THE NOTTINGHAM INQUIRY

CLOSING SUBMISSIONS ON BEHALF OF

NOTTINGHAM CITY COUNCIL (NCC)

Introduction

1. NCC begins these closing submissions by paying tribute to the victims of VC and to their family members and their single minded commitment to ensuring that the circumstances leading to and the terrible events of 13 June 2023 be scrutinised by this Inquiry.
2. NCC supports the Inquiry's valuable work and is very grateful to have taken part. The Inquiry has been forensic, thorough and amassed a great deal of evidence to show that agencies could have done better. In NCC's submission, this needs to be focussed so that the core thrust of the Inquiry's conclusions is aimed at the steps that would have prevented this tragedy from occurring in the first place. The starting point is public protection and the need to ensure this never happens again. To that end, the focus must be on the failings that left VC in the community untreated, unmonitored and able to perpetrate the attacks.
3. The Local Authority has been candid and thorough with this Inquiry. It has volunteered information; dealt with all requests made of it by both the Inquiry team and other core participants; and remains ready to take appropriate action once the recommendations are made public. As an example, it did not wait for this Inquiry to commence or to report before rapidly taking measures to deal with the shortcomings of staff in relation to data breaches.

4. The Local Authority continues to rely upon the opening statement, in particular the legal framework in respect of the statutorily limited role of the Approved Mental Health Professional (AMHP).
5. This closing is set out under the following headings:
    a. The data breaches.
    b. Attitudes and the role of the AMHP
    c. AMHP interactions with VC.
    d. The use of sections 2 & 3 Mental Health Act 1983
    e. The duty of candour & notifiable safety incidents
    f. The evidence of Christopher Atherton[1] and s.42 Care Act
    g. Availability of information
    h. Pre-MHAA planning.
    i. Risk assessment.
    j. CCTV.
    k. The local authority vigil.
    l. Suggested recommendations.

The data breaches

6. Although essentially last in time in the chronology from NCC's perspective, the data breaches committed by NCC are an important issue that can, once again, be dealt with briefly at the outset of these submissions: NCC remains, as do they, sorry for and embarrassed by the actions of its officers who committed data breaches.
7. There was no justification for accessing the data. The only mitigation that can be presented is that contrary to the impression given in the letters sent by

[1] INQT0000079 :1-66.

former Councillor, David Mellon, none of those who did accessed personal details of the victims; merely information about VC. Nonetheless, NCC is sorry this happened.

8. As made plain by NCC's Colin Wilderspin in his statements and evidence, they were disciplined, re-trained and their records remain marked by their mistake. In the aftermath, the local authority revised the way in which its officers could access information and adopted a rigorous audit process: NCC have introduced a spreadsheet system whereby an individual must justify their access to a file or record before viewing it. This spreadsheet is monitored by line managers and supervisors to ensure that access is always legitimate and within the scope of an individual's role.
9. The families called for consequences for those who failed and, where it identified a failure, NCC has already acted.

Attitudes and the role of the AMHP

10. NCC repeats its position as set out in the opening in relation to the wholly statutory role of the Approved Mental Health Professional.
11. Here, the desire to explain should not be confused with defensiveness. What follows is not designed to be an exercise in blame shifting or a failure to acknowledge shortcomings.
12. Although not included within the recommendations at the conclusion of these submissions, NCC recognises that the Inquiry can consider whether the role of AMHP requires revision or even continues to be conceptually fit for purpose in the light of any findings it might make. Although there is clearly room for improvement of information sharing and potentially attitudes to risk, it is NCC's position that the role remains fit for purpose and fundamental revision is not

justified even by the terrible events that concern this Inquiry. Further, during the time frame covered by the terms of reference, it is NCC's submission that its AMHPs worked effectively.

13. The risk management of individuals such as VC within the police and criminal justice system and the wider mental health landscape is a thread that runs through this Inquiry and about which the Inquiry has heard extensive expert evidence (largely focussed on the assessment of risk from a policing and health rather than social care context). Therefore, from the perspective of NCC's AMHPs, it is necessary to consider the contemporaneous context of risk posed by the likes of VC within the field of mental health.

14. Although attitudes and methods changed in the second half of the 20th century, mental health provision after 1983 marked a profound shift from an environment still characterised by Victorian asylums which erred to the custodial with an historical reputation at the extremes for the use of straitjackets, padded rooms, non-consensual electro-convulsive therapy and chemical coshes to a situation in which those with mental illness were treated where possible in the community and with dignity.

15. The reality of the risk equation from NCC's perspective is that the activities of its AMHPs must be considered through the prism of the orthodoxy that developed in the 40 years following the passage of the MHA as expressed in the Ministerial foreword to the MHA Code of Practice, namely:

> *Care and treatment should always be a means to promote recovery, be of the shortest duration necessary, be the least restrictive option, and keep the patient and other people safe*[2].

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[2] NHSE0000312.

16. This Inquiry is the opportunity to challenge that orthodoxy/consensus and to decide if it remains fit for purpose in the light of any findings it may make.

17. NCC repeats its submission from the opening that the role of the AMHP is prescribed: it is limited to interactions with individuals facing a mental health crisis or those discharged from psychiatric treatment under a Community Treatment Order (CTO). Once alerted to the need to assess such an individual, as we have learned usually by a report from family, police and/or mental health clinicians, it is the obligation of the AMHP to:

    a. Liaise with clinicians who can pronounce on whether the individual is suffering from a mental illness;
    b. Liaise with the family of the individual;
    c. Inquire as to the availability of a hospital place in the event that the individual needs to be detained;
    d. If necessary, seek a warrant to remove the individual to a place of safety so they can be assessed;
    e. Convene a Mental Health Act Assessment (MHAA) with two physicians;
    f. Once the MHAA has been convened, consider how the individual can be helped by the least restrictive means and how public safety can be vouchsafed;
    g. If the individual needs to be detained for either assessment or treatment, and if they are not already in a mental health setting, arrange conveyance of the individual to an appropriate psychiatric facility; and

h. If, after treatment pursuant to s.3 MHA, an individual is discharged from psychiatric in-patient care subject to a CTO, to consider how the individual's social needs can be met.

18. NCC underscores that the AMHP's role was and is limited. AMHPs have a binary choice between detention or not; each must act within the legal framework; independently; and balance the competing rights of the individual, including Articles 5 and 8 ECHR, against the right of the public to be kept safe. As the inquiry has heard, once the MHAA process is complete, the individual becomes either a detained patient or is cared for by community mental health (in Nottingham, CRHT); and, absent a CTO upon discharge, the AMHP service is required only to step in again when called upon to do so by a fresh referral.

19. It is the case that the actions of the AMHP do not render the individual part of the adult social work caseload. However, AMHPs are social workers. The very nature of the assessment of the individual is from the perspective of social need. AMHPs look at the impact of housing, isolation, relationship breakdown, here educational pressures, financial strains and their impact upon the person's distress.

20. Further, it is self-evident that, if there were vulnerable members of the household of the mentally unwell person, of course a referral to a colleague would be made. Furthermore, once a person is in hospital, the local authority expects the Trust to look at the wider picture, including a safeguarding referral, as part of discharge planning.

21. Once the immediate need to deal with an individual's mental health crisis is met, by either hospitalisation or treatment in the community, the AMHP's statutory role comes to an end.
22. At no stage prior to 13 June 2023 was a CTO effected during or at the point of VC's discharge from psychiatric care and, as a result, NCC was never involved either during or at the conclusion of any period of treatment in the consideration of or provision of any after care for the purposes of s.117 MHA.
23. It is also noteworthy that on only one occasion in September 2021, when VC was detained in the private Cygnet facility in Darlington, was an NCC AMHP (Alison Jacques (WITN0114001)) recalled in order to assess VC in hospital and convert his detention from s.2 to s.3 MHA.
24. Further, although Chapter 33 of the Mental Health Act Code of Practice deals with the provision of after care, as is made clear by NCC's Christopher Atherton at §35 of his statement [WITN0225001], there was no statutory guidance around discharge at the time of NCC's involvement or indeed prior to 13 June 2023.
25. Not until after the events giving rise to this Inquiry did the Department of Health and Social Care produce '*Discharge from Mental Health Inpatient Settings*' on 26 January 2024[3], which is exhibited to Mr. Atherton's statement [PHSO0000010]. No doubt the Inquiry will consider whether that approach survives its findings.

The AMHPs interactions with VC

[3] PHSO0000010.

26. The Inquiry has had the advantage of hearing live evidence from a number of NCC's AMHPs and has written statements from others. They were impressive and candid witnesses. Therefore, that evidence is not extensively summarised: the witnesses gave clear evidence of why, how and what they did.

27. Ben Williams carried out the first MHAA on VC on 24 May 2020, and he introduced a number of concepts common to those who followed.

28. It was the first time NCC had come across VC, but he was not the first psychotic person Mr. Williams had encountered[4]. He introduced the methodology of the MHAA and how, on the occasion he was involved, Annette Palmer, a CRISIS team psychiatric nurse, was also in attendance in addition to the two psychiatrists, Drs. Malik and Gandhi[5].

29. He explained the 'gatekeeping' role on behalf of the Trust which reflects the practicalities of bed availability and/or community treatment. Ms Palmer's input informed the feasibility of community treatment[6].

30. He also introduced the subject of the 'least restrictive principle'.

31. In the risk summary portion of the '*AMHP REPORT REFERRAL AND ASSESSMENT*'[7] form Mr. Williams identified VC as presenting with the following risks:

Risk:	Evidence	Risk Level:
Risk to Self:	Further MH deterioration	Likelihood: high – severity; high

[4] INQT0000058 : 27/ 20.
[5] INQT0000058 : 30/ 14-20.
[6] INQT0000058 : 75-76/ 21-1.
[7] NOCC0000044_0005.

Risk to Others:	Aggression towards neighbours – broke into neighbour's flat	Likelihood: med — severity; high
Other:	Disruption to studies	

32. Having been assured by Ms. Palmer that VC was capable of treatment in the community, Mr. Williams and Drs. Malik and Gandhi were content that detention was not necessary.

33. Therefore, it is submitted that at this encounter with VC, with the least restrictive principle in mind and that the local mental health team in the shape of Ms. Palmer was confident that community treatment was appropriate and available, the decision not to detain VC was and remains objectively justifiable.

34. It was not open to delay VC's release from custody or delay the outcome of the assessment pending arrival of VC's Mother as was suggested by CTI and Mr. Straw KC. Respectfully, that ignores the practicalities of the life of a busy AMHP and is essentially unlawful detention. Likewise, it would be inaccurate to conclude that VC was being allowed to remain in the community without a plan as was essentially suggested by Ms. Cartwright KC.

35. It rapidly became clear that VC could not be safely treated in the community. Following his re-arrest on 24 May 2020, NCC's Eleanor Cullen saw VC on 25 May 2020 and concluded that VC was mentally unwell and that the attempt to treat him in the community had not worked. VC was detained pursuant to s2 MHA.

36. Although Ms. Cullen also categorised risk levels as '*high*' she made the point that the risk matrix/table in the AMHP report (NOCC0000045_0004) is not to

be read in isolation: it is based upon the reasoning set out in the preceding pages.[8]

37. She had enough information regarding the incident involving Feven and the risks posed by VC to make a decision on VC's detention. As an AMHP, that was her statutory function. There was a clear need for expedition, and the focus was on ensuring that the public was protected by detaining VC for assessment.

38. Ms. Cartwright KC's questions about safeguarding for Feven overlooked that the need for expedition in dealing with VC meant that Ms. Cullen had to act on the basis of the information she had.[9] NCC repeats the submission that Ms. Cullen discharged her statutory function as an AMHP. Any decision to refer Feven's situation to the adult safeguarding board would be in the hands of the police given their criminal investigation. Likewise, the notion that NCC was required to make a report of a notifiable safety incident to the CQC was, respectfully, misguided. There is more below in respect of this.

39. Geoff Culpin carried out an MHAA on 14 July 2020. He gave evidence on 27 April 2026.

40. Although this does not do justice to the totality of his evidence, it is important in a number of respects:

    a. This was the first occasion upon which VC was detained pursuant to s.3 MHA.

[8] INQT0000060 : 43/14-15.
[9] INQT0000060 : 46/18-25.

b. Mr. Culpin had effective contact with the university and, despite the unfounded criticism in university email traffic (albeit recanted in oral evidence) passed on the concerns of Ms. Turner to Dr. Seedat.

c. He brought experience from managing AMHPs and forensic social workers and had experience of both assertive outreach and the HCR20 risk assessment model.

41. NCC's next involvement with VC came on 2 September of 2021 when NCC's Jen Shaw unsuccessfully attempted to carry out an MHAA.

42. The baton then passed to Amie Staples[10] who obtained a warrant pursuant to s.135 MHA 1983 and was the AMHP at the consequent MHAA on 3 September 2021 when VC violently assaulted PC Pritchard.

43. In the light of what happened on 3 September 2021 it was obvious that VC had to be detained. Ms Staples, and the attendant clinicians Drs. Lomas and Manzar, concluded that VC should be detained pursuant to s.2. MHA: assessment was required.

44. On 22 September 2021, NCC's Alison Jacques[11] saw VC at the Cygnet Hospital, Darlington where VC was again assessed and his detention sanctioned under s.3 MHA.

45. NCC's AMHPs undertook a further two MHAAs with VC:

a. Roseanna Crane[12]: 19 January 2022 (VC not detained); and

b. Fiona Parker[13]: 28 January 2022 (VC detained under s.2 MHA).

The use of sections 2 & 3 Mental Health Act 1983

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[10] INQT0000072 : commencing 46/20.
[11] WITN0114001.
[12] INQT0000079 : commencing 66/11.
[13] WITN0113001.

46. In the light of questions and in particular the opinion of Alex Ruck Keene KC[14] it will no doubt be suggested that NCC's AMHPs overused s.2 MHA out of a desire to appear 'less restrictive'; or that the use of s.2 MHA is a one off provision that permits detention under s.3 MHA on every future occasion a person is encountered. Respectfully, s.2 is not a permanent gateway to s.3.

47. It is submitted that the notion that s.2 is essentially a once and for all process in the context of evolving and/or waxing and waning mental illness risks a rigidity which fails to reflect the difficulties of psychiatric diagnosis. It also ignores the fact that the power to deprive someone of their liberty and subject them to a psychiatric assessment and/or treatment against their will is a draconian measure and must be based on solid evidence. It is no coincidence that, except in an emergency under s.4 MHA, the process requires the input of no less than three professionals.

48. Although it is incontrovertible that VC did not engage with his treatment, given the lengthy timespan across MHAAs (broadly Spring/Summer 2020, Autumn 2021 and January 2022) it would have been questionable reasoning in, say, January 2022, to rely upon a conclusion formed over 18 months previously. In any event, AMHP's are not clinicians and on each occasion were reliant upon the input of others in relation to diagnosis.

49. Furthermore, the proposition that NCC's AMHPs were driven by a desire to be less restrictive is not borne out given the number of times VC was detained; and that it was open to the Trust to recall NCC's AMHP service (as occurred in September 2021) to re-assess VC with a view to detaining him under s.3. That is, NCC's AMHPs could be contacted by the hospital and be requested

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[14] INQT0000053 : 43-45.

to undertake a further MHAA in hospital. NCC's Ms. Jacques travelled to Darlington to do just that.

The duty of candour & notifiable safety incidents

50. In the light of questions put to NCC's witnesses, and in order to avoid any misunderstanding, it is necessary to address the application of this to the Local Authority.

51. The law is uncontroversial: Regulation 20(1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provides as follows:

20 (1) A health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. (Emphasis added).

52. Regulation 20 continues:

(2) As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must—

(a) notify the relevant person that the incident has occurred in accordance with paragraph…

(7) In this regulation…

"notifiable safety incident" means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in—

(a) the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition, or

(b) severe harm, moderate harm or prolonged psychological harm to the service user…

53. The crucial words above are '*provided to service users'* and '*regulated*'.

54. It is the Local Authority's submission that:

    a. VC was not a service user;

    b. No incident occurred during an MHAA (emphasis added); and

    c. Feven was never part of the Local Authority's adult social work case load.

55. Accordingly, and for the avoidance of any doubt, at the point in time when the criminal conduct that resulted in Feven's leap to safety and her consequent injury, neither she nor VC were users of any service provided by the Local Authority. As Ms. Cullen pointed out in her evidence, it was not until she heard the evidence to the Inquiry that she became aware of the extent of Feven's injuries.[15] The section was not engaged.

56. There were questions to suggest NCC failed to carry out reasonable enquiries. Rhetorically, by what process is a busy AMHP/Social Worker to discover all those who require medical treatment/hospitalisation as a consequence of the criminal conduct of others? As Ms. Cullen pointed out, others, namely the police, were closer to the detail and could have referred Feven to safeguarding.[16]

57. In the interests of completeness, the following is also relevant:

    'Activity we regulate' is listed in Schedule 1 of Health and Social Care Act 2008 (Regulated Activities) Regulations:

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[15] INQT0000060 : 54/15-24.
[16] INQT0000060 : 47/8-12.

- *Personal care for persons of old age, illness or disability and are unable to provide it for themselves*
- *Accommodation for persons who require nursing or personal care*
- *Accommodation for persons who require treatment for substance misuse*
- *Treatment of disease, disorder or injury.*
- *Assessment or medical treatment for persons detained under the 1983 Act*
- *Surgical procedures*
- *Diagnostic and screening procedures*
- *Management of supply of blood and blood derived products etc*
- *Transport services, triage and medical advice provided remotely*
- *Maternity and midwifery services*
- *Termination or pregnancy*
- *Services in slimming clinics*
- *Nursing care*
- *Family planning services*

58. As can be seen from the list above, since she was not a service user, the injury to Feven was not related to a regulated activity vis-à-vis the Local Authority and her.

59. The fact of the MHAAs in respect of VC did not trigger the reporting requirement in respect of the injury to Feven.

60. Accordingly, it is respectfully submitted that the Local Authority was not:

    d. Engaged in a regulated activity at the time of the injury to Feven; and

    e. Obliged to make a report of the '*notifiable safety incident*' to the CQC.

The evidence of Christopher Atherton[17] and the Care Act

61. Mr. Atherton was questioned extensively by CTI and Ms. Cartwright KC in relation to the applicability of the Care Act 2014, the interplay with s117 MHA after care and the nature of AMHP involvement with VC.

62. It is uncontroversial that, until May 2020 VC was a stranger to NCC's social services department. Thereafter, save for one note from the Priory Hospital on 19 October 2021[18], on each occasion VC was discharged by the Trust or dealt with by the police NCC was not contacted. There was at no stage a CTO. Although it is fair to say that the AMHP has a role to play in the making of CTOs (see s17A(4)(b) MHA), discharge subject to a CTO is initiated by the responsible clinician (see s17A(1) MHA).

63. Therefore, NCC was largely not informed about the discharge of VC from psychiatric care. In the note referred to above, it is clear that there were concerns about housing but, by the time of discharge, they were met.

64. VC did not become a service user by reason of the MHAAs since the Local Authority acquired no attendant assumption of responsibility. The role of the AMHP is confined to the statutory duty (see ***Khamba v Harrow* [2024] EWHC 2803 (KB)**)[19]. Therefore, the right to a Care Act assessment was not engaged.

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[17] INQT0000079 : 1-66.
[18] PAGR0000025_0002.
[19] RLIT0000071 : "Khamba v Harrow London Borough Council, 29 Oct 2025 [2025] EWHC 2803 (KB).

65. In any event, so far as the Care Act is concerned, on each occasion NCC's AMHPs saw VC his social needs were considered in the context of the MHAA and they were met: he had a place to live; he was able to feed and clothe himself; and was in education/employment. VC did not require the assistance of the Local Authority to secure the things necessary to sustain independent living.

66. The inquiry has seen and heard the evidence from Ms. Cullen in relation to what NCC knew about the injury to Feven. It has to be borne in mind that that incident took place during the first national lockdown of the Covid 19 pandemic. Respectfully, without a safeguarding referral from either the police or the Trust following Feven's spinal surgery, how was a local authority supposed to gather information from a healthcare or police setting against the background that access to hospital was, understandably, tightly controlled? In any event, Feven was the recipient of medical care and, during what one presumes would be part of her period of recovery, VC was detained.

67. Nonetheless, Mr. Atherton's evidence demonstrated a clear understanding of how social care and mental health services must work together to support vulnerable individuals.

68. He acknowledged the need for better integration and communication between health and social care teams and accepted the need for formal protocols to ensure that local authorities are notified when patients are discharged from hospital, enabling timely assessments and support. He identified the value of embedding social work expertise within clinical teams, which would strengthen oversight and reduce the risk of individuals slipping through the net.

69. Mr. Atherton also pointed to the challenges faced by local authorities, such as the risk of being overburdened with referrals in the face of limited resources and the need for more training.

70. He underscored the importance of multi-agency safeguarding frameworks and the local authority's unique position to coordinate complex cases, drawing upon involvement in risk management in the fields of public protection (MAPPA and MARAC).

71. His evidence was candid, open and constructive reflecting a commitment on the part of NCC to learning and systemic change where required.

Availability of information

72. Whilst acknowledging that there is friction in the management and sharing of information that requires resolution, there is an important feature to bear in mind from the perspective of NCC: MHAAs concern people who are in crisis and urgency is often vital. It is in that context that assessments can take place at short notice, with limited information and in sub-optimal locations.

73. There is a risk when carrying out analysis at a granular level of super-imposing a system that is perfect which risks delay and dither for fear of repercussions. Information gathering has to be both proportionate and sufficient in order to formulate an educated assessment, but it does not have to be comprehensive or drawn from every possible source otherwise AMHPs will spend too long gathering information for fear of later criticism by reason of insufficiency when they should be at an MHAA.

74. As Dr. Skelton articulated[20] in relation to the MHAA conducted on 19 January 2022 with Ms. Crane, whatever information has been gathered prior to the

[20]INQT0000075 : 17/11-13; 21/16-18; 23/13-16; & 83-84/25-11.

MHAA, and whatever preconceptions the attendant professionals may have from a paper review, the AMHP and the clinicians have to assess the person in front of them. It is, after all, first and foremost a clinical assessment. To suggest, as Mr. Carr did, that anything other than detention in the prevailing circumstances was a 'gamble' ignores the point that an assessment is not a once and for all decision and that individuals may frequently and repeatedly present.

75. Again, the early MHAAs in this case took place at the beginning of the Covid 19 pandemic. For those required to work remotely, access to read only records accessible from an office computer was simply not possible.

76. However, this reveals the rather haphazard nature of access to relevant information in the first place: the historical (that is, before the events about which the Inquiry is concerned) decision to decouple the AMHP team from the local mental health trust meant that access to the Rio system thereafter became inconsistent for AMHPs, in particular new joins. It is ironic that, currently, it is only at ministerial level that health and social care are combined under one roof.

77. AMHPs and clinicians conducting MHAAs will still be called upon to act quickly and assess the person in front of them doing the best they can in potentially difficult circumstances. The only way to address any of the concerns about the quality of information available to the professionals involved is for all those involved to have remote access to the same database containing details about the prospective detainee.

78. Although NCC's AMHPs do not seek access to police records, and neither is it suggested that the police should have access to a health and social care

database, there needs to be frictionless information sharing between agencies that is underpinned by simple, easily understood protocols, mutual training and dedicated and appropriately resourced staff to facilitate that exchange of information.

Pre-MHAA planning

79. NCC notes that questions from CTI and the Chair explored with various witnesses, including PS Ellis, the idea of AMHPs being the co-ordinator of a pre-MHAA briefing, in particular when the assessment arises from the execution of a warrant under s.135 MHA and the removal of the prospective detainee to a place of safety.

80. It is NCC's submission that this is, essentially, the method that is currently in place: it is for the AMHP to organise the MHAA and, often, the prompt for doing so is a report from the police following arrest.

81. As the Inquiry has heard, discussions take place between the AMHP, the clinicians, any CRHT staff and police before warrants are executed and/or MHAAs are carried out. As the violent events of September 2021 demonstrate the execution of a s.135 warrant leading to an MHAA can require the attendance of the AMHP, two clinicians, several police officers and ambulance staff.

82. Some form of multi-agency briefing is clearly desirable in order that optimal information can be shared and risks appropriately and dynamically assessed. However, NCC repeats the submission that expedition/urgency is often required, and, in those circumstances, any such briefing may have to take place at short notice and may lack formality as all agencies converge on the address of the potential detainee. Unlike, say, the calm reflection of a multi-

disciplinary team meeting in a clinical setting, AMHPs ought not to be fettered by cumbersome process or the desire for formality in such a dynamic situation. A standard operating procedure will only create delay and add to the administrative burden of all involved.

Risk assessment

83. It fails to reflect the depth of their input but the evidence of Dr. Ruth Tully[21] and Professor Fazel[22] highlighted that risk assessment of individuals such as VC is complex and that a range of models exist.

84. Their evidence was, understandably, focussed upon clinical risk models. As Dr. Tully suggested, there is probably no justification for the rolling out of the complex and lengthy HCR20 model to non-forensic situations. Although the gold standard of structured professional judgment tools, from NCC's perspective it requires a degree of involvement that does not lend itself to an MHAA given the likely circumstances in which they are carried out and, once more, the need for expedition of decision making in relation to an individual likely in crisis.

85. Although possessed of appropriate training, skill and experience NCC's AMHPs are not clinicians. The risks they assess relate to the social stresses faced by the individual. Part of the reason for NCC's resistance to the points raised in questions in relation to the Care Act is that they ignored that the social needs of the individual are assessed by AMHPs at the MHAA.

86. Chapter 14 of the MHA Code of Practice deals with '*Applications for detention in hospital*'. The approach of the AMHP is a holistic one which is aimed at the

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[21] INQT0000052 : 1-96.
[22] INQT0000055 : 1-111.

integration of social care needs with health needs. Fundamentally, the risk assessments undertaken by AMHPs focus on such factors as housing, isolation, relationship breakdown, here educational pressures, financial strains and their impact upon the person's distress and any consequential risk to the public.

87. For example, included amongst the risks in the last MHAA undertaken by NCC's Fiona Parker (WITN0113001) on 28 January 2022 in her AMHP report were:

> *…Resides with 5 other house mates (currently moved out).*
>
> *Breakdown in University course and not being able to complete this*
>
> *Breakdown in accommodation provided by University*[23]

88. Therefore, Ms. Parker included elements that were not clinical and depended upon her skill as a social worker rather than the skills of Dr. Lomas and Dr. Manzar as psychiatrists. Within the risk summary Ms. Parker pithily summed up the situation from a social perspective as '*Unable to complete academic studies and risk of losing accommodation…Stigmatisation from peers*'[24].

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

90. Both Dr. Tully and Prof. Fazel's evidence recommends universal training in structured risk assessment for both forensic and non-forensic teams. Subject to the caveats about expedition/urgency at MHAAs and issues of resources, if it is anticipated that AMHPs fall into either category no-one could object to

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[23] NOCC0000043_0003.
[24] NOCC0000043_0006.

additional training in relation to risk assessment if that is what it takes to offer the families and survivors; this Inquiry; and the public the reassurance that might bring.

91. Further, the compelling evidence of Dr. Dissanayaka[25] cannot leave the Inquiry in any doubt that a return to genuine assertive outreach and the multi-agency risk management that is part of it carries with it many advantages, not least improved medication adherence and social stability for individuals such as VC. Here 'genuine' means that such services abide by the fidelity scale referred to in Dr. Dissanayaka's statement (WITN0412001) including that the services are delivered by a '*dedicated standalone team*'[26]. The continued existence of assertive outreach in Nottingham could have made a difference to VC.

92. With all due respect to Sir Andy Marsh, although it is fair to say that treatment of those suffering from mental illness requires a health response, some related training would also be valuable for police officers rather than the retreat behind 'right care, right person' he suggests.

93. As a generality, no agency could reasonably resist any training that would better inform dynamic assessment made on the frontline.

94. As above in relation to the notion of a pre-MHAA briefing, and acknowledging its undoubted importance, what NCC is hesitant about in the context of risk management is the prospect of additional layers of cumbersome, bureaucratic exercises. That will add delay in dealing with individuals in crisis and who may pose a risk to public safety; and risk replacing a dynamic process with one

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[25] INQT0000051 : pages 50-126.
[26] INQT0000051 : 70/7, et seq.

that is akin to a dropdown menu with limited options and less room for thought. There is also the risk that resources will have to be shifted in order to cope with the increased administrative burden.

CCTV

95. On 26 May 2026, the Inquiry heard live evidence from Brian Bussey, Jayne Harvey and Colin Wilderspin. The Inquiry has additional statements from Kenneth Cromwell (WITN0436001); James Pykett (WITN0479001); Gregory Hague (WITN0492001); Andrew Clarke (WITN0451001); and Kirsty Gregson (WITN0485001) on the subject of CCTV.

96. Although there is no statutory duty to install CCTV, and, as the Inquiry heard, NCC is unusual in that the system is staffed 24/7, NCC has an extensive network of 288 public space cameras; along with 15 redeployable cameras; and cameras in car parks and within NCC's commercial and housing estate.

97. They are controlled from the Woodlands CCTV centre by staff including Ms. Harvey and Mr. Pykett. Within the control room is a large wall of monitors from which a selection of the live feeds is visible from each numbered camera across the City.

98. The staff also have access to certain police radio communication channels but, contrary to CI Mather's evidence, specifically, and regrettably, not the firearms channel.

99. The CCTV system includes what is known as a 'Follow Me' feature which permits views from 6 cameras to be shared directly with the police.

100. The evidence heard and in the possession of the Inquiry includes the efforts made by those at NCC's Woodlands CCTV centre to locate VC following the report of the killings of Barney and Grace on Ilkeston Road;

liaison with police, including (limited) access to police communications; the location of VC after he had killed Ian and taken his van; along with software and connection issues; and that the camera at the point of arrest had an erratic 'PTZ' (pan, tilt, zoom) function.

101. NCC repeats the observation made by Colin Wilderspin that, unlike the way CCTV is often characterised as seamless in film and television, the reality is more difficult; and, in the absence of Orwellian facial recognition technology, NCC was and is dependent upon being provided with clear information as to location and a description from the police to begin an effective search and then it is down to observation.

102. Ms. Harvey and Mr. Pykett conducted a systematic search from the point of the initial incident on Ilkeston Road. From there, and contrary to the inaccurate evidence of CI Mather suggesting inactivity or a lack of initiative on the part of NCC's staff, the CCTV team did indeed use their initiative and conducted a systematic search[27], including searching in the area around the Cathedral; making assumptions about movement towards Alfreton Road and Bobbersmill and reviewing footage from flats in the Radford area[28]. Contrary to the impression from Mather's evidence, as ACC Rob Griffin explained, the Police trust and rely upon NCC's CCTV operators: hence his evidence that '*they're really, really good at this*'[29].

103. Where there is a dispute on the facts in this respect, NCC invites the Inquiry to reject the evidence of CI Mather as not credible and to prefer the sincere evidence of Ms. Harvey and the witness statement of Mr. Pykett.

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[27] INQT0000095 : 89/3-17.
[28] INQT0000095 : 94-95/3-25 & 1-4 and (Cathedral) 95-96/12-25 & 1-20.
[29] INQT0000037 : 83/22-25 & 84/1-8 and 13.

104. Ms. Harvey and Mr. Pykett knew that they were looking for a black male dressed in black clothing.[30] The Inquiry has heard that the initial intelligence was thrown off the scent by what turned out to be an unrelated incident close to the cathedral which is some way East of the killings of Barney and Grace and closer to the City Centre.

105. After the fact evidence from the police and a frame by frame analysis of the CCTV revealed that there were sightings of VC as he emerged from Radford into the Forest area of Nottingham and made his way towards Mapperley where he killed Ian. It is a tragedy that he was not seen and apprehended.

106. CCTV staff did not have access to the firearms channel, so the crucial bit of intelligence that VC might have headed North on Hopedale Close never made its way to them. As ACC Griffin pointed out, in the absence of the prompt about Hopedale Close, the CCTV team was left to guess as to VC's direction of travel.

107. As a result of after the fact analysis, VC is believed to have headed North East through Radford, where, coincidentally, there is a lower concentration of cameras than in other parts of the City. As he made his way through Radford some of the initial images of VC were from private CCTV sadly inaccessible to NCC contemporaneously.

108. As the Inquiry will recall, Ms. Harvey gave sincere and emotional evidence about the search and the efforts that she and Mr. Pykett made to locate VC: both of them looked at the CCTV feed, even during the period

[30] WITN0437001; WITN0479001.

between 04:38 and 04:41 when Ms. Harvey was making a report when VC was, subsequently, seen on CCTV on Gregory Boulevard.

109. Ms. Harvey noticed Ian's van, now driven by VC, on Milton Street and followed VC as he hit Wayne from behind. She and Mr. Pykett tracked VCs movements and informed the Police of the VCs location via the police radio.

110. Due to the recent re-numbering of the cameras, it was necessary for Mr. Pykett to call out the numbers to Ms Harvey so the van could be followed from point to point and the police given a seamless view. Ms. Harvey and Mr Pykett continued to relay information about VCs location to the Police who then pursued and apprehended him. Tragically, during the pursuit, he mowed down Sharon and Marcin.

111. As Mr. Bussey's evidence revealed, albeit in emails in histrionic tones that he regrets, NCC had experienced issues with the system following a recent software upgrade; and what NCC understood to be issues with the BT telephone link to some cameras. A consequence was that on some cameras, from time to time, the PTZ function was erratic. It also transpired that the software update had resulted in the renumbering of the cameras. During the period 12-13 June 2023 it was Mr. Bussey's evidence that nine of those cameras were affected[31].

112. Ultimately, during the attempts to locate VC, only one camera, 167, behaved erratically which was the one on Bentinck Road close to the point of VC's arrest. Ms Harvey made clear that there were no other functional issues for any of the cameras they '*used that evening, or that morning*'[32]. Despite Mr.

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[31] INQT0000095: 48/3-24.
[32] INQT0000095: 84/12-15.

Bussey's regrettable emails, the CCTV system was extensive; appropriately staffed; effectively utilised; admittedly awkwardly re-numbered; but suffering from no relevant faults on 13 June 2023.

The local authority vigil

113. In the aftermath of the shocking events of 13 June 2023, NCC organised a vigil on 15 June allowing the people of Nottingham to come together, mourn and reflect. Over 5,000 assembled in Market Square in Nottingham and stood shoulder to shoulder to pay tribute to the victims and survivors of the attacks.

114. The families of the deceased delivered emotional tributes to their loved ones and reminded the City of Nottingham to look after each other in the days that followed the attacks.

115. A book of condolences was opened at the Council House, and the flag lowered to half-mast to represent the City's mourning. Citizens were invited to lay flowers on the steps of the Council House and the lights on the building were to be lowered at night as a mark of respect.

116. Citizens were also welcomed to light a candle in their window or doorstep of their home.

Suggested recommendations

117. NCC starts the following submissions from the following perspective:

118. On the one hand, it is submitted that its AMHPs were able to liaise with other agencies; share information; obtain warrants where necessary; and undertake timely and suitable MHAAs. VC was assessed seven times between May 2020 and January 2022 and on five of those occasions he was detained. Accordingly, it is NCC's position that, although subject to differences

of professional judgment, the system worked and that its AMHPs carried out appropriate risk assessments.

119. On the other hand, if the role is to be revised or the methodology revisited, NCC is painfully aware of the realpolitik of local authority finance and conscious that change without additional resources means having to do more with the same.

120. Accordingly, what follows is upon the assumption that appropriate resources will be made available.

121. What is clear from the facts and the opinion evidence from, amongst others, Professor Shubulade Smith, Sir Louis Appleby and Julian Hendy is that structural alterations to the arrangement and provision of services to deal with those in mental health crisis are likely to be recommended by the Inquiry.[33] NCC offers the following, inexhaustive, suggestions:

a. Although the Inquiry has heard unimpressive evidence about the dangers of data access and acknowledging that it poses data protection challenges, a unified/integrated health and social care records system accessible to all clinical and/or mental health professionals is long overdue, with appropriate 'read only' safeguards (e.g. only clinicians can edit clinical notes). This to include mandated record keeping for MDT meetings.

b. Until then, the rapid introduction of national, unified policies and procedures for information sharing between local authorities, NHS, Police and universities with accompanying mandated rollout training

[33] INQT0000103 1-104; INQT0000101 1-68; INQT0000100 1-84.

upon their use. Leaving this at a local level risks piecemeal consideration and inconsistent introduction.

c. National, mandated, unified training for all professionals in the limits of Data Protection law including when one can and should share personal information in the interests of public safety and when one should not. It is now 23 years since the Laming report of the Victoria Climbie Inquiry which prompted the coining of the phrase 'death by data protection act' and it still remains profoundly misunderstood legislation.

d. Where necessary, and subject to appropriate safeguards around policing, amendment/ revision to Data Protection law to make clear when public safety trumps privacy and when and how health, crime and social care records can be shared between agencies (e.g. the evidence of Richard Clark, Sarah Jones MP and Sir Simon Wessely, 1 June 2026).[34]

e. Universal re-adoption of assertive outreach under one roof or unification of statutory services dedicated to mental health crisis and MHAAs in particular:

    i. Within that, dedicated teams including psychiatrists, psychiatric nurses, bed management, AMHPs and, possibly, embedded policing/dedicated police liaison.

    ii. Until then dedicated linked staff across all agencies ready to seamlessly share information, offer input and attendance in the event of an MHAA.

[34] INQT0000104, 1-67; INQT0000104, 67-102; INQT0000106, 8-70.

f. A focus on risk based rather than capacity based assessment for the mentally unwell.

g. Standardised, universal, unified and nationwide dynamic risk assessment training for all agencies engaged in dealing with the psychiatrically unwell, including the police. As an aside and allowing for the submission above that treatment of the psychiatrically unwell is a health matter, it is not reasonable for the police to treat the principle of 'right care, right person' as a means to excuse themselves from involvement: Sir Andy Marsh may be anxious to return officers to 'frontline duties', but in September 2021, for example, VC could not have been detained by Ms Staples and two psychiatrists. The prevalence of the mentally unwell amongst the prison population[35] (by definition those who have already encountered the police) indicates officers need better training in understanding mental health and improved co-ordination with other agencies rather than suggesting they are ill-equipped to cope. If officers are overstretched that speaks of an under-resourced service, not that dealing with the mentally unwell and/or mentally unwell offenders is something that can be shunted to another agency. This might be achieved by the creation of a police mental health professional.

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[35] According to the Prison Reform Trust:
Over half of surveyed men (56%) and almost three-quarters of women in prison (74%) say they have mental health problems.
A 2023 survey of mental health caseloads in three-quarters of English prisons found anxiety and depression to be the most common primary issue (29% of patients), followed by psychosis (22%) and personality disorders (17%). In London, where there are more local prisons with short-term and remand populations, the prevalence of psychosis was nearly double the national rate. RLIT0000075

h. An increase in the availability of places of safety and reconsideration of the use of police cells as a last resort until such time as there is a sufficiency of provision in the health care system.
i. An increase in the number of psychiatric intensive care beds.
j. A register of all individuals subject to CTOs (again, to be recorded in the combined health and social care database referred to in a. above).
k. The creation of a dedicated s.17A/117 MHA (CTO) pathway/protocol.
l. Until then, a mandatory requirement that AMHPs/Social Services be informed about discharge from hospital assessment and treatment.
m. An expanded role and, potentially, an accompanying statutory duty for Universities for student welfare thereby enabling the easy information sharing sought by the University of Nottingham and, therefore, between statutory agencies.
n. Until then, the rapid introduction of national, unified policies and procedures for information sharing with the higher education sector. Again, leaving this at a local level risks piecemeal consideration and inconsistent introduction.
o. Reconsideration by Government of the re-wording of sections 2 & 3 MHA by the 2025 amendments:
    i. Despite the optimistic view of the DHSC and the Minister, one has to bear in mind the revised language of the MHA 2025 and consider the earlier submissions about the trajectory of mental health law and practice over the four decades since the passage of the 1983 Act, reflected in what follows. The question remains: is the orthodoxy to be challenged?

ii. During the Lords' debate on the second reading of the Bill on 25 November 2024, amongst other things, Baroness Merron described '*Many elements of the Mental Health Act 1983*' as '*outdated*' and stressed that the reforms were aimed at '*strengthening and clarifying the detention criteria to make clear that people will be detained only if they pose a risk of serious harm to themselves and/or others*'[36].

iii. That observation; her evidence to this Inquiry; and the submission of the DHSC that, essentially, little will change and that issues relating to detention can be ironed out in the new Code of Guidance sit uneasily with the evidence of Alex Ruck-Keene KC. He was at pains to point out that, although the Code will be laid before Parliament, it is not legislation; and that '*One of the drivers for the review was the perception that there were too many detentions*'[37].

iv. The language of the Act matters. Rhetorically: if the Code of Practice is to be used to resolve the tension meaning there will be no practical change, why alter the wording of the legislation in the first place to add the test of '*serious harm*' only to restore the status quo ante? That is a definition of pointless legislative revision and risks opening the floodgates to legal challenge.

v. Professor Shubulade Smith, President of the Royal College of Psychiatrists expressed concerns regarding the new detention

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[36] RLIT0000076.
[37] INQT0000053: 49/2-3.

criteria and that the language risked confusion. The view of Sir Simon Wessely that the amendment to the Act is a clarification is also difficult to reconcile with the view of Julian Hendy that intervention only at the point of the risk of 'serious harm' may result in missed opportunities for early intervention. NCC anticipates that the families and survivors are unlikely to be reassured by any suggestion that the bar to detention will be unaffected.

vi. As Mr. Ruck Keene KC pointed out: training and guidance must bridge the gap between legal requirements and clinical realities.

vii. Postponement of the revised code of practice until this Inquiry has reported.

p. No NHS mental health Trust can be permitted to operate a model whereby patients such as VC become 'lost to services' resulting in discharge without, at least, disciplinary consequences from the GMC for the clinical staff who make such decisions.

i. It is submitted that it is not the language of the Act that requires amendment; the provision of mental health care must be better.

ii. Amongst the issues exposed here are the failures of the Trust at a systemic and individual level. The answer is not legislative change but the restoration of quality.

iii. There was a failure of discharge: VC was at large when he ought not to have been and agencies such as NCC and the Police were not informed by the Trust.

iv. Broadly what is needed is a change to the way the Trust keeps track of individuals; how they co-operate and work with others; and with repercussions for treating clinicians if/when things go wrong. The non-judgmental rhetoric of 'lessons learned' instead of consequences too readily adopted by the NHS in such things as serious incident reviews simply promotes cynicism amongst the public they serve, fails to weed out poor performers and does not help restore quality of provision or faith in institutions.

q. NCC's CCTV operators to have appropriate security clearance to permit access to all police communications channels.

r. Revision to the information sharing agreement with Nottinghamshire Police to reinforce clear systems and/or protocols, embedded by mutual training, between police and NCC regarding communication in the event of an emergency.

s. Dedicated and appropriately trained police officers to attend the Woodland CCTV centre in the event of emergency to assist with co-ordination of search efforts.

t. Inclusion of CCTV deployment in operational training, potentially in the form of inter-agency practical exercises like the mass disaster training already undertaken in the East Midlands, including police and CCTV staff to ensure readiness in the event that an emergency such as 13 June 2023 were to recur. Large scale exercises could take place, say, every 5 years; and table top exercises on an annual basis.

u. In the event of an emergency situation, all data request reports to be automated or completed at the conclusion of the incident rather than during.

Conclusion

122. 13 June 2023 was a tragedy for the individuals who were killed and injured and their loved ones; and it was a dark day for the City of Nottingham.

123. NCC hopes that this Inquiry and its recommendations serve to reassure the City's permanent and temporary citizens and helps to restore faith in the institutions that serve them.

124. These submissions began and end by paying tribute to the families of Ian, Grace and Barney and to Wayne, Sharon and Marcin and repeat the condolences and sympathies expressed at the outset of the Inquiry.

Andrew McNamara

Ropewalk Chambers

August 2026