IN THE NOTTINGHAM INQUIRY

WRITTEN OPENING STATEMENT ON BEHALF OF THE BEREAVED FAMILIES

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1. Barney Webber, Grace O'Malley-Kumar and Ian Coates are names that the lawyers instructed in this Inquiry should not have known. Today, Barney and Grace ought to have been looking forward to building successful careers and happy family lives to make them and their families proud. Ian should have been contentedly settled into his hard-earned retirement, looking forward to a day's fishing or the next game at the City Ground. Instead, their names and their images are forever tied in the public consciousness to the man who brutally ended their lives.

2. On 13 June 2023, life changed forever for each of the families we represent. It changed for Emma, David and Charlie Webber, for Sinead, Sanjoy and James O'Malley-Kumar, for James, Lee and Darren Coates; for Elaine Newton. No area of their lives has been untouched. Their working and private life, relationships with family and friends have all been damaged beyond recognition. And, life changed forever that day for each of those who survived: for Wayne, Sharon and Marcin. It changed forever for all of their families. They each live with the raw horror of that day today and every day.

3. Whilst this Inquiry must necessarily and unavoidably consider the circumstances in which Barney, Grace and Ian were unlawfully killed, the events of 13 June were not merely ones of great personal loss and tragedy. They represented the culmination of decades of unconscionable but entirely predictable structural, systemic and individual failures. These predictable failures were repeated, both in Nottingham and beyond, time and again. Failures which echoed down the years in the loss of life in homicides linked to mental health: repeated and repeated and repeated in the decades since the Clunis Inquiry recognised that fundamental change was required to better protect public safety in the face of known risk. Lives have been lost and families devastated, again and again and again.

4. This is the Nottingham Inquiry. It is happening because these families of the deceased refused to just move along. They refused to accept that there is nothing to see here.

And the issue of the role of poorly managed and treated mental ill health in homicides is now back in focus for the umpteenth time because of their refusal to move along.

5. This Inquiry is not only about Barney, Grace and Ian, but it is also about Jonathan Zito (who died at the hands of the Christopher Clunis; about which killing, Jean Ritchie concluded her report in 1994)[1] and each of the countless other unnecessarily bereaved, whose loved ones were lost to the unmanaged risk of people who were known to be ill and known to be a risk to public safety.

6. This Inquiry will consider afresh the complex relationship between mental health and public safety; treatment, criminality and culpability and must grapple with significant questions of individual and institutional responsibility when failure results in tragedy. Those we represent do not consider this is a simple task. It is however, a crucial one, and one long overdue. But it is an opportunity to change things for the better which must be taken. Any chronology of the subject matter of this Inquiry is inevitably replete with missed opportunities. It would be tragic if this Inquiry was another.

7. In this short opening, we cannot possibly cover the full breadth of the work that will be done by the Inquiry over the coming short year. To date, 49, 270 documents and many detailed and lengthy statements have been disclosed. The process of disclosure continues as we write.

8. Instead, we begin with a number of basic, overarching questions for the Inquiry's consideration, within its terms of reference:

   a. Was there a failure in both the healthcare and criminal justice systems to learn the well-known, ill-managed and oft-repeated lessons of the past?

   b. Were there tragic and predictable flaws in the healthcare and criminal justice responses to VC's deteriorating presentation from at least May 2020?

   c. Was the emergency response on the morning of 13 June 2023 adequately managed, co-ordinated and executed?

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[1] DHSC0000160

d. Did the emergency response adequately consider the continuing risk to life between the time the first attacks on Barney and Grace were reported by callers to 999 and the arrest of their killer 91 minutes later?

e. Did the steps taken by police and prosecutors in the investigation and prosecution which followed the killings adequately consider and scrutinise all lines of inquiry relevant to mental health and culpability?

f. Finally, in the investigations which followed, were the deceased and their families who were seeking transparency and accountability about the events of 13 June 2023 treated seriously and with respect?

A. LEARNING FROM THE PAST

9. The Report of the Clunis Inquiry began by stressing that not all people who live with mental illness are violent. There ought to be nothing in the work of that Inquiry – nor this – which seeks to stigmatise mental illness or mentally ill people. Those we represent recognise the rights of people with mental illness to autonomy, privacy, fair treatment and care without stigma. There are risks to public safety which arise when people are known to be both unwell and violent to others. In those cases, treatment is designed to protect both the health of the patient and to protect others from harm from the patient. This balance is intended to be reflected in the provisions of the Mental Health Act 1983 ("MHA"). As the Clunis report recognised:

> *"The serious harm that may be inflicted by severely mentally ill people on themselves or on members of the public is a cost of care in the community which no civilised society should tolerate. There will always be some risk that harm will be inflicted. However, we are concerned that such a risk should be reduced in so far as is possible."* (Clunis Report, [47.01.1])

10. The Recommendations of that report were designed to ensure that the statutory regime found in the MHA and the Care Programme Approach ("CPA") designed to support patients in the community worked well both for patients and for public safety. The concerns expressed and reflected in the Recommendations included that, despite guidance, professionals responsible for the aftercare of patients discharged from hospital did not understand the legal principles which applied (44.0.2), plans on discharge required clear assessment and must be managed effectively by a multi-disciplinary team; such plan including an effective assessment of risk to others such that "*each member of the team responds effectively to signs and symptoms which*

suggest a patient is likely to relapse" (44.0.3). The role of the keyworker (now Care Coordinator) was crucial (45.3) and recommendations were made for supervised discharge (now reflected in the power to issue a Community Treatment Order ("CTO")). It was recognised that there would always be a group of patients who required special supervision. The class identified then would have included VC today.[2] Those patients required intensive follow-up, including assertive and close supervision following discharge.[3] Concern was expressed over failures in the assessment of dangerousness ("*time and again either violent incidents were omitted from records, or referred to in the most general of terms*"); and for failures in record keeping and management.[4] There were concerns over barriers to the effective sharing of information. That Inquiry heard that where there was a risk that a patient may harm himself or others, everyone providing a service to the patient ought to know about that risk. While questions of confidentiality were acknowledged to be difficult, this was an issue that needed even then to be resolved "*urgently*". Effective reconciliation of the need to share information on risk and confidentiality was "*vital*".[5] The Inquiry regretted that - albeit sometimes for the most human of reasons - offenders were not charged because they were mentally ill (or where charged, the offence was minimised). The decision not to charge ought always to be informed by a clinical opinion and should reflect the seriousness – or potential seriousness - of the offence.

11. That Report was signed on 24 February 1994. 32 years ago today. Given the recommendations we have just set out, we might all ask what has changed in the three decades since. In the disclosure before this Inquiry, in the conclusions of the Care Quality Commission ("CQC")[6] and in the report prepared by Theemis for NHS England ("NHSE")[7] the same themes are repeated time and again in connection with the management of the risk to public safety posed by VC. Critically, the Inquiry may consider there were repeated failures in the approach to risk assessment (including in the failure to consider longitudinal risk), continued failures in joint working; in information sharing and continued failures in the approach to his offending.

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2 Any two of the following criteria: (a) patients who have been detained under the Mental Health Act 1983 on more than one occasion; (b) patients who have a history of violence or of persistent offending; patients who have failed to respond to treatment from general psychiatric services; and (d) patients who are homeless. (Indeed, by 13 June, VC would have satisfied all four of those criteria.)

3 DHSC0000160_0126-0128

4 DHSC0000160_0129 at [49.0.1]

5 DHSC0000160_0129 at [48]

6 CQCM0016518

7 NHSE0000298

12. The Inquiry might consider whether this failure to learn is not general but dangerously specific. NHSE identified that, not including the killings of Barney, Grace and Ian, there were 15 incidents of patients under the care of the Nottinghamshire Healthcare NHS Foundation Trust ("NHFT") or who had been discharged who were responsible for perpetrating serious acts of violence towards members of the community between 2019-2023. This included in February 2023, the case of Junior Dietlin, who only a few short months before the attacks on Ilkeston Road, had stabbed five people.[8] There were a total of five homicides and other attempted homicides reported by the Trust to NHSE as part of the Theemis investigation (including the killings on 13 June 2013).[9] Theemis could see no evidence that the February 2023 incident had been discussed by the Board at NHFT. Where incidents were discussed the response was reactive and failed to consider learning that might prevent similar incidents in the future.[10]

13. The Inquiry may consider that the events of 13 June were a tragedy waiting to happen in Nottingham, borne from a long-known failure within NHFT to deal with known systemic and operational risks to public safety. It will be for the Inquiry to consider whether these were risks that NHFT knew (or ought to have known) were putting the lives of the people of Nottingham in danger.

B. RED FLAGS AND OPPORTUNITIES MISSED

14. VC was known to mental health services in Nottingham from 24 May 2020, that is to say, over three years before the events of 13 June 2023. VC was compulsorily detained pursuant to the MHA four times between May 2020 and February 2022. He was under the care of Nottinghamshire Healthcare NHS Foundation Trust ("NHFT") for over two of those years, until he was prematurely discharged from their services in September 2022. That the approach to his care was inadequate is undeniable. The CQC, in their investigation, found that *"there were a series of errors, omissions and misjudgements"* in those few short years.[11]

15. There were repeated warnings and missed opportunities in <u>both</u> the clinical and criminal justice response between 24 May 2020 and 13 June 2023. As the Clunis Inquiry explored, more than 30 years ago, the Inquiry may consider whether the policing

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8 NHSE0000298_0227-9, at [7.5.4]

9 NHSE0000298_0077 at [4.18] (There were three further reports not yet completed which fell within the timeframe.)

10 NHSE0000298_0028-29

11 CQCM0015215_002

response to VC was altogether too quick to divert him to treatment and care under the civil pathway of the MHA.

16. Since the Clunis Inquiry reported, the policing response to individuals experiencing mental illness, emotional or behavioural crises or difficulties has been guided by the need to consider alternative causes, before reaching any automatic or stereotypical conclusion. As the College of Policing's Authorised Professional Practice on Mental Health ("APP") provides:

> *"Officers should also consider the possible explanations for an individual's behaviour, including physical illness, injury or neuro-disability, mental ill health, a learning disability and intoxication (caused by medication, illicit drugs or alcohol). Mental health problems and illness exist along a continuum of severity and even those with severe and enduring mental illness may have episodes of functioning very well and may have episodes of crisis."*[12]

17. Indeed the local force policies for Nottinghamshire Police ("NGPF") disclosed in this Inquiry reflect the need to ensure that, when there is evidence of a substantive offence, diversion away from a criminal justice response is not automatic, but instead considers where and how the public interest may best be served. "*Dealing with Persons with Mental Health*" (August 2019) provides:

> *"[W]hen a substantive offence may have been committed, it is generally more appropriate to arrest for the offence and convey to a custody suite, rather than detain under section 136. In such circumstances a mental health assessment can be conducted in custody if required."*
>
> *"In situations where officers might consider the use of powers under s136 MHA or the MCA the person must always be arrested for any substantive offence where there is evidence of such."*[13]

And further:

> *"Public interest issues: Under certain circumstances it may be necessary to prosecute an offender to allow Mental Health Treatment Orders, Hospital Orders and /or other statutory support. This will certainly be the case for serious crimes." … "Where the offence under investigation is indictable and sufficient evidence is available on the threshold test at the point of detention in custody then remand should be sought so that the courts can consider their powers to remand to psychiatric hospital for reports or treatment. Where the offence is either way and there are specific risks to the public then police might also want to remand in*

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12 HOMF0000001_0035

13 NGPF0006002_0006

order to protect the public. Acute hospitals under civil sections or informal admission do not offer the same protection that a custodial remand offers."[14]

24 May 2020

18. There were two violent incidents involving VC on 24 May 2020. In the early hours of the morning, he was arrested for criminal damage, having violently damaged the door of a neighbouring flat, and having required restraint by other neighbours. The Inquiry will hear from "*Liam*" about that incident and that he smelled weed (although he could not tell if it was coming from VC or not).[15] Inspector Katie Eustace; the attending officer also thought VC was either ill or under the influence of drugs. She now reflects for the Inquiry as to whether she could have arrested VC for attempted burglary rather than criminal damage.[16] VC was seen in custody by Approved Mental Health Professionals ("AMHP") and did not require detention. However, he was prescribed an anti-psychotic, Olanzapine and referred to the CRHT.[17] He was subsequently interviewed by PC Collins. When asked by the investigating officer whether he did drugs; he responded, "*not really*". Pressed, he provided a more definitive denial.[18]

19. Hours after leaving police custody, VC launched a violent, aggressive attack on another neighbour's home. "*Feven*" will tell of her fear, when after he spoke normally and asked to be let in, she refused. She was so small she couldn't see through the peephole without help. She lived with her female friend and her friend's son. They were out and she was alone. She had just had a shower. VC's subsequent sustained attack shook the door and its frame: she believed not just a man but a gang of men was coming in. With no where to hide, she sustained life-changing spinal injuries when she was forced to leap from a first floor window in order to escape VC.[19] The Inquiry has photographs of the broken door, wood splintered on the floor. He was again arrested and an investigation followed for the offence of suspected "*ABH*" or actual bodily harm. These were simply not ABH-level injuries. They amounted to really serious bodily harm.

20. VC's first detention under section 2 MHA started the following day.[20] He was admitted for just 24 days for assessment and discharged on 17 June 2020.[21]

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14 NGPF0006002_0023
15 WITN0307001_0005 at [37].
16 WITN0007001_0004 at [22], 0005 at [34].
17 NGPF0003538
18 NGPF0000070_0006
19 WITN0252001
20 NHFT0000168_0004-0005
21 NHFT0000168_0049

21. By this time, the criminal investigation arising from Feven's injuries had unjustifiably been abandoned. By 10 June 2020, with no interview having been conducted with VC, the investigation was closed for reasons of ill-health (a course known as "Outcome 12"). This was a decision reached solely on the basis of an email from Dr Seedat, the treating clinician at NFHT.[22] The Inquiry may wish to consider whether this was an appropriate task for Dr Seedat to undertake: and whether his view was sufficient basis on which to conclude VC lacked the capacity to form sufficient criminal intent. The Inquiry may hear that the force's own subsequent analysis concluded that the offence in this matter ought to have been considered as grievous bodily harm (as if there could have been any doubt when Feven had suffered a T12 fracture which required surgery to fixed with metal work and screws; fractures to the L1 and L2 vertebrae and damage to the Sacroiliac Joint)[23]: an offence where only the Crown Prosecution Service is able to take a decision on charge.[24]

22. The first investigation of criminal damage for which he had been arrested only a matter of hours before the terrifying ordeal of Feven largely laid dormant until January 2021. Thereafter, VC was offered a conditional caution which he refused. No prosecution followed. On 23 September 2021, he sought to accept a conditional caution. By this time, of course, VC had gone on to assault PC Pritchard and had been detained on a s.3 basis. He was in contact with a solicitor and was preparing for a Tribunal (which would ultimately deny his release). None of this appears to have been known by PC Collins. On 28 September 2021, this was reviewed by PS Powar. On 4 October 2021, VC chased for a response. By this time, he had seen the outcome of the Tribunal and the decision that should circumstances demand it, a CTO would be required with depot. Instead, he had been transferred to the Priory and was actively engaged in planning for his release.[25] Again, it appears none of this was known to PS Powar. By this time PC Collins had seen the e-mail from Dr Seedat sent on 2 June 2020, which led to the discontinuation of any prosecution for the serious incident with Feven. She relied on that to discontinue the original matter (It was again categorised as Outcome 12).[26]

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22 NGPF0000082_0015 (See also, statements of PC Marsden and PS Sparks).

23 NGPF0000082_0014

24 NGPF0007833_0005, Email from Nicholas Hall to ACC Rob Griffin, 6 March 2024: Police Incident Timeline: "*This should have been upgraded to GBH when the extent of her injuries was known.*" See also: NGPF0007835.

25 Continued contact with his solicitor is recorded in the records kept by the Priory. PAGR0000159_000 appears to be an MDT record, dated 7 October 2021. Under "*keeping connected*", the clinicians record that "[VC] *has not appeared to make any contact with his friends or family. He has been in contact with his solicitor recently.*"

26 NGPF0007922_0024; NGPF00000077_0045-6.

23. The failure to take the injuries to Feven seriously – and to consider these offences together – was significant. There was no clear rationale to dispose of the matter by Outcome 12. No account had been taken from VC despite local policies indicating that interviews in detention could be conducted with the permission of a clinician.[27] VC was discharged and available for interview on 17 June: only 10 days after the decision to take no further action. There was no formal assessment of VC's capacity conducted. As the offence was one of GBH if any thought had been given to it, any decision ought to have been taken by the CPS. We note – as NGPF did in their own internal review – the guidance offered by the CPS:

> *"Mental health conditions do not provide a carte blanche for criminal culpability or an automatic exemption from liability. In the case of serious offending its relevance may be to sentencing and disposal rather than to the decision to prosecute. A thinking approach is required when considering what information is required and in explaining the purpose (evidential and/or public interest factors) for which it is sought."*[28]

24. The missed opportunity for disposal and treatment in the forensic pathway for the MHA is significant not only because (as the policies above recognise), the forensic pathway brings alternative options for the protection of public safety, but that the fact of a forensic history would impact on VC's risk profile thereafter. At every risk assessment and on every occasion when VC's risk was considered (up to and including the reports of Professor Blackwood for the criminal proceedings)[29]: the fact of any previous caution, conviction or secure detention would be highly relevant. From the outset, the minimisation of VC's risk to public safety; a failure to share information and work collaboratively; and the failure to act in accordance with existing guidance led to a devastating lost opportunity to protect the public from the harm that would ensue.

25. By 17 June, of course, Feven had been told – without any real justification – that there was nothing more that could be done. We ask rhetorically, what if she had died when she jumped from that window and not "*merely*" suffered really serious injuries. She must feature in the litany of people let down by the police in the events with which this Inquiry is concerned.

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[27] NGPF0006002_0020: *"If the clinician determines that the suspect is fit for interview, but not to be arrested and detained at a police station, arrangements should be made to interview on Trust premises if possible."*

[28] CPSE0010218 *Mental Health: Suspects and Defendants, CPS*; as cited at NGPF0007833_0005.

[29] CPS0000011_0012 at [46] and [47].

13 July 2020

26. On 13 July 2020, just 14 days after his discharge from the Crisis Team, VC forced entry into another neighbouring flat and was reported to have assaulted another neighbour ("*They have him detained on the floor. He is kicking off though*").[30] He later said he had stopped taking his medication after release from hospital. He denied being unwell and considered this to be a "mild" event. VC's mother had previously tried to call the EIP team to express her concerns about his deteriorating mental state. No action was taken.[31] On this occasion, although an incident log was opened for burglary: VC was detained using s.136 powers and there was no investigation.[32] When this decision was taken, the Street Triage Officer concerned indicated that he was not aware of any outstanding criminal matters; another error (the original criminal damage investigation remained open, but no contact was made with the investigating officer, PC Collins).[33] Closed in this way, the Inquiry will consider whether or not it would have been recorded on the PNC or on Niche. And thus whether VC's risk was consequently consistently underestimated and understated. VC was detained for a second time, this time under s.3 MHA. During this admission, Dr Seedat recorded in VC's ward review that VC showed (emphasis added):

> *"[n]o signs of remorse or insight into how his actions have affected others. Just says `there will not be a next time'. Dr Seedat observed that there seems to be no insight or remorse and that the danger is that this will happen again and perhaps* [VC] *will end up killing someone.* [VC] *simply responds by saying 'it will not happen again'".*[34]

27. The Inquiry will examine Dr Seedat's explanation for this entry. No contemporary qualifier or explanation appears in the records. Dr Seedat was, of course, aware that this was not the first occasion VC had been violent when unwell, having engaged directly with the police in May.

28. During this admission Dr Seedat explained that VC could be detained for up to 6 months. VC's mother was concerned about VC having a relapse before his exam and she "*queried about starting [VC] on depot.*" With remarkable clarity and apparent insight, VC said he didn't think he needed to make that decision now. The Doctor

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30 NGPF0000049_0001
31 NHFT0000168_0055
32 WITNO014001_0005
33 NGPF0000049_0002
34 NHFT0000168_0064

"*stressed to [VC] mother that staying in hospital won't make a difference to [VC] whilst he is well. The important thing is that he continues to take his medication on discharge*."[35] The Inquiry might consider whether the indication that depot was raised by VC's mother (herself a nurse) showed precisely her understanding of the role of medication in VC's treatment. Given that VC had already shown himself to be non-compliant with medication by this stage, the Inquiry may wish to explore whether this was a missed opportunity to have a therapeutic discussion with VC around the role of long-lasting anti-psychotic medication (known as "depot"). In this regard, the nursing notes provide some insight. At this stage, VC was recorded as settled, having insight and understanding the role of his medication. In a remark which does not appear to have featured in expert psychiatric consideration of VC's presentation, it is recorded that:

> "*Has been settled on the ward. Spoke to Angela (APIP) yesterday, appears to understand the importance of continuing to take medication when he is discharged. Appears to have developed good insight into his condition*." [36]

29. The discharge summary completed on 31 July 2020 continues in the same vein and records that by this time VC's primary diagnosis was Paranoid Schizophrenia:

> "*[VC] worked with the APIP on the ward to improve his insight of his medication and emphasise the importance of continuing his medication. [VC] assures us that he fully understands the importance of taking medication and he has developed greater insight into his illness. As this is his second episode as an inpatient it was concluded that [VC] is most likely experiencing paranoid schizophrenia*."[37]

30. Following discharge, having been detained on s.3 MHA grounds, VC was entitled to care following discharge pursuant to s.117. In the months which followed, while under the care of the Early Intervention in Psychosis ("EIP") team, VC showed signs of accepting that his symptoms had improved, but he still did not attribute them to psychosis and he was unwilling to engage in psychotherapy. However, it is notable that by 18 January 2021, a Relapse Prevention Plan was completed for him. In this he is asked to record what triggers his illness and notes that workload and stress may have had an impact. He is asked what to do if he starts to become unwell or people are worried about him: "*People not to be overly judgemental. To increase contact with my team / CRHT, avoid hospital admission, use least restrictive practice, speak with my*

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35 NHFT0000168_0079

36 NHFT0000168_0077-78 (Ward Review, 21 July 2020).

37 NHFT0000222_0003

family to offer reassurance. I would like to remain on Aripiprazole."[38] His keyworker at this time was Claudia Birtles, who will give evidence in the coming weeks. The Inquiry will wish to ask whether – despite his very concerning behaviour and lack of remorse - any substantive work or safety planning was undertaken with VC by his Care Coordinator or the EIP during this time, in order to understand his risk, triggers, early warning signs, and relapse indicators.

31 May 2021

31. On 31 May 2021, VC travelled to London and presented himself to reception at MI5. Witness G is the head of physical security at MI5. He describes VC as "*claiming to have information regarding a case*" and that he "*wanted to be arrested but would not give any more information*". VC tried the same thing at multiple entrances over a period of around 20 minutes before the police were called.[39] MPS officers attended. The Inquiry will hear from PC Foster. VC said he'd asked to speak to staff but it was a bank holiday and he'd been asked to come back another day. He did not want to speak to officers and did not explain what he wanted to speak about. He gave his name and PNC checks were done. There were no offences or information markers to suggest he was a danger (the Inquiry will wish to explore what information would have appeared on the PNC at this stage given earlier disposals). When pressed about contact with the police VC was able to tell the officers that he had been arrested the previous year.[40] It was only one time. Officers confirmed VC was known to the police but there were no warning signals, markers or special checks against his name. VC got into a taxi and left. It appears no further questions were asked as to why he had presented himself at Thames House; nor why he was seeking to speak to someone in the security services. After police attended, an intelligence report was prepared and sent to the Fixated Threat Assessment Centre (FTAC). This did not record that he had asked to be arrested, nor that he had tried multiple entrances over a period of time.[41] There is no indication that anyone: MPS, FTAC or Witness G considered whether VC may require the assistance of mental health services. A dissemination report was completed which did record that VC had asked to be arrested, but which also indicated that VC "*did not display any unusual behaviour or make unusual comments to the police and left the location prior to the police*" (The Inquiry might consider whether turning up to the front door of MI5 and asking to be arrested by security services was, in itself, evidence of unusual

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38 NHFT0000270

39 WITN0382001_0001

40 A PNC printout for VC is provided; but this post-dates the events of 13 June 2023. (METF0000003)

41 METF0000002

behaviour.) It does not appear that the officers were aware from any of the markers available to them that VC had been sectioned twice in the last 12 months.

32. These actions were, of course, consistent with a belief that he was being subject to surveillance by MI5 and indicative of declining ill health. The Inquiry may wish to consider whether adequate information was available to the MPS and FTAC and whether an appreciation of VC's psychiatric and offending history would have made any difference to the response.

July - August 2021

33. The Inquiry will hear that in July 2021, VC assaulted his then flatmate Sebastian. Sebastian was encouraged by friends to report this to the police. He called 999 and then attended the police station to make his report. Sebastian's description of the assault is predated by VC acting strangely. After the assault, VC said to Sebastian "*People are going to contact you. When they do, tell them that I will find them.*"[42] The Inquiry will hear from PC Pannell who dealt with this report of assault and will consider whether the response was appropriate. It seems clear that no examination of VC's previous record, whether on Niche or on the PNC was conducted (and if it was, inadequate consideration was given to the history of VC's contact with mental health services and the police).

34. When Sebastian reported to the officer that he knew NHS workers had attended on VC the Officer may suggest that she or her tutor told Sebastian to tell them about the assault next time they called.[43] Sebastian said the officer said they would create a report so the appropriate agency could follow up. This was, predictably, not done. Sebastian will say that he was told that the police could contact VC but if they did "*he was unlikely to be arrested or taken away and I did not want to cause trouble with VC if he remained in the flat.*" He was worried that if VC were arrested he would be "*quite angry when he returned*". Sebastian was given the impression that while VC was unwell nothing could be done to charge or remand him (if appropriate) or to remove him to MHA detention following a MHA assessment. There appears to be no consideration of any safeguarding steps that may be required for Sebastian. This matter was ultimately closed as NFA for reasons of no evidence (Outcome 16) - essentially, one word against another. That was so even though there was no "word" from VC: no account had been

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42 WITN0151001

43 NGPF0000044; WITNO015001_0004, at [15]: PC Pannell cannot recall now whether this was her suggestion or that of her tutor. She was a new police officer and still under supervision.

taken from him. This appears to be yet another wholly inadequate response. NGPF now recognise – yet again – that more ought to have been done.[44]

35. Sebastian returned to the flat and tried to avoid VC. He consistently locked his door within the flat. On 14 July 2021, VC tried to gain access to his locked bedroom in the early hours of the morning, while Sebastian was in bed. This led him to move out. He did not formally report this to the police but he did text PC Pannell to tell her this had happened. He asked: "I was wondering if this is something worth reporting to the police as well?". No response came. He was responding to a message sent by PC Pannell to notify him that there would be no further action on his earlier report. He remembers feeling disappointed but assumed that her original text may have been a "no reply" message.[45]

September- October 2021

36. By 31 August 2021, VC's condition had deteriorated sufficiently that a fresh MHA assessment was required. It was during that assessment that VC violently assaulted a male police officer, PC Barnaby Pritchard.[46] This incident cannot realistically be described as anything other than extremely violent. VC seriously assaulted a number of male and female police officers who were there to support the assessment. His level of violence was such that CS gas and repeated taser discharges were required. He had to be removed from the property in handcuffs and ankle restraints.[47] VC was taken to a place of safety and detained under section 2 MHA. VC's behaviour was so violent that the risk warranted him being nursed in seclusion until 9 September while awaiting a Psychiatric Intensive Care Unit ("PICU") bed.

37. VC was then admitted to an out of area PICU bed at Cygnet, Darlington. This was a private provider. The Inquiry will hear evidence on bed management and out of area care. Pressure on beds was, again, an issue of concern in the Clunis Inquiry 30 years ago.[48] The Theemis Report completed for NHS England highlights particular problems in the co-ordination of data when patients are placed with private contractors:

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44 NGPF0007835 This was rated as a low risk incident with no evidence of any consideration of the history, including the addition of the intelligence report relevant to Thames House/MI5 added two months earlier. There was no thought given to any re-occurrence. VC ought to have been interviewed before finalisation which may have enabled diversion or treatment options.

45 WITN0151001_0007

46 WITNO040001_0001

47 NHFT0000168.

48 See, e.g. DHSC0000160 at [12.7.2]

> "*The current system capability does not allow for the timely sharing of important clinical information between the Trust and independent providers who are placing the Trust's patients in their services".*[49]

38. On 17 September 2021, while VC was detained in the Cygnet PICU, Claudia Birtles, VC's Care Coordinator, completed a social circumstances form while he was detained for the purposes of a Tribunal appeal. She noted that his engagement since July 2020 had been "*on a superficial level*". However, he did complete a relapse plan and identified the early warning signs of relapse and potential triggers. She expressed "*some concern that he possibly minimised symptoms and he wasn't fully convinced about a long term commitment to taking medication*". She recorded that the team was concerned that VC had been non-concordant for a while and had deteriorated over the last few weeks. There is no indication in this record that Ms Birtles was aware of either the visit to MI5 or the assault by VC on Sebastian. However, in strength factors for VC, Ms Birtles records: "*[VC] has no prior history of violence and aggression towards others. [VC] is usually a calm, peaceful and law abiding citizen. [VC] initially cooperated with health and social care staff during the MHS assessment appearing calm however escalated to violence when police intervened*." This is fundamentally inconsistent with VC's previous presentation when unwell.[50] Indeed, a page later, Ms Birtles records that his assault on the officer was serious: punching, headbutting, using handcuffs as a weapon and requiring use of CS gas and Taser to subdue. The document notes that this incident coincided with two periods of particular stress. VC was about to lose his accommodation; and he was coming to the end of the year's voluntary break in his studies. He was required to re-register with the University of Nottingham in October. Ms Birtles ends this record with a summary of VC's own views:

> "*VC said that this admission has been unnecessary much like the previous two because he is not mentally unwell. VC also said that I also 'know that' it is not psychotic. When asked why I would be involved if [VC] was not unwell, [VC] said that that he believed I continued to be involved with the hospital in a cover up, stating that he was unwell when he is not. [VC] said she* [sic] *is currently taking Haloperidol and that he would rather not but will continue if he has to, he said he would make a sacrifice if it meant he could be discharged. [VC] said he feels like he doesn't have a choice but it* [sic] *not taking it because he needs it. Similarly [VC] said he 'would have no choice' and would have* [sic] *engage with support following discharge although he does not think that it is necessary. Discussed possibility of depot medication as one option. [VC] said that this would depend on the side effects however stated it might be easier than taking medication everyday.*"[51]

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49 NHSE0000298_0029.
50 NHFT0000275
51 NHFT0000275_0007

39. Ms Birtles spoke to VC's mother and recorded:

> "*[I]t was difficult to offer her views as she hadn't had the opportunity to sell* [sic] *[VC] since his admission. Celeste said she would try and speak with [VC] over the weekend. Celeste does feel a monthly injection may be beneficial given issues with concordance.*"

40. Ms Birtles concluded this document with her concerns for VC and her view on depot:

> *"I have spoken to VC about a long acting intramuscular anti-psychotic depot and depending on side effects VC said he would be willing to explore this further. VC currently has no accommodation in Nottingham and will need to secure another tenancy. VC is possibly returning to University this year so I hope that he will be well enough to return to his studies and achieve his full potential.*"

41. Again, the Inquiry will consider whether this admission was a missed opportunity to consider a CTO and/or a move to depot medication.[52] Prior to VC's appeal to Tribunal, consideration is given by clinicians to the use of depot if VC is detained on s.3 MHA. VC's appeal was unsuccessful. VC participated in the hearing and he told the Tribunal that he had consistently taken his medication for 13 months up to August 2021. He said he had conversations with his family and with hospital staff and had been persuaded he had psychosis. He said he felt medication possibly helped him. He said he would have no issues with seeing Ms Birtles and "*had no concerns that the serious situations which had previously occurred could happen again*".[53] The Tribunal agreed VC had a psychotic disorder, most likely to be paranoid schizophrenia. They expressly cited concern over VC masking ("*his presentation was somewhat guarded*"), noting that he minimised the events including his serious assault of PC Pritchard.[54] He remained in the PICU and was detained from 24 September pursuant to s.3 MHA. The Tribunal said: "*given the rapidity and severity of relapses in his condition, it is essential that medication is maintained and optimised.*"[55] Appallingly, at no time was depot used.

42. This was despite an early view expressed by Ms Birtles that this ought to be considered ("*This is obviously his third admission and concordance remains an issue.*")[56] John Laverick said this was not planned and would best be discussed when VC had stepped

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52 CQCM0005446
53 CYGN0000056
54 CYGN0000056
55 CYGN0000056
56 WITN0348001_0113

down from PICU.[57] It remained Ms Birtles view that he would not take medications willingly and depot was needed to ensure his treatment. She considered he needed to be on a CTO and advocated for this at the Tribunal.[58]

43. On 1 October, VC was stepped down to acute care at the Priory Arnold (another private provider).[59] On admission, it was recorded that:

> *"[VC] spoke about the reasons for admission and showed insight into his mental health illness, he recognised that he has pscyhosis and he stated that he didn't mind taking medication (However notes suggest that he has been non-compliant before in the community.)"*

44. This qualifier to VC's statement appears to ignore the evidence of non-compliance and masking presented to the Tribunal less than a few weeks previously. In fact, it may be a reflective of calculated masking on VC's part: it is, as yet, far from clear that the Cygnet records were provided to the Priory; or whether a copy of the Tribunal decision was shared. Notably, on 23 September, following a remote hearing, the Tribunal recorded VC should continue to be detained. The decision recorded the view of Dr Shoilekova that she did not think VC had recovered insight but that he "*has the potential to*" if he complies with treatment; if his insight does not improve she would recommend a depot. She told the Tribunal that if discharged she would be very concerned about VC's safety and that of others: *"When he is unwell the risks are serious*".[60] There had been some concerns from his Mum "*on occasion*". VC is an intelligent man. He would have read this evidence and the conclusion of the Tribunal. The Inquiry may wish to consider whether this may provide any explanation for any change in his presentation once transferred to acute care; and, moreover, whether it was clear reason for any clinician thereafter, whether Priory staff in October 2021 or staff from NHFT in January – February 2022 or in the community, to exercise particular professional curiosity and care as to any risk of masking by VC.

45. In relatively short time, it appears VC's medication was changed at *his* request from Haloperidol to Aripiprazole; any discussion of a CTO or depot medication was seemingly

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57 NHFT0000168_0190

58 WITN0348001_0113

59 NHFT0000268

60 CYGN0000056_002-3. This application appears to have been made on 15 September 2021; with an earlier hearing postponed as VC choice of representative was not available. A further application may have made on his behalf on 27 September 2021 seemingly by different solicitors. PAGR0000016_011, compare CYGN0000079.

abandoned.[61] During this time there is little evidence of engagement with VC who is repeatedly described as stable and low profile, spending time in his bed space on his phone and his laptop. By 18 October, VC was discharged from his s.3 detention. Thereafter, the opportunity to consider a CTO and any conditional treatment by depot was missed. On 22 October, he was discharged to a new address.[62]

46. The Inquiry will wish to consider with clinicians and with Ms Birtles, what changed from the early weeks of October 2021 and what was being done by Ms Birtles to ensure continuity of care. We understand that Ms Birtles was on leave when VC was discharged.[63]

47. While VC was detained, a file was prepared on the assault of PC Pritchard and submitted to the CPS. In November 2021, this was returned incomplete with an action plan after officers had singularly failed to obtain medical evidence and statements. The investigation remained open and was not progressed until 20 March 2022 when a new OIC was appointed. The treating clinician was asked for a view on VC's mental state on the day of the assault. The Inquiry will note that Dr Benjamin Lomas refused to provide such without VC's consent.[64]

January – February 2022

48. On 18 January 2022, within three months of his release from hospital, VC was again detained under a place of safety after further violence. On 15 January, he had assaulted his flatmate and held two others hostage. Some video from this incident is available which the Inquiry has seen.[65] Consistent with his previous pattern of behaviour, he had been disengaging with the EIP team and was once again believed to not be concordant with his medication. On 19 January 2022, VC was assessed as not requiring admission to hospital and placed under the care of the Crisis Team. During this time Eleanor Turner, the University of Nottingham's Head of Mental Health Services, was in contact with the EIP and Claudia Birtles and repeatedly expressed her concern in calls and by e-mail.[66] When VC was assessed as fit, she recalls challenging the consultant as to whether he was safe enough to reside in student accommodation. The question was not answered, but she was told he was "*suitable for home treatment*".[67] On 21 January,

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61 PAGR0000159_0003. An MDT record for 7 October shows clinicians agree to VC request to change from Haloperidol to Aripiprazole, as the former made him salivate a lot.
62 PAGR0000025_0001
63 WITN0348001_0120-21
64 NGPF0007835
65 WITN0059002.
66 WITN0054001_0026 - 0035
67 WITN0054001_0026 - 0035

Ms Birtles wrote to Ms Turner and confirmed the prescient view of the EIP team: "*we are also concerned that home treatment is potentially quite risky and in my opinion unlikely to be successful.*"[68] In what might be thought of as an example of the tail wagging the dog, the flatmates were required to move to alternative accommodation so that VC could remain living at the property. *Their* lives were disrupted. Just *nine* days later (28 January 2022) concerns about ongoing medication concordance and disengagement from services meant VC was admitted to hospital under section 2 MHA. This final admission, was again, very short. He was discharged on 24 February, just shy of the date the s.2 detention would have lapsed (after 28 days).[69]

49. It was recorded in VC's medical records that the police would not proceed with the assault on Christopher as there were no injuries. When the police attended the flat on 15 January, VC refused to apologise and they left: VC remained in the flat and no other steps were taken. Christopher explains that he went to the police station to provide a statement. It appears far from clear that Christopher understood that if he did not want to take it further, no prosecution would proceed and it would not be recorded as a crime: "*After I said that I did not want to take it any further, there were no discussions as to whether the incident may/may not lead to a charge or should/should not be formally recorded as a crime and this was never explained to me.*"[70] Christopher added: "*After the incident VC would get aggressive and come into our rooms and tell us to "shut the fuck up". The mask came off after the incident*". He added that VC would knock on another flatmate's door (Ryan). Christopher said: "*I felt intimidated by him, and I wanted nothing to do with him. I thought he was crazy and did not want to get involved with him.*"[71]

50. While the records indicate that s.3 was considered, it is later said that it was determined that s.2 was more appropriate. The Inquiry will be invited to consider whether – given this was the fourth admission – in the context of consistent non-concordance and resulting acts of violence – it was appropriate for the admission to be on s.2 rather than s.3 grounds.

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68 UNIN0000734_0011
69 NHFT0000168_0261
70 WITNO059001_0009
71 WITNO059001_0010

April - September 2022

51. On 26 April 2022, Sebastian reports stalking behaviour by VC to the police. There appears to be no evidence that this complaint was considered either in the context of VC's history or in the context of the assault which Sebastian reported in July 2021. A further report is made by Sebastian on 28 July 2022. When it becomes clear that Sebastian is reporting multiple acts of apparent stalking behaviour there is no consideration of any harassment offence or whether any harassment notice ought to be served on VC. No contact is made with VC and no contact is made with his Care Coordinator. On 21 April 2022, VC was observed to have returned to his old address (where he had assaulted Christopher in January) and this is picked up by University of Nottingham staff. Security on site noted that he had been on site, when challenged he lied and said he was visiting a friend: giving false information. He was escorted from site, but the flat mates confirmed that he had been there two hours before security had seen him. It was recorded in the report to Res X that he had been wearing a balaclava.[72] The University again contacted Claudia Birtles.[73] The Inquiry may wish to consider whether in the context of the ongoing contact with the CPS regarding the prosecution of VC in connection with the assault of PC Pritchard, this apparently similar pattern of behaviour would and ought to have informed any risk profile for VC and any decisions taken in the public interest. The Inquiry may wish to ask whether certain people were doing their jobs. The Inquiry may wish to consider whether this was another opportunity to intervene that was lost.

52. On 28 April 2022, VC's care was transferred to a new Care Coordinator, Gary Carter. His care plan following discharge had not been updated.[74] In apparent contrast to the *response* of agencies to what he had *done,* his history of violence and aggression was sufficiently well known that a direction was given that he should not be visited unaccompanied.[75] No further proof of the appreciation of the serious risk he presented is needed.

53. In April 2022, the file relating to the assault of PC Pritchard returned from the CPS. On 23 August 2022, VC was summonsed to appear on 22 September 2022. There is no explanation for the substantial delay in progressing the file to charge.[76] However, the Inquiry may wish to consider whether this was yet another example of the holistic picture

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72 UNIN0000125_0002-3
73 UNIN0001437_0002 (Christopher Hoskins to Ellie Turner, 26 April 2022).
74 NHFT0000198.
75 NHFT0000190_005.
76 NGPF0007835.

of the risk posed by VC having been lost. Had a file on the GBH involving Feven earlier been presented to the CPS would the significance of the two offences taken together have created an impetus to interview and/or arrest VC during his period as an in-patient or on discharge in late October 2022? Would this risk profile, better understood have led to a period of remand in a secure setting in September or October 2022, rather than a step down to Priory Arnold? These are critical questions for the Inquiry to consider even before the consideration of VC's failure to appear.

22 September 2022

54. On 22 September 2022: VC failed to appear and a bench warrant was issued. On 23 September, he was discharged from the care of the EIP team. The coincidence of these two events is deeply frustrating for those we represent. The EIP may say they were oblivious to the charges laid and the warrant issued immediately prior to his discharge from care.

55. We do not propose to deal with the detailed events leading up to VC's discharge from care in this opening. The Inquiry has the benefit of the CQC and NHSE reports and will hear from both Claudia Birtles and Gary Carter. Engagement during this period was brief and VC was last seen on 4 July 2022. In July 2022, VC had stated that he had enough medication to last him until October. The EIP team, who were in charge of his dispensing, knew that this would not be true if he had been taking his medication as prescribed. When VC spoke to his care coordinator in August 2022 and provided NHFT with a new address, no attempt was made to visit him. In all the circumstances, the failure to contact the police when VC disengaged and appeared to be missing and avoidant, was unconscionable. The rationale provided for not contacting the police was because experience suggested it would not be *helpful*.[77] The Inquiry must carefully consider the implications of such an attitude being allowed to develop and continue in such a crucially important context. The Inquiry may hear that killings by people with poor mental health accounted for about in 1 in 5 of all homicides in the UK in 2025.[78] It is nothing less than shocking that community psychiatric services would consider it unhelpful to inform the police that they had just discharged for non-cooperation a man with apparently poor mental health who presented so much risk that he should not be visited unaccompanied.

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77 WITN0368001_0063 at [269].

78 The homicide statistics collated by ONS show there were 522 homicides recorded in the UK to March 2025. The Inquiry will hear evidence from Julian Hendy that his charity, Hundred families is so called because there are on average 100-120 mental health related homicides each year (see WITN0258001 _0004 at [15]).

56. After September, there was simply no action on the warrant. Despite the long history, available to be recorded on Niche and the PNC, there is no indication that the clinical team were contacted for any information as to VC's address; nor any indication that the University of Nottingham was contacted for similar reason. The Inquiry will hear evidence as to the minimisation by NGPF of the failure to act on this bench warrant. Those we represent will give evidence as to when they understood its significance. Notably, following sentence, a draft press release which invited senior officers only to address the warrant when directly questioned about it and, suggested that the reason the warrant was not acted upon was VC's "*nomadic*" lifestyle.[79] ACC Griffin addresses his amendment of the release at length, including that he removed this reference as inaccurate before it could be released. ACC Griffin recalls that he spoke with Matt Jarram and clarified that the police had not in fact made any proactive efforts to locate him.[80] This information - that no proactive efforts had been made to locate VC - was not communicated to those we represent at any time during the criminal proceedings, or at the sentencing. Nor, consequently, was it honestly and candidly reported by the police to the general public when police officers held press conferences to inform the world of the great job they had been doing.

5 May 2023

57. On 5 May 2023 VC assaulted two of his co-workers: a husband and his wife. Both were injured and the police were called. This time, response officers from Leicestershire Police attended: PC Taylor was new to the force. She was on her 12th operational shift and under supervision of her tutor PC Amos-Perkins. Their supervising sergeant was PS Mark Read[81]. There were a number of flaws in that investigation: BWV which recorded initial accounts and the available CCTV was not saved. Statements were not taken. It took weeks to confirm VC's name with an employment agency. (Officers obtained his name on 24 May 2023: coincidentally three years on from that first encounter with Nottingham Police). The Inquiry might hear that Arvato - where the attack occurred - had his full name on record.[82] Officers (and other witnesses) might be asked why that was not obtained before 24 May. The failure to act on VC's name and contact information once obtained remains for those we represent, a significant and

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79 WITN0074001_0081-82

80 WITN0074001_0081-82

81 WITN0009001

82 ARVS0000045_0011-12 (While he may have been known colloquially as Val Mendes, an email dated 2 May 2023 records VC's full name, for the purposes of time-sheets at Arvato.)

devastating one. It is admitted that no PNC check was done.[83] If one had been done the outstanding bench warrant would have been flagged. PC Taylor will say she didn't then know she should. PC Taylor did access Niche. She asked PC Amos-Perkins for help on how to add VC's details. In interview with the IOPC, PC Taylor said:

> *"During this shift I received an e-mail … with the suspect's name on it. I had to ask my tutor for help and how to add the suspects detail to niche what classification to recall them as I believe that when I did this I had a look at some of the previous investigations linked to him."*[84]

58. Those we represent now struggle to understand how even a junior officer, albeit one working on Niche with the support of a more experienced tutor would not have observed there to be a significant history of Occurrence Enquiry Logs entered on Niche ("OELs") connecting acts of violence by VC to his deteriorating mental health, as well as the warrant.[85] This will be a significant issue for the Inquiry's consideration which will require detailed questioning of the officers. It will likely be said that this act would have made no difference because even if the outstanding warrant had been acted on, VC would not have been in custody. This is a matter for the Inquiry, but such a response entirely neglects the seriousness of the attack on PC Pritchard; the potential for treatment in the forensic pathway; and separately, whether an assessment should and would have been sought, for the purposes of a civil detention. It may even have resulted in further consideration of a CTO and depot medication.

59. Those we represent find the dismissal of any of these actions, mistakes, or missed opportunities as being irrelevant to the events of 13 June not only difficult to endure but offensive. Each failure and each moment lost, may have changed VC's course and diverted him away from Ilkeston Road, away from Magdala Road and away from Wayne, Sharon and Marcin. The Inquiry will consider whether viewed individually, or collectively, these missed opportunities and this pattern of failure between 24 May 2020 and 13 June 2023 left VC free, untreated and dangerous and contributed directly to the tragedy that ensued.

60. In the disclosure provided to the Inquiry, the same, predictable failings identified in the Clunis Inquiry appear time and again. This brief chronology cannot possibly cover the

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83 WITN0009001_0023 (BWV), 0025 (PNC Checks, at [100]).
84 IOPC0000018_0016
85 WITN0009001_0024 at [97].

range of material now disclosed. The Inquiry will consider, for example, actions which appear to illustrate:

(i) Failures in joint working and information sharing between and within agencies

61. There were examples of failures to share information within institutions. The Inquiry will hear that PC Gail Collins didn't know about the details of the second attack on 24 May when she began her investigation as she believed data protection prevented her from considering it.[86] The Inquiry will hear that the Trust was unaware that VC had been charged with the offence of assaulting an emergency worker (even though it was an offence occurred in seeking to enforce a s.135 MHA warrant).[87] The University of Nottingham: who had raised concern over VC's early discharge in May 2020 was not notified that he had been sectioned in September 2021 and that he remained in detention subject to s.3 when he resumed his studies. The Inquiry will hear that in late April 2022, at around the same time Sebastian reported VC's stalking behaviour to the police: University of Nottingham Res X staff reported that he had been hanging around his previous home in a balaclava for hours.[88] Despite information sharing protocols between the two organisations predicated on risks of serious harm: it appears neither told the other about the information they held (or if they did, no connection was made). Information was communicated to the Trust: but not in its full detail: when VC was challenged he said he was picking up his mail.[89] Ms Birtles, who was still VC's Care Coordinator at that stage, wrote with foresight based on their joint experience of VC: "*Really difficult to assess to be honest but I think full disengagement from services is likely to be our only indication that things have deteriorated further.*" The issue went no further then.[90] The University of Nottingham witnesses, in their evidence will tell the Inquiry that information sharing remains a problem. The CQC and NHS England reached similar conclusions over information management in clinical care.

62. The Inquiry will hear from Alex Ruck-Keene KC on securing legal confidence amongst professionals as a recommendation. He adds: "*the law does not prevent appropriate*

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86 WITN0036001_0007

87 WITN0348001_0153 (Claudia Birtles, at [467]), WITN0368001_0310 at [310] – [311] (*"I cannot see how the EIP team could have possibly discharged VC on 22 September 2022 if they had known about the bench warrant. If we had known, we could have contacted the Police and explained that we have also not been able to find him."*)

88 UNIN0002328_00010 (21 April 2022)

89 UNIN0000633_0003

90 UNIN0000633_001-2

information sharing…to the contrary, it permits it and indeed, on occasion may even mandate it." Further, he will urge the Inquiry to consider how the MHA might be made to do what it says on the tin: "*a legal framework which did not focus upon crisis management (which is, in reality what the MHA 1983 does) would perhaps go some way to minimising the chances that* [attacks like those carried out by VC] *occur again.*"[91]

(ii) Failures to use existing tools effectively

63. The Inquiry may consider whether failure to use the power to utilise s.3 MHA and instead using s.2 MHA as a form of least restrictive practice is a flaw in clinical practice (Professor Simon Wessley will give evidence on his work on the Independent Review of the Mental Health Act 1983, in his statement at [110] – [111]).[92] When VC was detained in January 2022, having been repeatedly non-concordant with care and medication: the Inquiry will consider whether he ought to have been detained for treatment, and not assessment. The Inquiry may hear that on admission clinicians reflected "*we were not clear whether he required depot antipsychotic medication, a short period of admission to ensure he was in fact concordant with oral medication, trial of an alternative antipsychotic medication should he be concordant but still be found to be symptomatic*". It may be by said that the decision not to use s.3 was aligned to an understanding that s.2 would not rule out the use of s.3 later.[93] It is perhaps notable that on admission Dr Lomas recorded there had been a recent incident where VC held his flatmates hostage "*though the details of this are not clear*".[94] He accepts that it would have been good to have known more about that incident and to have spoken to VC's community consultant and his Care Coordinator. On 4 February, while VC was detained, it was recorded that VC's flatmates (one of whom he had assaulted) had reported him behaving oddly, trespassing into their rooms and his hearing screaming that was not there.[95] It is difficult to understand how these were not taken as evidence of direct repetitions of the earlier auditory hallucinations which precipitated each of the earlier detentions but instead were written off as an intermittent experience of hallucinations connected to stress.[96] Back in May 2020, again and again VC said he

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91 WITN0288001_0081-82

92 WITNO322001_0050, citing the recommendation in the Review (at WITN0155008), recommending that the Code of Practice make clear that s3 detention should be used when a person has been previously detained in the last 12 months.

93 WITN0316005_0003

94 WITN0316001_0054 (Benjamin Lomas)

95 NHFT0000168_0228 (This reflected what the students were telling others. See CPSE0001738_0005, and UN0001788_0001)

96 WITN0206001 _0094

heard his mother being harmed. There were repeated missed opportunities to consider a CTO or depot. All were missed in seemingly prioritising preferences expressed by VC. He did not like needles (despite having undergone Covid vaccination) and that was apparently that.[97] On this occasion there appears to have been a focus on VC's studies rather than his history. The benefit of any doubt lay with VC.[98] These were decisions taken which appeared to neglect that VC was known to mask his symptoms; known to have increased insight when medicated and known to resort to violence when in the community and unmedicated.

64. The Inquiry may wish to consider whether at any time a referral should have been made to the Community Forensic Team in light of VC's known risks, in order that the specialist knowledge of the forensic psychiatric services could be brought to bear in the assessment of risk. It appears such a move was never even discussed. Nor would it have been considered for any patient. As his Care Coordinator says*: "In my four years at the EIP team, I don't know of anyone referring a patient to forensic services"*.[99]

(iii) Failures in record-keeping and records management

65. A critical example of failures in risk management arises in the transfer of records between private providers and the NHS. For example, various documents completed on VC's final admission on 28 January 2022 record his diagnosis as "*First Episode Psychosis*", neglecting the history and diagnoses of likely Paranoid Schizophrenia, recorded on earlier detentions, including at Cygnet, for example.[100]

(iv) Failures in risk assessment and management

66. The Inquiry will consider these in detail. We have addressed some in our brief chronology of failure. One stark example appears in late October 2021, shortly before

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97 NHFT0000168_0229. Blood draws were taken during admissions with no issues noted, see e.g. NHFT0000024. Further, VC was given forced IM medication when necessary, without consent, during his nursing in seclusion before his admission to Cygnet, Darlington. Although there were delays in administration due to lack of staff, injections were given under restraint on 6. 7 and 8 September 2021 (NHSE0000298_0098).

98 WITN0206001_0094-95 at [313] – [320] (Kartik Thangavelu): "*It is of course possible that VC was not truthful, both with regard to his previous and current symptoms, and sought to conceal symptoms during every attempt by mental health professionals to elicit them throughout the during the entire period of admission to hospital did not in my opinion, support such a conclusion*." These decisions might be compared with the critical analysis in the approach of the Tribunal in September 2021.

99 WITN0368001_0025.

100 NHFT0000198_0002

VC is discharged from Priory Arnold. VC returns from section 17 leave away from the hospital: he is carrying a hammer in his backpack. It was recorded:

> "*There have been no issues regarding his safety…[VC] had brought some belonings [sic] brought in when he went on community leave. [VC] had brought a hammer in his rucksack, it is unclear as to whether he picked this up by accident or whether it was intentional*".[101]

67. As the Theemis Report for NHS England concluded:

> *"The way in which risk was being documented and formulated was not indicative of a dynamic approach to risk assessment and management. That is to say, risk was not considered to be changeable based on the presence of known hazards and in the context of different settings".*[102]

68. Even in January 2022, by which time VC had repeatedly tried to forcibly enter other people's homes; had required restraint by his flatmates; had seriously assaulted police officers assisting with an MHA assessment; had required nursing in seclusion due to violence when acutely unwell; and, had held a further two individuals hostage whilst assaulting one of them, his risk is recorded as including "*approaching neighbours*" and *"verbal hostility"*.[103] That assessment is simply unjustifiable.

(v) Failures to exercise individual professional curiosity or responsibility

69. The "*hammer*" may be a seemingly stark example of a failure. There were others. The Inquiry will hear evidence from many clinicians involved in VC's care. Those we represent ask the Inquiry to consider when and whether professional curiosity or responsibility may have failed. Some witnesses may fall back on "*the benefit of hindsight*". We ask the Inquiry to be sceptical and inquiring of witnesses who say that with the "*benefit of hindsight*" they may have acted differently. Those we represent wish to know why they did not deal with that which was in front of them.

(vi) Failures to listen to those expressing concern and urging caution / priority for public safety

70. The Inquiry will hear that individuals close to VC and his presentation raised questions over the safety of his discharge. Eleanor Turner, for the University of Nottingham took

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101 PAGR0000025_0006
102 NHSE0000298_0130
103 NHFT0000168_0209.

steps in Summer 2020 to question Dr Seedat, his responsible clinician as to whether it was safe for him to return to his accommodation. She was dismissed by Dr Seedat. Claudia Birtles, VC's Care Co-ordinator will give evidence that she also expressed concern over the approach to discharge and discharge planning for VC. Indeed, the conclusions of the CQC and NHS England acknowledge the significance of the input of community clinicians being ignored. (Again, the Clunis Inquiry considered the role of the keyworker would be crucial. It seems three decades on, this may have been forgotten. The Inquiry may hear evidence on how the role for Assertive Outreach has been diminished by 2026.)

(vii) Speedy diversion and/or discharge prioritised over public safety

71. Ultimately, the Inquiry may ask whether, despite the learning of Clunis, and everything that has followed since 1994: diversion from the criminal justice system and treatment in a forensic pathway was too quickly presumed. And the Inquiry may also ask whether the switch in his presentation between community and in-patient treatment was adequately considered as part of the risk matrix.[104] Once in the civil pathway for treatment, in each circumstance, speedy discharge was prioritised over risk management and care planning.

72. The Inquiry will hear evidence from academics and experts about the use of the existing tools in the MHA toolkit, in both the civil and forensic pathways. From secure hospitalisation in the criminal pathway, to the use of s.3, s.117 and CTOs, there will be questions as to whether VC's case is cause to revisit the guidance offered to professionals and/or the law itself or whether the tools were available, but ill-used as a result of systemic or individual failures.

73. The Inquiry is working at a time when the Mental Health Act 2025 has received assent but is not fully in force. In part, the purpose of the Act was to formalise the *"least restrictive"* approach to treatment, designed to preserve patients' rights to privacy and liberty. Significantly, section 1 defines "*least restriction*" as "*minimising restrictions on liberty so far as consistent with patient wellbeing and safety and public safety*" (Emphasis added). Section 5 amends the grounds for detention pursuant to ss 2 and 3 of the MHA. Detention will only be possible on evidence that serious harm may be caused; and the nature, degree and likelihood of such harm is such that the patient

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104 NHSE0000298_0130

ought to be detained (s2) or that it is necessary for the patient to receive medical treatment and; both the treatment cannot be provided unless the person is detained and the appropriate treatment is available (s3).[105] A Code of Practice for the Act is expected to be developed in 2026, concurrent with the work of the Inquiry. In the light of the evidence the Inquiry will hear about the response to VC and the risk he posed: the question of "*least restrictive*" only "*so far as is consistent with … public safety*" cannot be detached from an objective, fully informed, appreciation of the real risk posed to public safety. An understanding of the least restrictive appropriate intervention possible cannot be safely or responsibly reached without a full and longitudinal, *informed* assessment of the risk posed by a patient, whether to themselves or to others. The ability to adopt a truly "*least restrictive*" approach goes hand in hand with a professional approach to risk assessment and the understanding of dangerousness. Similarly, the Inquiry might consider whether the amendments to the thresholds for detention might properly be understood in terms of nature, degree and likelihood, or necessity, without a full and proper risk assessment. Those we represent may invite the Inquiry to consider whether anything less would be an abdication of professional responsibility both to the patient and to public safety. They remain concerned that no change in the law should make it more rather than less likely that these events will be repeated.

74. A further element for the consideration of the Inquiry will be in the management of the relationship between the NHS and private contractors and the role of oversight by the CQC in the management of risks to public safety. While VC's care was contracted out to private providers in September and October 2021, NHFT remained responsible for the oversight of his referral and continuity of his care. For example, the Inquiry will hear that his Care Co-ordinator, then Claudia Birtles, retained continuing responsibility for oversight of VC's progress and his continuity of care, for example.[106] NHFT was ultimately responsible for the referral and placement of VC with the relevant private providers, albeit under the terms of existing contractual arrangements. The Inquiry will

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105 The Inquiry will hear the evidence of Alex Ruck-Keene KC (Hons) on the implications of these changes. Our clients are concerned that he writes that much will hinge on the Code of Practice and associated guidance, professional training, resource pressures and how cross-team and cross-organisational working is supported. He further notes that the provisions on police powers are unchanged, save as regards places of safety at police stations for the purposes of ss135-6. He adds that it is conceivable therefore, that the existing strains between the NHS and local authorities and the police in the context of the Right Care, Right Person police will be "*accentuated*" (WITN0288001_0077).

106 WITN0389001_0018, Statement of David Waldron, at [23] "*the patient's CCO would be in charge of making regular contact with the placement provider and patient during their admission. The CCO would attend ward rounds and be charged with making the appropriate community referrals for the patient for both health and social care needs.*" At [25]: "*If any issue arose from the Daily Demand Meeting, including any issue of bed flow or admissions or discharges, these would be escalated to the Quality Assurance team within the Trust who oversees the out of area beds.*"

wish to consider the care with which these referrals were made and the care exercised by the Trust in maintaining oversight and continuity of VC's care.

75. In March 2021, the Priory Arnold had been rated inadequate by the CQC, including for reasons of patient safety and good governance. Concerns raised included patient safety and record keeping. On 19 August 2021, the minutes for the NHFT Contract Executive Board attended by both executives for the CCG and the Trust include a presentation confirming new admissions had been stopped, "*CQC restrictions remain in place - Priory have not yet approached CQC to have these removed*" and "*Trust continues with monthly operational meetings*".[107] At the next meeting on 23 September 2021, it was noted that the NHT Quality Assurance Group had asked for further assurance to be provided at the next meeting Scheduled on 29 September 2021.[108] On 1 October 2021, NHFT approved VC's step-down care from an out of area placement in Cygnet Victoria PICU in Darlington, to acute treatment at Priory Arnold. This arrangement proceeded while the CQC restriction was still in place. There was a brief pause, communicated to David Waldron, Out of Area Bed Coordinator for NHFT while Dr Gurusinghe sought CQC approval for the placement.[109] On 29 September, Mr Waldron had written to his colleague that "*the cygnet team are getting a little bolshy*".[110] Priory Arnold was local, but the Inquiry will wish to consider whether anyone at NHFT truly asked whether it was a safe, appropriate move for VC.

76. To return to the timeline: there is no question that VC ought never to have been discharged from the care of NHFT in September 2022 as he was. Gary Carter, VC's Care Coordinator at the time of his discharge will say the discharge happened without his knowledge.[111] Yet, discharged, he was.

77. VC posed such potential risk to human life and physical integrity that NFHT staff would not meet him alone in his home, yet he was left on the streets of Nottingham without support, care or oversight and without the people of Nottingham knowing the risks he presented. This was a person said to be known to lack insight. He was known to be habitually non-compliant with medication. He was known to have a history of violent acts when unmedicated. Those acts were known (or ought to have been known) to be increasing in scale and intensity. It was known that the only occasions when VC would

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107 NHNB0006177_0014 (The Inquiry has a statement from Julie Attfield: See WITN0329001_0051-52.)
108 NHNB0006181
109 WITN0389016_0001
110 WITN0389011
111 WITN0368001_0069 (at [295]): He was on sick leave.

engage with his care when he was detained, having been diverted to care as an alternative to criminal proceedings. Yet, there was no follow-up, no concern.

78. VC was no longer their problem, until the next crisis.

79. The Trust must have known (or ought to have known) that VC would never present for care other than in the context of a violent act of criminality. We know that a critical opportunity was missed on 5 May 2023.

80. Sadly, the next, predictably inevitable crisis came on 13 June 2023.

C. THE FIRST RESPONSE

81. The first call to 999 is recorded at 4.04.48.

82. The examination of the actions of those first responders who attended Ilkeston Road and Magdala Road should not diminish that they were faced with devastating scenes of brutality. Those we represent understand that there will be first responders who are themselves understandably traumatised by memories of that day. However, this Inquiry must examine what was done in order that they might appreciate whether everything that could be done was done to help prevent the loss of their loved ones that morning.

83. We do not propose to address the detailed evidence on the first aid provided, including the clinical evidence, in opening. There has been as yet no substantive inquest concerning the deaths of Barney, Grace and Ian.

84. The Bereaved Families CP Group have invited the Inquiry to instruct an expert suitably qualified in emergency medicine to consider the injuries inflicted on each of their loved ones and to report. This will ensure that any issue of their medical cause of death and the question as to whether any more could have been done to save them (Question 9(b)) can be addressed with appropriate sensitivity and actions taken by first responders examined only to the extent that proves necessary to meet the Inquiry's terms of reference.

D. "CALL TO CUFFS"

85. The Inquiry will hear that Nottingham police were and are proud of themselves and their response on 13 June. We will hear that, in the same draft press release where senior officers were instructed not to mention (unless asked) the outstanding bench warrant for VC's arrest which they had failed to act on for almost 3 years, they were to proudly publicise that there had only been 91 minutes from "*call to cuffs*".[112] We understand that this was edited in the final release to read: "*91 minutes after the first 999 call*".[113] The force remains defiantly proud of their response in the statements provided to this Inquiry.

86. However, there are some very serious questions to be asked of NGPF witnesses in the coming weeks as to whether more could have been done and ought to have been done after the first call made to 999:

a. First, there are significant questions over the tactical leadership afforded by the Force Control Room ("FCR") under the direction of CI Mather.

b. Second, those we represent are deeply concerned that the Inquiry does not yet have a full and clear picture of how instructions and information were being communicated across the force on the morning of 13 June. The Inquiry may hear evidence as to problems with Talk channels; recordings of calls from the FCR seemingly lost or unavailable; and that the recording of the top desk was not turned on until some time after Operation Plato had been declared. It is the evidence of CI Mather that none of the outgoing calls from the FCR were recorded.[114] The Inquiry may consider whether this lack of consistent contemporary record is reflective of the care with which NGPF approached the events of 13 June 2023.

c. Thirdly, there was no coherent command and control of the search for VC after the attacks on Ilkeston Road. There could be no doubt for anyone attending the scene that this was an horrific attack by a unbelievably violent and dangerous individual. VC was armed and at liberty in a city centre in the small hours of the morning. The police had a window of time before the city would be up and about. Those we

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112 NGPF0004449_0005 (Reference to the warrant only being released if asked at NGPF0004449_0004).

113 NGPF0004527_0016 (which is not the original release; but a compilation of statements in a single word document).

114 WITNO034001_0008, at [30].

represent ask the Inquiry to consider whether there is any evidence of urgency or professional direction in the actions taken - whether in the FCR or on the streets of Nottingham - between the attacks on Ilkeston Road and the killing of Ian Coates on Magdala Road. For now we highlight three elements of concern:

i. Deployment and Tactical Authorisation of Armed Response
ii. Live use of CCTV
iii. St Barnaby's Cathedral / Derby Road (Log 0069)

(i) Deployment and Tactical Authorisation of Armed Response

87. There were three Armed Response Vehicles ("ARV") in Nottingham that morning. Two were deployed by CI Mather to Ilkeston Road. The third also travelled to Ilkeston Road.

88. CI Mather was the Force Incident Manager ("FIM") and the Tactical Firearms Commander ("TFC"). PC Speeden was the Operational Firearms Commander for the day ("OFC").[115] The Inquiry may wish to consider the APP on Armed Policing guidance on deployment, threat assessment and working strategies. This guidance specifically instructs that decisions should be specific to the risk of harm and designed to consider tactical options to mitigate risk: "*As soon as the first information is received, potential immediate actions and generic options to mitigate identified risks should be considered. This may include the relocation or deployment of AFOs as a contingency, or to carry out an investigative assessment. As more information becomes available, specific tactical options should be further considered in the light of evaluated intelligence and the relevant powers and policy.*" Further: "*Along with the primary aim of securing public safety, consideration should be given to whether it is possible to identify, locate and contain the subject and take appropriate action to neutralise the threat posed. Generic options should not be considered in isolation and once a particular approach is determined, armed policing activity should be defined as specific tactics.*"[116]

89. It is anticipated that CI Mather will say his intention was to prioritise first aid for Barney and Grace: Authorised Firearms Officers ("AFOs") have greater first response training and equipment. While this may have been laudable: the Inquiry will consider whether the presence of highly skilled officers were resources that were required to be static at

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115 Albeit that it appears PC Yallop can seemingly be seen on BWV at the arrest of VC, later wearing the OFC insignia.

116 NGPF0010086 _0090

a time of incredible danger, once specialist East Midlands Ambulance Service ("EMAS") and Air Ambulance crews arrived on scene? The BWV demonstrates that the AFOs played a very limited role in providing first aid to Barney and Grace even before EMAS crews arrived.

90. At 04.05:49, authorisation for Taser was given by CI Mather. The tactical assessment was that the risk was low.[117] However, the working strategy was given as: *"Minimise Risk to Victims"…"Minimise Risk to Public in Vicinity; Maximise Safety of responding officers" and "Minimise Risk to subject"*. The first instruction given is "*locate and deal with subject safely*". The second is "*recover any weapon.*" There is no evidence on the log that this was revisited at any time. At 04:12:33 a "THRIVE" assessment is conducted and the harm identified is a risk of serious harm or death. The risk is assessed to be high.

91. Yet, no firearms authorisation was given until the declaration of Operation Plato at around 05.31.

92. It appears that no further tactical instructions were given to the two ARV crews who were static at the scene on Ilkeston Road for over 40 minutes.

93. The OFC instead becomes involved for a considerable time in securing access to an empty property at 316 Ilkeston Road and is diverted for some time in the repacking of cutting gear into a toolbox and back into his ARV. At 4:09:11, a voice currently believed to be F41, PC Speeden can be heard on radio as he asks of the FCR: "*I know our priority is the victims at the moment, my only concern is the offender. We have an unknown whereabouts for him. There could be future victims, or the offender might return to the scene*." (Regrettably, the response is, unclear: it appears to be "Oscar 1 listening".)[118]

94. It is far from clear that redeployment was actively and seriously considered whether by the TFC or the OFC and critical time was not lost.

95. Other ARV officers on the ground questioned whether they ought to be searching. A second exchange with PC Speeden follows at 04:24:06: "*Everything is covered off at the scene. If you can just make sure you are in the area searching for that offender. Like you say we can get an image of him. Only confirmation I have got is Ilkeston Road*

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117 NGPF0007846_0003-4
118 NGPF0004732

and back up towards City."[119]

96. It may be said by Nottinghamshire police that difficulties arose from the limited description available for VC. From the first, the description of VC as a black male, dressed in black and carrying a black bag was available (entered into the log at 04:05:51). Yet, it appeared inaccurate responses were being given on Talk channels when descriptions were requested: at 04:06:40, 442 is informed the only description available is that the killer was wearing a hoodie.[120] This was simply wrong. From 04.19, recorded on the log at 04.22, this description is confirmed by officers viewing CCTV in the home of the family who occupied 314 Ilkeston Road. Location information is relayed to the FCR and recorded on the log as follows: "OD42 – SUSPECT F509 – F510 , BLACK MALE, FAT, ALL IN BLACK, HOOD UP, KNIFE PLACED INSIDE A MAN BAG…TURNED LEFT POSS TWDS THE HOPEDALE ROAD AREA." Viewings by separate ARV officers are required on the scene to obtain no greater insight than that the description was correct, except for one flaw: VC was not fat.

97. No one at any time appears to acknowledge that VC's broad direction of travel is visible on available CCTV, nor that had been included it in the report back to the FCR. Direction remains towards City. Concerns over communication aside: the OFC can be observed on BWV watching the log update in real time from the passenger seat of his ARV.

98. Why were the ARVs waiting and static? There is some evidence they were waiting for an image of the offender to be uploaded to the log. This was the centre of Nottingham in the early hours of the morning. Very few people were on the streets before 5 in the morning. Was the description of a 5'10", black man, all in black, carrying a bag simply not enough to try to locate him? The OFC had seen the brutality of the scene. The FIM/TFC had not. Was PC Speeden waiting for full firearms authorisation before pressing the FIM to deploy himself, or his colleagues, to deal with a threat that was very obviously life-threatening?

99. PC Speeden is later heard on recordings from his BWV, being openly critical in his feedback to control of the failure to provide full firearms authorisation and the lack of direction from FIM / TFC in the Force Control Room. We have requested a copy of this recording.

100. Regrettably none of this criticism by PC Speeden is addressed in the witness

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119 NGPF0004751

120 NGPF0005090

statements of officers to date.[121]

(ii) Live use of CCTV

101. The Inquiry has instructed a CCTV expert to consider the material available to police on 13 June 2023. We have requested disclosure of copies, in the interim of all original CCTV (or other footage) which forms part of the compilation prepared by the police in connection with the prosecution of VC and which would have been accessible in real time, including through contact with the Local Authority central hub at Woodlands.

102. For now, we note that at 04.14:54, it was recorded on the log that CCTV had been tasked and were searching: "INCIDENT OCCURRED BTWN TWO CAMERA'S UNABLE TO SEE THE SCENE. THEY WILL DO A PLAY BACK TO SEE IF ANYTHING CAPTURED AND WILL SEARCH FOR SUSPECT"[122] Yet, it appears, from disclosure that these searches may have been limited only to cameras on Ilkeston Road. At 4.24.30 it is recorded "*Yeah from CCTV at Woodlands it is between two cameras and the scene is not captured*." This is consistent with the disclosed record from the Local Authority. A report produced for this Inquiry shows an extract from the Nottingham City Council log shows a Response deployed at 04:04:45, a separate Time start at 04:06 and another Arrived time of 04:09:56. The Entries made include:

> *""police request to monitor Ilkeston road for a black male in all black that had robbed a male and a female on ilkeston road and stabbed them both."*
>
> *"monitored the area and played back the cameras on Ilkeston Road but could not find the offender. Informed the police control room that the male was not seen."*[123]

103. We have as yet, seen no suggestion that CCTV were tasked again to consider cameras north of Ilkeston Road, towards Hopedale close and beyond, when the direction of VC's travel was confirmed at 04.22. We know that crystal clear footage of VC was obtained after the event; it remains to be explored by the Inquiry what could and should have been obtained in the critical time he travelled from Ilkeston Road to Magdala Road.

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121 See also, "*General discussion on Armed Authority with contributions from OFC and TFCs Each describing their NDMs*" appears in the local debrief document, at NGPF0007689_002: It is far from clear if this is a heading or a part of the conversation which is not recorded in detail, no similar marker appears.

122 NGPF0007846_0011

123 WITN0224006

104. The use of CCTV will remain an issue for exploration by the Inquiry.

(iii) St Barnaby's Cathedral/Derby Road (0069_13062023)

105. It is plain that the command and control of the search for VC could and should have been better coordinated. The response to the killings by VC does not bear comparison to the coordination and resource targeted at the response to a call made by an off duty police officer, 5-6 minutes after the 4.04am 999 call, at 04:10:08, about a female screaming and shouting *"fuck fuck off"*, near St Barnaby's Cathedral and Derby Road.[124] At 04:41:06, this incident is linked in the FCR to Ilkeston Road: search required to try and identify the female and confirm / negate any offences. There appears to be no record of consideration of the fact that VC had been observed to travel in a different direction, nor that he would have had to be very fast to have moved between the two scenes in the time available. There were resources tasked to search on this call. Despite there being no victim; no known perpetrator, and, in fact, no attack, this call merited the dispatch of ARV, dogs, drones and response officers to search. The Inquiry will explore how and why the response to the two scenes was very different. It appears this response may have been delegated by CI Mather to another officer.[125] Superintendent Allardice concedes that "*In terms of the coordination of officers engaged in the search it would be preferable for this to be coordinated by the control room dispatcher or supervisor… This would support officers to approach the search in a logical and structures manner…The approach taken for searching incident 0069 demonstrated this well*".[126] Indeed.

106. On his own evidence CI Mather did nothing to direct the search: *"The officers searching would have coordinated the search themselves, with the assistance of their dispatchers in the control room to have oversight of the search.*"[127]

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124 NGPF00006112

125 WITNO034001_0008: I tasked Police Sergeant Berry, the Force Incident Supervisor sat next to me, to ask more officers to attend to ensure that a thorough search had been completed. I am aware from checking the log that PS Berry deployed an ARV, dog officer, police drone, a Response Sergeant and two Response Officers.

126 WITN0311001_0115, at [547]

127 WITNO034001_0013 at [45]. However, a point to point call between CI Mather and Inspector Pete Shaw gives some insight. The FIM states he thinks the suspect will be long gone now so needs to concentrate on the scene and those two people. The Inquiry may consider this shows a shocking lack of concern for the risk to others, already highlighted by the OFC. On the numbers in the search, Inspector Shaw tells the FIM: "Aside from that / think we have got some cops looking for the suspect, if not many." NGPF0007311. See consideration in the Statement of Superintendent Allardice: WITN0311001_0049.

107. The Inquiry will be able to consider available evidence; including from logs and BWV whether there is evidence of appropriate, or any, tactical planning; coordination and response.

108. The adequacy of the search is critical for the understanding of the Coates brothers and Elaine Newton as to whether more could be done to save Ian Coates (Question 9(b)). There were resources available. The ARVs were available but engaged and deployed in the response following the attacks on Barney and Grace. There was a car crewed with a dog and a dog handler on the streets. But the question is whether they were being tasked or directed effectively (or at all) by those in command. Ironically, analysis of telematics provided by NGPF for this Inquiry suggests that between 4.21 and 4.30, PCs Yallop and Bower may have passed heartbreakingly close to VC. As VC appears to have spent a short time between two cameras – and as PCs Yallop and Bower sped towards Ilkeston Road and he walked towards Goose Fair before going on to Seeley Hirst House – they were potentially a few streets apart.[128] If the direction provided had been acted on swiftly and in an organised manner, and had CCTV been checked in the direction towards Hopedale Close and beyond, it is plausible that VC would have been picked up on one of the cameras where we know he was recorded. In those circumstances PCs Yallop and Bower might have been tasked by someone in the FCR doing their job competently to slow down and have a look around in the area of Goose Fair? It appears to be the evidence of Superintendent Allardice that the direction of travel may have been "*missed*" when first identified (albeit that the area was searched, sometime later, when VC had moved further down his journey towards Magdala Road).[129]

109. Armed with the direction of travel, the description from the earliest logs, from the CCTV at 314 Ilkeston Road, and what we now know was recorded on CCTV obtained later by the police, the search should have involved more active units searching in a co-ordinated way. This will all be critical evidence for the Inquiry to consider and explore in the coming weeks and after the Easter break.

110. Finally, the Inquiry will wish to consider the declaration of Operation Plato and whether this distracted from the investigation of events on the ground and/or was illustrative of

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128 NGPF0008785_0001 at p10. Near Forest Fields, VC is between CCTV spots, between Birkin Avenue (at 04:21-2) and heads to the edge of the Fields, spotted at 4:30. PCs YALLOP and BOWER Drive towards Ilkeston Road at 04:26 – 27 at speed. We have requested a copy of the dash cam footage for the ARV. Consider also sequence of events, lines 199-200, at NGPF0004340_0020.

129 WITN0311001_0114.

the degree of disorganisation within the FCR on that morning. Sadly, by the time that this step was taken, Barney and Grace had died and Ian would be found and declared dead a short time later. The declaration of Operation Plato in effect means that there is a terrorist killer at large. Ridiculously, when the declaration was made by CI Mather, Officers had moved to arrest VC. CI Mather did not know (the Inquiry may again, wish to consider this illustrative of lack of coordination between the FCR and actions on the ground).

E. MENTAL HEALTH, CULPABILITY AND CRIMINAL JUSTICE

111. VC was arrested at 05:35. By 13:32, the police had been provided with information from Liaison & Diversion services that VC had a history of mental ill-health, with a working diagnosis of paranoid schizophrenia.[130] From those early hours, the Senior Investigating Officer ("SIO"), Detective Superintendent Leigh Sanders, knew, or ought to have known, that questions as to VC's intention, his culpability, and the availability of the partial defence of Diminished Responsibility would be crucial issues in the investigation and preparation of his case.

112. Notwithstanding that knowledge, whilst VC was in police custody;

i. No mental state examination was carried out by a qualified psychiatrist;

ii. No samples were taken for the purposes of toxicology tests;

iii. No assessment was made as to VC's capacity.

113. In carrying out an investigation, investigators must identify and follow all reasonable lines of enquiry to gather all reasonably available material and, where a suspect is identified, investigate towards and away from the suspect.[131] The Inquiry will no doubt want to consider whether all reasonable lines of enquiry were properly followed in this case.

(i) No mental state examination was carried out by a qualified psychiatrist

114. That experts instructed in VC's criminal case could not draw on a detailed psychiatric assessment of his mental state at the time of arrest or shortly thereafter, may well have impacted on the course that the criminal proceedings followed: from the CPS'

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130 CPSE0000005_0019 (Custody Record)

131 Criminal Procedure and Investigations Act 1996 Section 23(1) Code of Practice

determination of the acceptability of pleas to manslaughter, to the eventual Hospital Order disposal.

115. Forensic Psychiatrists who were, in due course, asked to give an opinion on VC's mental health at the time of the attacks, had to rely on clinical interviews carried out several months after the killings by VC. By the time that those assessments were conducted, VC had been in a custodial setting for a significant period, during which time his presentation was noted by prison officers to have deteriorated.

116. Forensic psychiatrist Dr Latham notes:

> "*There is a legitimate question about the extent to which it is possible to `reconstruct' someone's mental state when considering diminished responsibility (or insanity). However, given the law, it is inevitable that psychiatric expert evidence will need to engage with this need for reconstruction*." Dr Latham's view is that *"Ideally, a psychiatric assessment would be carried out as soon as possible after someone is arrested*." [132]

117. Dr Blackwood comments that:

> "*this is one element of forensic practice that has perhaps deteriorated in the last 30 years: historically, a police surgeon would call out an on-call consultant or higher trainee to assess a suspect soon after arrest and reception into police custody. Today, police surgeons have been largely replaced by custody nurses and liaison and diversion practitioners (typically psychiatric nurses). Detailed mental state examinations by psychiatrists will typically only be available if there has been an assessment for admission under the Mental Health Act.*"[133]

118. In circumstances where VC had not interacted with medical services for 12 months prior to the attacks, a timely assessment was all the more key. And yet, despite knowing of previous episodic mental il-health – in a context where the detainee had perpetrated horrendous killings and had tried his best to kill others - the police, and thereafter the CPS, failed to instruct an expert clinical psychiatrist to conduct a timely assessment.

119. Nor was a Mental Health Act assessment conducted. Such an assessment would only be deemed appropriate for less serious offences, when diversion from custody is considered an 'appropriate response'. Healthcare Professional Rosie Draper noted on the SystmOne custody medical notes, "*L&D Service Manager Lousia Hagen stated that*

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132 WITN0126001_004 at [14]

133 WITNO308001_0018 at [40]

the Trust stance is that he [VC] will not be admitted to a psychiatric unit and therefore there was no need for a Mental Health Act assessment to be requested".[134]

120. Dr Latham adds:

> "T*his is commonly the position with very serious offences, where access directly from police custody to a secure hospital is not possible, and so the Mental Health Act assessment does not take place and is instead deferred until the defendant is remanded into custody.*"[135]

121. That this practice may have become common place in the 30 years since the Clunis Inquiry does not necessarily make it right.

122. Whilst VC was in police custody, Sergeant Oppon-Kusi did make a referral to the Nottinghamshire Liaison & Diversion service (NHS staff 'embedded within Custody'[136]), which offers a screening process, triage or full assessment dependent upon identified need at the time. That service however is based upon individuals' consent to engage[137]. In the event, VC refused to engage with the Liaison & Diversion services, and no further action was taken by the police thereafter to obtain a contemporaneous assessment of VC's mental health.

123. The severity of the incident in which VC had been brought into custody surely met the threshold for remand to prison setting, but the prosecuting and investigating authorities' failure to consider an early mental state assessment *for the purposes of the investigation* shaped the proceedings to come.

124. The provision of healthcare in Nottinghamshire Custody was provided by Mitie Care & Custody Ltd. At 16:00 VC was assessed by a Healthcare Professional (HCP) to be fit for interview in the presence of an Appropriate Adult[138]. Throughout subsequent interviews (on 14th, 15th and 16th June) he made no comment to all questions. HCP assessments are plainly no substitute for a full mental state assessment. The Inquiry may want to consider whether this assessment as 'fit for interview' can align with the later conclusions reached by the reporting forensic psychiatrists, or whether a Healthcare Professional can be asked to provide any reliable assessment, when their access to a detained person's medical records is contingent on the Detained Person's

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134 CPSE0000005_0075 Entry 17:31

135 CPSE0000017_0025 Expert Report from Dr Richard Latham, Consultant Forensic Psychiatrist at [23.2]0

136 WITN0153001_0065 (Witness statement of CI Lisa Murray at [269]

137 WITN0346001_003 at 8 (Louise Hagan)

138 WITN0346001_0079 at [337] (Louise Hagan)

consent. In this case, VC did not provide consent for HCPs to access the National Care Record System. HCPs therefore only had access to notes on Niche (the police detention log computer system) and SystmOne (the medical care records system used in custody). The HCPs were wholly reliant on L&D Services communicating information which they (L&D Services) had access to on *RIO*.[139]

125. Ultimately the assessment of VC's mental health by a forensic psychiatrist was delayed until several weeks later, when his presentation had deteriorated to such an extent that on 1 November 2023 he was transferred from HMP Manchester to Ashworth Hospital under ss. 48 and 49 of the Mental Health Act.

(ii) No toxicology tests were carried out on samples obtained from VC

126. The conclusion of Professor Kim Wolff's report leaves no room for doubt: *"To establish or discount recent drug use in VC prior in the run up to the attacks on 13 June 2025 a blood or urine [sample] was needed."*[140] Blood and urine will almost certainly enable the detection of drugs and metabolites used within the previous 24 or 48 hours.[141] Hair sampling may have provided historical information about drug use in the weeks before the event on June 13, 2023.[142]

127. Notwithstanding this, no samples were obtained from VC during his time in police custody for the purposes of toxicology tests.

128. The possibility cannot be dismissed that this failure may also have impacted on the course that the criminal proceedings followed, and the final determination by the sentencing court of VC's culpability, as "*there was no evidence to suggest that the offender's mental illness was precipitated or exacerbated by illicit drug use*".[143]

129. Absent crucial evidence which may have been obtained from toxicology tests, when assessing VC's culpability, the psychiatric experts, and the Courts and its officers were necessarily reliant on VC's self-report of having only once used cannabis and the absence of any evidence to the contrary.

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139 WITN0072001_002 (to WITN0072001 _003) (Cat Otterson (previously Jakins) at [4])
140 WITN0394002_0017 (Expert Report Kim Wolff)
141 WITN0394002 0015 (Expert Report Kim Wolff)
142 WITN0394002 0009 (Expert Report Kim Wolff)
143 NGPF0001124 *R v Calocane* [2024] EWCA Crim 490

130. The potential impact of any substance misuse on an individual's mental state and actions is clearly an important consideration in any forensic psychiatric examination, and it is standard practice for psychiatric experts to request toxicology results.[144]

131. In his police interview, VC was asked whether he had ever taken 'street drugs' and whether at the time of the murders he was under the influence of drugs or alcohol[145], to which he answered *'no comment'*. Despite VC's failure to deny illicit drug use, the police do not seem to have focussed on the need for a toxicology examination.

132. Blood and urine are intimate samples. Intimate samples may be taken only where a police officer of at least inspector rank has authorised the sampling on reasonable grounds that it may help to confirm or disprove involvement in a recordable offence, and where the individual has given appropriate written consent (Agreed Statement of the Law, paras 3(a), 5, and 6.2-6.4).

133. The custody record reads:

> *"Intimate Sample - Authority - At 15:50 Insp 717 Boylin authorises the taking of an intimate sample, namely blood, as there are reasonable grounds to suspect that the detainee is involved in a recordable offence, Murder, and there are reasonable grounds to believe that the sample will tend to confirm, or disprove, the detainee's involvement. The grounds for taking the sample are that the incident involved violence and the use of bladed weapons, the detainee may have left blood at the scene and the blood sample would tend to confirm or disprove alleged involvement."*[146]

134. Despite the Crime Scene Coordinator, Tess Buxton, having recorded in the Evidence Recovery Plan, "HCP required for following: Body mapping; Blood and urine"[147], VC's custody record only references authorisation given for the sampling of blood. The omission of authority for a urine sample, and the focus within Insp. Boylin's recorded grounds on VC's physical commission of the offences but not his mental state at the time, reflects the limitations of the stated aim of the Evidence Recovery Plan: "To maximise potential forensic evidence from the suspect providing forensic links between victim, suspects and crime scenes."[148]

135. There is no reference within the Evidence Recovery Plan (nor the grounds for authorisation by Insp Boylin) to a toxicology assessment. It does not appear that

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144 WITNO308001_0003 (Statement of Professor Blackwood at [7])
145 CPSE0000099
146 Custody Record as cited in statement of CI Murray WITN0153001_0070
147 NGPF0008888_0001
148 NGPF0008888_0001

consideration was given to one until several months later, when the issue was raised by the families we represent.

136. The Inquiry may wish to carefully examine the legitimacy and sufficiency of the basis for the police "*lack of suspicion concerning drug issues*" suggested by CI Lisa Murray and that "*there were no drug testing considerations relevant on the 13th June 2023 when* [VC] *was arrested for these matters*"[149] such as to obviate the clear need for drug testing/a toxicology assessment.

137. Having initially indicated at 16:00 that he "*may do body mapping and samples later - to handover to night shift*", a request made of VC for consent to take a sample of his blood later that evening was refused by him. There was a failure to warn VC that inferences from the refusal may be held against him in criminal proceedings (in accordance with the wording under s62 Police and Criminal Evidence Act 1984), and the request for a sample was not repeated at any other time, despite VC being held in police custody until 17 June 2023. No consideration appears to have been given by the police at that time for other forms of sample, such as urine or hair, which would be susceptible to toxicology assessment.

138. Whilst non-intimate samples were taken from VC without consent (namely hand swabs, body mapping, nail scraping and photographs) no authority was sought/provided, nor further requests made of VC for any other form of non-intimate sample for the purposes of toxicology.

139. Urinary drug screening was not conducted on VC's first remand into prison. Drug screening was only carried out when he was taken to hospital, after a drugs dog responded to a smell on VC's jacket (later disregarded as being probative of drug use).

140. The police failure to obtain samples for toxicology screening is all the more stark when consideration is given to the fact that on 13 June 23 the police had received a call from an individual who said that they thought that they had sold cocaine to VC[150]. This was subsequently disregarded, but it should have prompted lines of inquiry. Moreover, by the 15 June the police were aware that VC had spent the evening of the 11 June at the Monteiro family barbeque and the night of 12 June at Bill Monteiro's flat in London. An

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149 WITN0153001 _0072

150 NGPF0000137 (The call is logged as irrelevant on 24 July 2023, noting "in addition, intimate samples were also refused by the suspect in custody.) NGPF0003706 (Logged as no further action necessary on 15 November 2023), NGPF0003711

Intelligence report for Monteiro obtained by the investigation on 15 June confirmed he had previous links to Nottingham and known drugs intelligence.[151] The evidence is that VC, who had repeatedly asserted in clinical records and in police interview that he did not drink, was drinking.[152] The Inquiry will hear that many months later the families raised concern over press reporting on VC's possible drug use, and the availability of toxicology assessments to identify possible historical drug use, but these concerns were dismissed by the SIO. It is only now in his statement to this Inquiry that now retired Detective Superintendent Leigh Sanders accepts, albeit in hindsight, that "*I could have asked for compulsory head hair sampling whilst VC was in custody. Any negative result would have assisted in eliminating controlled drugs as being a possible cause of his paranoid schizophrenia.*"[153]

141. The Inquiry will want to consider whether the police failed properly to investigate a clear avenue which could have been of crucial import in the assessment of VC's culpability.

(iii) No comprehensive assessment was made as to VC's capacity.

142. VC refused consent to the obtaining of an intimate sample. Consent was key. Whilst capacity is assumed unless proved otherwise, in circumstances that DP had a known mental health condition of paranoid schizophrenia; an initial finding that "*V is mentally unwell and is not fit to interview*"; and, a broad failure to engage with the HCPs in police custody, it is perhaps surprising that no comprehensive assessment was conducted of VC's capacity. Yet, the presumption he had capacity to refuse a sample in these circumstances is indicative of the continuing incoherence of the consideration of mental health and culpability in the course of this investigation.

143. HCPs require consent to perform any assessment or other procedure (fitness to be detained, fitness for interview, toxicology) unless in the case of emergencies. And yet the current system does not allow for a meaningful assessment of capacity because the capacity to give such consent is assessed by the HCP, in circumstances where HCPs do not have access to medical records. Ultimately, VC's capacity to refuse his consent to the taking of intimate samples was never examined.

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151 NGPF0001671_0002
152 NGPF0008985_0002 (Carlos Monteiro)
153 WITN0359001_0115 at [341].

144. The Inquiry may want to consider whether, in instances of known mental health issues, meaningful assessments of capacity should be routinely carried out by suitably qualified experts with access to medical records whilst a detainee is in police custody.

Treatment resistive, not treatment resistant

145. On 28 November 2023, in the Crown Court at Nottingham, VC pleaded guilty to three counts of manslaughter, and three counts of attempted murder. These pleas were accepted by the Crown, who did not proceed against the defendant on charges of murder.

146. Crucial to the Crown's consideration in this regard, as well as in due course to the sentencing judge, was an assessment that VC's culpability was limited. As set out above, reliance was place on the absence of evidence to suggest that the offender's mental illness was precipitated or exacerbated by illicit drug use (there being no contemporary toxicology tests). Moreover, within psychiatric reports commissioned by the parties for the purposes of the criminal proceedings, it was suggested that VC's insight into his mental health was limited, which was in itself a symptom of his mental illness.

147. In Professor Blackwood's opinion, whilst the harm caused by the offender was at the highest level, the offender's 'retained responsibility' was at the "lower end of the spectrum":

> *"The offending was in my view entirely attributable to his mental illness. His failure to comply with the prescribed oral anti-psychotic medication in (at least) the twelve months before the index offence was in my view not a culpable omission, but rather one determined by his lack of insight into his illness, an integral feature of the disorder."*[154]

148. In light of VC's refusal to take Long-Acting Injectable Antipsychotics (depot) medication at a time when his mental state was stable and he was deemed fit for discharge, as well as his repeated non-adherence to his prescribed treatment including through periods where his illness was not acute, the Inquiry may want to examine this suggestion. Both VC's level of insight and his culpability will need to be explored in light of the evidence of his actions leading up to and in the aftermath of the attacks; for example VC's telephone and SIM, when reviewed, were found to contain relevant material including an article on psychosis, articles on mass killings and chats with Stonebridge Medical

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[154] CPSE0000152 (Addendum Psychiatric Report of Nigel Blackwood)

Practice regarding the collection of repeated medical prescriptions[155]. In his police interview on 16 June, the attacks are described to VC in graphic detail, during which he is described as 'smirking'[156].

149. The Inquiry may want to consider whether the psychiatrists had sufficient information from the police investigation to enable them to give the most reliable opinion possible on when VC's acute psychotic episode started, and therefore from which point in time his culpability for his actions should be measured.

150. The Inquiry will also want to consider carefully the diagnosis of "treatment-resistant schizophrenia" made by Dr Mirvis in his Jan 2024 report. Treatment-resistant schizophrenia ("TRS") is defined by the presence of at least moderate to severe psychotic symptoms, which are associated with functional impairment and are persistent despite serial trials of at least two antipsychotic medications that were adequate in terms of dosage, duration, and level of adherence[157]. Due to the delay in his transfer to hospital, VC had only been started on Olanzapine on 12 September 2023, which had been increased on 26 September 2023[158]. The Inquiry might ask if the doctor was in a position in January 2024 to make a conclusive finding that there had been an inadequate response to at least two trials of different antipsychotics at adequate doses?

151. The Inquiry may want to consider whether the evidential basis of the psychiatrists' assessment of VC's responsiveness to treatment (and therefore likelihood of future harm to the public) was based on a curtailed time period, within which time there were reports of non-adherence to medication in prison, and could not take into account VC's response to treatment with clozapine.

152. On 24 January 2024, again at Nottingham Crown Court, was sentenced by Mr. Justice Turner, for each offence, to a concurrent hospital order with restrictions, pursuant to ss. 37 and 41 of the Mental Health Act 1983.

153. Those we represent are deeply conscious that there is nothing which can be done within the scope of the terms of this Inquiry to revisit or to question the sentence upheld by the

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155 CPSE0000046 (MG6C Schedule of Unused Material) []

156 WITN0153001_0121

157 Howes OD, McCutcheon R, Agid O, et al (2017) Treatment-resistant schizophrenia: Treatment Response and Resistance in Psychosis (TRRIP) working group consensus guidelines on diagnosis and terminology. Am J Psychiatry, 174: 216–29. See also NICE guidance, including Quality Standard 80 (QS80) and CG178.

158 CPSE0003078

Court of Appeal Criminal Division. However, this Inquiry must consider whether the steps taken by the police in response to VC in custody and the actions of the CPS adequately equipped the forensic experts instructed and the Courts to consider a true picture of VC's mental health and culpability. These questions fall squarely within the Terms of Reference set by the Secretary of State and the questions which the Inquiry has posed for itself.

154. A significant factor in the decision by Mr. Justice Turner J not to impose a life sentence of imprisonment with a hospital and limitation direction pursuant to s. 45A of the 1983 Act ("a hybrid order") was the perceived difficulties in ensuring effective treatment for VC in a prison setting and on his release into the community. He said:

> *"If effective, a hybrid order would result in the offender being transferred to prison to serve the remainder of his sentence. However, in a prison setting, the offender could not be compelled to receive treatment. Given his lack of insight, there was a real risk of relapse. Further, clozapine could be challenging to manage in prison".*[159]

155. He went on:

> *"Release from prison is governed by the Parole Board and monitoring in the community would be conducted by a probation officer who may be less able to identify signs of relapse and whose recall powers are less responsive than the recall provisions following conditional discharge from a hospital order."*[160]

156. If shortcomings and inadequacies of the scope and effectiveness of recall power in the civil powers in the MHA play a significant role in whether a culpable defendant will otherwise serve a custodial sentence, those we represent ask the Inquiry to consider whether recommendations for change must be made to deter future offending and to protect public safety. In due course, the Inquiry may consider:

a. Whether there are means by which adherence to a medical regime by a detained person returned to prison on a 'Hybrid Order' can be assured; and
b. Whether there should be a mechanism whereby a 'Hybrid Order' could be combined with conditional release into the community under medical supervision.

157. The Inquiry's Terms of Reference place any analysis of the hard distinction in law between murder and manslaughter on the basis of diminished responsibility beyond the

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159 NGPF0001124: *R v Calocane* [2024] EWCA Crim 490
160 NGPF0001124: *R v Calocane* [2024] EWCA Crim 490

scope of this Inquiry. However, the Inquiry cannot do its work without an understanding of the impact on victims of a charge of murder becoming a conviction for manslaughter on the basis of diminished responsibility. We note that despite its earlier recommendations for reform in 2006: the ongoing Law Commission Review of the Law of Homicide is not expected to publish its final report until 2028.

158. The missed opportunities in policing outlined above highlight that failures to consider public safety in a criminal justice response impacted long before 13 June. There were victims impacted by VC's violence long before that day, some, such as Feven, whose lives were irreparably changed.

159. However, the failure to grapple with the difficult interplay between diversion and culpability finds prime illustration in the management of the investigation and prosecution of VC by NGPF and the CPS and in a sentence which, frankly, leaves those we represent, feeling fundamentally let down by the system.

160. The Inquiry has seen evidence from 2017, which indicates that over 87% of stays in high secure settings are for less than 10 years (and 55% are less than 5 years).[161] Julian Hendy, Hundred Families suggests in his evidence that release for those involved in a homicide after 3-5 years is "*not unusual*".[162] These figures are not irrelevant. In his sentencing remarks Mr. Justice Turner said "*I note in passing, however, that the diagnosis of treatment resistant schizophrenia means that, in any event, it [(sic)] very likely that you will never be released*". This reflected what he had been told by the experts. In the BBC Panorama episode filmed with the involvement of VC's family, Elias Calocane said words to the effect that he feels like he has his brother back now that he has had treatment.[163] Those we represent are horrified that less than three years on, they must live daily with the prospect that VC will be released to the community in a relatively short time-frame.

161. Put simply, they live in the belief that VC may have got away with murder.

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161 WITN0258015

162 WITNO258001_0029

163 BBC, Panorama, *The Nottingham Attacks: A Search for Answers*, 17 August 2024.

F. TRANSPARENCY AND ACCOUNTABILITY AND RESPECT

162. The work of this Inquiry does not start with a blank slate. As the Terms of Reference recognises there have been multiple investigations, reports and inquiries by a panoply of State bodies. Most of those same state bodies are represented in this Inquiry as CPs and/or will give evidence in the coming weeks. The Inquiry will consider those earlier findings and will benefit from their work but cannot be bound by them.

163. In their grief, those we represent have had to grapple with learning about and participating in multiple processes which were deeply unfamiliar to them. They sought to place trust in those bodies they thought were tasked with securing transparency and accountability to get to the truth and to consider responsibility where warranted. They hoped each of these processes would treat those they lost with dignity and respect. By February 2025, there were nine separate investigations and Inquiries in which the bereaved families were involved. Each one of them increases their trauma and each one of them drains resources which ought to have been devoted to their recovery. They are grateful that the Terms of Reference for this Inquiry will consider how the police and prosecution engaged with the victims and the bereaved families and will consider the reports which have been generated since 13 June 2023. Taken briefly:

(i) The Inquiry will hear the concerns of those we represent that the information provided to them by the police and the CPS during the investigation and prosecution was late, partial and inadequate in ways which increased their trauma. Some brief examples:

164. It beggars belief that most of the bereaved family members we represent discovered through digital media that their loved ones had died, rather than a police-led death notification. You will hear about how the families' individual names appear in police logs as early as 4.22:45 (when Barney's driving licence information was added and both Emma and David Webber's names were logged) and 4.25:25 (when a similar list is logged for Grace, naming Sinead and Sanjoy (and Grace's grandmother); and yet how they were left to make frantic calls to the police during the morning. The Inquiry will hear that the Coates brothers first found out from friends through social media. The SIO, now retired Detective Superintendent Leigh Sanders may invite you to consider the challenges of managing a tragedy in a digital age and under intense media focus.[164] We say, regrettably, this is not the first incident of national profile to occur in a digital age. In 2023, it was simply inconceivable that the police in Nottingham were not alive

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164 WITN0359001_00170-171

to the increased speed with which news of tragedy could travel. Indeed, after the attacks closed the centre of Nottingham and the declaration of Operation PLATO was made information on these offences was plainly going to be reported nationally. (That ACC Griffin can be viewed on video from the FCR discussing press statements as events of the early morning of 13 June unfolded; undermines any possible question that officers must have known that urgent notification of these families ought to have been critical.)

165. The HMCPSI Report found that the CPS could have handled engagement with the bereaved families better and recommended that the Government consider whether the Victims' Code and Bereaved Family Scheme should be revisited.[165] Notably, the Inquiry will hear that most of the bereaved families did not understand the implications of a diminished responsibility defence until after Professor Blackwood's report had been obtained in late November 2023. Despite requests, the first time they were able to have copies of the psychiatric reports produced in the prosecution was as part of the disclosure process in this Inquiry. When they requested access to the reports during the criminal proceedings, the Webber and O'Malley-Kumar families instead had the complex documents read to them. HMCPSI observed that the families felt "*unsupported and secondary to the whole process*" of prosecution. There is work yet for the Inquiry to do in considering how the relationship between the police and the CPS and victims / bereaved families ought to be managed in complex cases, particularly those with a national profile. Those we represent believe that given the profile of this case and their own determined nature to stay engaged, they cannot be the first to feel sidelined and treated like they were not central to the process of prosecution.

166. The Inquiry may consider the notification to the families of three ongoing Professional Services Department ("PSD") investigations concerning police and police staff and inappropriate access to data connected with the investigation of 13 June 2023 is a particularly sorry saga. The Inquiry is aware that PC Gell (who will give evidence on his involvement in the detention of VC on 28 January 2022) was given a final written warning in January 2023, in connection with the dissemination of a wholly inappropriate WhatsApp message shared by another colleague to a force WhatsApp group; that a member of police staff was dismissed for accessing files including files from this case (and others); and finally, the resignation of a Police Special Constable for the viewing of BWV connected with the scene at Ilkeston Road. Those we represent are continuing

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165 HMCP0000625_0008 – 9 (in Summary).

to discover information about these proceedings, even now as the Inquiry provides disclosure. For example, the families did not know until the preparation for these hearings that the Special Constable's brother had been one of the first responders on the scene at Ilkeston Road. The Inquiry will have significant questions for ACC Griffin, DI Reynolds (PSD), DI Gould and the SIO over the timing and substance of information given to the families about these investigations. The Inquiry will bear in mind which of the managing officers have historic experience of working in PSD. The Inquiry will appreciate the right of Interested Persons to be notified, to be updated, and where appropriate to attend and suggest questions for the Chair at any proceeding (Section 21, Police Reform Act 2002; Police (Complaints and Misconduct) Regulations 2020). The failure to provide notification, as intended by the statutory framework for all persons who have an interest in being kept properly informed about the handling of a complaint (including at s21(3)), is significant. These families would have wished to have known if they had rights in connection with even some part of these disciplinary procedures. That they did not know and were not notified till late, deprived them of the opportunity to make their views known in an impactful way. None were able to attend PC Gell's disciplinary hearing for example. The failure to be open on such topics of considerable embarrassment for the force understandably raised suspicion over candour. The Inquiry may consider the extent that such sensitivity was warranted.

167. For the first time, in the evidence provided to this Inquiry, police investigators accept that things could have been done differently. For example, the SIO will say that on reflection, complex information being communicated to families experiencing trauma and grief could have been reduced to writing.[166] Again, we question whether this ought not to have been obvious not only for any experienced, trauma-led policing response, but for anyone exercising any element of compassion and common sense. However, this change in position illustrates the potential value of this Inquiry even before it has begun to hear evidence. It also begs the question why it could not have been conceded before and illustrates the power of the prospect of accountability.

(ii) A lack of transparency even beyond the criminal justice response has been a consistent concern for those we represent.

168. First they had to fight to gain access to more than a summary of the NHFT internal report. They faced a similar battle in seeking access to the conclusions of the NHS England Theemis Report. The intervention of the Secretary of State for Health was

166 WITN0359001_0174 (Leigh Sanders).

necessary before the full report was provided to the families and to the public. Our clients' experience is not unique, but it is deeply disappointing.[167] While the duty of candour in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was intended to introduce a new era of openness, the experience of those we represent has been that defensiveness and secrecy continue to undermine true reflection, learning and accountability. The "*Hillsborough Law*" making its way through Parliament now – in the Public Office (Accountability) Bill – provides promise for families impacted by tragedy which the Bereaved Families CP Group welcomes. They invite the Inquiry to consider the extent to which the provisions in that new legislative framework may have changed their experience (if at all). That Bill, in Clause 2(1) provides: *"Public authorities and public officials must at all times act with candour, transparency and frankness in their dealings with inquiries and investigations*."[168] This has not been the experience of the bereaved families so far. Their experience has been that, without pressure from them, from the gaze of public scrutiny, and from political engagement by sympathetic Ministers and members of Parliament across all shades of the political spectrum, the public bodies involved in the treatment of VC and the management of the risk which he posed would have resorted to a default of secrecy and a strong message that "*lessons had been learned*". There would have been no Inquiry. The loss of their loved ones would have been yet another missed opportunity to grapple again with the questions society had been forced to face in the aftermath of the killing of Jonathan Zito, over three decades ago. They welcome now the fullness of the disclosure and anticipate openness and collaboration in the participation of all CPs in the coming months. They acknowledge that many families who suffered loss in similar circumstances to them before 13 June did not have the opportunity to ask their questions or to have questions asked such as those this Inquiry has posed. They regret that had these issues been taken seriously at any time before 13 June, we may not be here today.

(iii) The privacy and dignity of victims and bereaved people must be closely guarded in acts of violence and homicide which gain national attention and/or in acts of national loss or tragedy:

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167 See also statement of Julian Hendy, Hundred Families, on the publication of Independent Investigations by NHS England: WITNO258001_0013 ("S*ince 2023 however NHS England has stopped publishing Independent Investigations in full, citing patient confidentiality issues. I think this practice is wrong, ill-advised, and hinders effective learning and improvement.*")

168 This reflects and builds on the duty of candour well known to public authorities in judicial review: e.g. *R v Lancashire CC, ex p Huddleston* [1986] 2 All ER 94.

169. Despite concern for the privacy of others (including VC and his family) during these processes, the dignity of the deceased and the privacy of their loved ones has been repeatedly disrespected by individuals whose morbid curiosity led them to access the most sensitive of material. In the worst of cases, we understand this included sensitive video of the events of 13 June which justifiably will not be played during this Inquiry. These deeply culpable invasions of privacy were ill-managed by systems which ought to have been configured to offer protection.

170. Concerns about police data breaches began almost immediately following the events of 13 June. We do not revisit these failures again.

171. However, mishandling of data was not the sole preserve of the police: the bereaved families have been notified in respect of breaches and suspected breaches by HMCTS and by the Nottingham Universities Healthcare Trust, responsible for QMC and holding the medical records of the deceased. The investigations arising in connection with these medical records are a source of particular pain for the bereaved CPs. These ongoing investigations are addressed in the statements of the bereaved families in so far as they feel able to do so without any risk of prejudice.

172. It is somewhat ironic for those we represent that they have learned in the process of the Inquiry's disclosure that the clinical records of VC appear to have been extremely well protected following 13 June. So well protected, that the clinical staff at HMP Nottingham could not access them.[169]

173. This Inquiry has an opportunity to consider these challenges in a digital world and to make recommendations on data management in the aftermath of tragedy designed to prevent unnecessary hurt and indignity in the future.

(iv) Finally, and regrettably, the statutory processes for learning and accountability after acts of tragedy in the public eye must be independent, robust and effective. They must provide for accountability and individual responsibility where appropriate.

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[169] See, e.g. NHFT000455_0006 (18 June 2026: "*I have attempted to access the RIO notes of this gentleman however his account has been restricted*."), and NHFT0011718.

174. To give one example, the Independent Office for Police Complaints ("IOPC") investigations continue into the matters which this Inquiry will consider. You will hear evidence from the Director General of that organisation. Those we represent do not wish to prejudice any work which continues; any prospect of disciplinary proceedings; or any potential for constructive learning from findings on professional practice. However, their experience fundamentally undermines any suggestion that the IOPC is fit for its statutory purpose. As just one example, for bereaved families to learn that independent investigators appointed by statute to hold the police to account may have told officers that their complaints against them were "*politically motivated and driven by the families of the victims*" is unforgivable.[170]

175. While the Inquiry will, rightly, consider all the factors which contributed to the events of 13 June 2023, failures do not occur in a vacuum. The Inquiry will consider societal, systemic and individual failures. It will consider the role of bodies responsible for oversight, including the Integrated Care Board and NHS England, and the Care Quality Commission. Corporate evidence will be heard from those involved, over decades in the risks associated with dangerous discharge from care and the associated risk to public safety. The importance of improvements to systems and safety in the future should not detract from evidence that there were individuals involved in the management of the risk posed by VC. We note the evidence of Professor Simon Wellesley on the message he gave in the aftermath of 13 June:

> *"My main message was clear; the necessary powers to detain and treat VC against his will were available [...] It was my opinion that whatever it was that went wrong, it was not due to lack of powers, but the decision not to use those powers, and I expressed caution on not rushing to judgement that the answer was more legal powers but understanding why they had not been used."*[171]

176. Many of those involved in VC's care (including those who will give evidence to this Inquiry) will be professionals regulated by either the British Medical Association or the Nursing and Midwifery Council. Those we represent are conscious that this Inquiry cannot determine any question of civil or criminal liability. However, this constraint ought not inhibit any findings on the facts which may result in referrals to regulators required to protect public safety.

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170 See for example, the Police Federation Regulation 31 response prepared on behalf of Officers PC Taylor, Amos-Perkins and Read: LEPF0000125_0008; WITN0339001 _0025-26 (Witness Statement of Rachel Watson, Director General, IOPC.

171 WITNO322001_0048

177. This is an Inquiry which those we represent deeply wish were not necessary. Yet, its' work is critical both for our clients' understanding of the circumstances of their loved ones' deaths and for the effective future management of public safety consistent with the rights of people who are experiencing mental ill health but who are known to be dangerous and violent.

178. We began by highlighting how each of the bereaved family members' lives had been changed forever by 13 June 2023 and the events of that day. They continue to live on with the incomparable pain of traumatic loss which was not only shocking, violent and public, but avoidable and unnecessary.

179. They hope the work of this Inquiry will prevent any other family from ever suffering again in the same way. The urge the Chair to ensure that this is not just another Inquiry with recommendations warmly welcomed then forgotten: but that it instead secures accountability, responsibility and real change.

180. They hope that a future where public safety is taken seriously in the management of mental health in our communities will be a tangible outcome of this Inquiry and a lasting and fitting legacy to honour Barney, Grace and Ian.

181. They and we stand ready to assist the Nottingham Inquiry in that goal.

TIM MOLONEY KC
ANGELA PATRICK
PHILIPPA EASTWOOD
RACHEL WOODWARD

DOUGHTY STREET CHAMBERS

HUDGELL SOLICITORS
FLETCHERS SOLICITORS

19 FEBRUARY 2026