University of Nottingham Closing Submissions

Introduction

1. This Inquiry has been about understanding what happened, what went wrong, and what might be recommended in the future in order to try to avoid tragic events such as those of 13 June 2023 from happening again. As Julian Hendy of the charity 100 Families alluded to in his evidence, the need for accountability is often at the very heart of the recovery process for individuals and families who suffer the losses and the trauma which the bereaved and survivors suffered that day.

2. The University recognises and respects that need for accountability. It has participated fully throughout this Inquiry because it believes that meaningful accountability can only be achieved through a proper understanding of the full context in which these tragic events occurred.

3. Much of the evidence has been difficult for all concerned to hear. There have undoubtedly been failings, and the Inquiry will make its findings on those in due course. Too often, the evidence suggested that the legitimate concerns of the bereaved families, the survivors and also VC's family were ignored. The evidence has also suggested that there is inconsistent guidance surrounding information sharing and inter-agency working, and a lack of understanding of when risk information can be shared. It has also been difficult to hear evidence given to the Inquiry that police and mental health services are too often under-resourced, with staff working under overwhelming pressures, receiving insufficient support, and experiencing compassion fatigue and staff shortages.

4. The University has sought, in every way available to it, to assist the Inquiry and all other relevant bodies[1] in this process of accountability. As part of this Inquiry, it has provided full disclosure of relevant material, submitted detailed witness statements, given oral evidence, and reflected carefully on the actions it took. As outlined in the evidence of its witnesses, the University engages in continuous improvement and where it concludes that its processes or procedures require improvement, it implements these, such as the introduction of Cases of Concern[2].

5. Whether the University acted appropriately within the limits of the powers available to it is, ultimately, a matter for the Inquiry. Having heard the evidence as a whole, however, the University considers that it did act appropriately within the limits of its powers as an educational organisation. The University submits that it is important not to lose sight of the professionalism, commitment and dedication demonstrated by many of its staff. They worked diligently in difficult circumstances and often, through no fault of their own, without access to all the relevant information as it was often not made available to the University by the relevant statutory services. That context is an important part of the overall picture the Inquiry is now asked to consider.

6. However, most fundamentally, the Inquiry has heard no evidence from any witness, whether factual or expert, to suggest that any different action by the University would have altered the course of events. The University's position is that VC's trajectory was not shaped by the University's conduct but by the failure of statutory services to share critical risk information, to maintain effective treatment, and to manage the risks which he posed to the public. The tragic events of 13 June 2023 occurred over a year after VC had graduated and after he had been discharged entirely from secondary mental health services, a decision which the

[1] The University gave written evidence to Theemis after Theemis gave it the free choice of providing evidence either orally or in writing, see the oral evidence of Professor Linehan, INQT0000016, Professor Katherine Linehan, 9 March 2026, 43/3.
[2] Now known as Student Case Coordination Meetings.

University played no part in and was unaware of. It is therefore impossible to causally link any step which the University could realistically have taken, whether excluding VC from his course, triggering the Fitness to Study policy, or requiring medical disclosure after his VIS, to what ultimately happened or to come to the conclusion that any such step could have prevented what ultimately happened. Indeed, the actions of the University often assisted the police and mental health services. The fact is that there were failings in the way that information was shared by statutory services at the time when VC was a student at the University and the University's proposed recommendations are intended to address that issue.

7. In summary only at this stage, the University very much hopes that the tireless work of Ms. Eleanor (Ellie) Turner of the University's Mental Health Advisory Service (MHAS) and her team as detailed in the evidence of other witnesses, not just those of the University, will be recognised. Whenever the University was aware that VC was ill or potentially ill, Ellie Turner and her team made every attempt to ensure that mental health services and (if necessary) the police were aware, to query decisions around discharge and to challenge decisions not to detain. In that sense, Ellie Turner and her team provided an additional layer of oversight, escalation of concerns and facilitated co-operation often at times when no-one else was doing this[3].

8. The Inquiry's Terms of Reference require it to establish a chronology of events and to make recommendations for the future. In identifying failings and making recommendations however, it is important that the actions of those involved are not assessed solely through the lens of hindsight. In the University's case, any assessment must also take proper account of the context in which it was operating, including the nature and limits of its role and the powers available to it at the relevant time.

[3] It is worth noting the evidence of other witnesses on education as a protective factor for VC: see INQT0000069, Abigail Parsonage, 30th April 2026, 38/23-25 and INQT0000061, Dr Faizal Seedat, 23 April 2026, 60/17.

9. As the Inquiry will understand, the University cannot assist on all aspects of the Terms of Reference. In order to assist the Inquiry with the topics on which the University is able to assist, these submissions are drafted to move chronologically through the time during which VC attended the University, addressing the key issues such as inter-agency working and information sharing within that timeline, and will then finally move to recommendations. The structure of these submissions is therefore as follows:

(A) An introduction to the University, its support services and any existing information sharing agreements with statutory services;

(B) Terms of Reference: Timeline of Events to 13 June 2023 and Effectiveness of Inter-agency Working and Information Sharing. These Closing Submissions do not detail every email sent or telephone call made by or to the University. Considerably more detail is contained in: (a) the University's chronology, which was submitted to the Inquiry prior to the start of the Inquiry and is reproduced with these Closing Submissions[4]; and (b) in the witness statements provided by the University;

(C) Terms of Reference: Reflection and Recommendations; and

(D) Issues outside the Terms of Reference.

(A) The University, MHAS and other Support Services

10. The University of Nottingham was founded by Royal Charter in 1948, although its antecedents stretch all the way back to 1798. It is an exempt charity whose

[4] It is important that the Inquiry notes that this chronology is not intended to be a detailed chronology of everything that was happening with VC at the time that he was a student/on interruption, but instead is a record of the main interactions the University had with VC, and those events which the University clearly ought to have been informed of by the statutory services at the relevant time.

principal regulator is the Office for Students. As an exempt charity, the University can *only* act in furtherance of its charitable object and purpose, which, as set out in the Charter [WITN0066002], is to advance education, i.e. to promote, sustain and increase individual and collective knowledge and understanding of specific areas of study, skills and expertise. The University is not a statutory service; there is no statutory duty of care towards students[5] and its obligations in relation to those with physical or mental health issues are relatively limited. To the extent that the University provides health, support and wellbeing related services, it does so only in the context of an educational setting, in order to enable students to maximise their student experience[6].

11. The University provides a range of support services for its students and the detail of these is set out in the first witness statement of Professor Katherine Linehan [WITN0066001] at paragraph 39 onwards. MHAS is of direct relevance to the issues with which the Inquiry is considering.

12. MHAS is a specialist, referral-only service for students experiencing significant mental health difficulties. As its name makes clear, it is an advisory service only; it does not and cannot provide mental health diagnosis, assessment or treatment[7]. It provides advice and can liaise with relevant statutory mental health services, but it has no power to compel a student to attend or take advice from MHAS, to prescribe or monitor medication, or for information to be shared with

[5] At paragraph 22 of Professor Linehan's first witness statement [WITN0066001], she explains the fact that calls for a statutory duty of care on universities have been rejected and provides further information about this.

[6] Also see the oral evidence of Professor Linehan, INQT0000016, Professor Katherine Linehan, 9 March 2026, 4/1 onwards.

[7] Perhaps most importantly, it cannot and does not formally assess risk. As the evidence of witnesses such as Dr Tully [INQT0000052, Dr. Ruth Tully, 15 April 2026, 61/13-18] and Professor Fazel [INQT0000055, Professor Seena Fazel, 20 April 2026, 47/12-14] make clear, risk assessment is a specialist endeavour, carried out by specialists using specialist risk assessment tools such as the HCR-20-V3 or the Oxford Violence Tool which require appropriate resources, training and full sources of information. The University would be wholly incapable of formally assessing risk.

MHAS by a student[8]. The MHAS team is very small, with only 4 to 8 staff at any one time.

13. In addition to MHAS, the University has a Support & Wellbeing team, and they are based in schools and faculties within the University and are a 'first port of call', with referrals to MHAS if appropriate[9].

14. At the time that VC was at the University, Ellie Turner was Head of MHAS and Claire Thompson was her line manager, as Associate Director (Student Wellbeing).

15. Despite MHAS' very limited role, the evidence heard by the Inquiry can only lead to the conclusion that staff working for MHAS often went above and beyond their duties because of their concerns for VC and the wider student community[10]. Some key examples are as follows:

    (a) May 2020: Ellie Turner, as soon as she became aware of the incidents which had taken place in this month, liaised constantly with VC's mental health team, and was very concerned about VC returning to Brook Court and was the only professional advocating for VC to return to Wales[11]. This is despite the fact that Brook Court was not university accommodation;

    (b) As a direct result of this, on 9 and 10 June 2020, the University liaised with the police to let them know of VC's imminent discharge from his first admission

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[8] Further details about MHAS can be found at paragraph 60 onwards of the First Witness Statement of Professor Linehan [WITN0066001].
[9] Further details about the Support & Wellbeing Team are contained at paragraph 51 onwards of the First Witness Statement of Professor Linehan [WITN0066001].
[10] There was some apparent criticism of Ellie Turner in questions to her from VC's family as to why she had been 'reactive' rather than proactive in her responses, but (a) this is not accepted, given the timeline, and (b) she explained in evidence that her role was primarily reactive because she simply did not have a mechanism to make a student engage with her; and in VC's case he did not want MHAS's engagement and wanted his psychiatric profile kept away from the University. As such, this led her to be powerless to carry out any proactive work in relation to VC [INQT0000004, Eleanor Turner, 25 February 2026, 89/13].
[11] This is also independently corroborated by psychiatrist Dr. Ahmed, who was appointed by the CQC to conduct a desktop review of NHFT's care of VC. In her internal findings [CQCM0010415 at page 2] she noted that it was MHAS who were advocating that he not return to his flat, but that he return to Wales for support.

and the associated risks, and it is notable that neither the inpatient team nor the Crisis Team took the time to do this. It is thanks solely to the actions of Ellie Turner and Stuart Croy, then Head of Security, who proactively liaised with the police, that the police became aware that Brook Court was not University accommodation and had the opportunity to warn the relevant victims of VC's discharge prior to it taking place;

(c) January 2022. The context in relation to this incident involving one of VC's flatmates, Christopher, is that the University was wholly unaware of the incidents involving VC and his admission in September 2021 and was completely unaware that VC continued to be under secondary care. Neither the Trust nor the police advised the University of these, and it is accepted in evidence that the University should have been so advised. Despite this, as soon as Ellie Turner became aware of the assault on Christopher by VC, she contacted mental health services and it is thanks to her actions that the assault on Christopher became known to the EIP and, even more importantly, that the subsequent MHAA was arranged which led to VC's fourth admission. Ellie Turner repeatedly informed mental health services that VC could not remain at Raleigh Park and that she was concerned that the plan to care for him in the community would fail.

Police and MH services information sharing with MHAS

Information Sharing with Mental Health Services

16. As Professor Linehan explains at paragraph 158 of her first witness statement [WITN0066001], there is currently no written information sharing agreement between the University and local mental health services, and there is no national framework in place in relation to information sharing. Where a student has given consent to an external mental health service for information to be shared, then some information sharing does take place with MHAS, and if there is a good

personal relationship with local teams, that information sharing improves. It is much harder for the University to obtain information from wards outside Nottingham and private providers.

17. Where a student has refused consent, then the current position is that the University would expect information to be shared in certain circumstances, such as when a student is a risk to themselves or to the wider University community. However, in practice, the sharing of such information is not well understood by Nottingham Healthcare NHS Foundation Trust (NHFT) or private providers, and even more so with NHS services out of area. The sharing of information in the context of this case is set out within the timeline below.

18. The University has noted with interest the evidence of Dr. Elcock, the Deputy Chief Executive Officer of the NHFT (since October 2023) who accepted in oral evidence on 20 May 2026 that the relevant GMC guidance [WITN0356077] provides that clinicians must share relevant risk information with universities if there is a risk of serious harm, and that on the facts of the present case, that information about VC's triggers, as well as all the relevant incidents, should have been shared with the University [INQT0000091, Dr Susan Elcock, 20th May 2026, 10/19-25 – 12/1 and 120/11 - 124/3]. It will be a matter for the Inquiry to conclude whether sufficient guidance on this exists for clinicians.

19. As far as the University is aware, there is no national framework in place for information sharing between the NHS and universities and there is no guidance from the ICO and/or any other body which provides guidance for universities or other bodies on sharing information with universities. The recommendations sought by the University in respect of this are set out below.

Information Sharing with the Police

20. In terms of information sharing with police forces, the University has a strong relationship with the local police force, and the University's Associate Director of

Security Services, Stuart Croy, has a well-established relationship with them. A police officer is now physically based at the University which has improved information sharing and information is shared more easily than with the NHS [WITN0066001 at paragraph 162]. This process was formalised in an information sharing agreement, in place from at least 2015 [UNIN0001829] and the agreement was updated in 2024 [UNIN0001807].

21. However, as is detailed further below in the context of the timeline, information sharing is not readily understood by local police officers and if students become involved in incidents outside the immediate area, they are not covered by the information sharing agreement, and the University is very rarely informed of such incidents.

22. The 2015 Agreement was limited in its terms whereas the 2024 agreement is far wider and allows the significant sharing of information. However, the position remains that many police officers appear not to be aware of the agreement and misunderstand the need to share information with the University. Regardless, the University takes the view that: (i) the police ought, at all relevant times, to have been informed on the correct legal position when it comes to information sharing; and (ii) in any event, an information sharing agreement is not intended to replace the underlying legal framework for sharing information. Information can be shared in appropriate circumstances even if there is no information sharing agreement in place.

(B) <u>The Timeline</u>

23. The University is able to assist the Inquiry with the timeline between September 2017 and August 2022 (VC's time at the University), as per the Terms of Reference. It has prepared a detailed chronology to assist the Inquiry, as set out above.

September 2017 to March 2020

24. VC commenced Year 1 of a Bachelor of Engineering course (BEng) in September 2017. He did not disclose any mental health issues in applying to the University. No issues, academic or otherwise, were raised in relation to VC in this year or in Year 2 of the course. On 11 July 2019, VC transferred from the BEng to the Master of Engineering course (MEng)[12]. His progress during this period is set out in the statement of his personal tutor, Dr Stewart McWilliam [WITN0053001] at paragraph 18 onwards.

25. The Inquiry will no doubt note the evidence of other students such as Joel [WITN0061001], Jordan [WITN0062001] and William [WITN0060001] who worked with VC on a group project between September 2019 and June 2020 (although the in-person element was scrapped following Covid in March 2020) who described VC as "laid back", "quiet" but "not needing to be carried during the project" and "being good at turning up", with all also saying that they did not notice any signs of unusual behaviour, aggressiveness or mental health problems during this time.

26. Sebastian [WITN0151001] at paragraphs 4-14 describes living with VC between September 2019 and summer 2020 also without incident, describing him as "quiet" and noting that they were not friendly, although he was friendly with a fellow flatmate, Summer: "VC and Summer were quite close at one stage" [paragraph 12]. He reiterated this description in oral evidence [INQT0000011, Sebastian, 3 March 2026, 25/22 onwards].

27. Accordingly, the University was completely unaware of any mental health issues in relation to VC until May 2020.

[12] Statement of Dr Giddings [WITN0046001, paragraph 8] and UNIN0001339.

March 2020 to July 2020

28. On 23 March 2020, as a result of the Covid lockdown, all learning and teaching at the University moved online. At that time, VC lived at 48 Salisbury Street with Sebastian but moved out at some point and lived alone at 7 Brook Court[13].

29. On 24 May 2020, two incidents took place at Brook Court (Incidents 1 and 2). The cases appear not to have been linked initially. Despite VC being a student at the University and this being known to the police from the time of VC's first arrest, neither the police nor any mental health professional contemporaneously made the University aware of these two incidents, despite the fact that the second incident in particular must have raised real concerns as to his risk to others.

30. Further, when VC was admitted to hospital following the second incident, the treating team quickly became aware of a number of concerning factors: the text messages disclosed by Elias Calocane[14], VC's brother, which plainly contained violent thoughts and references to "red rum" and his references with Dr. Ludvigsen to 'thinking about capital punishment' and 'having the 'solution'[15]. It is of considerable regret to the University that neither the incidents, nor VC's risk profile, nor (to a large extent) the potential reasons or triggers for the incidents were disclosed to the University – in some cases neither contemporaneously nor in a timely fashion, and in some cases not ever[16].

31. The details of those involved in or around the time of these incidents are set out below, but what is clear to the University is that the evidence suggested that individuals often passed responsibility for information sharing to others when in

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[13] Sebastian statement WITN0151001 at paragraph 14; NGPF0000070 confirms that VC lived alone at 7 Brook Court at the time of the incidents; INQT0000001; and Opening statement by Counsel to the Inquiry, 23 February 131/15 onwards summarises the position in respect of VC's addresses.
[14] NGPF0002527.
[15] NHFT0000168.
[16] Claire Thompson confirmed in oral evidence that she was also wholly unaware of this information, see INQT0000005, Claire Thompson, 25 February 2026, 13/21.

fact it appears tolerably clear that if a professional is in possession of relevant risk information, then there is no legal or policy barrier to sharing it with others who may need to be aware of that risk. Some police officers were wholly unaware of the existence of an information sharing agreement with the University:

(a) Inspector Eustace, who attended the Brook Court Incident 1, was asked by CTI whose job it would have been to pass on information about the incident to the University. Her evidence was that she was aware when she wrote her OEL occurrence record that he was a student, but that details were not passed on to the University, and it would be for the officer in the case to do this. She was unaware of the information sharing agreement [INQT0000006, Inspector Katie Eustace, 26 February 2026, 51 and 54];

(b) PC Collins, who investigated the first Brook Court incident [WITN0036001]. She interviewed VC on 24 May 2020. She confirms in her statement that she did not, at any stage, inform the University of the incident and despite being asked in her Rule 9 request whether there was any barrier to sharing this information, her statement does not answer the question. In oral evidence it was acknowledged that VC was a student at the University when she was investigating the incident, as recorded by her in the occurrence log [NGPF0000068] [INQT0000007, PC Gail Collins, 26 February 2026, 68/16]. It is also worth noting about this evidence that PC Collins did not close her investigation until 4 October 2021, but that despite this, she accepted in oral evidence that she was not aware of the assault on Sebastian in summer 2021 and she accepted that she had not checked the records for other crimes VC had been involved in [INQT0000007, PC Gail Collins, 26 February 2026, 68/7-8]. As such, there was a failure to pass on relevant risk information to the University not only in May 2020, but in summer 2021;

(c) PC Marsden, who attended the second Brook Court incident, created the occurrence in respect of this incident and was in email contact with Dr. Seedat. He told the Inquiry at paragraph 29 of his witness statement that he

did not inform the University of this very serious incident at any time because "informing the university ... is not normally something I would do" [WITN0019001]. In oral evidence he made no reference to the University at all [INQT0000007, PC Richard Marsden, 26 February 2026]. Given the serious injury caused to Feven and the clear risk to others as a result, the University's position is that this information needed to be disclosed to it at the time;

(d) Mr. Williams, AMHP for the MHAA on 24 May 2020 which followed the Brook Court incident [INQT0000058, Benjamin Williams, 21 April 2026, 34/20-24] was asked when he gave oral evidence about paragraph 42 of his witness statement [WITN0115001] in which he stated that he did not contact the University on the Sunday 24 May because it was a bank holiday weekend but accepted that he would usually speak to the University if a student was involved [INQT0000058, Benjamin Williams, 21 April 2026, 34/25 and 35/1-2]. No explanation was given as to why he could not contact the University on a weekend or indeed, even if this was a barrier, why he could not contact it after the weekend to make it aware, given the seriousness (in particular) of the second Brook Court incident;

(e) Dr. Ludvigsen worked at Highbury Hospital during VC's first admission and completed VC's core assessment on 27 May 2020. She was aware that he was thinking about capital punishment and that he had come up with a 'solution'[17] and she had seen the summary of his text messages with his brother. She was asked about the changing picture on risk and whether she ought to have informed the University of the incident/admission, given the risk factors. She explained that she considered that there might be good legal reasons why such information should not be shared, and regrettably, she appeared to not fully comprehend the difference between sharing of information generally and sharing particular risk information. She did not share any relevant risk information with the University, despite her evidence that VC's behaviour was

[17] [NHFT0000168].

"worrying" [INQT0000059, Dr Anna Frances Ludvigsen, 22 April 2026, 80/3] and that there was a "higher risk of violence" if he became unwell [INQT0000059, Dr Anna Frances Ludvigsen, 22 April 2026, 73/1-2];

(f) Ms. Frost, Clinical Team Leader on Rowan 1 at Highbury Hospital during VC's first admission was asked in her oral evidence about VC's ward review on 28 May 2020 and she said that she had attempted to contact the University about his upcoming exam which he was concerned about missing [INQT000060, Amanda Lindsay Frost, 22 April 2026, at 109/18 onwards]. The record is that she attempted to contact the University "about [VC's] exam next week"[18], but the records do not include details of who she attempted to contact and no indication that she was proposing to share risk information as opposed to letting the University know that VC would miss the exam; and

(g) Dr. Seedat was the sole consultant on Rowan 1 ward during VC's first admission [INQT0000061, Dr Faizal Seedat, 23 April 2026, 7/14]. He gave evidence that he had first become aware that VC was a student through his mother, and that he attempted to contact the University because of VC's upcoming exam, but that his first email "bounced back" because he was given the wrong address by VC's mother [INQT0000061, Dr Faizal Seedat, 23 April 2026, 65/22-25]. However, as set out below, VC's mother made contact with the University about the exam late on Friday 29 May 2020 and on 1 June 2020. Ellie Turner of MHAS contacted Highbury Hospital to place the details of MHAS on his file (see further below).

In terms of risk information, Dr. Seedat also claims to have sent a letter to the University dated 3 June 2020 [NHFT0018629] which was addressed "to whom it may concern". The University has corresponded with the Inquiry to explain that this was never received, and it is not understood why a letter was sent to "to whom it may concern" when there was already an open channel of communication between Ellie Turner/MHAS and the ward by 3 June 2020. In

[18] [NHFT0000168, page 12].

any event, as put to Dr. Seedat by CTI, this letter is drafted from VC's perspective and concludes that he is going to make a full recovery, without actually knowing that this would be the case.

Perhaps most importantly of all, although isolation (and lack of sleep) were mentioned by Dr. Seedat in conversations with MHAS and in the letter of 3 June 2020 set out above, Dr. Seedat did not inform the University at any stage, either through Ellie Turner or by any other means, that the triggers for VC's psychotic episode might be stress caused by his academic work. The letter sent (although never received) makes no mention of this and in answers to questions, Dr. Seedat accepted as follows: "I may not have explicitly said [to Ellie Turner of MHAS] that we it's important that we try and address his stresses" [INQT0000061, Dr Faizal Seedat, 23 April 2026, 68/18-20]. In answer to questions from counsel for VC's family, Dr. Seedat accepted that the most likely triggers he had identified at that stage were social isolation and sleep deprivation, and that insofar as it was stress linked to his studies, it would have been better to tell the University that [INQT0000062, Dr Faizal Seedat, 23 April 2026, 91/14 and 92/13]. The University is very grateful for these admissions.

32. Despite all these opportunities to be made aware of them, the University knew nothing of the second Brook Court incident until 3 June 2020 (and even then, it did not know the full details) and it knew nothing of the first Brook Court incident until after 13 June 2023.

33. Late on Friday 29 May 2020, VC's mother emailed the University from VC's email account informing the University that VC had recently been admitted to Highbury Hospital due to a psychotic episode [UNIN0000966]. This email was sent to Dr. Donald Giddings and Dr. Alistair Campbell-Ritchie. A similar email was sent to the Engineering Support & Wellbeing team on 1 June 2020 [UNIN0000140]. Ms. Calocane stated that VC would be unable to take his online exam on 2 June 2020 and would need an extension, and that she was seeking advice on what to do on his behalf. Neither email refers at all to the two Brook Court incidents on 24 May

2020. This email that was sent to the Engineering Support & Wellbeing team was sent on to the MHAS shared inbox on 1 June 2020 [UNIN0000140]; this was the first time that MHAS had been made aware that VC suffered from any mental health problems. Ellie Turner of MHAS immediately called Ms. Calocane, who told her that VC's family lived in Wales and that she was very worried about him.

34. After this, on 1 June 2020, Ellie Turner took a number of proactive steps, which are further detailed in the chronology attached to these submissions:

(a) She called Paige Smith, Student Support & Wellbeing Officer (Engineering) to ensure that she would be a conduit to the Engineering academics, so as to ensure that VC was not caused any additional stress by receiving chasing emails relating to his assessment and that his academic studies were temporarily paused [WITN0054001 at paragraph 31, UNIN0000734];

(b) She emailed Jamie Dickinson, Off-Campus Affairs Manager, to find out if he knew where VC was living, and if so, whether there might be any affected housemates who needed to be reached out to [WITN0054001, paragraph 32, UNIN0000881]; and

(c) She called Highbury Hospital and gave them the details of MHAS to place on VC's medical file, so that there could be a channel of communication between MHAS and the NHS [UNIN0000734].

35. Ellie Turner spoke to Dr. Seedat on 3 June 2020, after receiving an email from him that day. It was only during this conversation that she became aware of VC's address and the second Brook Court incident of 24 May 2020. Dr. Seedat told Ellie Turner that VC was requesting discharge to his Nottingham address. He explained to her that he considered the trigger for the episode to be isolation [see case summary at UNIN0001401 and WITN0054001 at paragraph 35 which summarises

Ellie Turner's conversation with Dr. Seedat[19]]. She therefore called VC on the same day, advising him that she considered that it would be better for him to return to Wales where he had support from his family[20]. Her recollection was that when she spoke to him, VC was open to the idea of returning to Wales [WITN0054001, paragraph 37].

36. Ellie Turner explained in her evidence that she had no power to compel VC to return to Wales, but that, given that she had been told that VC's psychotic episode had been triggered by social isolation and lack of sleep, she tried to use her 'soft skills' to persuade him to return home and have family support available. Even without the benefit of hindsight, this would clearly have been preferable. When it became clear that discharge was planned back to his accommodation in Nottingham, Ellie Turner voiced concerns about the risk assessment and asked for a copy of the discharge plan (which would include a copy of the risk assessment). This was never provided to her [WITN0054001, paragraph 41]. Dr. Seedat confirmed in oral evidence that this was never sent to Ellie Turner and was unable to explain why: "I am unclear as to why the risk assessment that was requested from the nurse was sent or not sent" [INQT0000061, Dr Faizal Seedat, 23 April 2026, 72/8-9].

37. Following her call to the ward to ask for a copy of the discharge plan, Ellie Turner was so concerned about Brook Court residents and the wider University community that she had a discussion with Stuart Croy, the University's Head of

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[19] The note of the conversation with Dr. Seedat provides: "Feels trigger was isolation" [UNIN0001401] and Ellie Turner confirmed in answers to questions by counsel for VC's family that she was not told by Dr. Seedat that stress from academic work was a trigger for the episode in 2020, despite the fact that the medical notes (to which the University did not have access prior to disclosure in the Inquiry) made multiple references to academic stress being a trigger [INQT0000004, Eleanor Turner, 25 February 2026, 73/1 onwards]. She also confirmed that it would have been important for her to know that. She also confirmed at [INQT0000004, Eleanor Turner, 25 February 2026, 84/2-14] that at no time between May 2020 and April 2022 was she aware that there were any other triggers other than isolation caused by Covid restrictions.

[20] It is worth noting the evidence of psychiatrist witnesses such as Dr. Malik [INQT0000057, Dr Khuram Fraz Malik, 21 April 2026, 18/22-25] where he accepted in answer to questions that if a person being released was released to the care of a family member, this meant that they would be monitored more carefully and that this was likely to play a "crucial role". Dr. Gandhi also gave similar evidence [INQT0000057, Dr Rahul Sushil Gandhi, 21 April 2026].

Security, regarding liaising with the police. She explains [WITN0054001, paragraphs 41 and 42] that this was an unusual step, but that she was so concerned about VC being discharged to a property where there was a person so scared that she had jumped out of a window that she wanted to know the police view on VC returning and wanted the University's concerns about VC returning to that property to be shared with the police. She provided Stuart Croy with a case summary by email [UNIN0001401].

38. The police response provided to her was that because VC was being released by professionals there did not appear to be any risk [UNIN0000594] and that the police would be contacting the woman who jumped out of the window [UNIN0001503]. It appears that the police were not informed of VC's discharge by any other means, and the Inquiry did not hear any evidence that they were.

39. On 10 June 2020, thinking that VC had been discharged [he was not in fact discharged until 17 June 2020], Ellie Turner emailed him saying that he needed to engage with MHAS support [UNIN0000734]. He did not respond to that email, and she could not compel him to engage in any way. At that stage, she explains in her evidence, she had run out of options, as he had been assessed as safe for discharge by NHFT, she had contacted the police, she had robustly made her views known to NHFT and she had asked VC to engage with MHAS. It is in fact difficult to see what else MHAS could have done at that stage, as VC was not in University-owned accommodation[21].

40. As part of the chronology, it is also worth noting that Ms. Birtles became VC's Care Co-ordinator from June 2020 [WITN0348001 at paragraph 127]. She was asked in oral evidence about liaison with the University, and she told the Inquiry that her team frequently liaised with the University and that her team could liaise with the University "with the student's consent" [INQT0000067, Claudia Birtles, 29 April 2026, 76/14-25]. She also accepted that she had not shared with the University at

[21] The steps which the University might have been able to take if VC was in University-owned accommodation are detailed at paragraph 58 of Ellie Turner's witness statement [WITN0054001].

any stage the risk which VC posed to neighbours [INQT0000067, Claudia Birtles, 29 April 2026, 77/10-14].

41. The University is now aware (although it did not know then) that the stress of the course was considered, at least at one stage, as *potentially* one of the triggers for VC's illness[22], but this was wholly unknown to the University when VC was a student there.

42. **At no stage** was the University informed that work pressure/stress might be a trigger for VC's psychosis[23]. Given Ellie Turner's meticulous attention to detail and professional curiosity, there can be no doubt that she would have taken further steps had she been aware of this and she explained in detail what they would have been and notes that VC was offered a referral to the University's Disability Support Service in any event, which he refused, and he never applied for extenuating circumstances other than through his mother on the first occasion he was sectioned [INQT0000004, Eleanor Turner, 25 February 2026, 85/1 onwards]. There is no doubt that social isolation during a Covid lockdown and sleep deprivation are recognised mental health triggers and, in this regard, it is also worth noting the evidence of Ms. Hull, Chief Nurse at NHFT, who noted that Covid was really hard for university and school students, and that the absence of social contact had a very significant impact on many young people [INQT0000093, Diane Hull, 21 May 2026, 3/15-21]. It is hardly surprising that Ellie Turner found this trigger to be a plausible explanation for VC's psychosis[24].

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[22] The fact that this was not known to the University is detailed below, and the University also asks the Inquiry to note that many of the incidents which took place happened whilst VC was not in fact in education and did not have the stress of a course, such as in summer 2021 and the assaults on Sebastian and PC Pritchard, the Arvato assaults and the attacks on 13 June 2023.

[23] Although, for example, Dr. Gandhi gave evidence to the effect that VC had disclosed to him during the MHAA in May 2020 that he was stressed because of coursework exams [INQT0000057, Dr Rahul Sushil Gandhi, 21 April 2026, 130/12-14], there is absolutely no evidence that this was disclosed to the University.

[24] The University notes that in questions to Professor Linehan, CTI suggested to her that VC's medical records (to which the University did not have access until disclosure in this Inquiry) link his early episode of psychosis to stress and the nature of the work at the University, but it is important to understand that no witness (including Professor Linehan) accepted that the University was aware of this [INQT0000016, Professor Katherine Linehan, 9 March 2026, 7/19 where she states that they were not aware that there were concerns around academic stress].

July 2020 to November 2020

43. On 13 July 2020, Brook Court Incident 3 took place and on 14 July 2020, VC was readmitted to hospital. The University was not made aware of this incident or the admission contemporaneously and, without laying the blame with any one individual, considers that there were, again, missed opportunities to share important risk information with the University, given the previous incidents:

(a) PC Plant [WITN0013001] gave evidence that he was the officer who responded to this incident. He gave oral evidence in which he agreed that the Occurrence Log referred to VC being a full-time student, and he accepted that given this was known, it would have been very easy for him to make enquiries and to find out where VC was a student and to inform his educational institution of the incident [INQT0000009, PC Michael Plant, 2 March 2026, 72/25 onwards]. Given the University's involvement in relation to the earlier Brook Court incidents and the fact it contacted the police regarding VC's discharge in June 2020, the University takes the view that VC's status as a University student would have been readily known from VC's NICHE records. No information was shared;

(b) PC Severn [WITN0014001] of the Street Triage Team, who attended Brook Court Incident 3 that evening, accepted that he was aware that VC was a student, which he would have known either from NICHE or possibly from VC himself, although he did not ask him himself. He explained that he considered it the role of the AMHP to inform the University of the incident and that it would not have been practical for him to inform the University, as his role ended that evening [INQT0000010, PC Jamie Severn, 3 March 2026, 25/24-25 and 26/1-7];

(c) The AMHP who took part in the Mental Health Act assessment on 14 July 2020 was Mr. Culpin [WITN0189001]. He did not inform the University of the

incident, the MHAA or the re-admission to hospital, despite the fact that AMHPs are meant to seek information from all relevant sources [NHSE0000312 at 14.66 onwards]. He told the Inquiry in oral evidence that he did not consider there to be any barriers to sharing information with the University [INQT0000063, Geoffrey Culpin, 27 April 2026, 13/4];

(d) The two doctors who took part in the MHAA on 14 July 2020 were Dr. Manzar [INQT0000064, Dr Omar Manzar, 27 April 2026, 11/5-13] and Dr. Seedat. Again, neither doctor contacted the University, let alone shared risk information with the University. Given Dr. Seedat had already had contact with Ellie Turner in June 2020, this is surprising; and

(e) On 16 July 2020, the record of the 72-hour review stated that VC showed "No signs of remorse or insight" and Dr. Seedat told him that "the danger is that this will happen again and perhaps [he] will end up killing someone" [NHFT0000168/page 64]. Ellie Turner confirmed in answer to questions from CTI that she was never informed of any of this and that this was relevant risk information the University should have been made aware of [INQT0000004, Eleanor Turner, 25 February, 27/21 – 28/16].

44. Instead, the next involvement of MHAS was on 23 July 2020 when MHAS received an email from Rowan 1 Ward at Highbury Hospital informing them that VC had been readmitted [UNIN0000734][25]. As Ellie Turner was on leave at the time, Cath Gent at MHAS spoke to a staff nurse and was informed that VC had been admitted under section 3 of the MHA on 14 July 2020.

45. As set out above, the University had not been told contemporaneously, either by the police or by NHFT, of the third Brook Court incident on 13 July 2020 or VC's admission on 14 July 2020.

[25] This is undoubtedly on the basis that in early June 2020, MHAS contacted the ward in relation to VC's earlier admission and asked for MHAS contact details to be placed on his file.

46. Ms. Gent was also told during this call that discharge was planned for 30 July 2020 [UNIN0000614]. Ms. Gent then spoke to Ms. Parsonage from the EIP team [UNIN0000734] who explained that VC had been non-concordant with his medication for a period of two weeks before his admission. Again, the University had not been made aware of this, despite the significant risks posed by VC. Ms. Parsonage also explained that VC would be discharged to his Nottingham address, and again Ms. Gent expressed concerns about this, given the pattern of events.

47. On the same day, Ellie Turner emailed Stuart Croy and Claire Thompson in order to inform them that VC had been readmitted to hospital [UNIN0000620] and explaining that she was continuing to advocate heavily for him to return home. She repeatedly called the ward [UNIN0000734] to make her views known and to discuss risk, but was informed that they considered that VC had improved and could manage risks independently. Concerned about this, she emailed Mr. Culpin, the assessing AMHP, on 30 July 2020 to voice her concerns about the discharge plan [UNIN0000304]. She explains [WITN0054001 paragraph 57] that this is a very unusual step and that she was hoping that he might give an opinion about risk. Mr. Culpin responded to say that he would forward the concerns to the ward [UNIN0000304] and having heard Mr. Culpin's evidence, it is in fact now clear that he did discuss the University's concerns with Dr. Seedat [WITN0189001 at paragraphs 88-92], that he agreed with the concerns [INQT0000063, 27 April 2026, 14/21 – 15/1 onwards] and that he had concerns about Dr. Seedat's response.

48. The email chain and Dr. Seedat's response is at [WITN0163008]. Dr. Seedat claims within his emails that VC is "well", which Mr. Culpin queries. In oral evidence, Dr. Seedat indicated that his tone in the emails was born out of frustration, as the University was not aware that VC had two addresses and that he would not in fact be returning to Brook Court. Even with the benefit of hindsight, this response to the legitimate concerns of Ellie Turner was clearly unnecessary in tone, and the assertion that VC was "well" was also misplaced. Finally, the fact that Dr. Seedat is concerned in this response about VC's payment of rent was never

communicated to the University. As Ellie Turner said in oral evidence [INQT0000004 , Eleanor Turner, 25 February, 34/21 onwards], had she been aware that VC was in financial difficulties and that this might be relevant, she would have referred VC for financial support from the University, which could have been helpful and might have helped him access other benefits.

49. Ellie Turner also emailed VC on 30 July 2020 [UNIN0001200] asking him again to engage with MHAS. On this occasion, he emailed back and they had a telephone call [UNIN0000734]. He explained that he had felt well since discharge and was compliant with his medication. He had a query about his resit exam, and she advised him to contact the Support & Wellbeing Team in his Faculty. Ellie Turner encouraged VC to agree to a referral to the Disability Support Service in order for a support plan to be put into place, but VC declined this and, further, refused to agree to any additional MHAS support. Ellie updated the Support & Wellbeing Team [UNIN0000778] and tried to call VC during the first week of term [WITN0054001 at 64].

50. Ellie Turner explains at paragraph 59 of her witness statement that in July 2020, it was out of term time and during Covid, so VC was not accessing the University campus. Had it been termtime, a process might have been commenced to consider whether he should be excluded from campus. However, Ellie Turner's evidence in both writing and orally is that it is very unlikely that MHAS would have advocated for VC to pause his studies or stay off campus given that he held himself out as being well, had been judged to be well by the NHS, was under the care of the Crisis team who could be expected to flag any deterioration, and the fact that many people recover from first episode psychosis. This was plainly reasonable and is considered in more detail below.

51. VC sat his resit exam in the resit period (24 August – 1 September 2020) and achieved a grade of 73% [WITN0046001, paragraph 23].

4 November 2020 to 20 September 2021

52. This section is sub-divided into the following sub-sections, taken chronologically:

(a) VC's Voluntary Interruption of Studies (VIS) in November 2020;

(b) Thames House Incident on 31 May 2021;

(c) Sebastian Incidents in summer 2021; and

(d) The assault on PC Pritchard and re-admission in September 2021.

VIS

53. Between 4 November 2020 and 20 September 2021, VC was not a student at the University, having voluntarily interrupted his studies. Ellie Turner explained that she became aware of this when she was copied into an email from VC to Dr. Emma Barney (Senior Tutor) [UNIN0000067] explaining that he had decided to voluntarily interrupt his studies for the remainder of the academic year as he was unable to meet the current demands of his course. Ellie Turner replied to VC on 6 November 2020 [UNIN0001205] saying that she thought he had made the right decision, that she hoped he was getting the support that he needed, and asking him to let her know if there was anything she could do. Her oral evidence was that to the best of her recollection during the months while VC was on voluntary interruption, she made a number of telephone calls to the relevant NHS teams to check whether there was any information which she needed to be aware of. No information was provided to her [INQT0000004, Eleanor Turner, 25 February, 39/25 onwards] and she wished that she had recorded those telephone calls.

54. In questions to the University's witnesses, it was suggested by CTI that the University could or should have required VC to disclose any relevant medical

information when returning from his VIS in September 2021, the assumption being that VC would have voluntarily disclosed his admission, as well as the reasons for that admission[26].

55. First, regardless of the policies or forms in place at the time relating to VIS, this line of questions misunderstands the basis on which VC sought an interruption; there was no evidence that he was ill at the time of the request and therefore no requirement on the University to seek medical information on return. Secondly, it makes the false assumption that VC would have provided the University with full and accurate information about his mental health, when all the evidence discloses that VC did not in fact consent to sharing such information and VC himself often gave inaccurate information. Put another way, such a finding by the Inquiry would effectively place the onus of disclosure on a man who had a history of mistrust of persons in authority and who repeatedly did not tell the truth as a result of his illness, rather than on the statutory agencies who had a duty to share important risk information contemporaneously and in a timely fashion. As set out below, there is no basis on which it can be concluded that the University would have received any information this way.

Reasons Given for VIS

56. The starting point is that, in October 2020, there was no evidence VC was ill.

57. Dr. McWilliam, VC's personal tutor, describes that in the academic year 2020/2021 VC was undertaking an individual project being supervised by Professor Atanas Popov. On 26 October 2020, VC contacted him to discuss "a serious issue" and when they met on Teams on 4 November 2020, VC confirmed that he was finding studying difficult and did not feel prepared for Year 4 [WITN0053001 at 40 - 47, UNIN0000834, UNIN0001835]. Professor Popov also

[26] See oral evidence of Professor Linehan on this issue, at INQT0000016, Professor Katherine Linehan, 9 March, 33/13 onwards.

emailed Dr. McWilliam to inform him that he was having difficulties organising meetings with VC [UNIN0000521]. VC did not suggest that he was ill at any stage.

58. On 4 November 2020, VC emailed Dr. Barney, Senior Tutor, to inform her that he wished to interrupt his studies because "due to extenuating circumstances, it was not possible for me to prepare adequately during this past summer. Despite my best efforts, I am at present unable to cope with the demands of the current academic year" [UNIN0000067]. As set out below, Dr. Barney had been aware of VC's illness and previous admission in summer 2020 and as such was aware that these were the extenuating circumstances he was referring to.

59. On 10 November 2020, VC's interruption of studies form was signed off, with VC referring to "mental fatigue" and with 20 September 2021 being his proposed return date [UNIN0000054]. At that stage, it had been several months since his last admission and the University had no information at all to contradict the reasons put forward by VC for his interruption.

60. It might be said that had there been a mandatory requirement for medical evidence on return from a VIS or if relevant academics had more information about VC's condition, this should have triggered use of the Fitness to Study policy as opposed to the discretionary VIS policy only, and an interruption through that would likely have resulted in a condition that medical evidence be provided on return.

61. However, this is not accepted, and the University would be very concerned by any finding that medical evidence should be required in all cases where a student has a history of mental illness. As the Inquiry is aware, periods of ill health may be temporary and such a broad requirement would be wholly unworkable, given the number of students who interrupt. In any event, the position must be seen in context:

(a) As set out above, VC did not suggest that he was ill and was taking time off on this basis. Dr. Barney, the Senior Tutor who signed off on his interruption of studies was aware that he had suffered a mental health crisis and had been hospitalised in May 2020, but he was not advancing illness as a reason, and there was no evidence that he was currently ill;

(b) During the period of interruption, Ellie Turner did proactively check to see if there was any information about VC which she needed to know, see above;

(c) There is no suggestion (as set out further below) that VC would have voluntarily disclosed medical information. In fact, the contemporaneous evidence suggests the contrary; and

(d) Whether the University could or should have requested medical evidence from VC does not take away from the primary fact that the police and NHFT, who were in fact aware of the assault and detention should have informed the University of the incidents of summer 2021 contemporaneously and, if they had done so, the University would have known of them sooner than if it had asked VC for medical evidence prior to his return from the VIS. This was the only way of ensuring that the University was aware, rather than requiring disclosure from VC.

62. As set out above, requiring VC to disclose medical information to the University would have placed the onus on a person who repeatedly did not tell the truth to professionals, and in circumstances where the evidence is clear that VC did not wish to and chose not to disclose the truth to the University. As such, there is simply no reason to believe that he would have chosen to disclose his hospital admission in any event. The relevant evidence of this is as follows:

(a) On 7 September 2021, Dr. Barney proactively wrote to VC to see how he was and to check whether he would be returning at the start of the new term. He

was asked whether he needed any assistance in preparing for the new academic year, or in deciding whether returning to university was the correct course of action [UNIN0001293]. He replied on 12 September 2021 to say that he was in good spirits and that he was quite eager to get back into full-time education. He said that he had used the time away from university to work, save some money and earn a few skills. He had some administrative questions [UNIN0001012]. As set out above, Dr. Barney was aware that VC had previously been in hospital in May 2020, but there was simply no indication from VC that he had interrupted in November 2020 because he was ill, or that he was ill at that point[27];

(b) Dr. Shoilekova, responsible clinician for VC whilst he was at the Albert Ward in the Cygnet Hospital at the relevant time prior to his return to University told the Inquiry that she would not have told the University anything about VC's admission as he did not consent to this: see [INQT0000076, Dr Kalina Georgieva Shoilekova, 7 May 2026, at 68/25 onwards]; and

(c) Finally, Professor Blackwood when giving oral evidence was asked about VC's ability to speak to the University in September 2021 whilst he was in hospital and not disclose where he was, the assault on PC Pritchard, or that he was ill, even while he was detained. Professor Blackwood gave evidence that this did not surprise him as VC is an intelligent man who could separate out his desire to complete his degree and any interactions that were required with the University to achieve that from the fact that he was at that time detained [INQT0000043, Professor Nigel Blackwood, 30 March 2026, 76/18-77/12].

63. The key finding which the Inquiry is invited to make in respect of this period is that the University was not aware of the incidents which took place in summer 2021

[27] The oral evidence of Professor Linehan is relevant here: INQT0000016, Professor Katherine Linehan, 9 March 2026, 68/4 onwards]. She explains that the University has about 1000 students being supported by MHAS at any one time and the expectation that they should know what has happened to those students during VIS is unrealistic, but what the University did do was check in proactively with them at the start of term. This is plainly reasonable.

simply because statutory services failed to share relevant risk information with the University, as was required.

Thames House Incident

64. As the Inquiry is aware, VC attended Thames House on 31 May 2021. Although PC Foster [WITN0004001], who attended Thames House and spoke to VC on that occasion, wrote up the incident and sent it on to Nottinghamshire Police, the police did not inform the University of the incident, and the University remained unaware of it until this Inquiry.

Sebastian Incidents

65. Also wholly unknown to the University, over summer 2021, there had been four incidents relating to Sebastian, a PhD student at the University, who lived with VC at 48 Salisbury Street[28]. The University was not made aware of any of these incidents at the time and did not become aware of them until it received disclosure as part of the Inquiry disclosure process. Taking them in turn:

(a) On 5 July 2021, Sebastian reported to the police that VC had assaulted him in their shared flat. As set out above, VC was not formally a student at the University at the time as he was on VIS. Sebastian's written evidence notes that he called a friend of his to discuss the matter [WITN0151001 paragraph 31], but Sebastian also told the Inquiry in oral evidence for the first time that he also discussed it with his supervisor at the University [INQT0000011, Sebastian, 3 March 2026, 36/14-15]. This is not a matter which he had

[28] The timeline indicates that VC had previously lived at 48 Salisbury Street between September 2019 and summer 2020 but then moved back into the accommodation in early 2021, i.e. after he had voluntarily interrupted his studies [WITN0151001 at paragraphs 4, 15 and 16].

previously raised, and it was not put to the University's witnesses, but for the purposes of these submissions, it is important to note that there was no formal notification of the incident by Sebastian to the University. Sebastian was asked in oral evidence as to whether he thought of reporting the incident formally to the University and he responded that he did not, and that as the flat was not University accommodation, he did not think that the University accommodation office would be responsible [INQT0000011, Sebastian, 3 March 2026, at 46/11-20]. When pressed on why he did not report the incident formally to the University, when he knew that VC was a student, he replied that it did not occur to him to do so [INQT0000011, Sebastian, 3 March 2026, 46/23-25].

The University relies on notification of such incidents in order to ascertain what steps, if any, it can and should take and it is a matter of regret to the University that neither the police nor anyone else reported this incident to the University at the time, as it would have been relevant in assessing VC's return to the University in September 2021.

The University wishes to make clear that it does not recognise the version of events given by Sebastian in his oral evidence that Sebastian's supervisor knew the incident involved VC or indeed any other University student and told Sebastian to 'fight back' [INQT0000011, Sebastian, 3 March 2026, 36/18-19] - and the University's witnesses were never asked about this. However, the Inquiry is not required to determine this issue.

The police officer Sebastian spoke to, PC Pannell [WITN0015001], did not contact the University and PC Pannell accepted in oral evidence that she knew that both Sebastian and VC were University students, that she was aware of the information sharing agreement in place between the University and Nottinghamshire Police, that she believed that information could only be shared if the person was arrested or charged, and that there "wasn't time" to inform the University of the incident, despite the fact that an assault had taken

place. She also accepted that she did not ask anyone to check the PNC for any earlier incidents and said that she could not recall if she had done a NICHE search, but that if she had done, she would have seen references to the previous incidents, including Brook Court Incident 2, which led to very serious injuries for Feven [INQT0000012, PC Amy Pannell, 4 March 2026, 42/7-12]. The matter was then closed by the police on 5 July 2021 [Sebastian, WITN0151001, paragraph 35].

PC Wakefield, PC Pannell's supervisor, also gave oral evidence. She gave evidence to the effect that she was unaware of the information sharing agreement between the University and her employer, but that in any event, she considered there to be real barriers to information sharing because of the processes in place and the reasons which have to be given to share information [INQT0000013, PC Rachel Wakefield, 4 March 2024, 76/24-25 and 77/1-10].

The Inquiry also heard from Police Superintendent Price, who closed the police file on the assault. She accepted in her witness evidence that she had also not shared details of the assault with the University, that there were no barriers to the sharing of information and that with the benefit of hindsight, it would have been better to contact the University about the incident [WITN0016001, paragraph 34]. In oral evidence, she stated that having now considered the information sharing agreement, she considered that she would need the written consent of the victim before contacting the University [INQT0000012, PS Zoey Price, 4 March 2026, 77/17-19]. The University does not accept this. She also accepted that had she known she could contact the University, she could have directed an officer to do that [INQT0000012, PS Zoey Price, 4 March 2026, 78/9-14];

(b) Sebastian also gave both written and oral evidence that on 14 July 2021, VC attempted to open his bedroom door at 5am, but that it was locked [Sebastian, WITN0151001, paragraph 37]. He reported this by way of a text message to the

police officer who had taken his statement nine days before, but he received no response and PC Pannell in oral evidence confirmed that she was completing her studies at the time and did not leave her telephone to be checked by anyone else [INQT0000012, PC Amy Pannell, 4 March 2026, 38/10 onwards]. This incident was not reported to the University by Sebastian or the police at any stage, but Sebastian did contact a friend and another colleague who had a spare room, and he arranged to stay with him [WITN0151001, paragraphs 38-9]; and

(c) On 19 and 25 August 2021, VC made a number of calls to Sebastian, but Sebastian had blocked his number [WITN0151001, paragraph 43]. Again, the University was wholly unaware of this, and Sebastian did not report this to it.

3 September 2021 MHAA, Assault of PC Pritchard and Subsequent Admission

66. As set out above, VC was not a student at the University between November 2020 and 20 September 2021, but his intention was always to return for the start of the academic year in 2021, as set out above. On 7 September 2021, Dr. Barney emailed VC with a start of the year outreach email, as also set out above [UNIN0001293].

67. In fact, unbeknownst to the University, VC had been the subject of a MHAA on 3 September 2021 and was at that time detained on Albert Ward, Cygnet Victoria House Hospital in Darlington, on a PICU ward. During the course of his detention under the MHA under a section 135 warrant, he had seriously assaulted PC Pritchard.

68. The University remained unaware of the MHAA on 3 September 2021, the assault on PC Pritchard, the admission as an in-patient, the decision of the MHRT which considered the question of risk, and the discharge/plan for discharge (and the

subsequent non-engagement with the EIP team) until 18 January 2022. The CTI has described in questions to a number of witnesses as "astonishing" the fact the University was unaware of all these incidents and the University entirely agrees.

69. The University takes the view that these incidents in September 2021 were without question relevant to the risk which VC posed to the University's wider community. Hearing PC Pritchard's account of the assault, viewing the footage of the assault, and noting the unpredictability of what happened, it is particularly clear that the University needed to be aware of the risk which VC posed to others.

70. The fact that these incidents should have been shared by the police with the University was confirmed by Chief Constable Meynell in her evidence [INQT0000034, Chief Constable Meynell, 20 March 2026, at 38/5 onwards]:

> Q: But how you as an organisation share information around suspects or convicted offenders is obviously a matter of interest to the Inquiry. So this [information sharing] agreement is something that's in place between Nottinghamshire Police and Nottingham University. The significance of this, if I can say at the outset, we know in September, when PC Pritchard was assaulted, that Nottingham University were not informed about that attack, and at that time he was going back to the University to continue his studies and to be with other students and within the University. It's a serious attack on a police officer, and then he's obviously detained after it. Would you agree with me that it is astonishing that the University did not know of that event and his detention at that time when he was about to come back to the University and study?
>
> A: When he assaulted the police officer, he was detained under the Mental Health Act, wasn't he?
>
> Q: Yes. So both the detention and the fact of the assault. The University, at the time of those happening, was not aware. Did you find that astonishing?
>
> A: I would have expected that information to be shared.
>
> Q: And would you have expected the police to share the information that he'd attacked an officer?
>
> A: Yes.
>
> Q: If we look at the policy that was in place at the time, if we go to page 6, paragraph 3 refers to: "When the University is connected to a caution or conviction they will be informed of this sanction no more than 3 months from the caution or conviction date". So it appears to rely on the need for a caution or a conviction before being able to share information. Do

you think, irrespective of precisely what the agreement says, the police should have shared that information with the University about the assault?

A: I think that there are a lot of restrictions around what information can be shared. I believe that it would be preferable to be in a position where we can share as much information as possible with the universities and with other partners as well. I think at times, because of legislation, it becomes very difficult. But in principle, my position would be that I would like to be able to share as much information as we can to help one another in the different organisations.

Q. What are the barriers, do you think? For the officer who is dealing with a particular offence, what's the barrier stopping that officer thinking "I'll just give the university a ring now and tell them, my special point of contact there, what's just happened with this student"?

A: So, it's difficult for me to say what that individual officer thought

Q. I'm not asking for that, but more generally.

A. So, from my perspective I think there's probably a nervousness about sharing information because people don't quite understand what they can share and what they can't share. So there tends to be: err on the side of caution and not share information would be generally what I think.

Q. Do you think they think about GDPR and reasons for not sharing?

A. I don't think they probably have an in-depth understanding of GDPR but I think they know that, to put it simply, you can get into trouble if you share information you shouldn't share, so I think they get quite nervous of it.

Q. And when you say get into trouble, what do you think they think will happen if they share information they shouldn't share?

A. Well, I would imagine that people have seen, you know, instances that have happen to -- with regard to misconduct about information that's been shared.

Q. If we can go to the agreement in place subsequently, UNIN0001807, page 17. So this is the agreement now between the University of Nottingham and the Chief Constable of Nottinghamshire Police and if we see on page 17, types of crimes covered by the agreement: "Nottinghamshire Police will share: "Information where a student is under investigation for one of these offences." They'll share: "The outcome of an investigation to one of these offences, including charge and where relevant, court outcome. "Any other investigations where the safety or welfare of students might be currently at risk or likely to be put at future risk ... "[The] University Nottingham will share: "Personal details of students, where appropriate to include name, date of birth, next of kin details, where there are serious safeguarding concerns and/or risk of crime and disorder." Further down: "Information, including complaints from neighbours or the public relating to criminal or anti-social behaviour ... "Details of forwarding addresses of recent past Students, where the University deems it appropriate. "Concerns raised by Students, complaints and

intelligence, subject to the Students' consent and approval." That's much wider, isn't it, in terms of information sharing?

A. It is, yes.

Q. Do you think that is understood culturally within the police now? What efforts have been made to make sure that people on the ground understand what they can share so that students are protected from each other, protected from other people where relevant?

A. I've not been involved in policing for a year so I can only speak about previous to that. But I would --I don't know what training they were given at the time, to be honest, around information sharing.

Q: But it's an important topic, isn't it, and probably worthy, do you think, of training at all levels that people really understand this?

A: Absolutely, yes.

Q: And a lot of it is about assessing risk, isn't it, and understanding where risk might fall, and even if, from the policing perspective, there isn't going to be a conviction for whatever reason, understanding preventing crime and public protection is an important facet of police work, isn't it?

A. Most definitely.

Q. So do you think more effort could be made for people on the ground to understand that? What might happen next, not just what's happened, what can we prove; what might happen next and what information should we be sharing, sharing the risk between organisations.

A. I do, yes.

71. The oral evidence from individuals who might have informed the University was as follows:

(a) Police Sergeant Ellis was the relevant senior officer who attended on 3 September 2021. She was the individual who put a marker on the PNC to the effect that VC had been extremely violent to a male officer and that he was at risk of assaulting without provocation. She was asked in oral evidence about why she did not contact the University to make it aware of the incident and answered that she was unaware that he was a student, and that there was no

indication that he was, although it is noted that there was an indication within the police records. Surprisingly, given her seniority, her evidence was also that she was unaware of the information sharing agreement with the University, but she also agreed that had she known he was a student, then she would have informed the University despite being unaware of the agreement [INQT0000013, PS Louise Ellis, 4 March 2026, 44/1 onwards];

(b) PC Johnson was the officer in charge following the 3 September 2021 assault. He was entirely unaware of the incidents with Sebastian over the summer of 2021 [INQT0000014, PC Matthew Johnson, 5 March 2026, 45/25], although it is noted that there was an indication of these within the police records. PC Johnson confirmed in his witness statement that he did not inform the University of the assault and nor were there barriers to information sharing [WITN0023001 at paragraphs 32-3].

(c) PC Myers took over from PC Johnson as OIC, and in his witness statement he stated that he did not consider it necessary to inform the University of the assault on PC Pritchard, as the incident was being investigated and VC had not been convicted of any offence [WITN0042001 at paragraph 43]. However, by the time he gave oral evidence, his position was that he was unaware that VC was a student at the University and that he was completely unaware of the information sharing agreement between the University and the police. However, he also agreed, in oral evidence, that the information about the assault should have been shared with the University and that if it was today and given the violent nature of the assault, he would share the information with the University [INQT0000014, PC David Myers, 5 March 2026, 84/11-14];

(d) Dr. Manzar was present on 3 September 2021 when PC Pritchard was assaulted and was one of the two section 12 doctors who carried out the MHAA. He did not tell the University about the assault or the MHAA. He was asked about this in oral evidence [INQT0000064, Dr Omar Manzar, 27 April 2026, at 34/4 onwards] and said that he did not consider this to be his

responsibility, and that it was the responsibility of the in-patient team once he had been admitted. He accepted that it would have been "very relevant" for the University to know, as the risk needed managing and that part of his role as a section 12 approved doctor was to assess that risk. He also accepted that it was "astonishing" that the University was not informed of the incident and the assessed risk;

(e) The other section 12 doctor on 3 September 2021 was Dr. Lomas [WITN0316001] and he also failed to provide any information about the MHAA or the assault to the University; and

(f) Ms. Staples, the AMHP who prepared the report, accepted in oral evidence that she was aware that VC was a student at the University and that he was returning to his studies in September 2021. She accepted that she had not contacted the University despite the guidance for AMHPs referred to above [NHSE0000312 at 14.66 onwards], and that had VC not been accepted as an in-patient, she would have contacted the University as it was very important that it was aware. However, once admitted, it was for the ward to let the University know [INQT0000072, Amie Staples, 5 May 2026, 78/18 onwards].

72. A range of other individuals also could have shared the details of the incident and subsequent detention with the University:

(a) Ms. Birtles, VC's CCO, accepted in oral evidence that it was "astonishing" that the University was not informed of the assault on PC Pritchard or the admission and that someone ought to have informed the University. When pressed, she said that as VC was an in-patient immediately after the assault, the in-patient team was probably responsible for informing the University although she did not know who [INQT0000067, Claudia Birtles, 29 April 2026, 77/25 onwards];

(b) As set out above, Dr. Manzar, Ms. Staples and Ms. Birtles' evidence was that it was the responsibility of the in-patient team to let the University know of the incident and the admission. VC was first admitted to the Albert Ward in the Cygnet Hospital. The Cygnet witness Dr. Shoilekova, responsible clinician for VC whilst he was at the Albert Ward, told the Inquiry that she would not have told the University anything about his admission as he did not consent to this: see INQT0000076, Dr Kalina Georgieva Shoilekova, 7 May 2026,68/25 onwards; and

(c) Dr. Lloyd, the responsible clinician upon his discharge from Priory Hospital Arnold to the EIP team, did not inform the University of any of the incidents, the admission, or the involvement of the EIP team. This is considered further below in paragraphs 76 and 111.

73. This failure to inform the University of these very significant developments meant that it was wholly unable to make any decisions as to the risk to its community. It proceeded on the basis that VC's psychosis had resolved in summer 2020 and that he was returning to the University fully recovered.

74. It is also astonishing to the University that the police did not inform the University of the Sebastian incidents in summer 2021. These incidents indicated, at the very least, that VC presented a risk to flatmates. The evidence of the relevant police officers is set out above.

20 September 2021 to 15 January 2022

75. Having read, listened to and carefully considered all the evidence relating to this period, the University takes the view that it is also astonishing that the EIP team [Dr. Lloyd, Ms. Birtles, CCO] who were caring for VC in the community did not

inform the University of the risks which VC posed. The timeline appears to be as follows:

(a) In October 2021, when VC was discharged from hospital, no member of the EIP team made contact with the University, despite the fact that they were plainly aware that he was a student there and the nature of the risks posed;

(b) At no stage did the EIP team contact the University to find out where VC might be living; and

(c) In December 2021/January 2022, VC's flatmates started to sense change and the evidence from the EIP team was that he was disengaging and non-medication compliant at this time. Despite this, no steps were taken to contact the University.

76. The University is grateful to Dr. Lloyd for accepting, in answer to questions on behalf of the University, that the failure to inform the University of VC's increasing non-engagement and/or the risks associated with this was a failing for which she accepts personal responsibility. The exchange between counsel for the University and Dr. Lloyd was as follows [INQT0000074, Dr Tuhina Lloyd, 6 May 2026, 113/10 onwards]:

Q: Given that the NHS held the risk in relation to VC, do you accept that you or your team should have told the University, or arranged for the University to be told, about all the issues which took place between September 2021 and January 2022? So that's the assault, that's the admission, that's ... all the failures that your team had in engaging VC or treating him during the relevant period. Wasn't that something which you and your team needed to tell the University?

A: I think, in retrospect, yes, that ought to have happened. We ought to have said at that point, when we found that he'd completely disengaged, I think he was seeing Claudia right up to sort of December, but yes, after that, there was a disengagement and yes, there should have been better communication with the University.

Q: Were there any barriers to communication between your team and the University?

A: I don't think so and I don't know why, you know. I also take responsibility. I don't know why there wasn't that communication. That should have happened.

Q: I'm really very grateful for that answer".

77. The University is also grateful to Ms. Birtles for her evidence where she accepted that given that risk information can and should be shared, the difficulties which the team was having engaging with VC should have been shared with the University and that she did not know why they had not been shared, given that they did have a good relationship with the University [INQT0000068, Claudia Birtles, 29 April 2026, at 34/7-20]. Mr. Carter [INQT0000070, Gary Carter, 30th April 2026, 8/14 to 9/19] also agreed that the risks posed by VC during this time, and after 15 January 2022, should have been shared with the University.

78. During this period, on 20 December 2021, at 6.15am, Sebastian received a call from a random number which he did not recognise, and it rang again at 12.15 and this time he answered. The person calling was VC, so Sebastian hung up the telephone and blocked the number. He also blocked his Facebook and LinkedIn accounts [WITN0151001 at paragraphs 43-5]. Again, this was not reported to the University, and the University was wholly unaware of this.

15 January 2022 to August 2022

<u>January 2022 Incident</u>

79. As the Inquiry is aware, on the evening of 15 January 2022, VC assaulted his flatmate, Christopher, by holding him in a headlock and then refusing to let him leave the flat after the police had been called. Christopher's witness evidence is at WITN0059001 and his oral evidence is at INQT0000015, Christopher, 5 March 2026, 1-44. Another of VC's flatmates, Thomas, also gave evidence, although he did not witness the assault [WITN0178001 and oral evidence at INQT0000015,

Thomas, 5 March 2026, 58-72]. There is also a witness statement from Sam [WITN0064001] who witnessed the initial assault and filmed it on his telephone. The salient facts appear to be as follows:

(a) VC moved into the flat at Raleigh Park in October 2021. Raleigh Park is not University accommodation, and the University has no control over who is accommodated there and has no power to terminate occupancy. As set out above, at that time, the University was unaware of any current mental health problems for VC, the assaults on Sebastian or PC Pritchard, or indeed that VC had moved into this accommodation;

(b) When VC moved in, he was quiet and kept himself to himself, but from December 2021, his flatmates began to see a change in his behaviour, including paranoid behaviour regarding posters in his room [WITN0178001 paragraphs 16-17] and knocking on doors at night [WITN0178001 paragraphs 20-21];

(c) On 15 January 2022, Christopher confronted VC about the state in which he was leaving one of the shared bathrooms and when VC asked what he was going to do about it, Christopher called him "a dirty bastard" and VC then held Christopher in a headlock and refused to let go for a period (Sam describes it as "more than a minute" [WITN0064001 paragraph 27]), whilst Sam filmed this;

(d) The police were called and whilst the flatmates were awaiting the police, VC refused to let Christopher leave the flat, so a second video was filmed of this, and the police were called again; and

(e) The police attended and spoke to both VC and Christopher but decided not to arrest VC or take any further action that evening.

80. Given that there was a marker on the PNC against VC for serious violence in an unpredictable situation, given the history of incidents relating to people living in the same accommodation and given the obvious risk to the wider University community, it is a matter of considerable regret to the University that it was not immediately contacted by the police following this assault.

81. The evidence of the two police officers who attended after the two calls to the police on 15 January 2022 was as follows:

(a) PS Faulkner, the Response Sergeant for the City Centre provided a witness statement in which he stated that he had been informed by the Control Room prior to arriving on scene that he was aware that there was a warning marker on VC's record for assaulting a police officer [WITN0402001 paragraph 16] and that he was also aware that VC had been sectioned 5 months earlier [WITN0402001 paragraph 42]. His witness statement also records that despite this, and the assault which had just taken place, he decided to leave VC's flatmates in the flat with him as they would be staying as a group and had locks on their doors [WITN0402001 paragraph 28].

He also records in his statement [WITN0402001 paragraph 47] that "from memory, I requested PC 4242 Zacharia email the Safeguarding Department of the University on 16 January 2022 to make them aware of the incident to ensure that the acted quickly to remove VC from the property and to safeguard other students. However, I do not appear to have documented that". No such department exists, and his evidence that the University needed to be quickly informed because VC needed to be removed quickly from the flat begs the question as to why he: (i) did not try to contact the University as an emergency that evening – for example onsite security staff; and (ii) let the flatmates remain

in the flat that evening. He also accepted [WITN0402001 paragraph 49] that he did not consider there to be any barriers to information sharing.

In his oral evidence, PS Faulkner was asked about this request that PC Zacharia contact the University [INQT0000017, PS Anthony Faulkner, 9 March 2026, 58/3 to 58/12]. He was first asked who the 'Safeguarding Department" are and responded that, in the past, he had emailed a safeguarding officer at the University. He was adamant that he had told PC Zacharia to do so, and that PC Zacharia had heard and understood him. It was important that the University was aware, and that is why he asked PC Zacharia to contact it; and

(b) PC Zacharia [WITN0024001]. In oral evidence, it was suggested to him that it was likely, given the written record and PS Faulkner's evidence, that he had also been informed that VC had been involved in five previous incidents [INQT0000016, PC Zacharia, 9 March 2026, 89/15 to 89/16].

He was asked in evidence whether PS Faulkner had asked him to email the University's "safeguarding department" and he said that he could not recall this being asked of him, and that had he been asked, he would have noted it in the Occurrence Log, which has no such note [INQT0000017, PC Zacharia, 9 March, 1/4-10]. He did not, in fact, contact the University.

It is not for the University to express a view as to which of the two officers is correct about this conversation. The regrettable fact is that *either* PS Faulkner did not ask PC Zacharia to contact the University and did not do so himself, or that PC Zacharia did not follow this order. Either way, the police failed to inform the University of the assault, meaning that it did not become aware of the assault until the Monday morning, 17 January 2022, following contact from Christopher. If, as PC Faulkner stated, he had contacted the University before, it is inexplicable why he did not do so on this occasion or check with PC Zacharia that he had done so.

The Actions of the University once Informed of the Assault[29]

82. The detailed chronology provided by the University sets out all the key steps taken by the University and as such, they are not all repeated here. However, it is important to note that the chronology discloses that the University acted quickly and decisively, offered considerable support to the affected students, and that as soon as MHAS became aware of (some of) VC's history from summer 2021, VC's flatmates were moved to another flat within hours. The key chronology is as follows:

(a) Christopher emailed Jamie Dickinson, Off Campus Student Affairs Manager, in the early hours of Sunday 16 January 2022 to inform him of the assault. He explained that he had an exam on Monday, felt stressed and that VC did not seem "the most stable of people" [UNIN0000732]. Also on 16 January 2022, Christopher emailed the Support & Wellbeing Team (Social Sciences) [UNIN0002240]. Ryan emailed the Support & Wellbeing Team (Engineering) to let them know [UNIN0002340]. None of the emergency contacts provided to students such as University security or security at Raleigh Park were contacted that day;

(b) On Monday 17 January 2022 (all before 10am) Jamie Dickinson forwarded Christopher's email to the ResX team [UNIN0000732], both Support & Wellbeing teams responded to their students [UNIN0002240 and UNIN0002340] and the Social Sciences Support & Wellbeing team made a report through "Report and Support" [UNIN0000362]. Raleigh Park also replied to Christopher directly. Shortly after 10am, Claire Thompson was informed of the incident and received a copy of the Report and Support incident report [UNIN0002341]. By chance, she recalled VC's name from 2020 and contacted

[29] The University's account of this is also independently corroborated by psychiatrist Dr. Ahmed, who was commissioned by the CQC to carry out a desktop review of NHFT's care of VC; see CQCM0010415, page 17.

Ellie Turner later that same day, having first spoken to Christopher and Chris Hoskins of ResX. Ellie Turner advised that VC was known to MHAS, although the last contact with him had been in August 2020 [UNIN0000157, UNIN0000362]. On the same day, ResX repeatedly attempted to contact VC but were unable to reach him and ResX also repeatedly tried to call and email Christopher to ensure his safety (with Christopher responding by email that he was spending that night at his girlfriend's house) [UNIN0000194, UNIN0000157, UNIN0000362];

(c) In the early morning of 18 January 2022, Ellie Turner was sent the incident report [UNIN0000938], and she immediately called the EIP team to see if they had any information [UNIN0000734]. Ellie spoke to Ms. Pinder and was informed that Ms. Birtles was VC's CCO, that VC had been scheduled to attend an appointment on 17 January 2022, but had not shown up and that this was the fifth incidence of non-attendance. Ms. Pinder informed Ellie that VC's engagement was very poor and that he had run out of medication. Ms. Pinder also informed Ellie of the recent history: the assault on PC Pritchard, the subsequent admission and the continued non-engagement following discharge. She was unable to explain why the EIP team did not reach out to MHAS at all. Ellie confirmed to Ms. Pinder that they had the wrong address for VC and forwarded her the incident report relating to the assault. VC's correct address was provided by email later that day [WITN0054001 paragraph 72, UNIN0001476];

(d) It can be noted at this stage of the chronology that in questions from Ms. Benyounes on behalf of the survivors, Ms. Parsonage of the EIP team accepted that they had not been engaging VC prior to this point, and that it took the call from the University to escalate matters. When asked why this was the case, she said that she did not know [INQT0000069, Abigail Parsonage, 30 April 2026, 68/10 to 69/6]. Clearly, the University should have been told earlier of VC's continued non-engagement, which is essentially what Ms. Parsonage was acknowledging; and

(e) By 10.30am on 18 January 2022, immediately after this call, Ellie Turner spoke to Chris Hoskins of ResX and told him to seek alternative accommodation for VC's flatmates as she did not consider them to be safe. She shared her number so that Chris Hoskins could contact her if he was able to locate VC and she telephoned Stuart Croy (Head of Security) to ask if they could locate VC by use of his University card – it was confirmed that VC had left Jubilee library at 6am. Chris Hoskins contacted Raleigh Park immediately to ask about alternative accommodation and a different flat was identified. By 11am, keys were available and by 2pm, all five flatmates had been moved out of the flat [UNIN0001033, UNIN0000734].

83. Later on 18 January 2022, Ellie Turner was informed that that the AMHP was seeking a warrant to assess VC at his address, but on 19 January 2022, she was informed that the MHAA had not gone ahead as there was no place of safety available in Nottingham and the risks were considered to be mitigated because the flatmates had been moved. The MHAA instead took place that day, with ResX facilitating access to the flat. Ellie Turner was subsequently informed that VC has not been detained and would be returning to the flat. She repeatedly asked if this was safe for the flatmates and the question was not answered, with the consultant informing her that VC was "suitable for home treatment". She subsequently called Chris Hoskins to let him know that her decision was that the flatmates should remain in the alternative flat [UNIN0000734].

84. Dr. Manzar and Dr. Skelton were the two doctors who carried out the MHAA which resulted in the decision not to detain. Dr. Manzar gave evidence that he was unaware of VC's earlier paranoid behaviour with flatmates and that it was significant information [INQT0000064, Dr Omar Manzar, 27 April 2026, 76/11 to 77/14]. It is noted that neither Dr Manzar, Dr Skelton nor the AMHP spoke to the students or sought any information from them. In answer to questions from the Chair, Dr Manzar accepted that he was aware of the wider risks to students (not just those VC lived with) and that the University 'community' also included

students he lived with [INQT0000064, Dr Omar Manzar, 27 April 2026, 105/3-18]. He agreed that if he had been a student himself, he would have been worried due to the risk posed [INQT0000064, Dr Omar Manzar, 27 April 2026, 107/7-16]. Dr Skelton accepted that on reflection he should have spoken to the students and that he could have done that through Ellie Turner [INQT0000075, Dr Michael Skelton, 7 May 2026, 79/15 – 80/2].

85. By 20 January 2022, Raleigh Park informed Ellie Turner (through Chris Hoskins [UNIN0000734]) that VC could not remain in the accommodation as he had breached their code of conduct [WITN0054001 paragraph 84]. Additionally, there was no self-contained accommodation at Raleigh Park for him to move into. Ellie informed the Crisis team that it was not safe for VC to remain at Raleigh Park. Steps were taken to ascertain whether VC was struggling with his course[30]. On 21 January 2022, a further call took place between the Crisis Team and Ellie Turner during which VC's disengagement with the plan on day 1 was discussed [UNIN0000734].

86. By 25 January 2022, Ellie had spoken to the Crisis Team every working day and was continuing to communicate that her view was that a further MHAA needed to take place. On 27 January 2022 she was informed that a MHAA would take place that day, due to continued non-engagement. In fact, the MHAA did not take place until 28 January 2022 and VC was as a result detained under section 2 of the MHA. On 3 February 2022, VC's flatmates were informed that they could move back into the flat if they felt comfortable to do so as VC would not be returning in the foreseeable future [UNIN0000318].

87. A decision had been made by the EIP team on 28 February 2022 that two staff members needed to attend appointments with VC. Ms Birtles accepted in oral

[30] It was noted [INQT0000004, Eleanor Turner, 25 February 2026, 49/16 to 52/7] that Dr McWilliam provided a work reference for VC. This was provided in early November 2021 [WITN0053001 paragraph 61]. Ms. Turner explained in evidence that this was not a character reference and that if NHS services felt that VC was such a risk that he should not enter employment it would be for them to put some steps in around that.

evidence that it would have been useful for the University to know this, given the potential risk to staff and/or students, and that this information should have been shared, so that the University could have made its own assessment about what to do, if anything [INQT0000068, Claudia Birtles, 29 April 2026, 27/5 to 28/20].

88. In fact, it appears that throughout this period, the MDT treating VC had concluded that daily community visits by the Crisis Team would have to be done to VC in pairs: "red rag" [NHFT0000168, page 205]. This was obviously relevant to the risk to the wider University community whilst VC was not detained, but this was not communicated to the University. In oral evidence, Dr. Lomas (who was the consultant in the Crisis Team at this stage) did not accept that there was an obligation to tell the University that the risk assessed was so high that his team members needed to visit in pairs and that if any such duty to provide risk information was imposed on clinicians, this would open the floodgates and require estate agents or neighbours to be contacted directly [INQT0000065, Dr Benjamin Lomas, 28 April 2026, 76/6 to 77/12]. Regrettably, this disclosed a fundamental misunderstanding of the circumstances in which risk information should be shared by clinicians.

The Decision to Move Students rather than VC

89. One of the questions which appeared to be raised by CTI with University witnesses was whether it was sensible or fair to move VC's flatmates subsequent to the assault, given that they were in an exam period, and VC had been responsible for what happened. It was suggested that another option might have been to move VC rather than the students, which would have been less disruptive.

90. The decision to move the flatmates was made at very short notice. Despite this, **all** the evidence points to the decision to move the flatmates having been the right decision, even with the benefit of hindsight- and no mental health expert has ever

expressed a contrary view - given VC's deteriorating mental state. This decision was made by Ellie Turner, with her considerable experience, as the 'least-worst option' [INQ0000004, Eleanor Turner, 25 February 2026, 47/19 to 48/23]:

"... [moving the students] was really disruptive. That decision was made as soon as I had all of the information, and the reason why we asked the students to move out is because my impression at that point is that we have someone who can pose risks in accommodation, has disengaged from healthcare, hasn't been compliant with medication, and I was concerned about risks to those students. I think that if we had asked VC to move, that would have potentially increased the risk to those students. We knew that VC could experience delusions around people in accommodation. He has had a really worrying situation, he had been involved in a really worrying situation over that weekend, so I thought that moving the students was the least-worst option given where we were, and that moving VC could potentially increase risks to those flatmates which I wanted to avoid. I was also aware that what we needed to do now, if my formulation was correct, was to support a MHA for VC, and again, my view at that point ... it could have further disengaged him from the NHS support, which was not what we wanted to happen. So I have all the sympathy for those students. It is really, really difficult. Like you say, they are in the middle of exams, highly disruptive, highly scared, you know what happened is really, really frightening but this felt right at the time, and looking back I still feel it was the right course of action".

91. Her decision is wholly supported by all the evidence and the mental health witnesses who gave evidence to the Inquiry:

(a) The starting point is that as set out above, the University had always been told, since May 2020, that the triggers for VC's psychosis were isolation and lack of sleep, and to require him to immediately leave the accommodation into self-contained accommodation by himself (it would plainly not have been safe at that time to relocate him to a flat with new flatmates) would be to immediately isolate him in unfamiliar surroundings, when it was clear that previous incidents had taken place in these circumstances;

(b) The University had no power to compel VC to move flat in any event;

(c) All the relevant contemporaneous evidence was that in the circumstances which had arisen, VC needed to be kept stable. A number of professional

witnesses agreed that the correct course of action was to keep him stable during this time:

- Dr. Skelton was quoted in the AMHP report as emphasising that it was very important to keep VC stable during this time [NOCC0000040];
- Dr. Lloyd accepted in answer to questions from counsel on behalf of the University that she agreed with Dr. Skelton in this regard, and that it was very important to keep VC stable at this time [INQT0000074, Dr Tuhina Lloyd, 6 May 2026, 111/15-25];
- Ms. Crane, the AMHP in January 2022, also concluded in her report that VC needed to be kept stable during this time and that it was key to the success of any community treatment [NOCC0000040 page 5-6]; and
- Dr. Manzar accepted, in response to questions from the Chair, that this was the only way in which the risk to the community could be managed at that time [INQT0000064, Dr Omar Manzar, 27 April 2026, 106/8-24]; and

(d) Dr Blackwood in his report [CPSE0000011 paragraph 6] concludes that loss of accommodation and lack of resources and financial difficulties were triggers for the psychosis ahead of the attacks on 13 June 2023 – these triggers would have been present had the University moved VC to somewhere alone or had simply arranged for him to be moved out of the flat immediately, hence the requirement to keep VC stable at that time.

92. There is simply no evidence from any mental health professional that requiring VC to leave the flat (even had the University had the power to do this, which it did not) and thereby creating a trigger for psychosis would have been safer.

93. As soon as it was confirmed to the University that VC had been admitted as an in-patient following the second MHAA in January 2022, the students were assisted to return back to the flat and given several weeks to do so at a convenient time. Throughout this period, the disruption to the students was readily understood and significant support was provided to them, through extenuating circumstances

forms, emails and phone calls, and the details of this are set out in the University's chronology [appended]. In his oral evidence to the Inquiry, when asked if he had found ResX or Chris Hoskins to be helpful, Christopher answered "Yes, I'd say so. Yes" [INQT0000015, Christopher, 5 March 2026, 31/10-12].

Period between February 2022 and August 2022

94. Despite some of the flatmates having moved back in, on 3 February 2022, without any pre-warning, VC returned to Raleigh Park whilst on unescorted section 17 leave from Highbury Hospital. An accurate timeline of the events appears to be as follows:

(a) On 3 February 2022, just six days after admission, VC was granted unescorted section 17 leave. It is clear from the RIO notes [NHFT0000168] and from the answers of Dr. Thangavelu to questions from counsel on behalf of the University that there were no substantive conditions imposed on that leave [NHFT0000168, bottom of page 226] despite the fact VC had assaulted a flatmate just a couple of weeks before. Dr. Thangavelu accepted that the University had not been informed of the fact that VC had been granted unescorted leave, and this denied the University the opportunity to speak to VC about how he might obtain his belongings, to warn students, or to inform them of what they should do if VC returned [INQT0000083, Dr Karthik Thangavelu, 13 May 2026, 109/1 to 112/12];

(b) During the afternoon of 3 February 2022, VC returned to Raleigh Park, asking for bank statements [WITN0059001 paragraph 78]. Christopher, the flatmate assaulted by VC, rang Chris Hoskins of ResX to inform him of this [UNIN0000734 pages 13 to 14, WITN0032001 paragraph 44]. Chris Hoskins (after establishing Christopher's immediate safety) in turn called Ellie Turner. Ellie understood the flatmates to have been unnerved by the visit, but that VC

had not done anything inappropriate. As there did not appear to have been a criminal offence committed, but she had clear concerns, she telephoned Redwood 1 ward on the same day to discuss her concerns about this happening, request support in ensuring that VC understood the importance of not returning to Raleigh Park, and to advise that if VC wanted access to his belongings, support from Security could be arranged [NHFT0000168 page 227, UNIN0000734 page 14]. Ellie Turner also left her details and asked for a call the following day once her concerns had been discussed with the nursing team[31]. No call back was received;

(c) On 4 February 2022, this visit to Raleigh Park was discussed with VC [NHFT0000168 page 228]. VC denied that it had happened and Highbury Hospital took no steps to inform themselves by calling Ellie (or anyone else) to verify this event, but did restrict VC's leave; and

(d) Within 3 days, by 7 February 2022, VC's unescorted leave had been resumed [NHFT0000168 page 233]. Again, the University was not informed of this. No steps appear to have been taken by NHFT to explain to VC the matters which Ellie Turner had outlined.

95. VC was discharged from Highbury Hospital on 24 February 2022. It is accepted that in a conversation between Ellie Turner and VC on 22 February 2022, VC indicated that he did not wish to engage in any ongoing support from MHAS [WITN0054001 paragraph 116].

96. However, the University *was* entitled to be told of this discharge in order to understand and to assess for itself the ongoing risks posed by VC, and in order to make a series of informed decisions about the risks to its community. The University is grateful to Dr. Thangavelu for accepting responsibility for the failure to inform the University of the discharge, given that the hospital was well aware

[31] This is all also corroborated by the desktop review carried out by Dr. Ahmed on behalf of the CQC [CQCM0010415, page 20].

that he was a University student who would be returning and that he had returned to Raleigh Park already at least once [INQT0000083, Dr Karthik Thangavelu, 13 May 2026, 112/13 to 113/19]. In fact, the University only found out that VC had been discharged because Ellie Turner phoned VC on 28 February 2022 to check in on him, and VC informed her that he had been discharged. He continued to decline support from MHAS, explaining that he was engaging with his CCO, Ms. Birtles, and that he was compliant with medication [UNIN0000734 page 15].

97. On the same day, 28 February 2022, Ellie Turner emailed Ms. Birtles to let her know of the conversation and asking for a current address for VC, VC having left Raleigh Park [UNIN0000734 pages 15-16][32].

98. On 4 March 2022, so a few days after discharge, a meeting took place between Dr. McWilliam, VC's tutor, and VC during which Dr. McWilliam discussed with VC the options going forward. At the meeting, the following options were discussed: (i) the submission of extenuating circumstances forms; (ii) a further period of voluntary interruption of studies; and (iii) the possibility of transferring back to the BEng course, which would involve just the completion of an individual project report. VC confirmed on 11 March 2022 that he wished to transfer to the BEng course and this was also communicated to Dr. Barney [UNIN0000377, WITN0053001 paragraph 85-92].

Return to Raleigh Park on 21 April 2022

99. On 21 April 2022, it appears that VC returned again to Raleigh Park and to his former flat, the door of which had been left unsecured. He said that he was collecting post. VC's former flatmate Christopher deals with this in his witness

[32] This is of course important to note, as it is clear that the EIP team continued to have Raleigh Park as VC's address right up until discharge in September 2022, despite Ellie Turner having made it clear since January 2022 that he would not remain there and having made it clear on 28 February 2022 that he was no longer residing there. Ms. Robinson, Ms. Birtles' supervisor, accepted in oral evidence [INQT0000071, Emma Robinson, 5 May 2026, 33/17-20] that her team ought to have known throughout this period that VC was no longer there, on that basis.

statement [WITN0059001 paragraphs 77-79]. Christopher reported this to ResX and was advised to contact Raleigh Park security and if necessary to contact the police. After VC had left the flat, it appears that he stayed outside Raleigh Park and was then recognised and asked to leave by Raleigh Park security staff. Christopher's evidence to both the police and to the Inquiry was that he had been told by Raleigh Park security that VC had "his hood up, trying to conceal his identity" [WITN0059001 paragraph 79 and NGPF0000059 page 5]. There is no evidence at all that VC was carrying a weapon other than the evidence of Sam [WITN0064001 paragraph 52] in which he says that the security guard mentioned that he "might have a weapon". None of the contemporaneous documentation from the Raleigh Park security team or ResX reflects this [UNIN0000377, UNIN0002328].

100. Chris Hoskins of ResX was on leave when this incident occurred, but ResX were informed of the incident by Raleigh Park security [UNIN0001066]. On 26 April 2022 on return from leave, Chris Hoskins contacted Ellie Turner to let her know that he had spoken to Christopher, that he had ascertained that VC had come to collect his post but not been aggressive or confrontational. He asked if MHAS could check that VC was ok and to reiterate boundaries [UNIN0001354 and reply at UNIN0001437].

101. Ellie Turner emailed Ms. Birtles on the same day explaining what happened, in case this was evidence of deterioration in VC's mental health [UNIN0000633 page 4]. Ms. Birtles replied to this email explaining that she would try to raise it with VC and that he may have returned to collect post because he had recently alluded to trying to find some information. In response to this email, Ellie Turner emailed Ms. Birtles to remind her that as VC had chosen not to engage with MHAS, their contact with him was minimal [UNIN0000633 page 2].

102. Ellie Turner was asked when she gave evidence to the Inquiry why she did not contact the police about this incident [INQT0000004, Eleanor Turner, 25 February 2026, 62/1-19]. She said that the priority was for the information to go to the NHS

because they were the people in charge of this case. She had no idea that around the same time, Sebastian was reporting issues with VC and she said that it would have been useful for her to know this. It is important to understand that no crime was committed by VC: he did not force entry to the Raleigh Park flat, stated that he had come to collect post and left when asked to leave.

Sebastian Incident 6: 26 April 2022

103. Just five days after VC returned to Raleigh Park for the second time, on 26 April 2022, Sebastian informed the police that VC had tried to follow him home from the gym [WITN0151001 paragraph 53]. This had followed a number of occasions when VC had appeared at the gym where Sebastian exercised [WITN0151001 paragraphs 46-52]. He was very worried about this and went to Radford Road Police Station and spoke to the receptionist to report what had happened. He said in his witness statement to the Inquiry [WITN0151001 paragraph 55] that he did not speak to an officer as he had on the previous occasion.

104. The police did not inform the University of this, and it did not become aware of the incident until after 13 June 2023. PS Langham [WITN0029001] who was tasked with reviewing the incident, told the Inquiry that he would not usually share information with the University unless there was an immediate threat to students [INQT0000018, PS Neil Langham, 10 March 2026, 32/7-15]. Sebastian was in fact a student and this would been apparent from the police records. Further, a cursory glance at VC's history as set out in the police records would have indicated that VC could be an immediate threat to Sebastian and the wider University community.

105. Finally, on 28 July 2022, VC tried to follow Sebastian home from the gym again [WITN0151001 paragraph 57]. Sebastian called 101 on the same day to report the

incident, and he received a call back on 30 July 2022 from PC Barnes[33] who stated that she wished to speak to VC about the incident and asked for Sebastian's consent, which he gave. Sebastian never heard anything further.

106. Having now heard the evidence of PC Barnes, it is clear that she identified that this was a course of conduct and made a decision to add a crime number on the incident of stalking. She and her supervisor concluded that the contact could be coincidental because VC and Sebastian used the same gym and walked the same way home[34]. It is not for the University to make findings on the evidence, but given the level of detail about VC waiting for Sebastian and following him even when he turned and walked away from home, this does seem like a surprising conclusion to have reached. Despite this, PC Barnes visited VC's address and knocked on his door. He did not answer. On 10 August 2022 she visited again and again she received no answer.

107. PC Barnes did not contact the University to let it know of this incident and her response to it; as such, the University remained wholly unaware of both the assault on, and the stalking of, Sebastian. Had the University been aware of these later stalking incidents, it likely would have offered support to the impacted student (Sebastian) and informed the Crisis and/or EIP team who were supervising VC in the community.

108. The evidence of PS Small is also relevant. He agreed that the incident on 28 July 2022 was not properly investigated, that the PNC should have been checked [INQT0000033, PS Ashleigh Small, 19 March 2026, 28/3 to 30/14], that there had been a lack of supervision of PC Barnes and that accordingly, she had been put in danger [INQT0000033, PS Ashleigh Small, 19 March 2026, 37/2 to 38/5]. Ultimately, he accepted that he and PC Barnes were both inexperienced and had huge workloads but should have done more.

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[33] WITN0043001 paragraph 14.

[34] It will be for the Inquiry to decide on the reasonableness of this decision, but it is asked to consider the evidence of Temporary DCI Goucher on the definition of stalking, see WITN0383001 paragraphs 40-44.

Graduation from University

109. In July 2022, VC graduated from the University with a 2:1 BEng degree, and an average mark of 67 [UNIN0000497]. He did not attend a graduation ceremony. The last contact with the University was on 8 August 2022, when VC contacted the University's Registry and Academic Affairs Team about his academic transcript, which was emailed to him on the same day [WITN0066034].

110. As a result of this Inquiry, the University is aware that VC was discharged to his GP in September 2022. It has been suggested by a number of witnesses, and the CQC in its section 48 review [CQCM0016518], that the University should have been consulted prior to discharge.

111. The University absolutely agrees that the EIP team could and should have contacted the University when it became clear that it was struggling to locate VC, both prior to the January 2022 assault and during the period February to July 2022. The University had regular contact with VC during this time and may have been able to assist in furthering communication with the EIP team. Further, the Inquiry will have noted that Dr. Lloyd in her evidence accepted that the University ought to have been told that the EIP team was struggling to engage VC in terms of risk [INQT0000074, Dr Tuhina Lloyd, 6 May 2026, 113/10 to 114/7].

112. However, as set out above, VC graduated from the University in July 2022 and ceased being a student. Had NHFT consulted the University in respect of discharge planning, the University would have had no ongoing role to play[35], although it is likely that Ellie Turner on behalf of MHAS would have asked that they continue to update the University with any risk information relating to the University community.

[35] The Inquiry should note in this respect that although Ms. Parsonage noted that the University had not raised any concerns at the time of his discharge [WITN0317001 paragraph 212], in oral evidence she accepted no inference could be made from this as he had graduated by then [INQT0000069, Abigail Parsonage, 30 April 2026, 50/16 onwards.

113. The University reiterates its submission that, in many respects, VC's continued participation in higher education provided an important safeguard. Although the University's powers were limited, it remained actively engaged in his welfare by regularly sharing information with the relevant agencies, advocating for appropriate interventions where concerns arose, and providing an additional source of oversight during periods of concern.

Other Issues Raised by Reference to the Timeline

Fitness to Study and Disciplinary Policies

114. One of the questions which appears to have been raised by the Inquiry is whether, the University ought, at any stage, to have triggered its policies to either discipline VC or to consider his fitness to study at the University. The University has a whole range of disciplinary, complaints and fitness to study policies, and the full range of policies is set out at paragraph 179 onwards of the first witness statement of Professor Linehan [WITN0066001].

115. The first witness statement of Professor Linehan accepts that decisions about whether or not to use various policies in the summer of 2020 and early 2022 should have been made with more formality and should have been documented better with reasons, and that the changes to policy mean that the University would deal with some aspects differently now [WITN0066001 paragraphs 335 and 336].

116. However, the bottom line is that at no stage whilst VC was a student at the University did there come a time when staff considered it appropriate to trigger any of the disciplinary and/or fitness to study policies in respect of a young person who was plainly very ill. The relevant policies and periods of time are considered

below, but it is important to note that the Inquiry has heard no evidence at all from any witness who takes the view that the University was wrong in its approach.

Disciplinary Policies

117. Relevant details of the University's student Code of Discipline are set out in full at paragraphs 182-196 of the first witness statement of Professor Linehan [WITN0066001]; as such, they are not set out again here.

118. At no stage did the University consider it appropriate to discipline VC for any of the incidents which took place during his time at the University. Only one of the incidents which the University was aware of at the time involved a University student, namely the assault on Christopher on 15 January 2022. VC was the subject of two MHAAs immediately after the assault, was then detained in hospital, and then converted his degree so as to graduate early. No witness has suggested in evidence that the correct course would have been to subject VC to disciplinary proceedings during this time. It is also noted that in order to bring disciplinary proceedings under the Code of Discipline, the actions of the student must be shown to be "intentional" or "reckless", which would have been very difficult to establish in the context of VC's illness. It would have also been destabilising for VC for disciplinary action to be taken, at a time when NHFT and Nottingham City Council (through the AMHP) were telling the University that stability was important for VC.

Fitness to Study

119. The Fitness to Study policy was first implemented at the University in September 2020, at the start of the 2020/1 academic year [UNIN0001824]. A slightly revised version of the policy was implemented in September 2021 [UNIN0001825] which

was not amended until the 2023/4 academic year when it was replaced entirely by a "Support to Study" policy [UNIN0001826 and UNIN0001827].

120. The Fitness to Study policy was not an alternative to the Code of Discipline and this was explicitly stated in the Fitness to Study policy.

121. There were three stages to the Fitness to Study policy:

(a) An informal stage intended to check whether a student about whom concerns had been raised was in receipt of support and, if not, to encourage them to seek support;

(b) A case review stage where low-level interventions had not resolved the issue. Outcomes could include the proposal of a support plan or, with the consent of the student, temporary or permanent withdrawal from the University; and

(c) A senior case review panel would meet with the student and possible outcomes included a support plan, or temporary or permanent withdrawal from the University.

122. It is important to understand that the Fitness to Study policy only applied in certain circumstances and these are set out in paragraph 200 of Professor Linehan's first statement [WITN0066001].

123. Further, any recommendation to permanently exclude a student from the University would only be made in the most serious cases where there was clear medical evidence and it was felt that there was no reasonable prospect of the student re-engaging with their programme in the short to medium term[36].

[36] See first witness statement of Professor Linehan [WITN0066001 at paragraph 204].

124. Ellie Turner explained in her witness statement [WITN0054001 paragraph 23] that she (correctly) considered the Fitness to Study policy as primarily linked to a student's academic performance and not one which would help assess or manage risks posed by a student. Her evidence was also that she has (again correctly) triggered the Support to Study policy in circumstances where a student's mental health issues were causing distress and worry to others, and the student would not accept advice to stay off campus.

125. The Fitness to Study policy was the subject of questions to Ellie Turner, with the aim of understanding whether this policy should have been triggered at any stage during VC's time at the University:

(a) Ellie Turner was first asked in general terms whether an interruption of studies, or VC being required to withdraw from his course, should have "happened much earlier" [INQT0000004, Eleanor Turner, 25 February 2026, 13/15-17]. She replied as follows:

> "No, I don't see an opportunity for us to have done that. The relationship with his studies was described to me as a protective factor; although we were in Covid there were touch points with his academic school. I think withdrawal from studies could have had the opposite effect... The periods between [periods of ill-health] the impression I was left with was that he was managing and it was a protective factor"[37];

(b) Ellie Turner was asked [INQT0000004, Eleanor Turner, 25 February 2026, 30/3-11] whether by July 2020, when there had been two admissions and three

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[37] Ellie Turner gave powerful oral evidence on the question of education being a protective factor for VC at INQT0000004, Eleanor Turner, 25 February, 76/17 onwards, stating that engagement in academic study is supportive of wellbeing in a broad way and that in conversations with VC's treating inpatient and community teams, the impression being given to her was that he was managing his studies and that he felt motivated to remain engaged in them.
The oral evidence of Professor Linehan is relevant here: INQT0000016, Professor Katherine Linehan, 9 March 2026, 68/4 onwards. She explains that the University has about 1000 students being supported by MHAS at any one time and the expectation that they should know what has happened to those students during VIS is unrealistic, but what the University did do was check in proactively with them at the start of term. This is plainly reasonable.

incidents, this might have been the time to consider withdrawal. The exchange is as follows:

"A: I don't think we would have had the rationale to do that".

Q: Would it be the sort of thing you would think about, or would you expect somebody else, his tutors or somebody more senior in the governance of the University to make that kind of decision?

A: I think it would depend on the circumstances. I think if there was concerns that VC wasn't managing the academic pressures to the point where the school were concerned around progression, you know, that could be a route to have that conversation. I think in different times, if we weren't in Covid restrictions, if there was more contact with the student community, the staff here, I think we would certainly have documented a more detailed discussion, but this is a case where I'm talking to my line manager on a regular basis, and in that respect we would have been considering all of the options, but we didn't have information at that time that would have led us to start the process leading to interruption or withdrawal against VC's wishes";

(c) Professor Linehan set out in her first witness statement [WITN0066001 paragraph 197] the position in respect of the Withdrawal on the Grounds of Health and Safety policy; and

(d) Professor Linehan was asked about whether the Fitness to Study policy should have been triggered in January 2022, following the assault on Christopher [INQT0000016, Professor Katherine Linehan, 9 March 2026, 28/5-19]. She explained as follows: "I think the challenge in January 2022 was that VC was being assessed for detainment under the Mental Health Act. It would be in appropriate for the University to try to engage in establishing whether a student is fit to study, when they are unwell and they are awaiting an assessment from the NHS. So we didn't apply it in those circumstances. What we did do was we were making sure that we didn't do anything that was going to escalate risk, so the information that came to us from the NHS was that VC needed to remain as stable as possible and that we should not do anything that might escalate that, and so taking him through a Fitness to Study policy in the middle of that would potentially not have been helpful, and so we were making judgments about reducing the risk as much as possible ... [The risk to other students] was considered. I think we were always considering both

aspects to it. I think the key bit was that... we were very, very reliant... on the NHS in terms of telling us how well or unwell VC was...". [INQT0000016, Professor Katherine Linehan, 9 March 2026, 28/20 to 32/10]

126. Ultimately, there is no evidence — and certainly no expert psychiatric or mental health evidence — to suggest that requiring VC to withdraw from the University without completing his degree would have had any positive or safeguarding effect. Nor would such a decision have resulted in his exclusion from private accommodation, as that was beyond the University's powers. The evidence of the University's witnesses is that such a course of action would likely have been detrimental to VC, increasing his social isolation while removing the ongoing oversight and welfare engagement provided by the University.

127. Furthermore, there is no evidence that the risks associated with VC diminished after he left the University. On the contrary, the evidence demonstrates that he continued to disengage from secondary mental health services and was ultimately discharged from them; he failed to attend court in relation to the assault on PC Pritchard; he remained only intermittently in contact with his family; he went on to assault colleagues at his place of work; and, ultimately, committed the offences of 13 June 2023.

Information Sharing by the NHFT

128. As set out above, there is no information sharing agreement between the University and the Trust at present[38]. The University's position is that in any event: (i) there is a duty on clinicians to share relevant risk information; and (ii) that relevant risk information ought to have been shared with the University.

[38] Steps are being taken at present to develop an information sharing agreement with NHFT and Professor Linehan gave evidence on its progress and the challenges being faced [INQT0000016, Professor Katherine Linehan, 9 March 2026, 38/24 to 40/10].

129. As the Inquiry will be aware, it is accepted that there are significant legal restrictions on data sharing, including data protection laws. Whilst data protection and its impact on information sharing have been an issue that the HE sector has navigated for many years, the introduction of the GDPR and the Data Protection Act 2018 has added a layer of complexity to an already complex area. In addition, due to the very large fines that can be imposed by the ICO on institutions under the GDPR and DPA for data breaches and the publicity surrounding that power, institutions such as the University have become even more cautious about the sharing of personal data such as health information. This is reflected in the University's Data Protection Policy[39]. However, relevant risk information can and should be shared, as set out further below.

Duty to Share Risk Information

130. Dr. Elcock, the Deputy Chief Executive Officer of the NHFT (since October 2023), accepted in oral evidence on 20 May 2026 that the relevant GMC guidance [WITN0356077 page 19, paragraph 60] provides that clinicians must share relevant risk information with universities if there is a risk of serious harm, and that on the facts of the present case, that information about VC's triggers, as well as all the relevant incidents, should have been shared with the University [INQT0000091, Dr Susan Elcock, 20 May 2026, 6/16 to 11/12]. In answer to questions in re-examination by Mr. Beer, she then appeared to suggest that such disclosure to non-statutory bodies is only possible in exceptional cases [INQT0000091, Dr Susan Elcock, 20 May 2026, 121/18 to 123/16]. There are three points to be made here:

[39] The Inquiry's attention is also drawn to the University Mental Health Charter [WITN0066003, WITN0066046], which also mandates a careful, case-by-case consideration of sharing of information, as a result of an appropriate clinical assessment underpinned by effective, consistent clinical governance, and that risk is a key factor, see [INQT0000016, Professor Katherine Linehan, 9 March 2026, 11/8-20].

(a) The University considers this to be a misinterpretation of the guidance. The test is "risk of serious harm" and any sensible interpretation of the guidance is that if there is a risk of serious harm, risk information should be shared;

(b) This is plainly not the understanding of clinicians. All clinicians who expressed a view on this issue agreed that risk information should be shared, as risk and safety supersede everything else; see for example the evidence of Chief Nurse Hull of the NHFT [INQT0000093, Diane Hull, 21 May 2026] and perhaps most importantly the evidence of Professor Smith who explained that medical information can be shared by clinicians in two circumstances: (i) with the consent of the patient; and (ii) where there is thought to be a risk to others.

Professor Smith was taken to the Royal College of Psychiatrists' Good Practice Guide: "Assessment of risk and management to others",[40] which permits information sharing on a need-to-know basis. She was asked to describe the circumstances in which patient information can be shared and what kind of information sharing would be expected across agencies.[41] Professor Smith explained that sharing was permissible legally and that good practice would also be to obtain patient consent. She also referenced MARAC which facilitates inter-agency sharing[42]; and

(c) In any event, the incidents involving Feven, Sebastian and PC Pritchard individually and cumulatively created a real risk of serious harm and the test for disclosure was plainly met.

131. It should be noted that the NMC Code also has a section on information sharing, which applies to nurses and midwives, at 5.4 [WITN0299002 page 9]. Mr. Rees MBE, Director of the Nursing and Midwifery Council, accepted there was NMC

[40] WITN0320005; INQT0000103, Professor Smith, 1 June 2026, 14/21 onwards.
[41] INQT0000103, Professor Smith, 1 June 2026, 15/15 to 15/20.
[42] INQT0000103, Professor Smith, 1 June 2026, 16/4 to 16/11.

guidance on information sharing which included a requirement on nurses to "share necessary information with other health care professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality". He accepted that the guidance does envisage circumstances where confidentiality can be overborne[43].

132. This corroborated the evidence of Ms. O'Brien from the Royal College of Nursing, who was asked about the College's Suicide Awareness Guidance. She accepted that this amounted to guidance about information sharing where there was a risk to patient safety, but that there was no equivalent guidance on information sharing for the purposes of public protection[44]. She recognised that such guidance would probably be helpful to nurses, but that "without really clear standards from the regulator, whose role it is to protect the public, it's quite difficult to develop that guidance"[45]. She stated that the NMC guidance (referred to above) was not sufficiently clear for nurses[46].

133. Mr. Ruck Keene KC's evidence to the Inquiry was that he considered that the person responsible for information sharing should be the responsible clinician, rather than there being collective responsibility, as this led to a lack of accountability [INQT0000053, Alex Ruck Keene KC, 16 April 2026, 35/3 to 36/16].

Failure to Share Information

134. Many of the failings to share information by clinicians working for NHFT are set out above and are not repeated here. It is to be hoped that in its Closing Submissions, NHFT will accept that, on a number of occasions, risk information which should have been shared with the University was not shared.

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[43] INQT0000106, Paul Rees, 2 June 2026, 4/3 to 4/18.
[44] INQT0000105, Amber O'Brien, 2 June 2026, 80/6 to 80/11.
[45] INQT0000105, Amber O'Brien, 2 June 2026, 82/1 to 82/4.
[46] INQT0000105, Amber O'Brien, 2 June 2026, 80/19 to 80/23.

135. Insofar as NHFT relies on any principled basis for failing to share the information, it is important for the Inquiry to note that detailed information was in fact shared by NHFT in January 2022 (but only once the University made contact with the EIP team) and there would therefore be an inconsistency; it is presently unclear as to what NHFT says changed between September 2021 and January 2022.

136. It is also worth noting the independent evidence of Dr. Dracass, one of the two psychiatrists who conducted a desk top review of NHFT's care of VC on behalf of the CQC. Her detailed internal findings [CQCM0016210] conclude that NHFT made little contact with the University, but that in comparison, Ellie Turner contacted the EIP team whenever concerned.

Information Provided by the University to Nottinghamshire Police and Nottinghamshire Police to the University

Police Information Sharing Agreements

137. As set out above, an Information Sharing Agreement between the University and Nottinghamshire Police has been in place since at least 2015[47] [UNIN0001829] and it was updated in 2024 [UNIN0001807]. This later agreement extends the list of University staff who can request information from the police and provides a far wider basis for sharing information[48].

138. However, as set out above, the fact that this information sharing agreement is even in existence is not widely known amongst even amongst senior Nottinghamshire Police officers and, even if it is, it is often misunderstood:

[47] The evidence given by Professor Linehan was that whilst the agreement was not always applicable, the University would expect relevant information to be shared regardless [INQT0000016, Professor Katherine Linehan, 9 March 2026, 58/22 to 60/25].
[48] See oral evidence of Professor Linehan on this, [INQT0000016, Professor Katherine Linehan, 9 March 2026, 20/6 to 21/19].

(a) DS Sanders, Head of Homicide and the person responsible for Operation Hendrix, was asked during his oral evidence as to whether he was aware of the information sharing agreement and he confirmed that he was not [INQT0000030, DS Leigh Sanders, 18 March 2026, 31/10-15]; and

(b) PS Ellis was the relevant senior officer who attended the incident on 3 September 2021. She was the individual who put a marker on the PNC to the effect that VC had been extremely violent to a male officer and that he was at risk of assaulting without provocation; her evidence was that she was unaware of the information sharing agreement with the University, but she also agreed that had she known VC was a student, then she would have informed the University despite being unaware of the agreement [INQT0000013, PS Louise Ellis, 4 March 2026, 44/2 to 45/5].

139. However, the importance of sharing information transcends any information sharing agreement and any information sharing agreement does not override the law. The University is grateful to the witnesses who set out the clear basis on which information can and should be shared by the police:

(a) Mr. Arnold, Interim CEO and Deputy Information Commissioner gave evidence that if there is a genuine policing purpose and it is necessary to share information with a health trust or university, then it can be shared by the police [INQT0000095, Paul Arnold, 26 May 2026, 16/9-14]. This is not well understood by the police;

(b) Sir Andrew Marsh from the Royal College of Policing gave evidence that in his considerable experience, the police need to get much better at information-noting and information sharing [INQT0000050, Andrew Marsh, 14 April 2026, 55/12 to 57/4]; and

(c) Mr. Clarke, Director General of the Public Safety Group at the Home Office, gave evidence on the MH Crisis Care Concordat which sets out the duty to share essential 'need to know' information and the JESIP Joint Doctrine Interoperability Framework (2024) which provides that the starting point should be the sharing of information [INQT0000104, Richard Clarke, 1 June 2026, 10/10 to 25/10].

Information Sharing from the University to the Police

140. In questions to Professor Linehan it was suggested by CTI that there had been limited information shared by the University with the police. This is not accepted. There were arguably four occasions when this issue arises:

(a) June 2020 shortly before VC was discharged from his first admission. VC was not in University accommodation and the country was locked down so all teaching and exams were online. Given this, in fact the University could have legitimately done nothing in terms of informing the police. However, Ellie Turner was so concerned about the residents of Brook Court that on 9 June 2020 she called Stuart Croy, Head of Security, to ask him about liaising with the police in order to share the potential risks on VC's discharge and provided him with a case summary for the police [UNIN0001401 pages 3-4]. It is notable that this was not done by the Crisis team or the inpatient team at that time. Stuart Croy contacted the University's 'beat manager', PC Shaw, to seek a police perspective. On 11 June 2020, PC Shaw, Sergeant Hallsworth and Stuart Croy liaised by email, and the police became aware that Brook Court was not university accommodation[49]. It is as a result of the University's actions that the

[49] It was suggested in questions to Professor Linehan that insufficient evidence had been provided to the police at this stage, but this is plainly wrong, as she explained in answers to questions at INQT0000016, Professor Katherine Linehan, 9 March 2026, 63/3 onwards: the case summary provided to the police included a detailed chronology, sensitive information about VC's diagnosis, references to compliance with medication and so on.

police agreed to contact Brook Court residents to inform them of VC's imminent discharge [UNIN0000734 and UNIN0001503]. It is important to note that the police were plainly aware of the Brook Court incidents, as well as VC's psychosis, as it is on this basis that they did not proceed to prosecute him;

(b) 15 January 2022. Entirely appropriately, VC's flatmates rang the police immediately upon the assault taking place, and a second time after he refused to let some of them leave the flat. It was therefore clear to the University when they became aware of the incident that the police were already aware of it;

(c) 3 February 2022. On that date, while VC was an inpatient at Priory Arnold hospital, VC returned to Raleigh Park whilst on unescorted section 17 leave. As set out above, Ellie Turner was informed on the same day about this, but was also told that VC had not done anything inappropriate. As such, this was plainly not a criminal offence and did not justify involving the police, but on the very same day, as soon as she became aware of VC's return to Raleigh Park, Ellie Turner called Redwood 1 ward and informed them of it, explained that if VC needed his belongings that support from Security could be arranged and she provided her details and asked for a call back to discuss; and

(d) Return on 21 April 2022. As set out above, this incident occurred when VC was out in the community and being supervised by the EIP team. He came to the flat and asked to collect his post and was not aggressive or confrontational. There is no indication at all that any criminal offence had taken place and the University in fact did exactly what was required, namely contacting VC's CCO with a view to ensuring that the EIP team was aware of the incident in case this was evidence of deterioration. As the Inquiry will be aware from the chronology, VC had already informed the University that he did not wish to have ongoing support from MHAS so there was no further support which the University could offer in this regard.

141. In comparison, the number of occasions when the police had relevant risk information of which the University needed to be aware, and did not share it with the University, is significant. In fact, the stark fact is that the University was never proactively made aware of **any** of the incidents involving VC and the police, by the police – despite the fact that he posed a risk to the University community:

(a) Brook Court incidents, all three incidents;
(b) The September 2021 assault on PC Pritchard;
(c) The assault on Christopher on 15 January 2022; and
(d) *All* the incidents involving Sebastian, who was a student at the University.

142. This failure to share relevant risk information was accepted by senior officers within Nottinghamshire Police, such as DS Sanders, Head of Homicide and responsible for Operation Hendrix. He was asked in oral evidence about the fact that the University had not been made aware of the assault on PC Pritchard until January 2022 and agreed that he could not think of any reason why the police would not tell the University about that at the time, given the risk of violence [INQT0000030, Detective Superintendent Leigh Sanders, 18 March 2026, 31/12 onwards]. He also agreed that it was relevant information if he was living with other students at the University and further agreed that if there was a risk to others, then the risk was not just to other students but to the wider community and that the duty to share was on the police as ultimately the police are responsible for risk to the public and crime prevention. He also agreed that all three of the Brook Court incidents should have been shared contemporaneously with the University.

143. He was also asked whether there was a culture of sharing with the University within the police or whether there was more of a concern about the privacy of the individual. He explained that information sharing was complex and that the police

were concerned that information should be shared only when the law allows for this and where an agreement is in place [INQT0000030, Detective Superintendent Leigh Sanders, 18 March 2026, 34/3-10]. The University does not agree an agreement needs to be in place to share information. The University respectfully submits that even with an agreement in place, there is a real reluctance to share information by the police and national guidance is required.

Information Sharing by the University with its own staff

144. The Inquiry is invited to recognise that the approach of the University, which was to share risk information internally on a 'need to know' basis, was clearly the right approach[50]. The Inquiry's premise for raising this issue appeared to be twofold, namely that: (i) the manner in which VC's VIS was dealt with; and (ii) to ensure the safety of staff.

145. In terms of the former, this has been dealt with above.

146. As to the second, it is important to understand: (i) the limits on information sharing as set out above; and (ii) the facts. The following timeline is relevant[51]:

(a) The first people at the University who became aware that VC was in hospital for his first admission as a result of a psychotic episode were in fact two academics, namely Dr. Campbell-Ritchie and Dr. Giddings. The Inquiry will recall that VC's mother emailed them at 11.12pm on Friday 29 May 2020 to inform them that he was in hospital and that he would not be able to take an online exam on 2 June 2020 [Dr. Campbell-Ritchie, WITN0030001 paragraph

[50] The oral evidence of Professor Linehan dealt with the approach to sharing within the University at INQT0000016, Professor Katherine Linehan, 9 March 2026, 6/7 onwards, explaining that (as advocated by Paul Arnold in his evidence) information is shared, in accordance with the legal framework and the Mental Health Charter, on a 'need-to-know' basis and that in every case there is a careful balancing of the confidentiality of students, the sensitivity of the information and the risks involved. She explained that those who could make decisions about what support could and should be offered (MHAS) were aware and that decisions around sharing of information were considered throughout.

[51] The Inquiry is also asked to consider the oral evidence of Professor Linehan on this issue, see INQT0000016, Professor Katherine Linehan, 9 March 2026, 14/19 onwards.

18 and Dr. Giddings, WITN0046001 paragraph 10, and email from VC's mother at UNIN0000966]. Dr. Campbell-Ritchie was an Assistant Professor and module convenor for VC's group project and Dr. Giddings was Year 3 Lead in the Engineering Department;

(b) At that stage, neither academic had any information as to the triggers for the psychotic episode. However, Dr. Campbell-Ritchie emailed Ms. Calocane back at 5.52am the following morning (a Saturday) to confirm that VC's mark for his group project would not be affected, but that he would check that Dr. Giddings and other module convenors had been notified [UNIN0001758]. In the event, VC took the exam in the late August resit session, and he passed this exam with a result of 73%;

(c) On Monday 1 June 2020, VC's mother also emailed the University's Support & Wellbeing Team (Engineering) and provided contact details for both herself, and the hospital. This was picked up by Paige Smith who informed Claire Thompson, Associate Director (Student Wellbeing) who in turn informed MHAS [UNIN0000140];

(d) Also on 1 June 2020, Dr. Barney, Senior Tutor within the Engineering Department also became aware that VC was in hospital as a result of a mental health crisis [WITN0047001, paragraph 15] when she was emailed by Dr. Giddings [UNIN0000070]. She explains that Dr. Giddings sought her advice given she was the Senior Tutor [52];

(e) On 3 June 2020, after Ellie Turner of MHAS had proactively called Highbury Hospital to ask for MHAS details to be placed on file, a conversation took place between Dr. Seedat and Ellie Turner. As is set out above, in this conversation, the University (through Ellie Turner) became aware for the first time of the second Brook Court incident and that VC was seeking a return to his Brook

[52] The role of Dr. Barney as the single point of contact for all personal tutors is described in the oral evidence of Professor Linehan at INQT0000016, Professor Katherine Linehan, 9 March 2026, 65/15-21.

Court address. Ellie Turner strongly advocated for a return to his family home in Wales. Triggers were not mentioned to Ellie Turner save for a reference to social isolation;

(f) On 9 June 2020, after Ellie Turner called the ward for an update and was told that VC would be returning to his Nottingham address, she expressed concern about this and asked for a copy of the risk assessment. This was never provided to Ellie Turner, so she had no further information on triggers or risks;

(g) On 23 July 2020, MHAS received an email from Rowan 1 ward at Highbury Hospital, informing them that VC had been admitted to hospital 9 days earlier [UNIN0000734]. As such, this is the date on which the University became aware of the third Brook Court incident. Again, at this stage, there was simply no need for the University to inform additional staff of the further incident. It was summer vacation, during Covid, and there was no direct contact between VC and academic staff;

(h) As set out above, soon after the new term started, VC contacted his personal tutor and informed him that he was struggling with his studies. As a result, VC voluntarily interrupted his studies between November 2020 and September 2021. As such, there was no need for academic staff to be provided with any more information during this period. Ellie Turner was asked in questions from CTI whether, when she became aware that VC was voluntarily interrupting his studies, this might have been the right time to share his history with Dr. Barney, Dr. McWilliam, and "his supervisors, his personal tutors" [INQT0000004, Eleanor Turner, 25 February 2026, 38/12-18]. Ellie fundamentally disagreed, with good reason:

> "I think it was reasonable that I didn't at this point. VC was interrupting his studies. They were aware that he has been under, very loosely, my service and they were originally aware of the first admission because VC's Mum has emailed the academic school. I don't think that there is any information I would have wanted to share at that stage".

She went on to say, [INQT0000004, Eleanor Turner, 25 February 2026, 41/19]:

> "So it's really tough – it's a really tough decision in terms of how much we share with academic and we have to balance that very carefully, but given that he was interrupting, I didn't know the risk he posed because I hadn't been given that information and given that we were still experiencing COVID restrictions, I feel it was reasonable not to have shared that information with the academics, and would also consider what that could have done, so what we would have expect to happen if they did have more information.
> My – I can't speak on behalf of the academics but my view is that that may have involved more meetings with the person tutor and... VC being recommended to work with our disability support services to have reasonable adjustments, but in actual fact, VC was fully aware of those support options available to him and he didn't want to engage in them, so I'm not sure that we would have achieved very much from sharing more information";

(i) In September 2021, as set out above, the University was wholly unaware of the assault and further admission which took place that month, all the incidents to date with Sebastian and VC's visit to Thames House. VC was reporting to the University staff that he had worked whilst on interruption and was well and wished to return. He also informed MHAS that he did not want any further support from them. There was no basis on which further academic staff could or should have been informed[53]; and

(j) By 31 January 2022, when the University became aware of the September 2021 assault on PC Pritchard, subsequent admission, non-concordance and non-engagement with the EIP team in the period leading up to the January 2022 incident and that VC may well be relapsing, all remaining relevant academic staff were informed that VC had been detained under section [Dr. Barney records this at WITN0047001 paragraph 37, Dr. James Rouse at WITN0048001 paragraph 44, Dr. Giddings at WITN0046001 paragraph 28 and Dr. McWilliam at WITN0053001 paragraph 74; he was informed in a telephone call from Ellie Turner on 24 January 2022 in which she also gave him "risk information in

[53] This is dealt with in the oral evidence of Professor Linehan at INQT0000016, Professor Katherine Linehan, 9 March 2026, 27/18 onwards.

context of [VC's] current and historical presentation." [UNIN0000734 page 12]. Professor Antonino La Rocca, module convenor for one of VC's courses, was also informed by email [UNIN0001745 page 1].

147. Most academics take the view, even with the benefit of hindsight, that they had sufficient information about VC [Dr Campbell-Ritchie at paragraph 33, WITN0030001, Dr. Giddings at paragraph 47, WITN0046001; Dr. Benjamin Rothwell at paragraph 20, WITN0031001; Dr. Rouse at paragraph 58, WITN0048001; Dr Samantha Piano at paragraph 21, WITN0049001; Professor Popov at paragraph 30, WITN0051001].

148. At paragraph 44 of her statement, Dr. Barney provides evidence that she considers that as she did not have any interactions with VC personally, she does not believe that she should have had more information about his mental health condition. However, she goes on to say that she has some concerns that people who had one-to-one interactions with him such as a personal tutor and project supervisor should perhaps have had information that VC had been violent. Dr. McWilliam, VC's personal tutor, was in fact aware from the call with Ellie Turner referred to above that VC had previously been violent. Dr. McWilliam states that he ought not to have had all details of VC's medical history, but that he ought to have known of the "severity of the situation" so that he could have supported VC, though he acknowledges that it is a complex issue and a balance between data protection, privacy and not stigmatising people and the purpose of sharing the information must be considered [WITN0053001 at paragraph 102].

149. The University's position is that appropriate disclosure was carefully considered and balanced (bearing in mind GDPR and DPA requirements) and that it remains satisfied that it made the right decisions, especially as no member of staff was having face-to-face contact at most relevant times, as follows:

(a) When the University first became aware of VC's mental health issues, in May/June 2020, the country was in lockdown and VC had no one-to-one

interactions with any member of the University staff community. As such, there was no one to inform at that stage and some academic staff were already aware, as set out above [Ellie Turner gave detailed oral evidence on this, at INQT0000004, Eleanor Turner, 25 February 2026, 88/4-17, explaining that she made her decision not to share further information about VC on the basis that many people recover from first episode psychosis, and thinking about VC's privacy, dignity and sharing on a need-to-know basis].

(b) Dr. McWilliam was VC's personal tutor during his time at the University. He confirms that he had no personal contact with VC during the entire academic year 2019-2020, which was disrupted by the pandemic [WITN0053001 paragraphs 36-7]. As such, there was simply no need for him to be informed on the grounds of safety. He explains this lack of contact with VC during the third year of his studies was entirely normal [WITN0053001 paragraph 37][54]:

> "As explained above, in the third and fourth year the role of personal tutor become less significant and more responsive for most students as the supervisor of their group project is generally the person they will go to as the first port of call, and students are assured by this time, having already completed two years at university. Rather than scheduling meetings, personal tutors often only see tutees if they get in touch";

(c) In July 2020, again, the University community was locked down by Covid restrictions, so contact was minimal [INQT0000004, Eleanor Turner, 25 February, 88/14-17];

(d) On 26 October 2020, VC contacted Dr. McWilliam to discuss "a serious issue" and when they met on Teams, VC confirmed that he was finding studying difficult and did not feel prepared for Year 4 [WITN0053001 at 40 - 47, UNIN0000834, UNIN0001835]. Professor Popov also emailed Dr. McWilliam to

[54] This is also corroborated by Professor Linehan at INQT0000016 Professor Katherine Linehan, 9 March 2026, 8/1 onwards.

inform him that he was having difficulties organising meetings with VC [UNIN0000521]. VC did not suggest that he was ill;

(e) Professor Popov taught VC one module in Year 3 and was VC's individual MEng project supervisor in Year 4 [WITN0051001, paragraphs 7-12]. In Year 3, the only direct contact he had with him was when VC emailed him once to say that he would be late in submitting coursework. In Year 4 (2020/1), Professor Popov did not have any direct contact with VC other than by way of online Teams meetings as a result of the pandemic (which he often failed to attend); and

(f) All relevant academics were informed by 31 January 2022 that VC had been hospitalised and Dr. McWilliam had been informed of the background and risk information by Ellie Turner on 24 January 2022. This was because the position had changed: restrictions had been lifted, there was some face-to-face contact within the department and the picture of this being first-episode psychosis had changed.

150. As such, the position is as follows:

(a) The University is subject to the requirements of the DPA and GDPR and can only share information in certain circumstances, even with its own staff. All personal information, such as highly sensitive medical information, is only shared when there is a specific requirement to do so; and

(b) All relevant persons at the University who needed to be aware of VC's medical information held by the University were informed at the appropriate times.

Information Sharing with VC's family

151. Information sharing with students' families is generally only with the consent of students, and this is made clear in several ways, such as on the University's

website [WITN0066017]. The general position is that the University will not even confirm whether a student is actually a student at the University, as students are adults and may have legitimate reasons for not wanting family to know where they are, or whether they have interrupted their studies.

152. At the relevant time, the University also had a specific policy governing communications with third parties [WITN0066018] and in summary, this only permitted communication in exceptional circumstances.

153. Although the University had contact from VC's family once, as set out above, it is important to note that VC's family did not contact the University again to ask for further information about VC or ask it to provide any further support to VC.

(C) Reflections and Recommendations

154. As set out above, it is not for the University to comment on each and every one of the potential recommendations for the future which the Inquiry may consider. In summary, the recommendations which the University would respectfully invite the Inquiry to make are set out in this section.

Information Sharing Mechanisms and Guidance

155. In order to understand the recommendations being requested on behalf of the University under this heading, it is important to understand the barriers to the sharing of information, as disclosed by the evidence.

Lack of Confidence

156. A key theme which emerged was the lack of confidence in statutory services to share information in situations where it was lawful to do so and warranted from a risk assessment perspective.

157. As set out above, witnesses who gave evidence from healthcare contexts repeatedly made this point. Asked about a point made in her written evidence, that staff often feel uncertain about what can be shared and what cannot, Professor Smith distinguished between nurses and doctors, saying "doctors are generally pretty good at this, actually... the staff who have the hardest time with this are the nursing staff."[55] This was corroborated by Ms. O'Brien, who gave evidence that "there is... ongoing confusion amongst nurses around, you know, when confidentiality can be broken, when that might be appropriate"[56].

158. Sir Simon Wessely considered that this issue was part of a broader culture of risk aversion within health care services: "It's a reason why people don't share data when I think they should. They're averse to the consequences and they often have over-exaggerated view as to what the consequences would be"[57]. Asked how to overcome that, he emphasised that failing to share data can pose real risk to life, and that documentation of decision making, including reasons for disclosure, would be helpful ways forward. He also emphasised the role of the GMC in providing professionals with advice about information sharing. He concluded that this was a matter of guidance, culture and training[58].

159. When asked how information sharing could be improved by the police, Mr. Clarke also described the problem as a "small C cultural issue"[59]. He suggested that "the most important thing is to ensure that we are creating the environment in which ...

[55] INQT0000103, Dr Shubulade Smith, 1 June 2026, 98/3-8.
[56] INQT0000105, Amber O'Brien, 2 June 2026, 80/25 to 81/1-13.
[57] INQT0000106, Professor Sir Simon Wessely, 2 June 2026, 31/16-20.
[58] INQT0000106, Professor Sir Simon Wessely, 2 June 2026, 31/22-25 to 32/1-19.
[59] INQT0000104, Richard Clarke, 1 June 2026, 20/13 -14.

it is as easy as possible for individual officers ... in the appropriate circumstances to share information"[60]. He described the current culture where the balance as to the "weight of responsibility" was felt more in relation to sharing rather than in relation to what might happen if an officer failed to disclose information.[61] Ms. Jones MP, the Minister for Policing, when asked whether legal confidence within the police to know when it was appropriate to share information in the public interest, accepted that that was an issue[62].

160. When asked how to communicate the message that officers should start from a position of considering the risks and harm if they do not share information, Mr. Clarke suggested that this could be achieved partly though guidance and training, for example through the College of Policing approved professional practice[63]. He also emphasised the need for a cultural change, specifically: "the way in which senior leaders across the sector respond in circumstances where individuals believed they were doing the right thing by sharing information, making sure that is appropriately recognised".[64] Ms. Jones MP suggested that this could be reflected by police reform legislations, which would include a "mandated requirement to share"[65].

Confidentiality and the Therapeutic Relationship

161. Unsurprisingly this was touched on by a number of healthcare professional witnesses. There was emphasis on the balance between confidentiality and information sharing to account for the purpose of confidentiality, particularly in psychiatric contexts.

[60] INQT0000104, Richard Clarke, 1 June 2026, 20/8-21.
[61] INQT0000104, Richard Clarke, 1 June 2026, 20/22-25 to 21/1-3.
[62] INQT0000104, Sarah Jones MP, 1 June 2026, 76/24-25 to 77/1-4.
[63] INQT0000104, Richard Clarke, 1 June 2026, 21/11-18.
[64] INQT0000104, Richard Clarke, 1 June 2026, 21/2025.
[65] INQT0000104, Sarah Jones MP, 1 June 2026, 77/5-13.

162. Professor Smith was asked about the guidance regarding confidentiality in the document "Information sharing and suicide prevention consensus". She accepted that the principle set out in that document, that bringing organisations together, was important also when assessing risk of violence towards others.[66] She was pointed to the principle that information sharing duties did not conflict with the duty of confidentiality, and was asked whether this conflicted with a "best interests" approach to clinical practice. Professor Smith responded that the Mental Health Act encapsulated this balance[67]. She agreed that in that respect, information sharing with local authorities would amount to best practice and stated that "people will do this as a matter of good practice"[68]. She was clear this was not just about information sharing but also information gathering: "people are overstretched and overwhelmed... you won't necessarily have the details of that person's housing, you have to find out who their housing officer is... But clearly, information sharing is very important"[69]. In her evidence she stated that getting to know patients and their families was an important part of building trust and developing a therapeutic relationship[70]. When asked whether information sharing was a "challenge" to that therapeutic relationship, she responded that transparency as to confidentiality and information sharing was part of good practice at the outset, because with patients who had a chronic, remitting illness, psychiatrists were likely to have a long relationship with them[71].

163. Ms. O'Brien was referred to the Mental Health Handbook and the section on building the therapeutic relationship. The Inquiry identified a "helpful guide" regarding development of the therapeutic relationship and put to her that the handbook "is assisting with many of the communication skills needed to ... build that therapeutic relationship"[72] but that it didn't "address the need to have

[66] INQT0000103, Dr Shubulade Smith, 1 June 2026, 39/7 - 40/20.
[67] INQT0000103, Dr Shubulade Smith, 1 June 2026, 40/25 to 41/1-8.
[68] INQT0000103, Dr Shubulade Smith, 1 June 2026, 41/23-25 to 42/1-5.
[69] INQT0000103, Dr Shubulade Smith, 1 June 2026, 42/5-14.
[70] INQT0000103, Dr Shubulade Smith, 1 June 2026, 29/14-23.
[71] INQT0000103, Dr Shubulade Smith, 1 June 2026, 16/21-25 to 17/1-15.
[72] INQT0000105, Amber O'Brien, 2 June 2026, 82/5-25 to 83/1-10.

challenging conversations, to challenge patients or to disagree with them". Ms O'Brien accepted that and welcomed recommendations from the Inquiry[73].

164. Ms. Sokolov, Regional Medical Director at NHS England spoke to this in the context of sharing CQC reports. She was asked by the Chair whether it was right that disclosure of information to those most affected by that information is determined by consent, to which she responded that "Confidentiality exists for many reasons. We need our patients to feel confident to share information with us that they wouldn't share with anybody else. We need our clinicians to feed confident in documenting what is shared with them ... if there is an understanding that some of that may end up in the public domain, it may change behaviour ... we need to have open and trusting therapeutic relationships without patients. I don't know how you change this framework without potentially impacting that"[74].

Fragmentation

165. The number of agencies involved in service response was identified as a potential barrier to information sharing. In the context of policing, Ms. Jones MP stated that part of the rationale for the NPS was that in the current system "you have 43 data controllers, and I know data and information sharing is a very important part of what you are looking at. Having those 43 does not necessarily make for good policing when it comes from working across forces"[75]. When asked what reforms were being invested in to "ensure improved multi-agency sharing", she referred to MAPPA and MARAC as examples of forums which brought representatives of different agencies "where people come together and share data"[76]. When asked by the Chair about the existence of MAPPA and MARAC and whether there was "any difficulty... in actually joining up into much larger set of principles", Ms. Jones

[73] INQT0000105, Amber O'Brien, 2 June 2026, 83/18-22.
[74] INQT0000107, Dr Jessica Sokolov, 3 June 2026, 107/14-25 to 108/1.
[75] INQT0000104, Sarah Jones MP, 1 June 2026, 73/3-13.
[76] INQT0000104, Sarah Jones MP, 1 June 2026, 81/24-25 to 82/1-11.

responded, "we need to do more in that space" but that "it may well be that there is a better way of nationally sharing information"[77].

166. Professor Smith's comments on fragmentation are interesting because she stated her belief that the functionalist approach to psychiatric healthcare delivery in the mid-00s was now recognised as a "fragmented approach" and that services had gone from "a continuity of care approach to this fragmented approach"[78]. Although these comments were made in regards to the issue of continuity of care, it relates to information sharing because of comments made about trust and the therapeutic relationship, see above.

Recommendations

167. At paragraph 377 of her first statement [WITN0066001], Professor Linehan explained on behalf of the University that it would be beneficial[79]:

> "to have mechanisms for national information sharing so that all the agencies like the NHS and police have standardised information sharing processes across trusts and universities. There have been discussions between the University and the local NHS Trust regarding an information sharing agreement, but that would not be a full solution, given that it would not apply to other NHS Trusts or private health providers. A national system with any necessary approval by, and clear guidance from, the Information Commissioner's Office would give all agencies confidence and would be welcome. The University is aware that this is a national issue…".

168. Although a national framework is important, it is also important to understand that the University considers that further guidance is necessary because such guidance has two essential purposes. First, it acts as a resource for non-lawyers at universities and within the police/ the NHS on issues of some legal complexity

[77] INQT0000104, Sarah Jones MP, 1 June 2026, 97/12-24.
[78] INQT0000103, Dr Shubulade Smith, 1 June 2026, 25/1-5.
[79] Also see the oral evidence of Professor Linehan on this, at INQT0000016, Professor Katherine Linehan, 9 March 2026, 24/15-25 to 25/1-4.

such as when information can be shared in the context of data protection legislation. Secondly, such guidance can have the valuable purpose of ensuring that universities can explain their decisions to ask for or withhold information.

169. To this end, the Inquiry is asked to note the evidence of T/CC Sandall of Leicestershire Police in this respect [INQT0000021, T/CC David Sandall, 11 March 2026, 55/17-25 to 57/20]. He notes that Leicestershire Police had a range of information sharing agreements with a number of strategic partners such as the NHS, charities and local authorities but that as to the universities in his area, because they have no statutory duties and no statutory obligations to share information, they have to have specific information sharing agreements with them individually and that information is accordingly shared back and forth on risk, but that the type of information which could be shared depended on the risk. He indicated that the DPA and GDPR requirements were a real barrier to information sharing in this context. The University respectfully agrees that further guidance is needed in order to assist in an understanding of the legal requirements. However, the University does not agree that forces are required to have specific information sharing agreements with universities in order to share information, as the law allows certain sharing of information irrespective of whether an agreement exists. The issue is the lack of national guidance, rather than the existence or otherwise of agreements.

170. The Inquiry heard from Mr. Vineall of the DHSC, Mr. Arnold from the ICO and Ms. Jones MP, the Minister for Policing. All three agreed that there was need for a national mechanism and/or further relevant guidance to fill the current 'information gap':

(a) Mr. Vineall was referred to the Suicide Consensus Statement (August 2021). He accepted that guidance on information sharing in the context of risk to third parties might involve "different principles and different factors"[80]. His view was that confidentiality could be overridden but that

[80] INQT0000109, William Vineall, 4 June 2026, 28/16-23.

this would likely be a question of individual judgments and situations and that Government had issued guidance to that effect in 2025[81]. He accepted, however, that clinicians may need something more robust, with examples. He also referred to Caldicott Guardians but accepted that "something bespoke for the kind of situations that have brought us here today would be helpful"[82]. Ms Cartwright put to him that issues around information sharing "need to be absolutely ironed out to ensure that all relevant risk information about a patient that's held by the policy or any other agency … ensure clinicians have access to the relevant evidence as to serious harm". Mr Vineall agreed and said this would be tackled in the new Code of Practice accompanying the new mental health legislation[83].

Mr Vineall was also asked about a framework for information sharing with universities. He accepted that: a) risk assessment information sharing would influence decision making; b) that guidance could be part of a national framework, if not expressly legislated for; c) agencies were averse to sharing information and needed guidance that makes it clear that it is lawful and warranted to share information where there is a "particular serious risk" and that this issue was not understood; and d) agreed that universities were a "core partner" to the NHS in places where they have a "big presence". He committed to developing any guidance in conjunction with the universities[84];

(b) Mr. Arnold of the ICO accepted that there is currently a paucity of guidance for universities. There is a "Sharing Personal Data in an Emergency: A Guide for Universities and Colleges" but this is a one-page piece of guidance on the ICO website which does not deal with information sharing with a university and only applies in emergency situations. Mr Arnold helpfully

[81] INQT0000109, William Vineall, 4 June 2026, 29/5-14.
[82] INQT0000109, William Vineall, 4 June 2026, 30/1-6.
[83] INQT0000109, William Vineall, 4 June 2026, 89/15-25 to 9/1-6.
[84] INQT0000109, William Vineall, 4 June 2026, 106/19 to 108/21.

agreed, in answer to questions from counsel for the University, that he would undertake to work with the University and the HE sector more generally to provide guidance which covers a wider range of issues [INQT0000095, Paul Arnold MBE, 26 May 2026, 36/1-21]. As the Chair alluded to in questions to Mr. Arnold, there is a real 'information gap' and even if the law is clear, this does not make it user-friendly; and

(c) Ms. Jones MP, the Minister for Policing, accepted that the fact that the University has an information sharing agreement with one local police force does not allow for information sharing with other forces and she agreed that a national information sharing agreement would be preferable. She was asked about the utility of individual data sharing agreements such as the one between University of Nottingham and local police. She responded that the police reforms, including the NPS and replacement of the PNC/PND were about developing a national mandate for when information should and should not be shared.[85] Although she made no concrete commitment, she stated that any such reforms would be part of new legislation[86].

Improvements to the HE sector when dealing with acutely mentally ill students/those who pose a risk to others

171. As set out at paragraph 380 of Professor Linehan's first witness statement [WITN0066001], a very difficult area for an HE establishments is the extent to which information about students with mental health issues can and should be shared within a university. There are complex considerations including data protection, breach of privacy and stigmatisation of students. The University Mental Health Charter identifies that students are less likely to access services if

[85] INQT0000104, Sarah Jones MP, 1 June 2026, 80/8-20.
[86] Ibid.

they believe that their information will be shared with academic staff [WITN0066046 page 52]. The University would welcome a recommendation from the Inquiry which invites the ICO to work with the HE sector to provide detailed guidance on internal information sharing, which balances the need for privacy with the need to share with academics on a 'need to know' basis.

(D) Issues Outside the Terms of Reference

172. The University understands that the bereaved families and the survivors wish the Inquiry to consider a wide range of issues. However, the Inquiry is bound by its terms of reference[87] and the Inquiry is invited not to stray into areas not covered by the Terms of Reference. The Inquiry is asked to note that some issues outside the Terms of Reference are dealt with in the second witness statement of Professor Linehan which was submitted to the Inquiry in June 2026 but has not been disclosed via relativity. The University reserves the right to make oral submissions on these issues if they are raised in the Closing Submissions of other parties.

Conclusions

173. In summary, the University invites the Inquiry to make the recommendations above, which primarily deal with the issue of information sharing between universities and statutory services, as well as the need for guidance relating to internal information sharing.

174. In the meantime, the University will continue to support its community affected by the tragic events of 13 June 2023, including Wayne Birkett's partner, Tracey. It

[87] https://nottingham.independent-inquiry.uk/document/terms-of-reference/

would like to thank the Inquiry for the focussed and dedicated way in which it conducted the evidence hearings, Counsel to the Inquiry for the immense work put into those hearings, and everyone involved in the writing of the report for the task ahead. The University remains committed to understanding, and learning from, the full context leading to the tragic events of 13 June 2023.

Carine Patry KC

14 August 2026.