opinion may have recognised he was unwell.

262. There should also be mandatory national **training and guidance** for CCOs and other mental health nurses, to include:
- a. how to assess the risk of relapse (including the need to take a longitudinal approach and take account of non-overt signs);
 - b. clear and simple guidelines on information sharing;
 - c. the assessment of mental capacity;
 - d. for those involved in an EIP service or equivalent services, on (i) patients who disengage and are non-concordant, and (ii) on discharge of this type of patient, including the need to take all available steps to re-engage the patient, communication with the patient's family, and information sharing;
 - e. the role of CCO.
263. **National guidance and tool for risk assessment.** There should be national policy on the assessment of risk to others, applicable at a local level, which is clear, simple and meets best practice. This should be developed by NHSE (or its replacement) in consultation with the RCPsych and other relevant stakeholders such as those with lived experience and family and carers. There should be a national clear and simple risk assessment tool.
264. **Supervision.** There should be minimum national standards for supervision, including for supervision of CCOs.
265. **Capacity.** There should be a legal duty on professionals to consider capacity where there is 'a reason to do so'.
266. **Governance/data.** Trusts should be obliged to collect and publish data to show whether they are complying with NICE EIP requirements.

267. **A national oversight mechanism**, to help ensure that concerns or recommendations made in inquiries, inquests, and by other respected reports, are addressed: §195 above.⁶⁹³ The State-related Deaths (National Oversight Mechanism) Bill is a starting point.⁶⁹⁴
268. **Serious incident investigations** and other investigations into deaths, including mental health homicide investigations, should be independent, published, and bereaved families of the deceased victim should be able to effectively participate. There was poor engagement with the bereaved family in a number of the Trust's investigations which do not appear to have been adequately addressed under the current policy in respect of homicides.⁶⁹⁵ Such changes are likely to improve the quality of those investigations and to encourage learning from them, which was poor.⁶⁹⁶
269. **Information sharing:** Within the health services, a single electronic patient record should be available to all relevant clinicians. Discrete digital medical systems should also connect and communicate with each other (interoperability). At present it is not clear whether full interoperability of digital systems used within the NHS will be addressed by the provisions in the Health Bill 2026 for the creation of a single electronic patient record.⁶⁹⁷ Measures introduced should however maintain safeguards against inappropriate disclosure of confidential information.
270. There should be joined-up digital systems to ensure appropriate and lawful information sharing between police, health services and public institutions such as universities. For example, one option to ensure police share relevant information with health services could include a system where a mental health marker is placed on police records combined with a requirement for the police involved in any significant incident to check for markers; and if there is a marker, a requirement to inform mental health services of the incident. Such systems must be considered alongside the rapid advances in Artificial Intelligence and work

⁶⁹³ INQT0000100, Baroness Merriman, 4 June 2026, PM, 63/7-21, INQT0000104, Mr Clarke, 1 June 2026, PM, 95/25-96/7

⁶⁹⁴ RLIT0000137, It will not make progress, unless revived. The need for a National Oversight Mechanism is addressed in more detail in INQUEST's 'No More Deaths' report: RLIT0000138

⁶⁹⁵ NHFT0015629, p17

⁶⁹⁶ INQT0000087, Dr Brewin, 18 May 2026, AM, 61/13-63/17 and 69/2-16, and NHFT0000518, p1.

⁶⁹⁷ RLIT0000139

in this area must be joined-up and nationwide.⁶⁹⁸ Any system must maintain patient confidentiality while ensuring communication where appropriate.

CONCLUSION

271. We repeat the key starting point: VC's risk was exclusively driven by his psychotic relapses. He was not a risk when well. Had VC received full and proper treatment and management of his schizophrenia, beginning in earnest during his first admission in May 2020, there is every reason to think this tragedy would have been prevented. It is the individual and systemic failures linked to medical care and treatment that were the critical causative factors. In order to best reduce the risks to patients and the public in future, by ensuring schizophrenia is properly treated and managed, VC's family invite the Chair to make far-reaching and detailed recommendations in relation to mental health services, and to the information sharing procedures on which those services rely.

Adam Straw KC
Kirsten Heaven
Doughty Street Chambers

Bhatt Murphy Solicitors
14 August 2026

⁶⁹⁸ INQT0000050, Sir Marsh, 14 April 2026, PM, 48/17-52/13