

Witness Name: T/DCC Rob Griffin

Statement No: WITN0074001

Dated: 28 November 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF T/DCC ROB GRIFFIN

I, T/DCC Rob Griffin, will say as follows: -

Introduction

1. I am Temporary Deputy Chief Constable Rob Griffin of Nottinghamshire Police.
2. This witness statement is made to assist the Nottingham Inquiry (the "Inquiry") with the matters set out in the Rule 9 Request dated 4 August 2025. I have not yet had the chance to read all the material held by Nottinghamshire Police (nor, of course, the disclosure from other Core Participants, which is still being disclosed) but I have done my best to review all the material in my possession which is pertinent to the questions posed to me.
3. Before I begin my response to the Rule 9 Request, I would like to express that my thoughts continue to be with the families and loved ones of Barnaby Webber, Grace O'Malley-Kumar, and Ian Coates, who have suffered the most profound and immeasurable loss. I want to express my

sincere condolences to the families who lost their loved ones.

4. I also want to extend my heartfelt sympathies to the survivors of the attacks of 13 June 2023, Wayne Birkett, Sharon Miller and Marcin Gawronski and their families, who continue to endure the lasting impact of these devastating events.

Career Background & Relevant Education and Training

5. I was born and raised in Nottingham, where I attended comprehensive school, achieving ten GCSEs and three A Levels. I am from a Nottingham-based family; both of my parents are from the city, and I have four siblings who also reside locally.
6. I went on to study Law at university, graduating with a 2:1 honours degree.
7. Following university, I spent a year working at Boots Headquarters in Nottingham, continuing a role I held during my student years. I then spent time in the United States coaching football and travelling, before returning to the UK to begin my policing career.
8. I joined Nottinghamshire Police in September 1995 and have served continuously within the force for the past 30 years. My entire policing career has been dedicated to serving the communities of Nottinghamshire.
9. I began my policing career as a response officer in Bulwell, an inner-city area of Nottingham. In this role, I was responsible for attending emergency calls, managing public safety incidents, and providing immediate support to victims of crime. This front-line experience laid the foundation for my investigative career.
10. In 1998, I joined a proactive acquisitive crime team, where I began my journey toward becoming a detective. Initially focused on burglary and

robbery investigations, I progressed to dealing with more serious offences including armed robbery, serious assaults, and sexual offences.

11. Promoted to Detective Sergeant ("Det Sgt") in 2002, I spent four years between Divisional Crime Investigation Department ("CID") and the Homicide Unit. This period coincided with a surge in gun violence and organised crime in Nottingham, which became nationally recognised following the tragic drive-by shooting of 14-year-old Danielle Beccan and the targeted killings of John and Joan Stirland in 2004, the latter linked to the Gunn crime family. During this time, I supervised teams working on, and contributed to numerous complex investigations, including the prosecution of serial killer Mark Martin, who was convicted of murdering three vulnerable women and the conviction of John McSally, a hitman who shot dead one victim on a pub car park, and shot and attempted to kill another victim on his own driveway a few months later.
12. In 2006, I was appointed Detective Inspector ("Det Insp") in the City of Nottingham, leading investigations into serious violent crime. These included the multi-handed murder of Lezek Milon and the attempted shooting of a taxi driver.
13. Promoted to Detective Chief Inspector ("Det Ch Insp") in 2009, I held roles in serious and organised crime, public protection, and from 2012 to 2015, served as a Senior Investigating Officer ("SIO") in the murder team. In this capacity, I led high-profile and politically sensitive investigations, working closely with bereaved families. These included:
 - The murder of Debbie Starbuck: A deeply tragic case in which Debbie Starbuck was killed by her husband, Jamie Starbuck shortly after their

wedding. The investigation revealed a calculated and prolonged deception following the murder, which involved the offender travelling the world on their “honeymoon”, spending his wife’s money in the process, and creating the illusion that his wife was with him and still alive. He was ultimately convicted and sentenced to life imprisonment.

- The murder of Andrew Doziuk: This investigation centred on the killing of Mr Doziuk, which was perpetrated by Michael Furniss. The case involved significant planning and premeditation and required extensive forensic and intelligence-led work to secure a conviction.
- The killing of Mark Blades: Mr Blades was fatally assaulted in circumstances that led to a conviction for manslaughter. The offender was made subject to a hospital order under the Mental Health Act (“MHA”). The case highlighted the intersection of mental health and violent offending and required sensitive engagement with both the victim’s family and medical professionals.
- The murder of Kevin Kennedy: Mr Kennedy was killed by Peter Healey in a violent and unprovoked attack. The investigation involved complex forensic reconstruction and community reassurance, culminating in a successful prosecution.
- The murder of Nathan Somers: Mr Somers was fatally stabbed by Jemelle Rodney. The investigation was fast-paced and involved significant public concern due to the nature of the attack. The investigation involved a complex covert strategy as a result of which

the offender was convicted and sentenced to a substantial term of imprisonment.

14. In 2015, I was appointed Detective Superintendent (“Det Supt”), responsible for all criminal investigations and intelligence functions on Nottinghamshire’s County Division. During this time, I led a landmark case resulting in the UK’s first conviction for both gross negligence manslaughter and corporate manslaughter in a care home setting. This followed a review requested by HM Coroner into the death of an elderly resident. Despite initial decisions by the Crown Prosecution Service (“CPS”) not to pursue charges, I challenged this position and, after 18 months of appeals, secured a successful prosecution, setting a positive precedent for future safeguarding investigations.
15. In 2016, I became Head of Public Protection, overseeing strategic and operational safeguarding across the force. This included rape and serious sexual offences, domestic abuse, child abuse, online paedophile investigations, and the management of sexual and violent offenders. I was deployed as a PIP4 strategic adviser to Operation Equinox, Nottinghamshire Police’s response to widespread allegations of non-recent sexual abuse in children’s homes. The investigation led to multiple convictions and helped restore trust among survivors.
16. When Nottinghamshire was selected as a strand in the Independent Inquiry into Child Sexual Abuse (“IICSA”), I was nominated by the Chief Constable to act as a Core Participant. I provided a corporate witness statement and gave live evidence at the Inquiry in October 2018. Following this, I worked extensively with survivors to influence the commissioning of

a new specialist support hub in Nottinghamshire, ensuring victim care was central to service delivery.

17. In 2018, I was appointed Chief Superintendent (“Ch Supt”) and joined the Force Senior Leadership Team as Head of Local Policing. I led all operational functions across the City and County Divisions, including Response policing, Neighbourhood Policing, CID, and specialist teams tackling burglary, robbery, and knife crime. I also oversaw Contact Management and Custody, managing a workforce of over 1,800 and an annual budget of £89 million. I held strategic responsibility for hate crime, Independent Advisory Groups, missing persons, coronial inquiries, and liaison with Higher Education institutions.
18. During this time, I was appointed PIP4 adviser to an investigation into the death of an Egyptian-Italian woman following an assault in Nottingham. The case attracted international scrutiny due to issues surrounding the repatriation of the victim’s organs. I engaged extensively with the family, community leaders, and Egyptian officials, ultimately travelling to Cairo to offer explanations and apologies under intense media attention.
19. In July 2021, I was appointed Temporary Assistant Chief Constable (“T/ACC”), with responsibility for Crime, Intelligence, Criminal Justice, Specialist Operational Support (including firearms, roads policing, and dogs), and Events and Emergency Planning. I led a workforce of over 1,400 and managed a budget of £76 million across this broad portfolio.
20. In this role, I led a team of senior policing professionals, including a Det Ch Supt, three Det Supts, an operational Superintendent (“Supt”), and a Police Staff Head of Criminal Justice, to develop and implement

operational plans aligned with the force's delivery plan and strategic priorities. These included key areas such as knife crime and Violence Against Women and Girls ("VAWG").

21. I chaired several strategic boards, including the Force Tasking Board, which oversees the prioritisation of threat, harm, and risk across the organisation, and the Force Operational Performance Board which monitors and drives investigative performance. These forums enabled me to discharge my strategic responsibilities for all force crime investigations, intelligence, Organised Crime Group ("OCG") management, Criminal Justice, and the deployment of specialist resources.

22. In April 2024 the oversight of specialist operational support functions such as firearms, roads policing, and dog units was transferred to the Local Policing Command. In return, I assumed strategic responsibility for the force's Custody functions, ensuring safe and lawful detention practices and the effective management of detainee welfare and risk.

23. In May 2025 I was appointed as Temporary Deputy Chief Constable ("T/DCC") of Nottinghamshire Police. The Chief Constable, Kate Meynell, was unwell due to a cancer diagnosis and was therefore absent from work. During this period, the Police and Crime Commissioner ("PCC") appointed the Deputy Chief Constable, Steve Cooper, to serve as Temporary Chief Constable. Subsequently, Steve Cooper appointed me to the role of Temporary Deputy Chief Constable. In this role, I support the Chief Constable in the overall leadership and strategic direction of the force, ensuring the effective delivery of policing services across the county. My responsibilities include oversight of operational performance,

organisational development and strategic governance, with a particular focus on ensuring that our policing response remains aligned with public expectations and national standards.

24. My professional development has been shaped by a progressive series of specialist and strategic training programmes, each relevant to the stage of my career at the time, reflecting a career dedicated to operational policing, investigative leadership, and strategic command.

25. In June 2000 I successfully completed my first detective accreditation through the Initial CID training course, hosted by West Yorkshire Police, which is the precursor to the Initial Crime Investigators Development Programme (“ICIDP”) which exists today. This foundational training equipped me with core investigative skills and introduced me to the principles of serious crime investigation and resulted in my Professionalising Investigations Programme (“PIP”) 2 accreditation.

26. The PIP is a structured, tiered development and accreditation framework designed to enhance the capability and professionalism of investigators across UK policing. It defines four levels of investigative responsibility; each aligned to the complexity and seriousness of the crimes being investigated:

- PIP Level 1: Focuses on priority and volume crime. It provides foundational investigative skills and is typically undertaken by graduate investigators and police staff investigators.
- PIP Level 2: Prepares investigators to handle serious and complex crimes. It builds on Level 1 and includes further training, experience, and successful completion of the National Investigators Exam (NIE).

- PIP Level 3: Designed for Senior Investigating Officers (SIOs) leading major crime investigations such as homicide.
- PIP Level 4: Focuses on strategic management of complex and high-profile investigations.

27. In May 2005 I completed the Initial Management of Serious Crime course through the National Policing Improvement Agency ("NPIA"), which is designed for Det Sgts. This programme focused on managing serious and organised crime investigations, including scene management and investigative planning.

28. From August 2007 to May 2008, I undertook the SIO programme for homicide and major crime investigations (PIP3). This intensive course developed my capability to lead complex investigations, from initial response through to prosecution, with a focus on major crime and homicide.

29. In June 2012 I completed the Kidnap and Extortion SIO course with the NPIA. This specialist training provided the skills to manage covert, high-risk investigations involving threats to life and ransom scenarios.

30. In July 2012 I attended the Review Officers Course (Major Crime), enhancing my ability to critically assess and review major investigations to ensure quality, integrity, and learning.

31. In September 2014 I completed the Strategic Management of Complex Cases accreditation (PIP4) with the College of Policing. This advanced programme focused on managing high-profile investigations involving vulnerable victims, media scrutiny, and multi-agency coordination.

32. Between January 2015 and December 2017, I participated in the Senior Leadership Programme, a flagship College of Policing initiative aimed at developing strategic leadership, ethical decision-making, and organisational influence at the executive level.
33. In July 2017 I qualified as a Senior Identification Manager (“SIM”), specialising in Disaster Victim Identification (“DVI”). This course prepared me to lead sensitive and complex identification processes following mass fatality incidents, in line with national and international standards.
34. In September 2018 I completed the Strategic Firearms (Gold) Commander (“SFC”) course. This accreditation provided the strategic command skills necessary to lead armed operations, ensuring public safety and legal compliance.
35. In November 2020 I undertook the Multi-Agency Gold Incident Command (“MAGIC”) course. This programme focused on leading multi-agency responses to critical incidents, enhancing interoperability and strategic coordination during major emergencies.
36. In January 2022 I completed the Strategic Public Order Commander (Gold) course. This qualification enables me to lead large-scale public order operations, ensuring lawful, proportionate, and effective command in dynamic and high-risk environments.
37. Most recently, between June 2023 and June 2024, I successfully completed the Executive Leadership Programme, delivered by the College of Policing. This advanced leadership development programme focused on strategic vision, transformational change, and executive-level decision-

making, preparing senior leaders to meet the evolving challenges of modern policing.

Experience of responding to major and complex incidents

38. In the ranks of Ch Supt and Assistant Chief Constable (“ACC”), I have consistently led the strategic response to high-risk incidents, major investigations, and complex events as Gold Commander. Prior to the incident of 13 June 2023, I held responsibility for a wide range of critical operations, each requiring the setting of clear strategic objectives, the assessment and management of threat and risk, and the direction of resources to ensure an effective and proportionate response aligned with both force and legal requirements.
39. My experience spans serious and unpredictable violence, firearms discharges, organised crime, safeguarding failures, and public confidence challenges.
40. In March 2018, I led as Gold the strategic oversight of a complex and rapidly evolving critical incident in Worksop, later designated Operation Dialate. The situation began with two separate but likely connected shootings, one targeting the parents of an individual through the window of their home, and another involving a member of the travelling community who sustained gunshot wounds to the legs. Early indications suggested the use of a shotgun in both attacks, and intelligence pointed to the two victims being criminal associates.
41. The backdrop to these events was a simmering dispute between one of those individuals and a third person, which had escalated since Christmas 2017 and culminated in a serious assault the previous week. Arrest

attempts for both individuals had already been initiated, with covert tactics deployed on multiple occasions. Despite these efforts, both suspects remained at large, and tensions continued to rise, evidenced by further confrontations and culminating in the shootings.

42. From a strategic perspective, the incident required careful coordination of resources, rapid assessment of threat levels, and close liaison with intelligence and operational teams. The potential for retaliatory violence and community impact was significant, necessitating a measured but assertive response. My role involved ensuring that operational decisions were informed by the broader intelligence picture, maintaining oversight of risk management, and supporting efforts to restore stability while progressing the investigation.

43. In November 2018, I managed the strategic response and oversight to a firearms discharge outside a city centre venue, Das Kino, which presented both immediate public safety concerns and longer-term implications for organised criminality. An unknown male, later identified as arriving on a motorcycle, discharged five rounds from a handgun toward door staff, resulting in a female bystander sustaining a gunshot wound to the arm. The scene was quickly secured, and ballistic evidence recovered, including five casings.

44. Initial intelligence suggested the attack may have been targeted, with the individual providing security at the venue potentially being the intended victim. This hypothesis was supported by a previous incident in October 2018, where shots were fired through the window of his home in Derbyshire. That earlier event had already led to the arrest of a known

Nottinghamshire OCG member, and the security provider's presence at the scene, combined with his apparent lack of concern, added complexity to the assessment of threat and motive.

45. The incident required a coordinated response, from two different police forces, across firearms, intelligence, and investigative teams, with a focus on both immediate containment and the wider strategic picture. The potential link to drug supply networks and OCG activity necessitated careful consideration of community impact, reputational risk, and operational tempo. Ultimately, two individuals, Jordan Murray and Dianvelli Williams were charged, convicted and sentenced for firearms offences, reinforcing the seriousness of the threat and the importance of a robust, intelligence-led approach.

46. In May 2019, I led the strategic oversight during Operation Virtuality, a protracted and volatile series of firearms incidents linked to an escalating feud between two rival OCGs operating across Nottingham. The dispute, involving numerous individuals, manifested in a pattern of tit-for-tat shootings that posed a significant threat to public safety and required a sustained, intelligence-led policing response.

47. The firearms conspiracy encompassed several serious offences, beginning with a discharge in Minver Crescent in December 2018, and intensifying in May 2019 with a shooting on Brindley Road, where a man was shot in the neck. Further incidents followed, including a discharge at Hazel Hill Crescent targeting the home address of another male, and culminating in the recovery of four firearms, ammunition, and substantial quantities of drugs at Wyton Close, Bestwood.

48. The strategic considerations throughout this operation were multifaceted. It was essential to maintain momentum across investigative and enforcement strands while managing community reassurance and mitigating the risk of further violence. The coordination of covert and overt resources, alongside effective engagement with regional and national partners, led to the arrest, charge, and conviction of all key subjects. The operation demonstrated the importance of sustained pressure, clear command structures, and the ability to adapt tactically within a dynamic and high-risk environment.

49. In late 2020 I was responsible for the strategic coordination of Operation Guardstone, a multi-strand response to a series of violent incidents across Nottingham that appeared to stem from escalating tensions between youth-affiliated groups in the Top Valley and Radford areas of Nottingham. The initial catalyst was a stabbing on 8 October 2020, when one youth stabbed another during an altercation at a city centre fast food outlet. That same night, retaliatory gunfire was directed at the suspects home address, suggesting an immediate and targeted response.

50. Just days later, on 12 October 2020, another youth, affiliated with Top Valley, was fatally stabbed outside the Victoria Centre shopping centre in Nottingham city centre. Two suspects were subsequently arrested and charged. The gravity of these events, coupled with uncertainty around motive and the potential for further retaliation, prompted the establishment of a Gold command structure which I led to oversee the strategic response. These meetings ran for several weeks, focusing on threat mitigation, community reassurance, and intelligence development, before

being stood down on 26 October 2020 when tensions appeared to subside.

51. However, the situation reignited in November. On the 20 November 2020 a further youth was stabbed multiple times inside an off-licence on Alfreton Road, Nottingham. The following morning, a person who was believed to be a close associate of that victim was shot in the neck at a party. Both victims were of East African heritage and affiliated with Radford-based groups. Later that same day, a further confrontation occurred at a takeaway in Radford involving individuals linked to both Radford and St Ann's, adding to the complexity of the landscape.

52. Given the renewed violence and lack of clarity around group dynamics and motivations, the Gold group was re-established with an expanded partnership footprint. The strategic objectives included identifying and disrupting further incidents of serious violence, managing threat-to-life subjects, safeguarding vulnerable individuals, particularly young people, and maintaining community cohesion. The response required close collaboration across policing, intelligence, safeguarding, and family and community engagement functions, with a focus on both immediate containment and longer-term stability.

53. In January 2021, I led the strategic coordination of Operation Myrrh, a partnership-driven response to a complex public health and safeguarding concern involving a care worker operating across Nottinghamshire and Derbyshire. The incident began with a call to the force control room ("FCR") from the chief executive of a domiciliary care provider, reporting that one of her employees had tested positive for Covid-19 on 2 January

2021 but had allegedly continued to work with vulnerable clients in the community. It was also disclosed that the individual held a second role at City Hospital as a discharge coordinator, raising further concerns about potential exposure.

54. Given the dual nature of the issue, public health risk and potential criminality, a Gold Coordination Group was convened to ensure a balanced and proportionate response. The strategic priorities were clear: to mitigate any further spread of the virus through effective track and trace, safeguard potentially exposed individuals, and assess whether any offences had been committed under Covid-19 regulations or other relevant legislation.
55. The operation required close collaboration with health partners, local authorities, and safeguarding teams. It was essential to maintain public confidence while navigating the sensitivities of employment law, data protection and community reassurance. The incident highlighted the importance of agile partnership working, clear communication, and the ability to respond decisively to emerging threats that straddle both criminal and public health domains.
56. In October 2021, I led as Gold for Operation Windblown, a multi-agency strategic response to a surge in reported “spiking” incidents across Nottinghamshire. The issue quickly gained national attention and provoked widespread concern, particularly among women engaging with the night-time economy. As the volume and geographic spread of reports increased, it became clear that the partnership faced diverging political and

operational views, particularly around communication strategy and resource coordination.

57. Drawing on my experience leading both Local Policing and Public Protection, I adopted a whole-systems approach to bring clarity and cohesion to the response. I identified and engaged key stakeholders across local authorities, public health, licensing, emergency services, hospital trusts, and both universities. Listening carefully to concerns, ranging from inconsistencies in victim reporting to service delivery pressures, I facilitated a collegiate dialogue focused on shared objectives: reducing harm, supporting victims, and restoring public confidence.
58. Through these conversations, I secured high-level commitment to a multi-agency Gold group, which I chaired. This enabled the development of a joint strategy and communications plan, ensuring consistency and transparency across all partners. I established a dedicated investigative team and encouraged close collaboration between detectives, paramedics, and hospital staff. This led to the creation of a joint trigger plan and forensic strategy, which I approved, ensuring every report received a consistent and high-quality response. Notably, the deployment of joint first responders and enhanced forensic support from hospital partners significantly improved investigative outcomes.
59. The group also agreed on a robust multi-agency reporting and recording protocol, involving licensed venues, universities, and hospitals. A shared resource was used to analyse data collaboratively, deepening our understanding and refining our operational approach. I advocated for engagement with other regions facing similar challenges, and colleagues

responded positively, sharing best practice with Devon & Cornwall and Lincolnshire.

60. The operation was subject to public scrutiny, including media coverage and examination by the Home Affairs Select Committee, where a Nottinghamshire victim gave evidence. Feedback from both forums was highly positive. The collaborative effort not only strengthened inter-agency relationships but also laid the groundwork for a systematic review of our approach to safeguarding children at risk of serious youth violence.
61. In December 2022, I led as Gold for Operation Paradigm, a critical and complex response to a misconduct investigation involving an SIO alleged to have falsified documentation relating to investigative policy across multiple homicide cases. Recognising the gravity of the situation and its potential to undermine public confidence and judicial integrity, I took immediate responsibility for understanding the scope of the issue and managing the associated risks.
62. The implications extended beyond Nottinghamshire, affecting twelve active homicide investigations at various stages within the criminal justice system, and involving other forces where the SIO had previously led inquiries. I convened a joint Gold group with the CPS to ensure a coordinated and transparent approach to disclosure. Together, we agreed to appoint Treasury Counsel to advise on the content and consistency of disclosure letters to defence teams, reinforcing our commitment to fairness and legal integrity.
63. I personally engaged with ACCs from other affected forces, providing a clear account of the situation, outlining our strategy, and offering a sincere

apology for the potential impact on victims' families and the operational burden placed on their teams. Within Nottinghamshire, I addressed staff in the Major Crime Unit directly, acknowledging their concerns and offering reassurance, while outlining contingency plans to support Family Liaison Officers ("FLO"s) in the event of any case failures.

64. Seizing the opportunity to drive improvement, I initiated a review of our Major Incident Room procedures, particularly around policy writing and recording. I also invited the College of Policing to review our SIO assessment and accreditation processes. As a result, I introduced a strengthened approach to SIO accreditation, which I now still personally oversee.
65. Through decisive leadership and collaborative engagement, I ensured that there was no denial of justice for victims or their families. The operation reinforced trust across the criminal justice landscape and delivered tangible improvements in investigative governance and professional standards.
66. In GRO-C 2023, I led as Gold Commander for Operation Statehood, a critical incident involving a GRO-C GRO-C. The attacks, carried out by a GRO-C GRO-C, sparking significant community concern and attracting political attention. Recognising the potential impact on public confidence and the imperative to protect life, I declared a critical incident and implemented a comprehensive command structure to coordinate the response.

67. At the initial Gold group, I set out a strategy focused on minimising harm and ensuring a consistent, coordinated communications approach across the partnership. The possibility that the attacks were hate-motivated made a Community Impact Assessment (“CIA”) a priority. I delegated this to the Divisional Commander acting as Bronze for communities, empowering her to engage directly with affected groups and stakeholders through trusted platforms. Her insight and connectivity helped address concerns around under-reporting and legitimacy, and I personally briefed Chief Executives and the PCC to provide reassurance.

68. I appointed a crime Bronze to lead the investigation and mobilised resources from across the force and regional collaboration to ensure a robust and professional response. Balancing public protection with operational effectiveness, I made the strategic decision, after consultation with Bronze investigation and Bronze media, to delay a public appeal for 24 hours. This was based on a clear assessment that such a release might cause the suspect to pause or relocate, undermining our ability to prevent further harm.

69. To sustain momentum and ensure resilience, I authorised a covert deployment in a defined area, supported by a comprehensive threat assessment and contingency planning to safeguard officers. This led to the successful arrest of the suspect by covert officers acting on a known description. Subsequent intelligence analysis, directed through my command structure, identified further offences across Nottinghamshire and in another force area. I initiated Gold-to-Gold dialogue with the affected

force, encouraging a self-referral to the Independent Office for Police Conduct (“IOPC”) to support learning and transparency.

70. Through decisive leadership and strategic coordination, Nottinghamshire Police delivered an effective response to [GRO-C]. The arrest and charge of the suspect prevented further attacks, and feedback from communities and stakeholders was unequivocally positive. The operation strengthened engagement with previously hard-to-reach communities and reinforced public trust in our ability to respond to serious and unpredictable threats. The defendant, [GRO-B] case was [GRO-C]

Previous Knowledge of Valdo Calocane

71. I can confirm that, to the best of my knowledge, I did not have any personal knowledge of any police involvement with Valdo Calocane (“VC”) prior to 13 June 2023.

Notification of the attacks and steps prior to chairing the Gold Group

72. I have been asked to detail when I first became involved in the matters relating to the attacks on 13 June 2023, and to describe the steps I took prior to chairing my first Gold Group meeting on that date.

73. On the 12/13 June 2023, I was the On-Call Chief Officer for Nottinghamshire Police, which is a strategic leadership role providing senior oversight and decision-making support outside of standard working hours.

74. As the most senior officer available during the On-Call period (evenings, weekends, and public holidays), my role was to act as the strategic point

of contact for critical incidents, major investigations, and any situation requiring executive-level input or authorisation.

75. This role ensures continuity of command and maintains the force's ability to respond effectively to significant events at any time. The on-call Chief Officer is also responsible for offering guidance and support to Force Incident Managers ("FIM") and Silver Commanders (in Nottinghamshire we have Supts on-call who perform this role), particularly where incidents may escalate, attract media or political attention, or have the potential to impact public confidence.

76. I was also the on-call Strategic Firearms Commander ("SFC"). In this role, I hold ultimate responsibility for the strategic oversight and direction of all armed policing operations. As SFC it was my role to ensure that any deployment of armed officers was lawful, necessary, proportionate, and aligned with national policing standards. Working closely with Tactical Firearms Commanders ("TFC") and Operational Firearms Commanders ("OFC"), my role is to ensure that the strategic intent is clearly communicated and that tactical plans are consistent with the agreed objectives.

77. The TFC is responsible for developing and implementing the tactical plan during a firearms incident, ensuring that the deployment of armed officers is safe, proportionate, and aligned with the strategic objectives set by the SFC.

78. The OFC is responsible for the direct command and control of armed officers on the ground during a firearms deployment. As the most immediate level of command, the OFC ensures that tactical plans are

executed safely, lawfully, and effectively in line with the direction set by the TFC.

79. The most senior officer on duty after 17:00hrs in Nottinghamshire is the FIM. In Nottinghamshire the FIM is a Chief Inspector (“Ch Insp”) and is responsible for the real-time management of incidents across the force area. Operating from the control room, the FIM provides strategic oversight and tactical coordination, ensuring that incidents, particularly those that are complex, high-risk, or fast-moving, are managed effectively, proportionately, and in accordance with national and local policies.
80. The FIM must maintain a dynamic overview of force-wide activity and will also coordinate the deployment of resources. This function is often supported and performed by the Response Policing Inspector (“RPI”), who is the most senior officer on the ground, after 17:00hrs.
81. In addition, Nottinghamshire Police also had a senior detective on duty, at the rank of Det Insp. We refer to this role as the “Golden DI”. The role of the “Golden DI” is to oversee serious and complex crime investigations during out-of-hours periods. They provide oversight, guidance, advice and decision-making support for ongoing investigations and may assume responsibility for the early stages of major crime investigations, which often involves attending crime scenes.
82. I first became involved in matters relating to the attacks carried out by VC on 13 June 2023 when I received a telephone call from the FIM, Ch Insp David Mather. While I do not have a precise record of the time of this initial call, I have since caused a check to be made of the times of my calls on that morning (and the chart of calls that has been produced on my

instruction is now referred to as URN: NGPF0007786). From this, I can see that I received the call from Ch Insp Mather at 05:01 hours. Ch Insp Mather contacted me in my capacity as the on-call Chief Officer. I was not acting as the SFC at that time.

83. At that stage, the circumstances were still emerging and remained unclear.

Ch Insp Mather informed me that two individuals had been stabbed on or near Ilkeston Road in the Radford area of Nottingham. The motive was unknown at that time, although it was initially considered that the incident may have been a robbery. It was believed that the victims might be students. One of the victims was thought to be deceased, and the second had sustained serious injuries.

84. At 05:53 hours (also taken from NGPF0007786), I received a second call from Ch Insp Mather. He informed me that a van had been driven through Nottingham city centre and had deliberately collided with several pedestrians, causing injuries. He also confirmed that he had declared both Operation Plato and a major incident in response to the developing situation. I remember that he also told me that a person had been arrested. At this point I assumed the role of Gold Commander.

85. Operation Plato is the United Kingdom's national policing response plan for a Marauding Terrorist Attack ("MTA"), particularly one involving firearms or other weapons, which includes vehicles as weapons, in a public space. It is designed to provide a structured, coordinated, and rapid response to incidents where attackers move through a location with the intent to cause mass casualties.

86. The plan outlines how police, emergency services, and partner agencies should respond, including the immediate deployment of armed officers, the establishment of command structures, and the prioritisation of life-saving interventions.
87. The primary aim is to save life, neutralise the threat, and restore public safety as quickly as possible.
88. Operation Plato is by its very nature, a major incident. Major incidents are broadly described as any event or situation that requires a coordinated, multi-agency response due to its scale, complexity, or potential impact on the public, infrastructure, or environment. It typically involves serious harm, disruption, or risk to life, and exceeds the routine capabilities of emergency services.
89. Declaring a major incident enables structured multi agency command arrangements, which I will describe more fully later in my statement.
90. I ordinarily arrive at work at approximately 07:30 hours each day. However, following the initial call from Ch Insp Mather, I made the decision to travel in earlier than usual on that morning, aiming to arrive by 06:30 hours to receive a briefing from him prior to the end of his duty at 07:00 hours.
91. It was as I was preparing to leave my home address, that I received the second call from Ch Insp Mather. I recall departing very shortly after that conversation.
92. During my journey to work, which typically takes around 30 minutes, I made a further telephone call to the FCR to gather additional information at 05:55 hours. During this call, I confirmed that a man had been arrested and that there was a possible link between the earlier stabbing incidents

and the subsequent van attacks. I believe I was also informed, during one of these calls, that a further incident had been reported of a man having been found with serious stab wounds on Magdala Road, Nottingham.

93. During my journey to work, I made further telephone calls to inform and update key individuals whom I knew would play an important role in shaping and leading our response to the developing situation.

94. At 06:00 hours, I contacted Chief Constable Kate Meynell to brief her on the incidents as they were understood at that time.

95. At 06:09 hours, I telephoned Det Supt Leigh Sanders, Head of the East Midlands Major Crime Unit (Homicide) ("EMSOU"). I provided him with an initial briefing and informed him of my intention to appoint him as the SIO. Given the nature and seriousness of the homicides, I considered it essential that the investigation be led by an officer of his rank, experience, and accreditation.

96. Det Supt Sanders confirmed that he would travel to the Major Incident Room ("MIR") at Radford Road Police Station to assume responsibility for leading the investigation. We agreed to remain in contact and speak again later that morning.

97. I arrived at Force Headquarters at approximately 06:20 hours and having visited my own office briefly I attended the FCR, arriving there at 06:30 hours.

98. Upon arrival, I received a more detailed briefing from Police Sergeant ("Sgt") Jon Straszewskyj, who was working in the FCR at the time. I began making notes of this briefing in a notebook that I had collected from my

office, and became my Gold Commander's log, which I commenced at that time. I refer to this log as URN: NGPF0007787.

99. Sgt Straszewskyj informed me that police had received a call at 04:04 hours reporting a stabbing incident outside Mario's Pizza shop on Ilkeston Road. He explained that both victims had sadly lost their lives. They were believed to be University of Nottingham students, Barnaby Webber, aged 19, and Grace O'Malley Kumar, aged 20.
100. He went on to describe a second call received at 05:25 hours, reporting that a white van had deliberately struck a male on Milton Street in Nottingham city centre. The driver was described as a Black male. The van had subsequently been sighted by police officers and had collided with additional pedestrians. Early indications suggested that three or four individuals had sustained injuries.
101. Sgt Straszewskyj explained that the vehicle was followed to Maple Street in Radford, where the sole occupant was tasered and detained by police officers.
102. He also described a third call received at 05:37 hours, reporting the discovery of an unidentified deceased male, found either in the gutter or on the kerb of Magdala Road, Nottingham.
103. He informed me that Operation Plato had been declared at 05:32 hours, although I note now that this time may be subject to later clarification. He also provided an update on the deployment of armed response resources, which included officers from Nottinghamshire as well as neighbouring forces.

104. At 06:50 hours, I telephoned Det Supt Chris Sullivan, who serves as the force's Director of Intelligence and is also a Specialist Tactical Firearms Commander ("STFC"). I asked him to attend the FCR to join me and to discuss the role he would play in our response to the unfolding incident.
105. The Director of Intelligence is a senior leadership role within policing, responsible for setting and overseeing the force's intelligence strategy and to ensure that intelligence products are clear, consistent, and effectively inform decision-making across all levels of the organisation.
106. At 06:55 hours, I contacted Ch Insp Chris Pearson, responsible for Community Policing in the City Division, to inform him of the incident and to advise him of the need to attend the Gold Group meeting later that morning. I will explain and describe the Gold Group later in my statement. During our conversation, we agreed on the importance of initiating a CIA and making early contact with key stakeholders to support reassurance and engagement efforts.
107. At 06:59 hours, I had a discussion with Ch Insp Mather regarding the potential need for a referral to the IOPC, based on the possibility of death or serious injury arising from police contact with the subject. We also considered whether it would be appropriate to initiate a Post Incident Procedure ("PIP").
108. A Death or Serious Injury ("DSI") matter refers to any incident where a person dies or sustains serious injury following direct or indirect contact with police officers or staff acting in the execution of their duties. This includes situations where the individual was under arrest, in custody, or otherwise engaged with police at the time of the incident.

109. Under the Police Reform Act 2002, as amended by the Policing and Crime Act 2017, police forces in England and Wales have a statutory duty to refer all DSI matters to the IOPC. This referral must be made promptly and without delay, especially where there is any indication that police contact may have caused or contributed to the death or serious injury.
110. The PIP is a structured process implemented by police forces following a DSI incident. Its purpose is to ensure that any subsequent investigation, whether internal or by an external body such as the IOPC, is conducted fairly, transparently, and in accordance with legal and ethical standards.
111. On the basis that I believed police officers were following the van at the time it struck several pedestrians, I considered that the incident could meet the criteria for referral to the IOPC. I noted an action to consider this further, which I intended to address during the Gold Group meeting later that morning. I thought that documenting this decision within a Gold Group meeting, where it would be formally recorded in the minutes, was the most transparent and appropriate course of action.
112. At 07:02 hours, I made a further call to Chief Constable Kate Meynell to provide an update following my briefing. She informed me that she would now be travelling back to the force from Harrogate, where she had been attending a work engagement.
113. At 07:25 hours, I contacted DCC Stephen Cooper. I briefed him on the incidents and raised the possibility of him assuming a role within the command structure as the Specialist Strategic Firearms Commander ("SSFC"), which I will explain in more detail below.

114. At 07:30 hours, I met with Det Supt Chris Sullivan. I provided him with a situational update, including details of the arrested individual, identified as VC, born 04/09/1991. I also shared two addresses associated with the suspect that were known to us at that time. I formally appointed Det Supt Sullivan to the role of STFC and asked him to begin preparations for any potential search activity or further arrest considerations.

115. During this briefing, I noted that the suspect may have been a student and that he had previously been sectioned under the MHA in 2020.

116. At 07:45 hours, I spoke by telephone with DCC Paul Gibson, who was the Head of the EMSOU. DCC Gibson holds oversight and responsibility for the regional murder investigation teams and acts as the conduit for Nottinghamshire Police's access to the counter-terrorism policing network. He provided reassurance that resources from both areas were available and actively responding to the incident.

117. Following this, I recorded my initial thoughts regarding an appropriate command structure and began drafting some early considerations regarding the content of my Gold Strategy, which I will outline in more detail below.

118. At 08:15 hours, I met with Chief Constable Kate Meynell, Lyn Heath (Head of Corporate Communications), and Matthew Jarram (Senior Communications Officer). We discussed my proposed strategic approach, which was approved by the Chief Constable.

119. At 08:45 hours, I had a further telephone conversation with Det Supt Leigh Sanders, ahead of his briefing to the investigation team. The purpose of the call was to establish whether there was any additional

information I might require for the forthcoming Gold Group meeting and to ensure that he had the necessary support and resources to progress the investigation effectively.

120. At 09:45 hours I chaired a multi-agency Tactical Coordination Group (“TCG”) meeting. A TCG meeting is a key component of the multi-agency response structure during a major incident. It brings together tactical-level commanders from relevant agencies, such as police, fire and rescue, ambulance services, local authorities, and others, to coordinate the operational response and ensure that actions are aligned with the strategic objectives set by the Strategic Coordination Group (“SCG”).

121. I will explain police attendance at other meetings more fully later in my statement. However, it is relevant to note here that it is unusual for the Gold Commander to chair a TCG. On this occasion, I chose to do so to initiate the coordination of the multi-agency response at the earliest opportunity. Given my situational awareness at that stage and the urgency of the developing incident, it felt both pragmatic and practical to take this approach. This was intended as an interim measure, pending agreement with partner agencies on who would formally chair future TCGs and, in due course, SCG meetings.

122. At 10:50 hours, I had a discussion with Ch Insp Amy English, who is a trained Post Incident Manager (“PIM”). Following our conversation, I authorised the initiation of a PIP in relation to the DSI associated with the van incident.

123. At 11:05 hours, together with Chief Constable Kate Meynell, I provided an update briefing via telephone to Deputy Assistant Commissioner

("DAC") Tim Jacques, the Senior National Coordinator ("SNC") for Counter Terrorism ("CT") policing. The SNC operates within the CT policing network and is responsible for coordinating the national police response to terrorism. This includes oversight of regional CT units and close collaboration with intelligence agencies, government departments, and local police forces.

124. In major incidents or terrorist attacks, the SNC plays a key role in ensuring that resources are deployed appropriately and that communication between agencies is clear and effective. During our conversation, DAC Jacques confirmed that the CT policing network would be supporting the investigation, offering both investigative and intelligence capability. He also confirmed that I could make direct contact with him at any time throughout the course of the investigation.

125. At 11:45 hours I commenced my first Gold Group meeting.

Gold Groups and response to the Incident.

126. I have been asked to explain why the Gold Group was set up, why I was appointed to the chair, how and why attendees were selected and the aims and objectives of the group.

127. I was the chair of the Operation Hendrix Gold Group from Tuesday 13 June 2023 up to and including Monday 19 February 2024.

128. In relation to the attacks on 13 June 2023, Operation Plato and a major incident had been declared, and I had also declared the incidents as critical.

129. A critical incident is any incident where the effectiveness of the police response is likely to have a significant impact on the confidence of the victim, their family and/or the community.
130. In the immediate aftermath of the tragic attacks in Nottingham on 13 June 2023, it was my professional judgement that Nottinghamshire Police's response would inevitably have a profound impact on the trust and confidence of those most affected. This included the bereaved families, those who were injured and their loved ones, as well as the wider community. It was for this reason that I formally declared the incident to be critical.
131. Through my experience and training, I have come to understand that the strategic leadership of a critical incident must be both effective and clearly defined. In such circumstances, it is essential that roles, responsibilities, and lines of accountability are unambiguous. This clarity ensures that the response is coordinated, and capable of meeting the complex needs of those affected.
132. Establishing a Gold Group with a clearly defined command structure is a recognised and effective method of delivering strategic leadership during a critical incident. In response to the attacks, I convened a Gold Group to provide strategic oversight and direction throughout the management of the incident.
133. My primary purpose in doing so was to ensure that Nottinghamshire Police's response was coordinated and aligned not only with the expectations of the bereaved families and the wider public, but also with the organisation's operational priorities. The Gold Group brought together

senior leaders and subject matter experts to support informed decision-making, assess emerging risks, and help deliver the strategic objectives I had set. These objectives are outlined later in my statement.

134. I also convened the group to deliver a structured approach to managing the complexity of the incident, ensuring that operational activity was underpinned by clear strategic direction. It also helped facilitate effective communication across the organisation and with external partners, supported resource allocation, and ensured that issues such as family and community impact, safeguarding, and public confidence were considered from the outset.

135. Before outlining the command structure and the membership of the Gold Group, I believe it is helpful to provide some context regarding the senior leadership structure within Nottinghamshire Police, which informed the selection of individuals involved in the strategic response.

136. As is the case in all police forces outside of the Metropolitan Police Service, Nottinghamshire Police is led by a Chief Constable and a DCC. Supporting this leadership are two ACCs: one with responsibility for investigations, intelligence, and criminal justice, and the other overseeing uniformed policing.

137. The force also includes three Ch Supts. Two of these are aligned directly with the portfolios of the ACC, while the third, who holds responsibility for corporate services, reports directly to the DCC.

138. Each operational business area within the force is led by a Supt. In June 2023, there were twelve Supts in post, each responsible for a distinct area of operational delivery.

139. This structure provided a clear framework from which to draw the necessary expertise and leadership for the Gold Group, ensuring that the strategic response was informed, balanced, and appropriately resourced.
140. My proposed approach to the command structure was discussed and agreed with the Chief Constable at 08:15 hours Tuesday 13 June 2023.
141. I had proposed a Gold, Silver, Bronze command structure because this is the nationally recognised framework used across UK policing to manage major incidents and operations. It provides clarity of roles and responsibilities, ensuring that strategic, tactical, and operational decisions are made at the appropriate levels.
142. Gold Command is responsible for setting the overall strategy and direction of the response. The Gold Commander defines the strategic objectives, allocates resources, and ensures that the response aligns with organisational priorities and public expectations. This role does not typically involve direct operational command but provides overarching leadership and accountability.
143. Silver Command translates the strategic intent set by Gold into a tactical plan. The Silver Commander coordinates and directs resources, assesses risks, and ensures that the tactical response is coherent and effective. Silver acts as the bridge between strategy and operational delivery.
144. Bronze Command is responsible for implementing specific elements of the tactical plan on the ground. Bronze Commanders manage frontline activity, ensuring that operational tasks are carried out safely, efficiently, and in accordance with the tactical direction.

145. This structure ensures that decision-making is both scalable and responsive, allowing for clear lines of communication and accountability throughout the duration of an incident.
146. I was selected to undertake the role of Gold Commander due to my position within the organisation at the time, serving as ACC for Crime, Intelligence, and Specialist Operations. This portfolio was considered the most appropriate for leading the response to an incident of this nature. In addition, I brought extensive experience in managing serious crime investigations, particularly homicide, and had a strong track record of working collaboratively with strategic partners across the region.
147. This arrangement enabled the Chief Constable to assume a role sometimes referred to as "Platinum." In doing so, she was able to focus on engagement with senior and national stakeholders, oversee liaison with government and partner agencies, manage media relations, and undertake public communications and interviews as required.
148. It also allowed the DCC to take on the role of Specialist Strategic Firearms Commander ("SSFC"), leading the ongoing firearms operation which was primarily focused on search activity. He remained available to assume further command responsibilities should any counter-terrorism links have emerged, or additional enforcement activity become necessary.
149. My colleague, ACC Gary Hooks, who held responsibility for uniformed policing, was able to maintain oversight of all other operational demands on the force that were unrelated to Operation Hendrix. This ensured continuity of service and resilience across the wider policing landscape during a period of significant pressure.

150. The other roles within the command structure, all of whom attended my Gold Group, were selected based on their expertise, responsibilities, and relevance to the incident. Their inclusion ensured that the strategic response was informed by operational insight, subject matter expertise, and strong partnership engagement.
151. Silver Command was undertaken by Ch Supt Suk Verma, the head of uniform policing. He is an experienced firearms commander with a particular strength in community engagement and partnership working. I selected him for this role due to his proven ability to build relationships and work collaboratively with strategic partners, skills that were essential in managing the tactical response.
152. Supt Kathryn Craner, the City Divisional Commander, was appointed as Welfare Bronze. She had direct responsibility for officers and staff working in the affected area and was a key figure in stakeholder engagement. Her contribution was central to the strategic objective of providing welfare support to affected officers and staff. Additionally, she line-managed two other Bronze Commanders and could represent them at Gold Group meetings if they were unavailable.
153. One of those was Ch Insp Jon Foy, responsible for City Response Policing, who was appointed Bronze Ground Commander. His role involved coordinating officers and staff managing the scenes, ensuring operational activity was organised and effective.
154. Ch Insp Chris Pearson was appointed Bronze for Communities, Stakeholders, and Community Impact. As the City Ch Insp for that function, he had strong relationships with communities and partners in the

affected area. His role was instrumental in supporting the strategic objectives related to partnership working and maintaining public trust and confidence.

155. Det Supt Sanders was appointed Bronze for Investigations, tasked with delivering strategic objective four: ensuring a professional and effective investigative response to the murders and related incidents, identifying suspects, securing arrests and prosecutions, and ultimately achieving justice for victims and their families.

156. Supporting this function was an experienced Family Liaison Advisor ("FLA"), reporting directly to the SIO. I was informed before 08:15 hours on 13 June 2023 that Det Insp Claire Gould had been appointed to this role. Her experience provided reassurance, and both she and the SIO were crucial to delivering strategic objective two, ensuring effective engagement, communication, and support for affected families.

157. Det Insp Dave Bola was appointed Bronze for Intelligence. An experienced senior detective with a background in investigations and intelligence, and at the time working within CT policing, his expertise was vital in supporting strategic objective one: minimising the risk of further harm to people in the affected areas.

158. Although Gold Group minutes from 13 June 2023 indicate that Matthew Jarram had been appointed Media Bronze, I can confirm that this function was shared between him and Lyn Heath, Head of Corporate Communications. Both committed to attending Gold Group meetings during the first week and were present each morning at planning meetings with myself and the Chief Constable. Their role was fundamental to

achieving strategic objective three, providing reassurance through an effective media and communications plan.

159. Insp Craig Berry, from our Emergency Planning and Resources Department, was appointed Bronze for Logistics. His position and expertise made him ideally suited to coordinate resources in response to the incident. To support him, Supt Louise Clark, Head of Operational Support, was also invited to Gold Group meetings due to the scale of the logistical challenge.
160. Det Supt Hayley Williams, Head of Professional Standards (“PSD”), was appointed Bronze for Professional Standards. As a subject matter expert, she provided legal and technical advice on police regulations and supported decisions relating to strategic objective six, ensuring appropriate notifications to scrutineers.
161. Other attendees included Supt Claire Rukus, County Divisional Commander, who was invited to ensure she was fully briefed and able to manage any community impact within the county, as well as contribute to the resourcing effort.
162. Det Ch Supt Leona Scurr, Head of Crime, attended most meetings. She played a key role in linking EMSOU with Nottinghamshire Police, and ensuring the SIO had the necessary resources. She also attended most of the murder team briefings and was allocated responsibility for managing welfare within the investigations command, supporting strategic objective seven.

163. Ch Insp Karl Thomas, part of the City Senior Leadership Team, attended to lend support and advice to the overall policing effort, particularly in relation to community impact.
164. Sgt Helen Walker, from the duties team, attended Gold Group meetings to support Insp Berry in the logistics function.
165. Finally, the meetings were minuted by one of the Business Support Officers to the Command Team, predominantly Wendy Walker.
166. The membership of the Gold Group evolved over time. During the first week of the response, attendance was largely consistent. Where key attendees were unavailable, appropriate representatives were present. As the strategic objectives narrowed and the incident progressed, the requirement for attendance reduced accordingly.

Response groups established or attended by the police.

167. I have been asked to explain what, if any, other response groups were established by the police and/or did the police attend.
168. In addition to the Gold Group, two further multi-agency response groups were established and attended by the police: the SCG and the TCG. These groups were convened to support the wider coordination of the response and ensure effective communication and decision-making across agencies.
169. In response to the declaration of a major incident, I took prompt steps to activate established multi-agency coordination mechanisms. This included the formation of both an SCG and a TCG, with police representatives chairing each meeting to ensure effective leadership and operational oversight.

170. These groups are convened under the framework of the Local Resilience Forum (“LRF”), which is a statutory partnership comprising emergency services, local authorities, health agencies, and other relevant organisations. The LRF exists to plan and prepare for emergencies, ensuring a coordinated response across agencies when incidents occur that require collective action.
171. The SCG is responsible for setting the overall strategy and direction of the response. It brings together senior leaders from partner agencies to assess the evolving situation, agree on priorities, allocate resources, and provide public reassurance. The SCG operates at a strategic level, focusing on long-term implications and inter-agency coordination.
172. The TCG supports the SCG by translating strategic objectives into operational plans. It is composed of tactical leads from each agency who coordinate the day-to-day response, manage logistics, and ensure that actions on the ground align with the strategic intent.
173. The activation of these groups through the LRF arrangements reflects established protocols for managing major incidents, ensuring that the response is proportionate, collaborative, and in the best interests of public safety.
174. I chaired the first TCG (which I explained above) at 09:45 hours on 13 June 2023, and thereafter, assumed the role as chair for the SCG. Ch Supt Suk Verma was the chair of the TCG. I refer to the minutes of this meeting as URN: NGPF0007927.

175. The first meeting of the SCG was convened at 13:30 hours on Tuesday 13 June 2023. I refer to the minutes of that meeting as URN: NGPF0007788.

176. Subsequent SCG meetings were held at the same time, 13:30 hours on Wednesday 14 June, Thursday 15 June, and Friday 16 June 2023. The minutes of these meetings are referred to as URN: NGPF0007789, URN: NGPF0007790, and URN: NGPF0007791, respectively.

177. The SCG meetings were attended by a broad range of partner agencies and stakeholders, reflecting the multi-agency nature of the response. These included representatives from military liaison, CT policing, the fire and rescue service, the police, East Midlands Ambulance Service (“EMAS”), government liaison, the tram network, the University of Nottingham, Nottingham Trent University, Nottingham City Transport, Nottingham City Council, Nottinghamshire County Council, East Midlands Railway, British Transport Police, and National Highways.

178. Each meeting commenced with introductions and a discussion regarding chair-ship. On each occasion, the group expressed a clear preference for me to continue in the role of Chair. We reviewed the membership of the group and addressed any matters requiring urgent decision. I then provided a situational update to inform the group’s deliberations.

179. Throughout the meetings, we consistently revisited and refined the strategic aims and objectives of the response. These included:

- Saving and protecting life
- Reducing harm

- Containing the emergency
- Providing public warnings and advice
- Protecting the health and safety of responding personnel
- Facilitating the recovery of the community
- Maintaining critical activities and normal services
- Supporting investigations
- Evaluating the response and recovery
- Identifying lessons learned

180. Actions and tasks were agreed upon collaboratively, with clear allocation of leads to ensure accountability and progress. We also ensured that appropriate links were established between local and national levels of response, maintaining alignment and coordination.

181. A dedicated media cell was established to operate in parallel with the SCG. It was agreed that the police would lead on media communications, with the Chief Constable undertaking any public interviews. All media activity was informed and supported by the media cell to ensure consistency and accuracy.

182. Each meeting included a discussion on long-term predictions and community resilience. We also reflected on the importance of transitioning to recovery and the need to establish a Recovery Coordination Group (“RCG”) to support that phase of the response.

183. At the final meeting of the SCG, held at 13:30 hours on Friday 16 June 2023, all attendees collectively agreed that most of the strategic objectives set out at the outset of the response had been achieved. The remaining areas requiring continued attention were the facilitation of investigation

and inquiry, the evaluation of the response and recovery, and the identification of lessons learned.

184. Considering this assessment, the group reached a consensus that the incident had progressed to a stage where it was appropriate to transition from the response phase into the recovery phase. Accordingly, it was agreed that the SCG should formally stand down and that an RCG should now be established to lead and oversee the recovery efforts.

185. This decision reflected both the operational progress made and the need to ensure that recovery planning and implementation were given appropriate focus and leadership moving forward.

186. An RCG also operates under the framework of the LRF and typically includes similar multi-agency representatives. It was established to lead and manage the recovery phase following this major incident, once the response phase was complete. Its primary purpose was to coordinate efforts that restore affected communities, services, and infrastructure to normality, or to an improved state, following the disruption caused by the incident.

187. The second meeting of the TCG was convened at 17:30 hours on Tuesday 13 June 2023. I refer to the minutes of that meeting as URN: NGPF0007792. Although the second TCG meeting, it was the first to be chaired by Ch Supt Verma.

188. Subsequent TCG meetings were held at approximately 10-10:30 hours on Wednesday 14 June, Thursday 15 June, and Friday 16 June 2023. The minutes of these meetings are referred to as URN: NGPF0007793, URN: NGPF0007794, and URN: NGPF0007795, respectively.

189. I have taken the timings of the TCG meetings from the recorded minutes. However, I am aware, through LRF debriefs, that due to the operational demands at the time, the scheduling of these meetings was subject to frequent change. As such, I cannot be certain that the times recorded in the minutes are entirely accurate. I also note that the final meeting held on Friday 16 June was incorrectly dated in the minutes as Thursday 15 June 2023, and this appears to have been carried over from the previous day's entry.
190. The TCG meetings were similarly attended by a range of partner agencies and stakeholders. While broadly reflective of the multi-agency membership of the SCG, attendees at the TCG typically held more tactical roles within their respective organisations.
191. Each TCG meeting commenced with an introduction and welcome from Ch Supt Verma. The group routinely reviewed its membership to ensure appropriate representation was maintained. Matters requiring urgent decisions were prioritised early in the agenda.
192. A situational update was consistently provided, and the group reflected on the SCG aims and objectives. Media strategy was a standing item, as were discussions around longer-term considerations, including community resilience. The potential need to establish an RCG was regularly considered, and the chairing arrangements for the TCG were kept under ongoing review.
193. The final TCG meeting took place on Friday 16 June 2023. Following the SCG's decision later that day to formally establish the RCG, the TCG was stood down.

Gold Group Meetings

194. I have been asked to set out the dates of the Gold Group meetings and to summarise matters that were discussed within each meeting.
195. Throughout the course of the incident, I chaired a series of Gold Group meetings under the operational name Operation Hendrix. These meetings formed a critical part of the strategic oversight and decision-making process, ensuring that the police response remained coordinated, and aligned with wider multi-agency objectives.
196. Contemporaneous notes were taken during each meeting by my Business Support Officer, who was present throughout. These notes served as a summary of the discussions and were subsequently developed into a fuller set of minutes following each meeting. The draft minutes were submitted to me for review and approval prior to being circulated to group members and attendees.
197. The matters discussed during these meetings are summarised within this statement. Where relevant, I have also referred to entries from my Gold Log (NGPF0007787), which was initiated at 06:30 hours on Tuesday 13 June 2023, and concluded with a final entry at 09:30 hours on Thursday 22 February 2024. This log provides additional context to the decisions made and actions taken before, between, and after specific Gold Group meetings.
198. In most operational contexts, a Gold log serves as a formal decision log, commonly used by strategic firearms or public order commanders to document decisions made during the management of an operation. However, in the case of Operation Hendrix, where I was not the firearms or

public order commander, my Gold log functioned more as a personal record. It captured updates, discussions, and notable developments as they occurred, rather than serving as a contemporaneous record of strategic decisions made in relation to the operation.

199. The Gold Log and meeting minutes together provide a comprehensive record of the strategic considerations, and inter-agency coordination that took place throughout the duration of Operation Hendrix.

- Gold Group 1 - Tuesday 13 June 2023 11:45 to 13:00:

200. The first Gold Group meeting under Operation Hendrix was scheduled for 11:30 hours on Tuesday 13 June 2023. However, as recorded in my Gold Log, the meeting commenced at 11:45 hours due to operational commitments earlier that morning. I refer to the minutes of this meeting as URN: NGPF0007796.

201. I opened the meeting by welcoming attendees, whose identities and roles have been outlined earlier in this statement. I explained that while the formal Gold Strategy had not yet been finalised, I would outline its key components during the meeting and circulate a draft alongside the minutes. This was due to the time-sensitive nature of the incident and my operational responsibilities earlier that morning.

202. I informed the group that Det Supt Sanders, the SIO, would not be attending the meeting, as his focus was required in the MIR to lead the investigation.

203. I confirmed that I had declared the incident a Critical Incident, and provided an explanation of this designation, which is not detailed in the meeting minutes but is covered earlier this statement.

204. Having arrived at the FCR at 06:30 hours, I received an initial briefing from Police Sergeant Jon Straszewskyj, and subsequently from Ch Insp David Mather, followed by a conversation with Det Supt Sanders at 08:45 hours. These updates enabled me to provide a timely and informed investigation briefing to the group, listed as item two on the agenda.
205. I outlined the sequence of events as understood at that time, namely:
206. At 04:04 hours, a call was received reporting an incident on Ilkeston Road, Nottingham. Two individuals were confirmed deceased. While formal identification had not yet occurred, we were confident the victims were Barnaby Webber and Grace O'Malley Kumar.
207. At 05:25 hours, a second call reported that several pedestrians had been struck by a van on Milton Street in Nottingham city centre. The suspect was detained and arrested shortly afterwards on Maple Street.
208. At 05:37 hours, a third call reported a male found with stab wounds on Magdala Road, Nottingham. Tragically, he died from his injuries. He was named in the minutes as Robert Coates.
209. I explained that the precise sequence of events was still being established, but the SIO's working hypothesis was that the suspect had first attacked the victims on Ilkeston Road, then fatally attacked the van owner on Magdala Road before stealing the vehicle and driving into the city, where he struck three pedestrians.
210. Concerns were raised about the possibility of further victims between Ilkeston Road and Magdala Road. I tasked search advisors to consider a search of that route and had already asked Det Supt Sanders to consider an urgent interview with the suspect to clarify this.

211. I confirmed that the suspect in custody was VC, born 04/09/1991, originally from Guinea-Bissau. I noted that mental health had already been identified as a potential factor, although the motivation or ideology behind the attacks remained unknown.
212. I informed the group that Det Supt Sanders was being supported by a CT policing SIO, and that enquiries were ongoing into the possibility of additional offenders or whether VC had been transported by another individual.
213. We discussed the ongoing search activity and the impact of road closures across the city. I shared my preliminary thoughts on the Gold Strategy, which was later embedded into the meeting minutes. I refer to this strategy as URN: NGPF0007797.
214. I also proposed the command structure for managing the incident, which is summarised in the minutes and explained in detail earlier in my statement at paragraph 141.
215. Det Supt Williams, Head of PSD, informed the group that a verbal referral had been made to the IOPC regarding officers being behind the van when it struck the final two pedestrians. I confirmed that this aspect of the incident had been declared a DSI incident and that a PIP had been initiated.
216. I requested reassurance regarding the timeliness of our response to the first call, to properly consider whether any actions could have prevented subsequent deaths or injuries.
217. Det Supt Williams also advised that VC was wanted for failing to appear at Nottingham Magistrates' Court in September 2022, following a

2021 arrest for assaulting an emergency worker, and may have been involved in a hit-and-run incident the previous day.

218. I set three actions to ensure all police contact with VC was reviewed, that learning was identified, and that appropriate referrals to the IOPC were made. These included a full IOPC referral for the van incident and a scoping exercise by PSD to examine previous police contact, including the outstanding warrant.

219. We held a detailed discussion on community impact, stakeholder engagement, and tension management. I was reassured that a CIA had commenced. Ch Supt Verma confirmed that briefings had taken place with key stakeholders, including the City Council Chief Executive and members of the Community Protection Department. He reported emerging community tensions and that MPs had approached Neighbourhood Policing Inspectors (“NPI”s) with concerns about whether VC had acted alone. I agreed to consult with the Chief Constable to establish an effective briefing system for Members of Parliament (“MPs”).

220. Ch Insp Chris Pearson provided a briefing on concerns from asylum seekers and black communities, who feared being targeted in response to the incident. He noted that social media commentary could inflame tensions and confirmed that a meeting with key stakeholders was scheduled for later that afternoon to ensure consistent messaging.

221. As part of the strategic engagement planning, it was confirmed that the Independent Advisory Group (“IAG”) would be involved in shaping the response.

222. Within Nottinghamshire Police, the IAG is a strategic group made up of volunteers who are representative of the diverse communities across Nottingham City and Nottinghamshire County. The group acts as a “critical friend” to the police, providing independent advice, guidance, personal insight, or constructive challenge on the development and review of policy, procedure, and practice. It also assists the police in preventing or resolving critical incidents where the police response may significantly impact community confidence. They help to highlight issues of concern within communities and escalates these for action.

223. Ch Supt Verma outlined that a broader strategic engagement approach was being developed, involving members of the Independent Scrutiny Panel, majority black-led churches, and other community networks. He also reassured me that the student population, likely to be significantly affected, would be considered within these engagement plans.

224. I examined the resourcing demands associated with managing an investigation of this scale and acknowledged the inherent challenges, particularly given the number and size of crime scenes and the complexity of the incident. At that time, there were four separate crime scenes, all located on roads. Two of these, Ilkeston Road and Milton Street, were particularly significant routes either leading into or situated within the City Centre. I was reassured by colleagues in the meeting regarding the robustness of our operational plans. To ensure resilience across both the incident response and wider force demands, I imposed a temporary block on officers booking annual leave for the remainder of that week. I also approved a request for some enabling services departments to work

remotely, freeing up estate capacity for operational teams. I was encouraged to hear that staff were volunteering to work on their rest days, and that the National Crime Agency (“NCA”) had offered their support.

225. Lyn Heath, Head of Corporate Communications, briefed the group on the significant media interest from local, national, and international outlets. She confirmed that a communications cell was being established to report into the LRF. Matthew Jarram, also from the communications team, advised that a first written media release had been prepared. I made clear that no release should be issued until we were confident that all relevant families had been informed of the incident.

226. The group discussed key messages for early media communications, recognising the need to address confusion and speculation. Agreed priorities included:

- Reassuring the public that it was safe to enter the city.
- Acknowledging the impact on the university community.
- Dispelling rumours that a firearm had been involved.
- Clarifying the number of suspects involved.

227. We agreed on the importance of filling information gaps within communities and among partners and stakeholders. It was noted that several other murder trials were ongoing, contributing to heightened media interest. I shared my intention to meet with the Chief Constable, who was leading on media strategy, to relay the group’s views. We also discussed the appropriateness of holding a press conference, and I committed to raising this with the Chief Constable.

228. Under any other business, I was informed that information about the incident had already been published on the Nottinghamshire Victim Care website. I briefed the group on the governance structures of the LRF and confirmed that a SCG meeting would take place later that day.
229. The second Gold Group meeting was scheduled for the following day.
- Gold Group 2 - Wednesday 14 June 2023 12:00 to 1330:
230. The second Gold Group meeting took place at 12:00 hours on Wednesday 14 June 2023. I refer to the minutes of this meeting as URN: NGPF0007798.
231. In preparation for chairing this second Gold Group meeting, I attended the major crime (homicide) investigation briefing at 2020 hours on Tuesday 13 June 2023, met with the SIO at 07:00 hours on Wednesday 14 June 2023 and attended his 09:00 hours briefing with the investigation team. During that briefing I provided an update on the gold structure and arrangements and included some of the key points from my gold strategy, which included putting families first, ensuring the quality of the investigation and maintaining trust and confidence. I informed the briefing that the response to these incidents was the priority for the force and gave my commitment to ensure the investigation had the appropriate support.
232. I also met with the FLA Det Insp Claire Gould, who reassured me that the family liaison framework was in place, FLOs had all been deployed to all families, including the families of the injured persons. We also discussed arrangements for the families to meet with the Chief Constable later that day.

233. Upon welcoming attendees to the meeting, we agreed the minutes from the previous Gold Group and reviewed the six actions I had set during the first meeting:
234. Action 1: I was reassured that search advice had been taken and confirmed that no further casualties had been identified.
235. Action 2: A full referral to the IOPC regarding the van incident had been made.
236. Action 3: A review of our initial response to the first call confirmed that officers had arrived on scene within four minutes, which I considered a timely and appropriate response.
237. Action 4: The scoping of previous police contacts with VC, including the fail to appear ("FTA") warrant, was discussed. I was informed that our response on the night was appropriate and that the use of force during the arrest was proportionate. The suspected link to a road traffic accident the day prior had been ruled out. However, it was confirmed that the FTA warrant had been placed into the appropriate inbox within our crime management system (NICHE) but had not been actioned. I acknowledged that this meant no arrest action had been recorded.
238. Initially, I agreed that the issue relating to the system for management of outstanding warrants could be dealt with outside the Gold Group. However, later in the meeting, I reconsidered and decided to retain oversight of this matter within the Gold Group, until I was satisfied that appropriate scrutiny and governance had been established to oversee the review. I therefore set a new action during this meeting to ensure continued visibility and accountability.

239. Action 5: I had committed to speaking with the Chief Constable to organise briefings for MPs. This had been completed and was therefore discharged.
240. Action 6: Planning for additional space to accommodate operational resources at headquarters had also been completed and was discharged.
241. During the introduction to the meeting, we held a detailed discussion regarding the media release. It was confirmed that the release had not yet been issued. I reiterated that it must not be shared with the media until it had been reviewed and agreed by the families. I was reassured that arrangements were being made via the FLOs to facilitate this.
242. I provided a further investigation update, confirming that VC remained in custody. An application was being made that day to the Magistrates' Court for a warrant to extend VC's detention. The CPS was now present in the incident room, and post-mortem examinations were scheduled to take place later that day.
243. I also confirmed that the chronology of events had now been established as follows:
1. Ilkeston Road
 2. Magdala Road
 3. Milton Street
 4. Parliament Street
244. I informed the group of a new relevant incident that had occurred at 05:15 hours at Seely Hirst House, Mapperley Road, Nottingham. VC had reportedly attempted to force entry but was fended off by a resident.

245. Search activity was ongoing. The four roads discussed in the previous meeting had now been reopened, and new searches were underway. I confirmed that the incident had not been declared a CT incident, although support from the CT policing network continued.
246. We revisited the Gold Strategy, and its contents were agreed during the meeting. I confirmed that the command structure remained unchanged and emphasised the importance of maintaining discipline in reporting lines.
247. Det Supt Williams updated the group that the IOPC had requested a full written referral and were assessing whether to adopt the van incident for independent investigation. I set an action to ensure I was updated on their decision and a further action to inform the Police Federation, enabling them to support and advise key police witnesses.
248. Det Supt Williams also outlined previous police contact with VC, including: two assault incidents in Leicester, the FTA warrant and an incident in which a victim had jumped from a window following VC's actions.
249. She identified learning points from these incidents but did not raise any concerns regarding misconduct. I set a new action to review our warrants system, to ensure that any procedural gaps were identified and addressed.
250. Finally, I was informed that the force had received numerous complaints regarding road closures, which were noted for further consideration.
251. We next discussed the impact on communities and the management of resultant tensions. I was informed that the first community engagement forum had taken place the day prior and had been attended by thirty-five

participants. The forum identified key priorities, including community safety, engagement, communication, and reassurance.

252. The group recognised significant tensions and challenges affecting several communities, notably: residents of asylum hotels, the student population, local schools and Black and Islamic communities.
253. Ch Supt Verma explained that for each of these areas of concern, a lead officer had been appointed. He also advised that faith leaders were drafting a co-signed statement of solidarity, and that an overarching community engagement strategy was in development. He provided an update on the CIA, which had become a live document accessible to all twelve NPIs across the Nottinghamshire Police area. Plans were in place to share this document with partners, and daily briefings were being conducted.
254. He raised concerns about a potential increase in hate crime and the possibility of an English Defence League (“EDL”) protest scheduled for Saturday 17 June 2023. He also noted suspected information leakage from partners to the media, particularly regarding VC’s ethnicity, which was unhelpful. I commended the structured and comprehensive approach to managing community impact and noted its direct alignment with the third Gold Strategic objective: managing and maintaining trust and confidence in our communities.
255. Insp Craig Berry, representing Operational Planning, provided updates on four upcoming events: A vigil at the university later that evening, a public vigil in Old Market Square on 15 June 2023, a ministerial visit and the potential EDL protest on 17 June 2023.

256. I set two actions arising from this discussion: To ensure officers attending the vigils received appropriate briefings and to replace the agenda item titled "Search and Ongoing Activity" with a new item titled "Planned Events".
257. We discussed how partnership and stakeholder updates were being provided. I was reassured that this was occurring effectively through multiple channels. Ch Supt Verma and Ch Insp Chris Pearson explained that updates were being delivered via NPIs through their CIA, supplemented by daily conversations, co-located partners, and strong existing relationships. These efforts were further supported by the LRF structures, including both Strategic and Tactical Coordination Groups, chaired by senior police officers. I commended this approach and acknowledged the risk of information leakage, clarifying that I did not believe it to be intentional, but recognised its potential impact on our external media strategy.
258. We revisited the welfare of the workforce, and I confirmed that Det Ch Supt Leonna Scurr would replicate the welfare provision being offered to local policing officers within her own command. I reiterated the importance of supporting our staff and requested that updates on welfare measures be provided at each Gold Group meeting. I set an action to create an internal communication message for the workforce, outlining how they could access support.
259. During discussions on our communication strategy, I acknowledged the challenges posed by the media's access to information via digital and social media platforms. I confirmed that the police would lead on the

communication strategy, a position agreed by all strategic stakeholders, including the City Council, EMAS, and the Fire Service. A communications cell had been established, with representation from each of these stakeholders.

260. I explained that all external messaging would be reviewed and authorised by the Chief Constable, who would also undertake any press interviews. This approach was discussed and agreed with the Chief Constable. Given the unprecedented nature of the event and the significant national media attention, it was her preference to lead on communications, which I considered to be a sensible course of action.

261. I emphasised that the families must always be the first to receive any information, and that they remained our primary consideration. I outlined the sequence for external communications as follows: family first, community second, media third.

262. Under Any Other Business, Det Supt Williams raised concerns about staff members not involved in the incident accessing related information on police systems. She advised that auditing all system checks would be too time-consuming and proposed issuing a reminder to staff outlining the criteria for accessing such information. I agreed with this pragmatic approach and set an action for each of the three Ch Supts to deliver this message to their teams.

263. Det Ch Supt Scurr raised a concern regarding VC's family, who were returning to Pembrokeshire, and the potential risk they might face. I set an action for Det Ch Supt Scurr to ensure that South Wales Police were informed and tasked with managing and mitigating any associated risks.

264. The third Gold Group meeting was scheduled for the following day.
- Gold Group 3 - Thursday 15 June 2023 12:00 to 1330:
265. The third Gold Group meeting took place at 12:00 hours on Thursday 15 June 2023. I refer to the minutes of this meeting as URN: NGPF0007799.
266. In preparation for chairing this meeting, I attended the major crime investigation briefing at 18:00 hours on Wednesday 14 June 2023, met with the SIO at 07:30 hours on the morning of the meeting, and attended his 09:00 hours briefing with the investigation team.
267. At 10:00 hours, I met again with the FLA Det Insp Claire Gould. On this occasion, all the FLOs who had been deployed were also present. I have provided a further description of this meeting later in my statement.
268. Upon welcoming attendees to the third Gold Group meeting, it was acknowledged that, due to the operational pressures associated with managing the response to this incident, attendees had not yet had the opportunity to review the minutes from the previous meeting.
269. We talked through the eight outstanding actions that had been set in previous meetings.
270. The first three actions had all been completed and so were discharged. These included briefing the Police Federation to provide reassurance to our key police witnesses in the context of the IOPC referral, the briefing for officers attending vigil's and the three Ch Supts providing a communication to their respective workforces regarding the accessing of information.
271. I felt it was important for the Federation to offer reassurance to the officers involved in the PIP. For some, this may have been their first

experience of such a process, which can naturally cause concern and anxiety. My intention was simply to ensure they understood the purpose of the process and felt supported throughout.

272. Although not updated on the action tracker, I could see that action four had also been completed because the “search and ongoing activity” agenda item had been replaced with “planned events.” This was agenda item three.

273. Action 5, which related to drafting an internal message for the workforce outlining how they could access support, had not yet been completed. It was agreed that this action would be carried forward to the next meeting for an update.

274. Action 6 concerned the review of our warrants management system, which I had allocated to Det Ch Supt Scurr. I acknowledged that this would require a detailed and potentially lengthy review. However, I was keen to retain this action on the tracker until I had received reassurance regarding the forum through which this matter would be progressed. I confirmed that oversight would remain with the Gold Group until appropriate governance arrangements were in place.

275. Action 7 related to an update from Det Supt Williams on whether the IOPC had adopted our referral for independent investigation. While the action tracker later confirmed that the IOPC had adopted the investigation, this update must have been added after the meeting, as during the meeting itself, I was informed that a decision was still awaited.

276. The final action was discharged following confirmation from Det Ch Supt Scurr that she had been in contact with South Wales Police, who were now managing any risk to VC's family.
277. I then provided the group with a brief update on the investigation. I confirmed that VC remained in custody, and that his detention had been extended by a further 36 hours. I also reiterated that the incident had still not been declared a CT incident, although the CT policing network continued to provide support.
278. We proceeded to discuss planned events. I was informed that the previously anticipated EDL protest had now been cancelled. In relation to the vigil in Old Market Square and the visit of the Home Secretary, both scheduled to take place later that day, I was reassured that separate command structures were in place for each event and that planning was well developed.
279. I took the opportunity to remind the group of the strategic objectives underpinning our response. No changes were made to the Gold Strategy during this meeting, and we confirmed that the command structure remained unchanged.
280. The only update from PSD during this meeting was that we were still awaiting the IOPC's decision on whether they would adopt the van incident for independent investigation.
281. The community engagement strategy was shared with the group and discussed in detail. A copy of the strategy was embedded in the meeting minutes. Supt Verma explained that significant concerns continued to be expressed by the West African, Islamic, Black, and refugee communities. I

was reassured that each of these communities had a designated pillar lead, and that the strategy clearly articulated engagement opportunities. Supt Verma informed the group that he had a planned meeting with key individuals and networks later that afternoon, which he would attend in company with the Chief Constable.

282. Ch Supt Verma raised concerns regarding media intrusion, particularly at Mr Coates's school, within the student community, and among affected families residing outside the Nottinghamshire Police force area, specifically in London and Somerset. He had developed a patrol plan for key locations to manage this issue. I set an action to engage with the relevant force areas to ensure they were taking a similar approach to managing media intrusion and safeguarding affected families.

283. I provided an update that the LRF structures remained active, with ongoing discussions within both the SCG and TCG regarding the transition from the response phase into the recovery phase. I noted that, in due course, there would be a need to establish an RCG to lead and manage the recovery effort.

284. I was asked whether the affected families had been invited to the vigil scheduled for that evening. I confirmed that they had been invited but had chosen not to attend. I was also asked whether the families had any faiths they wished to be represented at the vigil. I explained that it would not be appropriate to ask further questions of the families on that day, as they were due to attend the mortuary to identify their loved ones.

285. I confirmed that I was continuing to have regular conversations with the CT SNC network.

286. We held a brief discussion on workforce welfare, and I confirmed that I was satisfied with the plans in place to support staff. No resourcing issues were raised during the meeting, and it was confirmed that overtime payments were continuing for staff providing a visible presence across the City to offer reassurance.

287. The group discussed a press release scheduled for later that day, which would reference the IOPC referral and confirm that VC was a student at the university. In line with the approach embedded in previous meetings, I instructed that the release must not be issued until the families had reviewed and agreed its content.

288. There were no items raised under Any Other Business, and the fourth Gold Group meeting was scheduled for the following day.

- Gold Group 4 - Friday 16 June 2023 12:00 to 1330:

289. The fourth Gold Group meeting took place at 12:00 hours on Friday 16 June 2023. I refer to the minutes of this meeting as URN: NGPF0007800.

290. In preparation for chairing this meeting, I met with the SIO at 21:00 hours on Thursday 15 June, again at 07:30 hours on Friday 16 June, and subsequently attended the major crime investigation briefing at 09:00 hours with the investigation team.

291. Upon welcoming attendees to the fourth Gold Group meeting, I advised that no Gold Group meetings would be held over the weekend, and that I was still considering when the next meeting would be scheduled.

292. We reviewed the outstanding actions carried over from previous meetings. Five actions had been completed and were discharged. Three were repeat confirmations: The change of agenda item three, that the

IOPC had adopted the van incident for independent investigation, and that Det Ch Supt Scurr had contacted South Wales Police regarding risk to VC's family.

293. The fourth action was to develop a message for the workforce on how to access support, and the fifth action relating to the warrants system remained incomplete and was carried forward once again.

294. I noted that one further action, set during the third Gold Group meeting, relating to contacting other forces to check how they were managing media intrusion, had not transferred onto the action tracker. As a result, it was unclear whether this action had been completed.

295. I provided a brief investigation update, confirming that the incident had still not been declared a CT incident, and that a final decision was unlikely to be made before VC was charged. We would therefore continue to work with CT policing colleagues until that decision was reached.

296. I explained that VC's current detention clock was due to expire at 03:00 hours on Saturday 17 June 2023, and that the CPS, who remained fully engaged, had indicated that a charging decision was expected later that afternoon.

297. We discussed the vigil from the previous evening and the fact that no further vigils were planned for the weekend. Insp Craig Berry informed the group that a refugee event had been planned for Sneinton Marketplace (an area in Nottingham City Centre) later that same day, and that this would be a neighbourhood policing event. He also shared details of a protest that was planned for the following day, by a group called Patriotic Alternative and that there was a multi-agency plan in place for the closure

of Ilkeston Road to facilitate a visit by some of the families. Further information was shared about Patriotic Alternative, who were described as a right-wing anti-immigration group with an overtly cultural nationalist ideology and that its high-profile leaders held fascist ideology.

298. We reviewed the Gold strategy and made a single change in relation to the bronze commanders, with the addition of Det Insp John Barnhill to the intelligence bronze function, who was from CT policing.

299. I was informed by Det Supt Williams that the FLOs had had a separate briefing by PSD, in order that they were able to be transparent with the families.

300. Ch Supt Verma provided a further update on community tensions and the CIA. He explained that the engagement plan had been implemented and for each community pillar, the appointed lead had a clear engagement plan which included, amongst other things, a patrol plan. He stated that the council and the university were still reporting concerns about rising hate incidents, and that there were continued tensions being experienced in the black community. He explained that an emergency meeting was planned for the following Tuesday (20 June 2023), and suggested that hate crime and incidents, as themes, should feature in one of the cells of the RCG.

301. Further discussion took place relating to the LRF structures and response and it was agreed that we should now propose moving from the response phase into the recovery phase and I agreed to take that proposal to the SCG later that afternoon.

302. Claire Salter, Head of People Services, presented a suite of well-being options for the workforce. I shared with the group the Chief Officer Team's ("COT") plans to attend police stations over the weekend to meet with some of the first responders. I also raised the point that some individuals present in the meeting may have viewed distressing footage related to the incident and could be affected by it. I emphasised that the offer of support was open to all, including those in strategic and command roles.
303. No issues were raised regarding the ongoing resourcing plan, and Matthew Jarram provided an update confirming our intention to issue a media release at the point of charge. I reiterated that this release must only be issued after the families had been informed of any charging decisions.
304. Under Any Other Business, I initiated a discussion on reviewing our progress against the strategic objectives. I acknowledged that while most objectives had been met, several remained live issues, and for that reason, I had decided not to close the Gold Group.
305. I identified the ongoing areas of focus as: Community engagement, family support, workforce welfare and communications.
306. I explained that, as we were still actively responding to the incident, and because the effectiveness of our response continued to influence public and family confidence, I had decided that the incident would remain declared as a Critical Incident. While there would no longer be a need for daily Gold Group meetings, I confirmed my intention to continue Gold governance under my command.

307. I concluded the meeting by thanking all attendees, and commended their resilience, leadership, and professionalism throughout the week.
- Gold Group 5 - Monday 19 June 2023 09:30 -1030:
308. The fifth Gold Group meeting took place at 09:30 hours on Monday 19 June 2023. I refer to the minutes of this meeting as URN: NGPF0007801.
309. This meeting was convened as an extraordinary Gold Group meeting, rather than a full Gold Group, with limited attendance. Its specific purpose was to consider issues relating to the well-being of our workforce and to begin planning for internal recovery.
310. I opened the meeting by explaining this focused intent and shared the experiences of the COT from their visits to police stations over the weekend, where they met with some of the first responders. I reported that our existing well-being support offer was adequately meeting the needs of approximately 97–98% of those responders. However, for a small number of individuals, the offer had proven insufficient, and the impact of the incident on them was significant.
311. I shared details of one team that had been severely affected and confirmed that I had given them a personal commitment to convene this meeting to develop a bespoke package of support tailored to their needs.
312. I instructed those present to ensure that, by lunchtime that day, individuals identified as “most affected” were proactively contacted, and that we give careful thought to enhanced support and contact for them.
313. We discussed whether this differentiated approach might inadvertently create adverse perceptions among other staff. However, the group agreed

that targeted support for those most affected was both appropriate and necessary.

314. Supt Kathryn Craner, City Divisional Commander and lead for welfare provision, reported that over sixty phone calls had been made to individuals across our response, firearms, and contact management teams. She noted a generally positive reception to the welfare offer, while acknowledging that it did not meet the needs of everyone. I reiterated the importance of direct contact with those most affected following the meeting, to begin shaping a bespoke support plan.

315. I set four specific actions arising from these discussions:

1. Ensure that Force Chaplains are provided with the contact details of the most affected group.
2. Instruct People Services to develop a bespoke package of support for that group.
3. Begin planning for an ongoing internal recovery programme.
4. Reflect on the learning from this incident regarding well-being provision and ensure that appropriate amendments are made to our major incident response plan.

316. There were no items raised under Any Other Business, and I confirmed that the full Gold Group would resume, with the sixth Gold Group meeting scheduled for the following day.

- Gold Group 6 – Tuesday 20 June 2023 13:30-14:30:

317. The sixth Gold Group meeting took place at 13:30 hours on Tuesday 20 June 2023. I refer to the minutes of this meeting as URN: NGPF0007802.

318. Having welcomed attendees to the sixth Gold Group meeting, I began by explaining that an extraordinary Gold Group meeting had taken place the previous day. This meeting had been convened specifically to address the well-being and welfare of the workforce, following the experiences shared by the COT during their visits to first responders over the weekend. We then talked through the outstanding actions that had been carried over from previous meetings.

319. The action relating to the review of the warrants management system was carried forwards again. I was reassured that the two force chaplains had been provided with contact details for affected officers and so this action was discharged. The actions relating to a bespoke plan for the most affected group, the development of an internal recovery plan and making appropriate amendments to our response plan, based on learning from this incident, were progressing, but that work was still ongoing and not yet complete.

320. Det Supt Leigh Sanders attended the Gold Group for the first time and provided an update in relation to the investigation.

321. He provided an update confirming that VC had been charged with three counts of murder and three counts of attempted murder. At that stage, no extremist ideology had been established as a motivating factor.

322. The SIO also confirmed that the FLOs remained actively engaged with the families, providing ongoing support and communication. He shared several key dates relating to case management within the criminal justice system and advised that the defence team had indicated an intention to explore VC's medical history as a relevant factor in the proceedings.

323. Additionally, the SIO reported that there had been significant media attention at the bail hearing held earlier that morning at the Crown Court.
324. We discussed several planned events which included the Patriotic Alternative group meeting outside the Magistrates Court on Saturday 17 June 2023 and the planned national Armed Forces Day, which was taking place on Saturday 24 June 2023. Although there were no relevant Armed Forces Day events taking place in Nottingham, it was explained that a few community events were taking place across the county that might be celebrating the day. We discussed a further ministerial visit, planned for the following week and received confirmation that there were no other relevant planned events.
325. During the meeting we had a further lengthy discussion relating to the strategic objectives the I had set during the first Gold Group meeting. Specifically, we considered each objective in turn to determine whether that objective had been met or achieved.
326. I decided that the first objective of minimising risk of harm to people and keeping people safe had been achieved.
327. The second objective focused on ensuring effective engagement, communication, and support for affected families. While I assessed that this objective had been met, largely through the dedicated work of the FLOs and coordinators, I also recognised that the need for ongoing support remains, and efforts to uphold this commitment continue.
328. The third objective, relating to reassurance to affected individuals and communities through a media and communications plan I decided was partially achieved with some elements still ongoing.

329. I determined that ensuring a professional and effective investigation (objective 4), working in partnership with the LRF (objective 5) and ensuring that we discharged our responsibilities relating to notifying scrutineers (objective 6) were all achieved.
330. The final objective, relating to welfare support to affected officers, I decided was still ongoing.
331. During the meeting I made a slight change to the command structure, appointing Claire Salter as bronze commander for workforce welfare.
332. Det Supt Williams reiterated the importance of ensuring that only those members of the workforce with a legitimate operational reason should be accessing incident-related materials or footage connected to this operation. She advised that an internal communication message would be developed to reinforce this position, making clear that curiosity alone is not an acceptable justification for accessing sensitive content. She emphasised the importance of maintaining the trust and confidence of the families affected by the incident.
333. Det Supt Williams proposed that the message would include an amnesty of responsibility for individuals who voluntarily disclosed inappropriate access, recognising that some may be reluctant to come forward. Staff would be directed to report any such access to their line supervisors, who would be responsible for conducting an initial assessment. It was made clear that any individual found to have made multiple unauthorised checks should be referred to PSD. The amnesty would not apply to anyone who had shared information, and this distinction was explicitly stated.

334. I gave careful consideration to the prospect of offering an amnesty, as accessing information without a legitimate policing purpose is unacceptable. Our systems are designed to make this clear, when accessing such systems, individuals are reminded to consider whether they have a policing purpose for viewing information. However, at that time, I judged it would be disproportionate to pursue disciplinary action against anyone who had accessed records related to this case. For those officers who came forward, I felt it was a pragmatic and proportionate approach to provide appropriate advice, rather than initiate misconduct proceedings.
335. I set an action for this message to be developed in conjunction with the Police Federation and staff associations, to ensure clarity, consistency, and support for those affected.
336. A further discussion took place regarding the prospect of restricting access to incidents from the outset of major operations of this nature. I articulated my view that this was not an approach I would be minded to adopt in future. I expressed the belief that this issue was more reflective of organisational culture, and that as senior leaders, we must take responsibility for setting clear expectations around when it is appropriate to access incident-related material and when it is not.
337. Ch Supt Verma informed the group that his community engagement pillar meetings were scheduled to begin the following evening. I suggested that community impact and tension management had now returned to business as usual, and this was agreed by the group. Similarly,

partnership and stakeholder management were also considered to have returned to routine operational practice.

338. During the discussion on workforce welfare, I was reassured by the progress made in developing bespoke support plans for the most affected group. It was confirmed that FLOs and Crime Scene Investigators had now entered the trauma support process. I highlighted the need for ongoing proactive contact with other officers who were required to repeatedly view CCTV footage as part of the investigation. This included CCTV officers, interviewing officers, and file officers. The SIO confirmed that these individuals would be subject to mandatory referral into the trauma support process.

339. A similar discussion was held regarding staff within PSD who had viewed footage of the van striking pedestrians. It was agreed that the same trauma support approach would apply to them. I set an action to ensure that all senior officers and members of the Hendrix Gold Group were also offered appropriate well-being support.

340. A discussion on resourcing requirements across the force focused primarily on the challenges within the City response function. No immediate concerns were raised, but the issue was noted for ongoing monitoring.

341. I informed the group that the SCG had now been stood down, and that the RCG had been formally established, led by the Local Authority.

342. It was agreed that no further media communications would be issued regarding the case until after the trial, as the matter was now sub judice. Although some partners had expressed a preference for further narrative

to be shared, it was agreed that this was not appropriate, to protect the integrity of the criminal proceedings and avoid any risk of prejudice.

343. Under Any Other Business, I initiated a conversation about our approach to the debriefing exercise. I explained that this would be a significant piece of work, and proposed that the debrief be compartmentalised into three distinct phases: A structured debrief on the declaration of the major incident and the establishment of LRF governance, a debrief on the events of the following week, from a LRF perspective and a debrief on the management of the investigation

344. The seventh Gold Group meeting was scheduled for Friday, 23 June 2023.

- Gold Group 7 – Friday 23 June 2023 11:00 – 12:00:

345. The seventh Gold Group meeting took place at 11:00 hours on Friday 23 June 2023. I refer to the minutes of this meeting as URN: NGPF0007803.

346. There were many fewer attendees at this meeting and was limited to representation from People Services (Claire Salter), PSD (T/Det Supt Andy Reynolds), CT Policing (Det Insp Dave Bola), Operational Support (Supt Louise Clarke) Communications (Simon Cotton) and the City Divisional Commander (Supt Kathryn Craner). I was content to go ahead without any representation from the investigation team, as I had received an update only three days earlier. Having welcomed the attendees, we reviewed the outstanding actions that had been carried over from previous meetings.

347. The action relating to the warrant management system review was still ongoing. Two actions relating to bespoke welfare support plans and the ongoing internal recovery plan for the workforce, and the offer of trauma support for senior officers and members of the gold group had all been completed and so were discharged.
348. The action which related to ensuring we incorporate learning related to well-being into our response plans going forwards was remitted to firearms policing governance, overseen by Supt Louise Clark. This action was discharged from the Hendrix Gold Group.
349. The final action related to our approach to debriefs and I was reassured by the approach that Supt Louise Clark proposed, which was to undertake the debriefs in five stages: a debrief for unarmed officers, the firearms response, the LRF debrief, investigations and CT policing debrief, and communications. I agreed that the learning points from these debriefs should feed into firearms command training and into the organisational risk and learning board where progress against them would be monitored. This action was therefore discharged from the Hendrix Gold Group.
350. Det Insp Dave Bola, from CT policing provided an update on the investigation and informed us that the assessment of whether the incident was CT related was still ongoing.
351. There were no new planned events reported in the meeting and no intelligence relating to future events or tensions.
352. I confirmed that the Gold Group had now achieved most of the objectives of the Gold strategy and during the any other business section, I explained that there would no longer be a need to have further regular

Gold groups, but that, because not all of the matters had been resolved in the longer term, I was keen to keep the Gold Group open and that there would be another meeting arranged for July 2023.

353. There was no further change to the command structure and T/Det Supt Andy Reynolds from PSD confirmed that the message to the workforce regarding the appropriate accessing of information had been sent. I refer to this message as URN: NGPF0007804.

354. Community impact, managing intentions and partnership and stakeholder updates were all further confirmed to have returned to business as usual.

355. Claire Salter provided a further update on managing the welfare of the workforce and I was reassured by the current approach.

356. Nothing further was reported during the meeting relating to resourcing or communications and the meeting was closed with my announcement that the next Gold Group meeting would be arranged for week commencing either the 17 or 24 of July 2023.

- Gold Group 8 – Wednesday 19 July 2023 09:00 – 09:45:

357. The eighth Gold Group meeting took place at 09:00 hours on Wednesday 19 July 2023. I refer to the minutes of this meeting as URN: NGPF0007805.

358. Having welcomed attendees to the eighth Gold Group meeting, I explained that the purpose of the meeting was to discuss any developments since the last meeting, with a particular focus on the ongoing investigation and to gain a clear understanding of our forward

plans. We then reviewed the two outstanding actions that had been carried over from previous meetings.

359. We revisited the action relating to the warrant management system review, which remained ongoing. I agreed with Det Ch Supt Scurr's assessment that this was a longer-term piece of work, more appropriately governed through the Strategic Criminal Justice Board, which I chair. Det Ch Supt Scurr confirmed that she was in the process of establishing a working group to develop a robust approach to warrant management, and that this group would report progress into the Criminal Justice Board.

360. Although the action concerning the incorporation of well-being-related learning into future response plans had been formally remitted to firearms policing governance, I provided an update following the previous Gold Group meeting. I had met with Ch Insp Ash Thornton, who confirmed that a paragraph addressing welfare had been included in our operational plans. This assurance enabled me to conclude that the action had been completed and could be discharged.

361. I reminded the group that, in my assessment, the strategic objectives set at the outset of the operation had been met. While the meeting minutes may have suggested that the focus was now shifting primarily toward welfare, I now note that this was not an accurate reflection of the discussion. Much of the meeting was centred on the investigation itself, and welfare, while important, was not the primary focus.

362. During the Any Other Business agenda item, I clearly outlined the elements of the operation over which I would continue to retain strategic oversight. I confirmed that welfare was not among them, as appropriate

governance and support structures were already in place to manage that aspect of the response.

363. Det Supt Sanders provided a comprehensive update on the progress of the investigation.

364. He explained the strength of the forensic evidence and in particular, the forensic links between VC and all three homicide victims, links between the knife recovered and two of those victims, the forensic link between VC and that knife and the link between VC and the location Seely Hirst House.

365. He shared further information about the criminal justice timetable that had been set and confirmed that the stage one service of evidence date had been set for 18 August 2023. This is the date by which the CPS were required to submit their file of evidence to the court and defence lawyers. He updated that a plea and trial preparation hearing (“PTPH”) had been set for 31 October 2023, which would be the next hearing at the Crown Court and that a provisional trial date had been set for 12 January 2024.

366. He shared details of the prosecution team which included leading counsel, Khalid Khalil KC, Samantha Shallow, the head of the CPS Complex Case Unit and the allocated lawyer, Alan Murphy.

367. Det Supt Sanders provided an update on continued engagement with the families, informing the group that two funerals had already taken place, and that the final funeral was planned for Friday 21 July 2023, and that the FLOs had attended and will be attending the funerals at the request of the families.

368. He confirmed that the family liaison strategy had been written and the structured debrief had taken place with the FLOs and that trauma support had been made available to them.
369. He stated that the media intrusion had subsided but alerted the group to potential future trigger points which included the funerals and the trial.
370. He explained that the CT investigation had now concluded and that all lines of inquiry in relation to possible terrorism ideology had been closed off. He announced that a CT debrief was due to take place the following day, and that the regional review unit had also completed their review of the investigation.
371. The only items discussed in relation to planned events were the funerals, in respect of which, no relevant intelligence was shared.
372. There was no further discussion about the Gold strategy or the command structure.
373. Det Supt Williams updated that the IOPC investigation was ongoing and that they were receiving monthly updates, that the investigation team were taking statements from witnesses and that there were no concerns at present. No further information was provided from PSD during the meeting.
374. Ch Insp Chris Pearson confirmed that the community impact had stabilised and that no concerns had been raised from the local or partnership meetings. The subgroups that had been set up during the first week of the incident were still in existence and regular contact continued. He also shared that the police were discussing with the University the concept of a university policing team, which I was supportive of.

375. Supt Kathryn Craner and Claire Salter both confirmed that plans to deal with individual and collective welfare needs were now fully embedded. I acknowledged that whilst this work would be ongoing, I was content with the way that plans were being delivered and stated that I no longer felt the need to retain any strategic oversight.
376. Simon Cotton, deputy head of corporate communications (representing Lyn Heath/Matt Jarram), explained his team were planning to build media packages in readiness for the trial and that he did not anticipate any media challenges prior to that.
377. We discussed the update relating to debriefs and learning. An armed policing and initial response debrief had taken place on the 11 July 2023, a resource management unit and operational planning debrief had taken place on the 18 July 2023 and that debriefs with response officers were still ongoing. A QR code had been set up for the workforce to provide feedback, which also included the FCR.
378. We were informed that the LRF debrief was still pending and a CT debrief was due to take place on 10 August 2023.
379. During the "any other business" section of the meeting, I reminded the group that we had previously reviewed the Gold strategy at the meeting held on 23 June 2023. At that time, I had confirmed that each of the strategic objectives had been achieved. However, I also explained that, given the significance of the incident, there remained several matters over which I intended to retain strategic oversight. These included the outcomes of debriefs and the embedding of any resulting learning, the progress of the investigation and prosecution, associated communications,

and the impact on communities following the outcome of the IOPC investigation.

380. I explained that although there would now no longer be a need to schedule weekly or even monthly Gold meetings, I would arrange a further meeting for late October 2023 to align with the PTPH, and that I intended to retain the same membership of the group.

381. Before closing the meeting, I invited attendees to raise any concerns directly with me should anything arise before the next scheduled meeting. I also explained that, if necessary, I would convene an additional meeting to address any urgent matters.

382. The next Gold Group meeting was planned for Thursday 26 October 2023.

- Gold Group 9 – Thursday 26 October 2023 11:30 – 12:00:

383. In advance of this meeting, I recorded an update in my Gold log (on 9 October 2023), that had been provided to me by Det Supt Sanders, that a psychiatrist report had now been received from VC's lawyers and that diminished responsibility was being raised as a defence. In response to that, the CPS were now in the process of instructing a psychiatrist and because of this, the PTPH had been moved back to 28 November 2023. He confirmed to me that the families had been updated by the FLOs, and we agreed to move the Gold Group meeting back to 23 November 2023 to align with the new PTPH date.

- Gold Group 10 – Thursday 23 November 2023 15:30-16:30:

384. The tenth Gold Group meeting took place at 15:30 hours, Thursday 23 November 2023. I refer to the minutes of this meeting as URN: NGPF0007806.
385. There were no outstanding actions carried over from previous meetings, and so we began the meeting with a further update from Det Supt Sanders, relating to the investigation.
386. He informed the group that the prosecution instructed psychiatric report had been received on 20 November 2023, and that a meeting had taken place earlier that morning between the police, the CPS and counsel.
387. He explained that the consensus in that meeting was that both the defence and prosecution psychiatrists had seemingly reached the same conclusion about diminished responsibility and that there was now a strong possibility that VC would plead guilty to manslaughter, based on diminished responsibility, and that this would be accepted by the Crown. He said that VC might therefore be convicted on Tuesday 28 November 2023 but expressed a view that sentencing would be more likely to take place in January 2024.
388. Det Supt Sanders explained that a Teams meeting was planned to take place on Friday 24 November 2023 between the families, the CPS, and counsel. He stated that he had arranged a visit to one family with the FLOs on either the 30 November or 1 December 2023, a meeting with another family the following week and that the other families were to be offered visits as well. He also shared with the group information relating to the possible sentencing options.

389. T/Det Supt Andy Reynolds, who had recently taken over as the temporary head of PSD, provided an update on the IOPC and PSD investigations. He confirmed that the investigation into the van incident was now complete and that the IOPC had found no evidence of misconduct nor identified any learning. He explained that although this had been communicated to the officer it had not been communicated to the public more broadly following legal advice.
390. He also provided an update in relation to the unactioned FTA warrant and reminded the group that he had sought advice from an IOPC lead investigator who, following advice from a senior investigator and head of the assessment unit, had confirmed in writing to the police that the criteria for a referral to the IOPC had not been met, and that there was no legal route for us to refer the matter.
391. He stated that IOPC/PSD matters were closed.
392. Ch Supt Verma updated that the CIA was still live and that the recovery coordinating group was still active, that both universities were represented on that group and that the communications cell was also still active. He explained that all those groups that had been established during the first week of the incident had now either been merged into different meetings or formed part of his wider engagement strategy.
393. The group had a long discussion about how we would ensure that partners and stakeholders were updated on the criminal justice proceedings, and we identified a list of those stakeholders. I allocated each one to an individual who was to take responsibility for providing an update briefing. I also set an action for Det Supt Sanders to prepare a draft

e-mail outlining clearly what information we were able to share and for that e-mail to be sent to all attendees of the group. I gave an instruction that no action was to be taken by anybody until that e-mail had been received.

394. We also discussed the approach that we should take to communicating updates to the workforce and agreed that face to face meetings would be arranged for the most affected groups, that the Police Federation and staff associations would be briefed, and that I would prepare an internal intranet briefing for the rest of the workforce.

395. Det Supt Sanders explained that the FLOs were being tasked with showing the CCTV footage to families and reiterated the need to consider support for them and I set an action to ensure that the names of those officers were provided to ensure that their support was catered for.

396. We discussed the external and internal communications strategy. I was updated that these were still being developed and would be presented to me for sign off and would include a draft communication relating to the warrant. It was proposed and agreed that any messages would go out after the court hearing.

397. The final matter discussed briefly in the meeting related to reward and recognition and I set an action for myself and Claire Salter to discuss with the Chief Constable later as it was not a priority for today.

398. The next gold group meeting was planned for Wednesday 29 November 2023.

- Gold Group 11 – Wednesday 29 November 2023 15:30-16:30:

399. I recorded two relevant updates before the date of this meeting in my Gold log (on 26 November and 28 November 2023), that had been provided to me by Det Supt Sanders.
400. The first was that families had raised their concerns regarding the psychiatric evidence, which had been acknowledged by the CPS and was now being reviewed. The second update was that the CPS had agreed to instruct a further psychiatric report and that the PTPH had therefore been adjourned until 16 January 2024.
401. We agreed to postpone the Gold Group meeting set for 29 November 2023, and to set a new date at an appropriate time. Det Supt Sanders reassured me that he would update me with any significant development in the meantime.
- Gold Group 12 – Friday 19 January 2024 13:15- 14:15:
402. The twelfth Gold Group meeting took place at 13:15 hours on Friday 19 January 2023. I refer to the minutes of this meeting as URN: NGPF0007807.
403. Having welcomed the attendees, we reviewed the three outstanding actions that had been carried over from previous meetings. The first action, which related to a draft communications message being prepared for partners and stakeholders, had not been completed because the court dates had been changed, and it was agreed that this matter was due to be the subject of further discussion during the meeting. The action was therefore discharged. The second action, which related to providing details of CCTV staff and the FLOs to ensure welfare support had been provided, had been completed and so was discharged. The final action was also

completed and discharged because the Chief Constable had decided that any reward and recognition would be managed later through a special event.

404. Det Supt Sanders informed the meeting that, although the Crown had not yet accepted any guilty pleas, this was expected to occur on Tuesday, 23 January 2024. Following this, the sentencing hearing, which would cover three counts of manslaughter on the grounds of diminished responsibility and three counts of attempted murder, was scheduled to commence on the same date and was anticipated to last several days.

405. He provided an update that engagement with the families was ongoing through the FLOs and that victim personal statements had been completed.

406. Det Insp Claire Gould, the FLA, described the arrangements that had been made for the victim's families at the court for the hearing. We discussed whether there would be sufficient seating available for the families. I was assured that there would be, but I instructed that, should there be any shortage, police officers were to give up their seats to ensure families were prioritised. I was also reassured that arrangements for accommodation, transport, and a private room within the court building for families had all been made.

407. Although there was no representative from PSD present at the meeting, I had held several discussions beforehand, including email exchanges, with both the SIO and T/Det Supt Andy Reynolds. As a result of that dialogue, I was able to update the group during the meeting that there were three PSD matters requiring consideration.

408. The first involved a Special Constable who had been dismissed on 11 December 2023 for viewing material, including body-worn video footage of the murder scene. I had previously instructed the SIO that this matter should be shared with the relevant families, but we had agreed it would be inappropriate to do so before Christmas. Det Supt Sanders had updated me (via email at 21:07 hours 15 January 2024, which I refer to as URN: NGPF0007808) that he had informed the families of this case. However, during the meeting, and because I was not satisfied with the level of detail that had been provided to them, I set an action for Det Supt Sanders to provide a further briefing to the families about the specifics of this case at an appropriate time, based on advice from the FLOs.

409. The other two matters concerned a front counter clerk with a pending hearing, and a constable whose hearing was scheduled for later that day.

410. Ch Supt Verma provided an update to the meeting covering both community impact and partnership/stakeholder engagement. He confirmed that, in terms of community impact, he continued to manage engagement as part of business-as-usual activity. Regarding partnership and stakeholder communications, he reaffirmed that the previously agreed approach to issue a consolidated message would be implemented at an appropriate time.

411. We discussed engaging the workforce and I set an action to produce an internal update regarding court dates which should be released on Monday 22 January 2024.

412. I informed the meeting that I would be doing some pre-recorded briefings to the media that afternoon, and I had met with the corporate

communications team to help prepare for this. A further meeting was planned for immediately after the Gold Group.

413. Matthew Jarram and Lyn Heath, who were both present in the meeting, confirmed that a media package had been produced which included a CCTV timeline of the events on the night, and it was confirmed that the families had agreed that this could be released. I confirmed that I had reviewed the issues relating to the warrant and that the families had given me permission to use the names of the victim's during my media interviews.

414. I also confirmed that the progressing of actions and learning that had been identified during the debriefs would now be monitored within the strategic ethics, integrity, and learning board chaired by ACC Gary Hooks.

415. During any other business, Det Supt Sanders raised with me several questions that had been raised by Mrs Webber via the FLO, and we talked about the proposed response. The minutes indicate that I had already agreed the response, but it is my recollection that we discussed this matter during the meeting and then again further in a communications meeting immediately after the Gold Group. The content of that email is not noted in the minutes, but I will explain this matter in full later in my statement.

416. At the conclusion of the meeting, I informed the group that I would take a view on the need for further meetings after the court hearings, which were scheduled for the following week.

- Gold Group 13 – Tuesday 30 January 2024 1015 – 1115:

417. The thirteenth Gold Group meeting took place at 10:15 hours on Tuesday 30 January 2024. I refer to the minutes of this meeting as URN: NGPF0007809.

418. We agreed the accuracy of the minutes, and I was updated that the only action set during the previous meeting, namely, for Det Supt Sanders to further inform the families about the Special Constable case at an appropriate time, had not yet been completed. Given the families' current media commitments, it was agreed that this action would be carried forward.

419. Det Supt Sanders updated the meeting that on Thursday 25 January 2024 Mr Justice Turner had sentenced VC to a hospital treatment order with restrictions, having pleaded guilty to three counts of manslaughter on the grounds of diminished responsibility and three attempted murders.

420. During this meeting I introduced a new agenda item titled Areas of Concern Raised by the Family. I did so in response to several concerns expressed by the families of the deceased following the sentencing, which had been shared across various media platforms including television and newspapers. I explained that, while these concerns had not been formally submitted to us as complaints, I was keen to understand them fully. I also noted that the Chief Constable had already written to the families, offering for either herself, myself, or both of us to meet with them to discuss and address any concerns they may have. I refer to this letter as URN: NGPF0007810.

421. I asked attendees to share anything they had seen or heard in the media or gathered from any other source that they believed might reflect a

concern raised by the families. Together, we compiled a composite list to ensure these matters were acknowledged and could be considered appropriately.

422. That list included the following matters:

- The management of the warrant.
- General previous contact between police and VC.
- The investigation (toxicology, searching for the Slazenger bag, family updates and referrals for support).
- The prosecution (diminished responsibility, consultation about murder versus manslaughter, disclosure of psychiatric reports, sentencing, unduly lenient submissions).
- Notifying families on the night of the incident.
- Police use of language (deceased).
- Protection of data, specifically the CCTV of the attack.

423. I noted that, although reviews of all encounters between VC and the police had been undertaken between June 2023 and the present, I was not confident that these reviews had been collated in a single, accessible location. To ensure clarity and accountability, I set an action for all relevant documents to be gathered and made available to this meeting.

424. We discussed PSD and IOPC matters, and I divided the discussion in two parts.

425. The first related to the misconduct investigations that Nottinghamshire Police had undertaken in relation to our officers and staff conduct throughout our response to this incident.

426. T/Det Supt Reynolds confirmed that there were four relevant matters, summarised in the minutes as follows:

- A special constable had been dismissed on 11 December 2023 following an accelerated misconduct hearing.
- Front counter staff member, who was pending a gross misconduct hearing.
- A constable who had received a final written warning at a misconduct hearing 19 January 2024.
- Several other officers who had been dealt with outside of misconduct proceedings for looking at material.

427. There was a detailed discussion about what information should be shared with the families regarding these matters. I set an action to meet with T/Det Supt Reynolds to consider the issues raised, discuss what now needs to be communicated to the families and identify any organisational learning. This included reflecting on how officers conduct themselves in relation to viewing sensitive material and ensuring that any lessons are properly understood and embedded.

428. I reminded the group that, during the previous Gold Group meeting, I had agreed with the suggestion to delay sharing information about the Special Constable case due to its proximity to the VC sentencing hearing. I expressed my dissatisfaction that this information had not been shared in September 2023. The minutes state, “and had been informed it would have been.” I believe “would” is a typographical error and that it should read “should.” However, recognising that this had not occurred, I acknowledged that sharing such information in the lead-up to the

sentencing hearing would have been insensitive and inappropriate. I emphasised that the priority now must be to ensure that any communication on this matter was handled in the right way, at the right time, and by the right person.

429. The second part of the discussion focused on the IOPC referrals relating to our organisational response. I reminded the group that the van incident had been referred to the IOPC from the outset, and that their investigation had concluded with no findings of misconduct or performance issues. I also noted that we had engaged the IOPC in discussions regarding the FTA warrant, but they had determined that this matter did not meet the threshold for formal referral.

430. I informed the meeting that earlier that day, I had made the decision to refer our organisation to the IOPC in relation to all contact with VC prior to the events of 13 June 2023. T/Det Supt Reynolds confirmed that this referral was being submitted by his team whilst our meeting took place, and that the families had already been informed. I now refer to that IOPC referral as URN: NGPF0007811.

431. I was also advised that Leicestershire Police had made a similar referral to the IOPC concerning events in May 2023, which had been declined by the IOPC. I was made aware that our referral might also be rejected. Nonetheless, I gave a clear instruction for the referral to proceed, recognising the importance of transparency and accountability.

432. I updated that the Nottinghamshire PCC had commissioned a review to be undertaken by the College of Policing and that I understood the terms of reference for that review would be informed by a planned meeting with

the PCC. Matthew Jarram said that this review had been announced in the media.

433. A detailed discussion took place regarding the continued deployment of the FLOs, which I have addressed more fully later in this statement. I set an action for a plan to be developed outlining the phased withdrawal of the FLOs for some families. I instructed that this approach should be informed by advice from the national advisor, employed by the NCA, Sian Lewis, and emphasised that support must not be withdrawn until a clear and appropriate alternative offer is in place. I also requested that a range of options be considered to ensure families continue to receive the support they need.

434. Ch Supt Verma confirmed that no concerns had been raised by stakeholders in relation to this matter. Lyn Heath also updated the group that an announcement from the Prime Minister was expected regarding a review. This was something that Lyn Heath mentioned having seen or heard in the news but was unsure about the type of review that was being considered.

435. A discussion took place relating to the impact of the recent media coverage on our workforce. We agreed that it was not the right time to undertake any internal communications, and that this was something that would be done by the Chief Constable.

436. Before concluding the meeting, I confirmed that it would be appropriate to continue reminding our workforce of the sentencing judge's complimentary remarks made during the sentencing hearing when he stated as follows: "*The investigation into this case was both lengthy and*

complex, and those who played their part are to be commended for the extremely professional and skilful way in which they carried out their duties. The same applies to all those who helped in the aftermath of the shocking events of that morning. In particular, I would like to commend: the members of the family liaison team; the three members of the CCTV team; the Scenes of Crime Officer; the Files Officer; the police and medical staff who attended on the victims together with all other police officers involved in the investigation.”

- Gold Group 14 – Monday 19 February 2024 11:30 -11:45:

437. The fourteenth Gold Group meeting took place at 11:30 hours on Monday 19 February 2024. I refer to the minutes of this meeting as URN: NGPF0007812.

438. The purpose of this meeting was to formally close my Gold Group. I informed attendees that the Chief Constable had now assumed the role of Gold Commander for our continued response to the matters of concern identified as part of Operation Hendrix. I explained that this ongoing work was now being governed under a new operational name, Operation Chain Link, and that the new Gold Group had first convened on 6 February 2024, with the next meeting scheduled for 21 February 2024.

439. I also clarified that any residual matters, including outstanding actions from Operation Hendrix, would now be managed under the new Gold structure. No further matters were raised, and I formally closed the Operation Hendrix Gold Group.

Arrangements to communicate with other agencies, the media and the bereaved families and survivors of the attacks.

440. I have been asked to describe the arrangements that were put in place to communicate with other agencies, the media and the bereaved families and survivors of the attacks and to detail who was responsible for those arrangements.
441. As Gold Commander, I held strategic oversight for communications with key stakeholders following the Nottingham attacks, which I managed through my Gold Groups. This included liaison with other agencies, engagement with the media, and contact with bereaved families and survivors. The approach to each of these groups was embedded within the overarching strategic objectives and is outlined in greater detail in the summary of my Gold Group minutes referenced earlier in this statement.
442. Strategic Objective five focused on collaboration with strategic partners. Communication with other agencies was facilitated through established LRF structures, which brought together a broad range of strategic partners as previously listed. In addition, the City Divisional Commander and her senior leadership team played a pivotal role, leveraging their strong relationships with co-located partners within the City. Direct engagement also took place with national agencies, including the CT policing network and government ministers, through either myself or the Chief Constable.
443. Strategic Objective three related to communication with communities via the media. The media strategy, including our approach to public messaging and press engagement, is described in detail later in this statement.

444. Strategic Objective two addressed communication with bereaved families and survivors. This was delivered through the established family liaison infrastructure, which is also explained more fully in a subsequent section of this statement.

Strategic Aims and Objectives

445. I have been asked to consider each of the strategic objectives that I set as Gold Commander for Operation Hendrix, and to provide a detailed account of how each objective was approached. This includes the rationale behind the strategies adopted, my assessment of whether each objective was achieved, and any concerns or issues that arose during their implementation. I have also been asked to explain how those concerns or issues were addressed, and to provide reasons where objectives may not have been fully met.

- **Minimising the risk of harm to people living in or visiting the area of the reported attacks and the wider area and keep people safe:**

446. From the outset of the Operation Hendrix Gold Group, where I set the strategic objectives, I was aware that VC had already been taken into custody. However, there remained a degree of uncertainty as to whether he had acted alone. The motivation behind the attacks was not immediately clear, and I wanted our response to remain alert to the possibility of additional offenders or ideological influences. I took steps to ensure that these lines of enquiry were investigated thoroughly. I know I was cognisant of this point because I referenced motive during the investigation update sections of my Gold Group as is noted in the minutes on 13, 14, 15, and 16 June 2023.

447. Keeping the public safe is the fundamental purpose of policing and must always be the foremost priority in any operational response. It was for this reason that I identified and set this as the first strategic objective during Operation Hendrix.
448. During the first Gold Group meeting, I could not be confident about the extent of any residual risk to the public living in or visiting Nottinghamshire. I recognised that the most effective way to minimise this risk was to maximise our efforts to understand its nature, whether through investigative progress, intelligence gathering, or inter-agency coordination, with a view to taking swift and proportionate action to mitigate any further threat.
449. I had already reflected on these points in my Gold Log between 07:30 and 08:15 hours on 13 June 2023, where I placed “minimise risk to the public” at the top of my list of considerations for the Gold Strategy. In those same notes, I also captured my initial thoughts on the command structure, including the appointment of an SIO, a CT SIO, and an Intelligence Bronze from CT policing, as well as specialist firearms commanders (SSFC and STFC).
450. The early declaration of a Major and Critical Incident enabled the mobilisation of resources and the establishment of a clear command structure, ensuring that our response was both proportionate and agile.
451. I was reassured during initial briefings, recorded in my Gold Log between 06:30 and 08:45 hours on 13 June 2023, and described in full earlier in my statement, that our initial actions had focused on understanding the nature and scale of the threat. By the time I arrived at

the FCR at 06:30 hours on 13 June 2023, multiple crime scenes had already been secured, a major investigation had been initiated, and the suspect had been detained. The arrest of VC, combined with the early involvement of CT policing, allowed us to assess and contain any further risk.

452. Search activity was prioritised to identify any further victims and to ensure that no additional threats remained. This was set as an action during my first Gold Group meeting. The swift reopening of key roads, once deemed safe, helped restore public confidence and reduce disruption. Throughout this phase, we worked closely with partners to coordinate our efforts, including the LRF and other emergency services.
453. We were acutely aware of the risk of hate crime and the potential for community division. Proactive steps were taken to mitigate these risks, including engagement with faith leaders, the development of co-signed statements of solidarity, and the involvement of the IAG. These measures helped to foster unity and reduce the likelihood of retaliatory or opportunistic harm.
454. Operational resilience was maintained through careful resource management. Officers were temporarily restricted from booking leave, and enabling services were adapted to support frontline needs.
455. I took the view that continuing to deliver a service to the public and keep them safe required the workforce to be fit and healthy. The welfare of our workforce was therefore a key consideration, with trauma support offered to those most affected, including those exposed to distressing material. This support was extended to strategic leaders and investigators,

recognising the cumulative impact of sustained exposure to traumatic events.

456. During the Gold Group meeting on 16 June 2023, under “Any Other Business,” I began to consider what progress had been made against the strategic objectives. I expressed a view that most had been achieved, but I wished to reflect further before making a final determination. I therefore made the decision to retain the Critical Incident designation and continue the Gold Group.

457. I revisited this again during the Gold Group meeting on 20 June 2023. Under agenda item five, I confirmed that the objective: Minimising the risk of harm to people living in or visiting the area of the reported attacks and the wider area and keep people safe, had been achieved. I made this assessment based on the passage of time, the absence of any ideological footprint linked to terrorism, as confirmed by Det Supt Sanders during his investigation update, and the indication that the defence team were already considering the medical history of VC.

458. The decision to retain the Critical Incident designation until the conclusion of Operation Hendrix reflected our understanding that safety is not solely defined by the absence of immediate threat, but also by the presence of trust, reassurance, and support. As such, our efforts to keep people safe extended beyond the operational response, encompassing community engagement, family support, and workforce welfare.

459. While I am confident that this strategic objective was achieved, I acknowledge that it was not without challenge. The scale and complexity of the incident, combined with intense public and media scrutiny, placed

significant pressure on our organisation. The only real concern that arose in relation to this objective was the possibility of outstanding offenders. Through coordinated leadership and partnership working, we were able to eliminate this as a likely scenario and, in doing so, minimise further harm and maintain public safety.

- **Ensuring that effective engagement communication and support is provided to the affected families:**

460. From the outset of Operation Hendrix, I recognised that the families of those who had lost loved ones, as well as those who had been injured, would require not only timely and accurate information, but also sustained and compassionate support. This understanding informed my decision to set “effective engagement, communication and support to affected families” as the second strategic objective.

461. While I did not have direct responsibility for managing or coordinating FLOs, a function that rightly sits with the SIO, supported by the FLA, I considered it essential in my role as Gold Commander to ensure that the appropriate structures were in place to deliver this objective. I placed particular emphasis on the early establishment of the family liaison framework and made regular checks to confirm that it was functioning effectively and am aware that both the FLA and FLOs have kept comprehensive logs of their contact with families.

462. I recorded the requirement for an FLA in my Gold Log at approximately 07:30 hours on 13 June 2023, and shortly thereafter the SIO confirmed the appointment of Det Insp Claire Gould to the role. I am confident that I was reassured about this matter, as I made a note in my Gold log during the

SIO's briefing later that evening, which I recorded as commencing at 20:20hrs. I noted: "FLO framework in place – FLA + 10/12 FLOs – includes injured". I recall that this was a note of the SIO confirming that a team of ten to twelve FLOs had been deployed, including support for injured victims.

463. A second FLA was appointed the following morning (14 June 2023) to provide resilience, given the number of families involved.

464. Throughout the operation, I maintained a consistent position that families must always be the first to receive any information. I know we discussed this during my first Gold Group meeting, because there is a note in the minutes under agenda item twelve, Comms strategy, where Matthew Jarram stated that a written media release would be ready to go out "as soon as the family" have been informed. I remember that this comment was influenced by me making clear the 'families first' approach and this principle was embedded in our communications strategy and reiterated during Gold Group meetings. During the SIO's briefing at 09:00 hours on 14 June 2023, I provided my key updates at the start of the meeting, which I also recorded in my log. I included the highlights of my Gold strategy where I noted the words "family first". I remembered telling the briefing that it was important that families were always the first to be alerted about information.

465. During that same briefing, I learned that a second FLA had been appointed to support Det Insp Gould. I noted this in my log, next to the heading "FLO." In the same note, I recorded: "CG will inquire re CC meeting with the families." I remember this was said after I alerted the SIO

and FLA to the Chief Constable's wish to meet with the families. I had also included this point as part of my key messages at the start of the briefing.

466. At 11:00 hours that day, I noted that I had spoken with the FLA. The FLA confirmed that the families would be available to meet the Chief Constable at 15:00 hours that afternoon. I also noted the words "homicide victim referral", which I believe will have been recorded because the FLA had told me that such a referral had been made.

467. During the introduction section of the next Gold Group meeting on 14 June 2023, there was further discussion about a media release. It was agreed that the FLOs would read the release to the families and confirm their agreement before it was shared with communities and then released to the media. During the same discussion it was confirmed that the families were currently proof-reading a "tribute piece". During Agenda item 12, which covered the communication strategy, I reiterated that all communications would be agreed with families. I acknowledged that waiting for their approval might cause a delay in releasing information. However, I emphasised that this is a necessary delay, as families are the most important people, and it is vital that we get it right for them. In the same section of the meeting, I further confirmed by saying that the sequence would always be family followed by community followed by media. As a result of this note, I can confirm that I had instructed that no media release should be issued until families had reviewed and agreed its content because these discussions are noted in the meeting minutes. This approach was upheld across multiple meetings and became a central

tenet of our external messaging sequence: family first, community second, media third.

468. I was very mindful of the need to inform the families about our previous encounters with VC. I therefore felt reassured when the SIO addressed this during the briefing at 18:00hrs 14 June 2023, which I noted at the time. I noted that he had set a (non-urgent that day) action to produce a composite timeline of previous encounters with the police and mental health services. He planned for the FLOs to take the families through this information at the appropriate time, once it was complete and fully understood, likely under the SIO's guidance. My recollection of this is that the SIO was indicating that his early thoughts were that this is something he would consider doing himself.

469. The note I made read: "take the families through this, at the right time, and when complete and fully understood – probs SIO?". I think it is relevant at this point to reflect on the phrase "right time." I was not surprised to hear the SIO use the phrase "at the right time." Considering the right time to share information with families is something SIOs do regularly, and it is a very challenging judgement. There were always likely to be occasions when we would need to consider what the right time would be to share certain details in this case. In reality, there is never an entirely "right" time to give difficult or sensitive information to families. There is always a balance to be struck. On one hand, providing too much information at once can be overwhelming and may compound trauma. On the other, delaying information for too long can also have a negative impact. I would be cautious about a position where we always, without

exception, provide information contemporaneously, as this could adversely affect families. At the same time, I recognise the risks of providing information too late. Each case must be judged on its own merits, taking into account the context and all other information being shared at the time.

470. I also took steps to ensure that FLOs were supported in their roles. I attended a briefing organised by the FLA at 10:00 hours on 15 June 2023 to meet with the deployed FLOs. I wanted to check on their welfare and reinforce the importance of transparency and a 'family first' approach. I was clear that families should never learn of developments from external sources. During this meeting, Det Insp Gould outlined the updates to be shared with families that day, which aligned with the SIO's earlier briefing. My note of this conversation, made at the time, has assisted me in remembering the content of it and I describe it more fully later in my statement.

471. I also supported requests from families to visit key locations, including Ilkeston Road, and authorised road closures to facilitate this. I considered such requests to be deeply important and was committed to ensuring that policing measures were in place to support them.

472. During the first week, I issued a direct instruction to the SIO regarding family liaison matters, which I will detail more fully later in my statement and related to the disclosure of information about the outstanding warrant at the point of charging VC.

473. In relation to the non-executed FTA warrant I wish to state that this resulted from a serious systemic operational failure on the part of Nottinghamshire Police. I feel a strong sense of responsibility for the

failings that took place. I deeply regret that these occurred, and I recognise the seriousness of what happened and the distress it caused. The warrant should have been executed in a timely manner. VC should have been arrested pursuant to the warrant and that did not happen. I offer an unreserved apology to the families of the deceased and the survivors for this. The fact that these actions did not occur needed to be shared with the families as soon as possible. While I have already spoken about the importance of timing, I gave the SIO some discretion in this matter. However, I set the parameter that this information must be shared with the families no later than prior to charging VC. I took this approach because I anticipated that the issue of the warrant would likely arise at the court hearing, and it would not align with my “families first” principle for the families to learn of it there.

474. Throughout the investigation I remained engaged with updates on family contact. During the Gold Group on 20 June 2023, Det Supt Sanders informed me that FLOs continued to be engaged, which is included in the minutes of that meeting under item two, investigation update.

475. During the meeting on 20 June 2023, I stated that the strategic objective “Ensuring that effective engagement communication and support is provided to the affected families” had been achieved but acknowledged that it would continue to be progressed by the investigation team and the FLOs. This was noted in the minutes under the Gold Strategy agenda item. I also said I was content that, due to the family liaison infrastructure in place, I was reassured that effective engagement, communication, and

support had been provided. However, I emphasised that this work would be ongoing.

476. At the next Gold Group meeting on 23 June 2023, I explained in the “Any Other Business” section that regular Gold Group meetings would no longer be necessary. I acknowledged, though, that not all matters had been resolved in the long term. For that reason, I proposed a further meeting for a month later in July 2023. As noted in the minutes, I indicated that I would decide at that time whether to close the Gold Group.

477. I do not recall any issues or concerns being raised to me in relation to family engagement between 23 June 2023 and the next Gold Group on the 19 July 2023.

478. During the Investigation update at the Gold Group meeting on 19 July 2023, I was reassured that the FLOs continued to provide support, including attending funerals at the request of families, which is also noted in the minutes.

479. Again, I do not recall any issues or concerns being raised to me in relation to family engagement during that meeting. I cannot recall whether Det Supt Sanders informed me during the meeting (it is not included in the minutes) or whether it was outside of the meeting at some point around that time, but I made a note in my Gold log, (which is not timed or dated) that says “Aug/Sept = planned meetings for SIO and families”. This entry must have been prior to 20 September 2023, because I made my next entry in my log at that point.

480. The first issue regarding family engagement stems from a note in my log on 20 September 2023. On that day, I was alerted by an email from

Det Supt Williams (in an email chain which also included Det Insp Claire Gould, which I refer to as URN: NGPF0007813) to matters relating to PSD investigations and the accessing of sensitive material by members of the workforce. I was in fact notified of two matters that day. The first matter related to Police Constable (“PC”) Matt Gell and the second related to information about a Special Constable (“SC”) viewing distressing footage.

481. Although I address this matter later in my statement, I believe it is relevant here because it directly concerns keeping families updated.

482. On reflection, the way we managed the sharing of information regarding the PSD investigations was wholly inadequate. Looking back, I can see that our approach lacked coordination and clarity. As a result, the families were not given the information they should have received in a timely manner. I regret this and I offer an unreserved apology for it. I am also personally disappointed by my oversight of the matter.

483. The email from Det Supt Williams on 20 September 2023 (NGPF0007813), in the section relating to PC Gell, did include information about a WhatsApp comment, and I noted this in my log. However, by the time I received any further correspondence on this matter, which was from Det Supt Sanders, beginning with the email chain dated 14 December 2023, which I refer to as URN: NGPF0007814, he described the same issue but did not mention a WhatsApp message. At that point, I had forgotten about my earlier exchange with Det Supt Williams.

484. In his email, Det Supt Sanders outlined three matters being handled by the PSD. These included the case involving PC Gell, the misconduct

matter concerning Special Constable Skenderaj, and a third issue related to a front counter employee, named Rutherford.

485. In my response to Det Supt Sanders, I explained that there was no requirement to disclose the matters involving Rutherford and PC Gell. Based on the information I had at the time, neither appeared to involve material relating directly to any of the victims. My understanding was that PC Gell's focus had been on VC, while Rutherford's focus had been more broadly connected to major crime investigations.
486. My response to Det Supt Sanders (in respect of the PC Gell matter) focused only on the information in his email, which related to PC Gell's accessing information about VC.
487. When I reflect on that email now, I can see there is a reference to the prospect of families being designated as "interested persons". At the time, however, I did not understand the concept of "interested persons" and so based my judgement on what I thought was the right thing to do based on the information I had been provided in the email and from a verbal briefing from T/Det Supt Reynolds. Since I believed that the matter involving PC Gell related only to accessing information about VC, I did not consider it appropriate to inform the families.
488. Had I realised at the time that the matters concerning PC Gell involved the sending of a WhatsApp message relating to any of the victims, I would have ensured that this was shared with the family. That was, in fact, the approach I took in my response to Det Supt Williams on 20 September 2023.

489. This was a mistake on my part but was not done with the intention of withholding anything from the families.
490. In my response to the email from Det Supt Williams (which is included within NGPF0007813), I had supported the approach suggested by the FLA (DI Gould) to share information about PC Matt Gell with the families, emphasising that families should hear such matters from the police first.
491. In hindsight, and regardless of the reference to WhatsApp message, I now believe that the right thing to do would have been to inform the families of each of the matters identified in Det Supt Sanders' email dated 14 December 2023, and to have done so without delay.
492. In relation to the information about the Special Constable in the email from Det Supt Williams on 20 September 2023, we were not given any further detail at that time, and I do not believe my email response dealt specifically with this matter.
493. Following my email exchange with Det Supt Williams, and DI Gould (NGPF0007813) on 20 September 2023 I do not recall discussing this matter any further with anyone, until I received the email from Det Supt Sanders on 14 December 2023 (NGPF0007814), which copied in T/Det Supt Reynolds and DI Gould.
494. In the email dated 14 December 2023 I learnt that the information about the PSD investigations had not, in fact, been relayed to the families, as I had asked for it to be in the email of 20 September 2023.
495. I hope that my response shows that I had completely forgotten about the earlier exchanges in September. When I received the email dated 14 December 2023, I did not react to the fact that the information had not

been shared. The following sentence reinforces this belief: “As it is, now that we (you and I) are aware, I think we need to disclose the fact and do so quickly. Indeed, this was the instruction of the Chief Constable following the hearing.”

496. What is clear though, is that as a result of my email response dated 14 December 2023, the families were not informed about the case involving PC Matt Gell, even though they should have been. I am truly sorry for this. Because of my error, I did not uphold my commitment to ensure that families heard important information from us first.

497. I also know through discussions at Gold Group meetings on 19 and 30 January 2024, that disclosures about the Special Constable matter had still not been fully made either.

498. On reflection, in respect of sharing information about PSD investigations, the strategic objective of ensuring that effective engagement communication and support is provided to the affected families communicating with families had not been achieved.

499. The Chief Constable wrote a letter to the bereaved families and to the surviving victims about the PSD matters on 20 February 2024 and 22 February 2024. In those letters she outlined the PSD investigations that had taken place and apologised for the fact that information had not been provided to the families when it should have been. I refer to these letters as URN: NGPF0007815.

500. There were other matters of concern raised by the families, that I deal with fully in the section of my statement relating to the issues raised post sentencing in my Gold Group meeting of 30 January 2024.

501. I can confirm, from the minutes of the Gold Group meeting on 19 January 2024, that I did ensure that arrangements were made for families attending court hearings, including seating, transport, accommodation, and access to private space within the court building.
502. On 24 January 2024, I met with the SIO, FLA, and FLOs to check on the families' welfare, recognising the emotional demands of supporting families through the sentencing hearing. I wanted to ensure that they had the necessary support to continue providing compassionate and professional care.
503. Endeavours to achieve this objective have required sustained effort, careful judgement, and a deep understanding of the emotional complexity involved. The relationship between the investigation team and bereaved families and victims is an extremely important one and it requires care and sensitivity. It is also important to carefully consider what information is shared with families, and when, as I mentioned earlier in my statement at paragraph 469.
504. In the earlier stages of the operation, and particularly at the point when I made the decision to reduce the frequency of Gold Group meetings (July 2023), I felt that the strategic objective of ensuring effective engagement, communication, and support to the affected families had been met. The family liaison structure was functioning well, and I had confidence in the approach being taken by the SIO, the FLA, and the FLOs. The feedback I was receiving at that time suggested that the families were being supported appropriately, and the relationships appeared to be managed with care and professionalism.

505. However, in the two months leading up to the sentencing hearing in January 2024, my confidence in that assessment began to shift. Several issues were raised by the families during that period, some of which later developed into formal complaints. Additional concerns were also expressed publicly during media interviews in the days following the sentencing. These developments have caused me to reflect more critically on whether this objective was fully achieved.

506. While I continue to believe that the foundations of the family liaison approach were sound, and that the structure, intention, and oversight were appropriate, I now question whether the delivery consistently met the needs and expectations of all families throughout the duration of the operation. I remain of the view that the professionalism, commitment, and dedication of the FLOs was impressive. However, I readily acknowledge that the families' perception of our support and communication may not have aligned with our internal assessment of how that support was delivered.

507. I can confirm that I did discuss making an offer (with the SIO and FLA), both personally and on behalf of the Chief Constable, to meet with families, with the option of doing so either before or after the sentencing hearing. I recorded this offer in my Gold Log during a meeting with the FLA and SIO at 15:15 hours on 19 January 2024. This offer was subsequently reaffirmed in a letter sent to families on 29 January 2024 (NGPF0007810), following the conclusion of the sentencing hearings.

- **Providing reassurance to affected individuals and communities through an effective and proportionate support, engagement, media and communications plan:**

508. From the earliest stages of Operation Hendrix, I recognised that reassurance, both to the families directly affected and to the wider communities, would be a critical component of our strategic response. The nature of the incident, its visibility, and the profound impact on public confidence required a communications and engagement strategy that was not only effective, but also sensitive and inclusive. It was for this reason that I set this as the third strategic objective.

509. I set this as a distinct objective, separate from the earlier objective which was specifically focussed on supporting and engaging with the bereaved families. This aim was designed to address the wider needs of affected communities and to help maintain their trust and confidence in policing.

510. To deliver against this objective, I appointed key individuals within the command structure who I knew could provide the necessary leadership and expertise. Ch Supt Verma was appointed as Silver Commander, bringing his experience as Head of Local Policing. Ch Insp Chris Pearson was designated Bronze Commander for Communities, and Lyn Heath and Matt Jarram were appointed as Bronze Commanders for Media and Communications. I also ensured the appointment of FLA and FLOs specifically to ensure effective communication with families as I have already described.

511. Before the first Gold Group meeting, I had begun to shape our approach. At 08:15 hours on 13 June 2023, I recorded in my Gold Log that I had briefed both media bronzes in company with the Chief Constable. We agreed a rhythm of daily briefings, with me attending the MIR each morning, followed by a meeting with the Chief Constable and the communications team to agree the approach for the day ahead. I committed to providing updates throughout each day, with the Chief Constable leading on external communications.

512. I can confirm that this rhythm was maintained, as evidenced by entries in my Gold Log at 15:00 hours on 13 June, and again at 08:15, 08:30, and 11:00 hours on 14 and 15 June, and at 08:30 hours on 16 June 2023. These meetings provided an opportunity to review messaging, respond to developments, and ensure consistency across all communications.

513. Our approach to reassurance was multi-layered and evolved in response to emerging needs. During the first Gold Group meeting on 13 June 2023, I was briefed on early signs of community tension, including concerns from asylum seekers and Black communities who feared being targeted. I was reassured that a CIA had already commenced and that key stakeholders, including the City Council and Community Protection Department, had been briefed. Ch Supt Verma confirmed that MPs had approached NPIs with questions about whether VC had acted alone, and I agreed to consult with the Chief Constable to establish a briefing system for elected representatives.

514. At the same meeting, it was confirmed that a communications cell was being established, led by our Corporate Communications team and

reporting into the LRF. I made clear that no media release should be issued until we were confident that all relevant families had been informed. This principle, “family first, community second, media third”, was embedded into our communications strategy and reiterated throughout the operation.

515. On 14 June 2023, during the next Gold Group meeting, we discussed the first Community Engagement Forum, which had taken place the previous day and was attended by thirty-five participants. The forum identified key priorities, including community safety, engagement, communication, and reassurance. We were informed of significant tensions affecting residents of asylum hotels, the student population, local schools, and Black and Islamic communities. For each area of concern, a lead officer was appointed, and a broader strategic engagement plan was developed. This included involvement from the IAG, majority Black-led churches, and other community networks.

516. In the Gold Group on 15 June 2023, the Community Engagement Strategy had been formalised and shared with the Gold Group. Ch Supt Verma confirmed that each community pillar had a designated lead and that engagement opportunities were clearly articulated. He also raised concerns about media intrusion, particularly at Mr Coates’s school and among families residing outside Nottinghamshire. I set an action to engage with relevant force areas to ensure they were taking similar steps to safeguard affected families. It is not clear from the minutes whether this action was completed.

517. Throughout this period, our messaging was carefully managed. We prioritised clarity, consistency, and the dispelling of misinformation. Key messages included reassurance that it was safe to enter the city, acknowledgement of the impact on the university community, and clarification that no firearms had been involved. We also addressed speculation about the number of suspects and VC's background, recognising the risk of inflamed tensions.

518. On 16 June 2023, I was informed in the Gold Group that the engagement plan had been implemented and that patrol plans were in place, and this was noted in the minutes. Concerns about rising hate incidents continued to be reported, and an emergency meeting was scheduled for 20 June 2023. Ch Supt Verma shared a consolidated statement from faith leaders, which had been disseminated. I agreed that hate crime and incidents should feature as a theme within the RCG.

519. By 20 June 2023, as recorded in the minutes of my Gold Group, I assessed that the strategic objective relating to reassurance through engagement, media, and communications had been partially achieved. While the engagement framework and its purpose were well considered, and much progress had been made, I recognised that some elements remained ongoing. I was reassured that community impact and tension management had returned to business-as-usual, and that partnership and stakeholder engagement was being delivered effectively through NPIs and co-located partners.

520. In the weeks that followed, media attention diminished considerably, and communications planning was deliberately slowed, with the intention of refocusing and intensifying efforts in preparation for the trial.
521. During the Gold Group meeting on 19 July 2023, Ch Insp Pearson confirmed that community impact had stabilised and that no concerns had been raised from local or partnership meetings. The subgroups established during the first week remained active, and regular contact continued. Although I felt that the objective relating to reassurance had been achieved, I explained during the “Any Other Business” section of that meeting that there were a few items I wished to retain strategic oversight of, given the significance of the incident. These included communications associated with the progress of the investigation and prosecution, and the impact on communities.
522. In the lead-up to the sentencing hearing in January 2024, I became aware of concerns from the families, particularly relating to the prosecutions team’s acceptance of diminished responsibility as a partial defence to murder. On the final day of sentencing, several families raised issues publicly through media interviews. These included matters relating to the investigation, prosecution, and communications. My approach to these matters is described later in my statement, where I explain how I responded to these concerns and managed related media activity.
523. Later in my statement, I will explain how my approach to media communications following the sentencing hearing was carefully created with the aim of supporting public trust and confidence in policing, particularly within affected communities.

524. I also reflect that, while the establishment of a Multi-Agency Communications Cell was agreed at the SCG, it was later acknowledged that this should have occurred earlier in the response in a subsequent LRF de-brief that took place on 11 September 2023. I was present at this de-brief, and I refer to the de-brief report as URN: NGPF0007816. The relevant reference is Theme 2, on page 5, and the associated action tracker.
525. The review concluded that the links between the Communications Cell, the TCG, and the SCG could have been more clearly defined, and some individuals within the cell were relatively new to the role, with limited experience of operating in a major incident context.
526. It found that at one point, the Communications Cell stood itself down without referring to the SCG, having assessed that there was no further information to convey. The review felt that this decision highlighted the need for clearer governance and coordination.
527. It also indicated a perceived tension between the public communication needs of Nottinghamshire Police and those of other agencies, particularly the Local Authority. While Nottinghamshire Police were identified as the lead agency for public communications, legal and operational constraints limited what could be shared in the early stages.
528. In the early stages of a police investigation, several legal and operational factors can limit what information is shared publicly. These constraints are not about withholding information arbitrarily, but about protecting the integrity of the investigation, safeguarding individuals, and ensuring justice is served fairly. In this case this included us not wanting to

share many details about VC and his background prematurely because that could compromise evidence gathering, alert suspects, or influence witness testimony.

529. The review also found that Nottingham City Council and other partners felt that opportunities for collaborative messaging were missed, and that the Communications Cell should have convened more regularly. An offer from the City Council to facilitate these meetings was not taken up and may have been misinterpreted.

530. These reflections have informed a key recommendation to review the LRF's 'Communicating with the Public Plan' and to follow this with training and exercising to ensure that future processes are embedded and understood across agencies.

531. In summary, I believe that this strategic objective was approached with care, and structure. The communications and engagement strategy tried to balance the needs of both families and communities, and it was underpinned by a commitment to transparency and sensitivity. I acknowledge, there were ways in which this could have been done more effectively, which I described fully later in my statement. While I assessed that the objective had been partially achieved by 20 June 2023, I acknowledge that reassurance is not a static outcome. It requires ongoing attention, and I remained mindful throughout that public confidence is shaped not only by what we say, but by how we listen and respond.

- **Ensuring a professional and effective investigative response to the murders and incidents, to identify the suspect(s) and effect**

their arrest and prosecution and secure justice for the victims and their families:

532. From the outset of Operation Hendrix, the investigative response was treated as the highest operational priority for the force. The scale, complexity, and public impact of the incident demanded a swift, coordinated, and professional approach to identifying the suspect, securing evidence, and progressing the case through the criminal justice system.
533. I want to take this opportunity to explain my use of the word complexity, which appears frequently throughout this statement. In some respects, the investigation was not complex: the perpetrator was identified on the day and was never in question. While the team carried out extensive CCTV and forensic work to link VC to all six attacks, the investigative process itself was relatively straightforward. However, the complexity I refer to lies elsewhere: in the psychiatric considerations, the scale and severity of the offending, the wide geographical spread across Nottingham, and the intense local and national media attention. Most significantly, it relates to the impact on public feelings of safety and the challenge of maintaining trust and confidence in policing during such a deeply distressing time.
534. Although VC had been arrested relatively quickly, I recognized that the investigation required a methodical and structured approach to progress from an initial position, where the sequence of events was not yet fully understood, to one where the CPS was satisfied that the evidential threshold for prosecution had been met. This included establishing a detailed properly evidenced chronology that linked VC to each of the six

attacks. The CPS ultimately determined that the evidential case was sufficiently robust to support formal charges, allowing the matter to progress to court.

535. By 06:30 hours on the morning of the incident, multiple crime scenes had been secured, and VC had already been arrested.

536. To ensure an ongoing professional and effective investigative response to these incidents, consider any further suspects, affect their prosecution and secure justice for victims and families, I appointed the Det Supt Leigh Sanders as the SIO. He led the investigation throughout and in the early stages, sought the support of a CT SIO, as well as an Intelligence Bronze Commander from the CT policing network.

537. This structure reflected the early uncertainty around VC's motivation and the need to explore all potential lines of inquiry, including ideological or terrorist links. The investigative structure was first considered by me shortly after 07:30 hours on 13 June 2023, which I know because I recorded it in my Gold Log, and then later discussed and confirmed in the first Gold Group meeting on 13 June 2023.

538. The SIO's working hypothesis was shared with the Gold Group, and search activity was prioritised to identify any further victims or evidence. I tasked search advisors accordingly.

539. I was reassured that the investigation was supported by a significant deployment of resources. When I attended Investigation briefings I was told, and could see, that resources had been provided from across the East Midlands collaboration murder investigation teams (EMSOU), and

that support was also being provided by resources from Nottinghamshire Police.

540. I imposed a temporary block on annual leave, approved remote working for some enabling services to free up estate capacity, and welcomed the offer of support from the NCA. Staff volunteered to work on rest days, and I was encouraged by the collective commitment across the organisation. The investigation was carried out on the HOLMES system, with all key roles appointed, and a Casualty Bureau was activated, receiving over 200 calls, an approach recognised as good practice during the peer review on 20 June 2023.

541. HOLMES stands for Home Office Large Major Enquiry System. It is a secure, national IT platform used by UK police forces to manage major investigations, particularly those involving serious crimes such as murder, terrorism, and complex multi-scene incidents.

542. The CPS was engaged at an early stage. By 14 June 2023, CPS representatives were present in the incident room. I know this because a note is made of that in the minutes during the Gold Group during the investigation update. An application was made to extend VC's detention on the same day, which I noted in my Gold log, during the SIO's briefing which started at 1800hrs on 14 June 2023. All three post-mortem examinations were also scheduled for that day, and the chronology of events was confirmed. The CPS remained closely involved throughout the investigation, and I was kept informed of key developments, including the charging decision.

543. On 20 June 2023, the SIO confirmed that VC had been charged with three counts of murder and three counts of attempted murder.
544. My confidence in the quality of the investigation was reinforced by the findings of the Major Case Review Self-Inspection Report, dated 22 June 2023 (which I now refer to as URN: NGPF0007817). This followed a peer review conducted on 20 June 2023 by Stuart Prior, Head of the EMSOU Regional Review Unit, and Review Officer Paul Cottee, both former senior Nottinghamshire Police officers and highly experienced in major crime investigations. Their assessment aligned with my own observations and professional judgement, informed by my background as a former SIO.
545. Stuart Prior served as a career detective in Leicestershire, progressing to the rank of Det Ch Supt and in that rank later became the Head of EMSOU. He finished his career as T/ACC (Crime) in Nottinghamshire. Paul Cottee was also a career detective, working in Nottinghamshire, and finished his career as Det Supt head of EMSOU Homicide Unit.
546. The review confirmed that the on-call murder SIO was notified promptly and responded immediately. The investigative structure was clearly defined, with Det Ch Insp Clare Dean appointed as deputy SIO, and three further deputies assigned to manage the respective crime scenes. A structured approach to scene examination was implemented across eleven identified scenes, with forensic inquiries prioritised. A Crime Scene Coordinator was appointed to oversee all scenes and develop forensic strategies. Fast-track submissions were authorised, and early forensic strategy meetings were held.

547. Specialist search advisors and licensed search officers were deployed to conduct searches at and between scenes. The SIO instructed three post-mortems, all conducted by Dr Mike Biggs, with each attended by separate investigation teams. Numerous fast-track actions were undertaken, including obtaining witness statements, deploying FLOs, reviewing key messaging, examining VC's property, and conducting CCTV trawls. The SIO identified and progressed appropriate main lines of inquiry, including forensic opportunities, telephone data, intelligence, and liaison with counter-terrorism policing.
548. The review acknowledged the significant resourcing support provided to the investigation, including regional murder investigators, Nottinghamshire detectives, and CTP staff. While some duplication occurred due to varying levels of experience, the overall coordination was effective. The review also noted the challenges posed by intrusive media activity during the first week, which included independent investigations and early identification of the suspect.
549. I believe what the review was referring to is the fact that, during the early stages of the investigation, the media were actively uncovering information about VC, including previous police encounters. They were also attempting to contact family members and witnesses directly. This presented significant challenges for the investigation team, particularly in maintaining the integrity of the inquiry, safeguarding those involved, and managing the timing and accuracy of public communications.
550. The review confirmed that the SIO had appointed an FLA and deployed trained FLOs both to bereaved families and injured victims. Upon arrival in

custody, VC's clothing was forensically recovered, and he was examined. While he refused to provide intimate samples, including blood, the review noted that other forensic opportunities were maximised.

551. CCTV comparisons were conducted between footage from the scenes and dashcam recordings. The CPS was satisfied that the individual depicted in all footage was VC. The review also referenced VC's mental health history and the need to expedite the charging decision to mitigate the risk of prejudicial media reporting, an instruction I gave to the SIO at the time.

552. The review concluded that the investigation was well-structured, proportionately resourced, and professionally managed. Praise was given to the SIO's policy log entries, which demonstrated clear rationale and sound decision-making. One area for improvement related to the remote working arrangements of some intelligence functions, though support to the SIO remained ongoing.

553. VC's medical history became a key line of enquiry, and this became increasingly significant in the months that followed, culminating in the acceptance of pleas to manslaughter on the grounds of diminished responsibility in January 2024. I also acknowledge some families have raised concerns about the approach from both the CPS and police regarding the acceptance of diminished responsibility.

554. Concerns have been raised by one family regarding toxicology, specifically not taking hair samples for evidence of drug use, and the recovery of a holdall that VC had in his possession when he had arrived in

Nottingham that night. These matters will be addressed later and separately, in my statement.

555. In summary, I believe that the objective of delivering a professional and effective investigative response to VC's savage attacks was achieved. The investigation was conducted to a high standard, with appropriate governance, resourcing, and legal oversight. VC was identified, arrested, charged, and prosecuted. The case progressed with diligence and integrity, with sentencing occurring within approximately seven months of the offending, the only delay being the need to secure extensive psychiatric evidence.

556. The concept of justice is deeply personal and often subjective. I am acutely aware, through the victim personal statements and the complaints that have since been raised, that some families do not feel that justice has been served. I recognise and respect that perspective, and I do not expect my own view to be shared by all those affected.

557. Nonetheless, from a Criminal Justice standpoint, and based on the legal processes that were followed, it remains my professional opinion that the objective of securing justice was achieved. The investigation was thorough, the evidential threshold was met, and the case was progressed through the courts in accordance with established legal standards and quickly. I acknowledge that this conclusion may not bring comfort to the families, but it reflects my assessment of the investigative and prosecutorial outcomes. I also note that the Court of Appeal, Criminal Division, chaired by the Lady Chief Justice, recognised that the convictions for manslaughter were properly founded upon the psychiatric evidence

and that the approach to sentencing was appropriate, see paragraphs 74 to 95 of the Court of Appeal's judgement dated 14 May 2024.

- **Working in partnership with the Local Resilience Forum, other strategic partners (both locally and nationally) and the CT network, to maintain the trust and confidence of communities in the response and actions of Nottinghamshire Police:**

558. As the response under Operation Hendrix began, I recognised that maintaining public trust and confidence would require a coordinated, multi-agency response, which is why I set this as a specific strategic objective. The nature and scale of the incident meant that reassurance could not be delivered by policing alone. It had to be underpinned by visible collaboration across the LRF, strategic partners, and the CT policing network. This objective was specifically about working effectively in partnership.

559. The activation of the LRF effectively began with the declaration of Operation PLATO (Major Incident), following the incidents on Milton Street and Parliament Street. The early stages of the partnership responses to these incidents presented challenges. It was the first time Nottinghamshire had ever declared Operation PLATO. The structured debrief later identified that the activation of the Resilience Direct response page and the issuing of the METHANE report were delayed, which impacted initial situational awareness for some partners.

560. Resilience Direct is a secure, web-based platform developed and managed by the UK Cabinet Office to support multi-agency coordination during emergencies. It forms part of the national resilience infrastructure

and is used by emergency responders and resilience professionals across the country.

561. The platform enables LRFs, government departments, emergency services, and other designated responders to share real-time updates, such as incident logs and situation reports, and to coordinate meetings like Tactical and Strategic Coordinating Groups. It also provides access to mapping tools and response templates and facilitates secure communication between agencies during major incidents.

562. METHANE is a structured mnemonic used by emergency services in the UK to communicate key information during the initial stages of a major incident. It helps ensure that all relevant details are shared quickly and consistently across agencies. The acronym stands for:

- **M** – Major incident declared?
- **E** – Exact location of the incident
- **T** – Type of incident (e.g. fire, explosion, chemical release)
- **H** – Hazards present (current and potential)
- **A** – Access routes (best routes for emergency services)
- **N** – Number of casualties (and severity)
- **E** – Emergency services present and required

563. The METHANE report is typically issued by the first responder or control room and is used to trigger multi-agency coordination, including activation of the TCG and SCG.

564. At 09:45 hours on 13 June 2023, I convened the initial TCG to provide an early situational briefing and begin coordinating the joint response.

Shortly thereafter, I assumed the role of Chair of the SCG, while continuing to lead the police Gold Group throughout the response phase.

565. The first SCG meeting was held at 13:30 hours the same day, and I was reassured by the breadth and depth of engagement from a wide range of partner agencies. The TCG was also formally established at that point and chaired by Ch Supt Verma, who had been appointed as Police Silver Commander.
566. Both the TCG and SCG met daily until Friday 16 June 2023, with the SCG following the TCG each day. These structures provided a framework through which operational decisions could be aligned with wider strategic considerations and ensured that partners were actively involved in shaping the response.
567. It was also noted that some organisations, including the Integrated Care Board (“ICB”) and universities, would have welcomed earlier notification of the incident. These reflections have informed several recommendations, including improvements to call-out cascades, notification procedures, and the use of Resilience Direct.
568. Despite these early challenges, the debrief also highlighted that partnership working and trust between agencies was strong. Relationships built through the LRF prior to the incident enabled an effective joint response. The Joint Emergency Services Interoperability Principles (“JESIP”) principles were applied, and agencies attending the SCG and TCG reported that they felt like trusted partners, with relevant information shared to support decision-making and that the meetings were well

chaired. The ability to join meetings virtually was welcomed and helped ensure broad representation.

569. The JESIP principles are designed to help emergency services in the UK work together more effectively during major incidents. They encourage a coordinated approach between police, fire, ambulance, and other responders.

570. The first principle is to co-locate, meaning that commanders from each service should gather at a single location to establish a shared command structure. This physical proximity helps streamline communication and decision-making.

571. Communication is the second principle, emphasizing the need for clear, concise language and the use of agreed terminology. This ensures that all agencies understand each other and can share information accurately and promptly. Coordination follows, where services agree on priorities, objectives, and actions to ensure a unified response.

572. Another key principle is jointly understanding risk. This involves sharing information about potential hazards so that all agencies have a common view of the threats involved. It helps protect both responders and the public.

573. Finally, the principle of shared situational awareness is about building a collective understanding of the incident by pooling information, intelligence, and assessments. This supports better decision-making and ensures that everyone is working from the same picture.

574. Together, these principles form the foundation of effective multi-agency response and are supported by tools like the Joint Decision Model, which helps structure collaborative decision-making.
575. Throughout the response, I maintained regular contact with CT policing colleagues. A CT SIO was appointed to support the investigation, and the CT policing network remained engaged until it was confirmed that the incident did not meet the threshold for a CT designation. I continued to liaise with the CT SNC network, and a CT debrief was held in August 2023.
576. I believe the Gold Group minutes also reflect a consistent commitment to partnership working. On 14 June 2023, we discussed the Community Engagement Forum and the development of a strategic engagement plan involving faith leaders, universities, and community networks. On 15 June 2023, the Community Engagement Strategy was shared with the Gold Group, and each community pillar had a designated lead. These structures were supported by the LRF and helped ensure that engagement was coordinated and inclusive.
577. The RCG was formally established on 20 June 2023, led by the Local Authority. While some partners felt that the RCG could have been convened earlier, the debrief noted that recovery actions were already being taken within the SCG and TCG, and that there were no negative impacts as a result.
578. One area of learning related to the multi-Agency Communications Cell. While it was established at the SCG, it was felt that this should have happened earlier and that links to the SCG and TCG could have been

stronger. Some individuals within the cell were new to the role and had limited experience in this context. At one point, the cell stood itself down without referring to the SCG. There were also perceived tensions between the public communication needs of Nottinghamshire Police and other agencies, particularly the Local Authority. These reflections have informed a recommendation to review the LRF's 'Communicating with the Public Plan' and to follow this with training and exercising.

579. Despite these challenges, there were notable successes. The use of the tagline "One City #NottinghamTogether" was recognised as effective in supporting community cohesion. The vigils were well organised and reflected the collective impact on the city. Nottingham University reported feeling well supported by Nottinghamshire Police and the team who organised the vigil.

580. By 20 June 2023, I assessed that the strategic objective relating to partnership working had been achieved. While some issues had been raised, I was reassured by the strength of the relationships, the responsiveness of partners, and the shared commitment to maintaining public confidence. I acknowledged that some elements would continue into the recovery phase, and I retained strategic oversight of communications and community impact.

581. In summary, I believe that this objective: Working in partnership with the LRF, other strategic partners (both locally and nationally) and the CT network, to maintain the trust and confidence of communities in the response and actions of Nottinghamshire Police, was approached with professionalism and integrity. The response was shaped by collaboration,

and while there were areas for improvement, the overall approach was consistent with the standards expected in a major incident. The learning identified has informed recommendations that will strengthen future multi-agency responses and ensure that the trust placed in Nottinghamshire Police, and its partners is upheld.

582. Trust and confidence, both during and following an incident, are inherently difficult to quantify and often shaped by subjective perceptions. However, based on the feedback gathered through the CIA, I was satisfied that our actions had contributed positively to public trust and confidence.

- **To ensure that Nottinghamshire Police discharge their responsibilities fully in relation to policies/guidance governing notifications to scrutineers:**

583. At the inception of Operation Hendrix, Nottinghamshire Police approached the responsibility of notifying scrutineers with a clear commitment to transparency and accountability. This objective was embedded within the Gold Strategy to specifically reflect that, the relevant scrutineers for policing being the IOPC. The IOPC is the body responsible for overseeing the police complaints system in England and Wales.

584. The declaration of a Critical Incident, which triggered enhanced governance and oversight mechanisms, enabled me to keep oversight of this matter.

585. In the early hours of 13 June 2023, I considered the composition of the command structure and made a deliberate decision to involve Det Supt Williams, Head of the PSD, at an early stage. This is reflected in an entry I made in my Gold Log shortly after 07:30 hours. I subsequently discussed

and confirmed this approach with the Chief Constable at 08:15 hours, as noted in the same log. Her formal inclusion within the command structure was then established during the first Gold Group meeting later that day.

586. Prior to establishing the formal command structure, I had a conversation with Ch Insp David Mather at 06:59 hours on that morning. During that discussion, I noted an action in my Gold Log to consider whether the van incident met the criteria for a DSI designation, which would necessitate a referral to the IOPC. Following further consultation later that morning with Ch Insp Amy English, who was acting as the PIM, I concluded that the criteria had been met. At 10:50 hours, I formally declared the incident as DSI and authorised the implementation of the PIP, which I also noted in my log.

587. I have described these procedures elsewhere in my statement, but in summary a PIP refers to a structured and formal process that is initiated following a serious incident involving police officers, particularly where there has been a death or serious injury. A PIM is a senior officer appointed to oversee this process. Their role is to ensure that the procedure is conducted fairly, consistently, and in accordance with national guidance.

588. PSD were then engaged in all Gold Group meetings, except for 19 June 2023 (which was the welfare Gold Group), 23 June 2023 and 19 January 2024.

589. During the first Gold Group meeting (13 June 2023), I was reassured that a verbal referral had been made to the IOPC concerning the van

incident. This was swiftly followed by a formal written referral, and the matter remained under active consideration throughout the operation.

590. In addition to this during that same Gold group meeting, as noted in the minutes under the PSD/ IOPC agenda item I instructed Det Supt Williams to undertake a scoping exercise, which was to include the FTA warrant and efforts made to arrest VC.

591. I acknowledge that the minutes do not articulate fully the extent of the scope that I had asked for but I know that it was understood in this way because later that same day I was provided with an e-mail from Det Supt Williams that outlined the police contact with VC (NGPF0007820), which is what was intended as well as information about the warrant (NGPF0007844). The minutes referred to previous contact with the police. It was noted that there had been several earlier incidents involving Nottinghamshire Police and other forces. We now know that the only police forces that had encountered VC were Nottinghamshire, Leicestershire and the Metropolitan Police. Cited as example, was an incident a month before the attacks, where VC was identified as responsible for two assaults in Leicester but was not circulated on the Police National Computer ("PNC").

592. Reference was also made to an incident where VC had taken someone hostage, and someone had jumped out of the window. I now recognise that the note in the minutes appears to conflate or confuse two separate incidents involving VC. One was in May 2020, when he kicked at a door and a female jumped from a window. The other was in January 2022,

when he held a flatmate in a headlock and then detained him to await the arrival of the police.

593. Detective Superintendent Williams assessed these incidents as opportunities for learning. In particular, the learning related to how VC repeatedly avoided conviction due to his mental illness yet continued to reoffend.
594. The Gold Group provided a consistent and structured forum for oversight, ensuring that all relevant matters were addressed in accordance with national guidance. Where appropriate, referrals were made to the IOPC, and updates were regularly provided. In instances where the IOPC determined that the threshold for referral had not been met, such as in the case of the unactioned fail-to-appear warrant, I asked for PSD to make further enquiry about this, as I wanted to be sure whether the criteria had been met. The response to this inquiry was not reported into the Gold Group, but I am aware that the inquiry is made, because I have seen the relevant email chain which I refer to as URN: NGPF0007818.
595. The email exchange in NGPF0007818 is summarised as follows: On 11 August 2023, Det Sgt Neil Allsop contacted Andrew Mellor of the IOPC to seek further guidance regarding a decision not to refer the unactioned warrant relating to the suspect, VC. Although the matter had been considered at the time and a referral was not made, I had subsequently raised a question about whether that decision had been appropriate, prompting Det Sgt Allsop to seek further advice.
596. In his correspondence, Det Sgt Allsop outlined the circumstances surrounding the warrant, which had been issued following a failure to

appear at court for an assault on an emergency worker. He confirmed that the warrant had been recorded on PNC but had not been actioned. He also described the internal process for managing warrants and highlighted concerns about the volume of outstanding warrant tasks across various inboxes, some dating back several years. This raised broader questions about the robustness of the warrant management system at that time.

597. Det Sgt Allsop concluded by requesting the views of the IOPC on whether a referral was now appropriate and confirmed that he would proceed with one if advised to do so.

598. On 14 August 2023, Andrew Mellor of the IOPC responded by saying that, following internal consultation with colleagues, including the Head of the IOPC Assessment Unit, the matter appeared to be a process issue rather than one that met the formal criteria for referral. He acknowledged the concerns raised and recognised the need for internal review and learning, but noted that, in the absence of a recorded conduct matter or a complaint from a member of the public, a referral was not required at that time. He encouraged Nottinghamshire Police to undertake a learning exercise to address the issue and to keep the matter under review.

599. I believe this demonstrated a commitment to due process, even when formal referral routes were unavailable.

600. During the Gold Group meeting held on 23 November 2023, T/Det Supt Reynolds confirmed that the IOPC had concluded its investigation into the van incident. He reported that no evidence of misconduct had been found, nor had any organisational learning been identified. He also reminded me of the earlier exchange of emails and the written confirmation received

from the IOPC, which clarified that the issue relating to the unactioned warrant did not meet the threshold for formal referral. At that point, T/Det Supt Reynolds advised that all IOPC and PSD matters connected to the incident were now considered closed. These details were formally recorded in the minutes of the meeting.

601. Following the conclusion of the sentencing hearing on 25 January 2024, T/Det Supt Reynolds contacted me by email to propose reopening the discussion around whether a complaint was now being made by the families, and whether this might meet the criteria for referral to the IOPC. I refer to that email from T/Det Supt Reynolds as URN: NGPF0007819. He suggested that we consider informing the families of their right to appeal. I responded to say that it would be sensible to wait until after the weekend before progressing the matter further and subsequently scheduled a Gold Group meeting for 30 January 2024 to allow for a fuller discussion.
602. During that meeting, I invited all members of the group, including Det Insp Gould, Det Supt Sanders, and T/Det Supt Reynolds, to share anything they had seen or heard in the media since the sentencing, so that we could compile a composite list of concerns that had been raised by the families.
603. This discussion was recorded in the meeting minutes, and I acknowledged that no formal complaint had been lodged at that time. The concerns identified included the management of the warrant, previous contact between the police and VC, the assault in Leicestershire in May 2023, matters relating to the investigation and prosecution, the notification

of families on the night of the incident, the police's use of language, and the protection of sensitive data, particularly CCTV footage of the attack.

604. In the same meeting, I informed the group that I had already taken the decision to refer Nottinghamshire Police to the IOPC in relation to all prior contact with VC leading up to the events of 13 June 2023. T/Det Supt Reynolds confirmed that the referral was being prepared and submitted while this Gold meeting was taking place, and that the families had been informed.

605. Although I was aware that the referral to the IOPC might not be accepted, I felt it was important to proceed regardless. This view was shared and discussed during the Gold Group meeting held on 30 January 2024, and the decision to refer was recorded in the minutes. My intention was to ensure that all avenues of accountability were explored, particularly considering the concerns raised following the sentencing hearing.

606. The Gold Group remained open for a period to ensure that all matters were properly concluded. The transition to Operation Chain Link provided a structured mechanism for continuing oversight, allowing residual issues to be managed under appropriate governance.

607. In reflecting on the delivery of the strategic objective relating to scrutineers, I believe that I made thoughtful and deliberate efforts to identify which matters ought to be referred to the IOPC, and through which route. This included challenging the initial decision not to refer the warrant issue. In hindsight, I recognise that public trust and confidence, particularly among the families affected, might have been better served had I referred all relevant matters to the IOPC at an earlier stage, inviting them to

undertake an entirely independent assessment of each contact between the police and VC.

608. While the IOPC were procedurally correct in determining that the criteria for referral had not been met, either through the mandatory or voluntary route, I do reflect on whether I should have made a stronger case under the voluntary limb of the referral criteria and been more persistent in my attempts. That route allows for referrals which are in the public interest, even where the mandatory threshold is not met. I acknowledge that even under the voluntary route, a complaint or identified conduct issue needs to exist.

609. Although the matters might not technically meet the referral criteria, I now consider whether a more assertive approach might have been justified in the circumstances.

- **To provide welfare support to affected officers and staff from all agencies:**

610. Welfare support was recognised as a priority from the early stages of Operation Hendrix. It is my belief that staff welfare is not just a moral responsibility but is also a strategic necessity. In policing, where officers and staff face high-risk, emotionally demanding, and often traumatic situations, welfare provisions are essential to maintaining operational effectiveness, public trust, and long-term resilience.

611. My early consideration of workforce welfare began shortly after 07:30 hours on 13 June 2023, when I started drafting the command structure. At that point, I included Supt Kathryn Craner as the designated Bronze Commander for welfare. Welfare also featured in my initial thoughts

around the Gold Strategy, reflecting a clear recognition that the health and wellbeing of our workforce, both those who had responded to the incident overnight and those who would be involved in the days and weeks ahead, was intrinsically linked to the quality of our response and the service we would continue to provide to the public. I can see that I made a note about the welfare Bronze and welfare in my strategy in my Gold log.

612. Initial discussions on staff wellbeing began during the first Gold Group meeting 13 June 2023, where the scale and complexity of the incident, along with the emotional impact on officers and staff, were acknowledged.

613. The minutes of this meeting show that I placed a temporary block on annual leave, to ensure operational resilience, and enabling services were asked to work remotely to free up estate capacity. Staff volunteering to work on rest days was noted, and support from external agencies such as the NCA was welcomed.

614. From the first Gold Group, the welfare of the workforce became a standing agenda item. On 14 June 2023, Det Ch Supt Leona Scurr was tasked with replicating welfare provision across her command, and an internal communication was commissioned to inform staff how to access support.

615. By 16 June 2023, Claire Salter, Head of People Services, presented a suite of wellbeing options, and the COT committed to visiting police stations over the weekend to meet with first responders. The emotional impact of viewing distressing footage was acknowledged, and support was explicitly extended to those in strategic and command roles.

616. On 19 June 2023, an extraordinary Gold Group meeting was convened specifically to address concerns regarding workforce wellbeing. During COT visits to police stations over the preceding weekend, it was recognised that while the existing support offer met the needs of most, a small number of individuals had been significantly affected. A bespoke package of support was commissioned for this group, and direct contact was made with those identified as most impacted. The minutes recorded this discussion, and the group agreed that this differentiated approach was necessary and appropriate.

617. By 20 June 2023, trauma support processes had been initiated for the FLOs and Crime Scene Investigators, and mandatory referrals were planned for officers repeatedly exposed to CCTV footage. The welfare of staff within the PSD was also considered, and the same trauma support approach was extended to them. An action was set to ensure that senior officers and Gold Group members were also offered appropriate wellbeing support.

618. Throughout July, welfare remained a key focus. At a Gold Group meeting on 19 July 2023, it was confirmed that plans to address individual and collective needs were fully embedded, and strategic oversight of welfare was no longer deemed necessary. However, the Gold Group continued to monitor progress, and by 23 November 2023, it was agreed, and is recorded in the minutes, that reward and recognition would be considered at a later stage.

619. At a Gold Group meeting on 19 January 2024, further confirmation that actions set to ensure that FLOs involved in showing CCTV footage to families received appropriate support, had been completed.
620. By 30 January 2024, the impact of recent media coverage on the workforce was discussed, and it was agreed that internal communications would be paused to avoid compounding distress.
621. I believe the approach taken to workforce wellbeing was structured, responsive, and compassionate. Welfare was not treated as a single event but as an evolving priority, with support tailored to the needs of different roles and individuals. Concerns were raised throughout, particularly around the adequacy of initial support and the emotional toll on those exposed to traumatic material, but these were met with practical actions, bespoke interventions, and ongoing review.
622. In reflecting on this objective: To provide welfare support to affected officers and staff from all agencies, I feel that Nottinghamshire Police made sustained efforts to support affected officers and staff, and that the welfare response was both thoughtful and proportionate. While the need for support continued beyond the initial response phase, the systems and structures put in place ensured that this remained a live consideration throughout the operation.
623. I also note that the minutes of the SCG meeting held on 16 June 2023 recorded confirmation that the objective to protect the health and safety of responding personnel had been achieved. This acknowledgement encompassed all agencies involved in the response and, in doing so,

reflected the completion of the strategic objective as set within my Gold Group, where multi-agency welfare was a key consideration.

Knowledge and response to concerns raised by the families.

624. This section of my statement will address the concerns I recorded in the Gold Group minutes dated 30 January 2024, when I had asked those present at that meeting to share any issues or observations they had become aware of, whether through media coverage over the preceding weekend or from any other source, relating to this case.

625. I have been asked to clarify what knowledge, if any, I had prior to 13 June 2023 regarding three specific matters: the management of the warrant, general previous contact between the police and VC, and the report of an alleged assault in Leicestershire in May 2023.

626. In addition, I have been asked to provide a detailed account of what I understood each of the listed concerns to be, what steps were taken, either by the police or by others, to address those concerns to my knowledge, and whether, in my view, those concerns have been adequately resolved.

- Knowledge prior to June 2023:

627. Regarding the first three specific matters: the management of the warrant, general previous contact between the police and VC, and the report of an alleged assault in Leicestershire in May 2023, I can confirm that I did not have any knowledge of these matters prior to 13 June 2023.

- The management of the warrant.

628. I understood the concerns regarding the management of the warrant to fall into two distinct areas. The first related to the fact that the warrant

issued on 22 September 2022 had not been executed, meaning that VC remained wanted at the time of the attacks on 13 June 2023, having been subject to that warrant for over 8 months.

629. The second concern centred on whether the families had been informed about the existence of the warrant, and whether they had been provided with sufficient information regarding the actions taken by the police to locate and arrest VC, pursuant to the warrant.

630. In terms of police efforts to address these concerns, I believe the two issues are closely connected. Aside from circulating VC as wanted on PNC and placing the warrant in the relevant tasking folder, no further proactive steps were taken to locate VC. This represents a clear and unacceptable shortfall in policing. Any explanation offered is unlikely to fully address the gravity of that concern.

631. However, this links directly to the second issue. Although the failure to execute the warrant and arrest VC cannot be undone, its impact may be partially mitigated through full, open, and transparent disclosure.

632. This includes acknowledging the existence of the warrant, explaining the lack of effective action taken, and sharing our assessment of what the likely outcome might have been had VC been arrested prior to the attacks.

633. As previously outlined in paragraph 473, the unexecuted warrant represented a serious failing on the part of Nottinghamshire Police. While I believe the families were informed about the existence of the warrant and that VC had not been arrested, I do not believe they were given sufficient information regarding the lack of action taken in that regard.

634. This was one of the matters I had observed personally, having watched the family deliver their press conference from the steps of the Crown Court on Thursday 25 January 2024. During that statement, it was said: “.....*It took repeated questioning from us to finally receive an answer late last Friday afternoon to the question of his outstanding warrant issued September 2022 for a vicious attack on a police officer, such a violent assault that he was tasered.....*”

635. I became aware of the outstanding warrant at a very early stage in my leadership of Operation Hendrix.

636. The earliest recorded note of my knowledge is during my first Gold Group meeting at 11:45 hours on 13 June 2023.

637. However, it is possible that I was made aware of it prior to that meeting and simply did not record it at the time.

638. During that first Gold Group meeting, I was informed by the Head of PSD Det Supt Williams, as part of agenda item six, the PSD/IOPC update, that VC was potentially wanted, having failed to appear at court in September 2022 following the execution of a s135 MHA warrant on 3 September 2021.

639. Det Supt Williams explained that she would be undertaking an investigation into the efforts made to arrest VC for the FTA warrant and confirmed that the offence related to the assault of an emergency worker (i.e. a Nottinghamshire police officer) while VC was being detained under mental health legislation by police officers.

640. She advised that these details would be included in the scoping document she had been asked to prepare. A PSD scoping exercise

involves investigators from PSD reviewing previous police contact with an individual to determine whether there has been any indication of misconduct or whether learning can be identified. I can confirm, as recorded in the minutes, that I set an action for Det Supt Williams to include the fail-to-appear warrant and the subsequent efforts to arrest VC as part of that scoping exercise.

641. I also recorded in my Gold Log that I had informed the Chief Constable of the matter relating to the warrant at 13:00 hours on 13 June 2023.
642. During the murder investigation briefing held at 18:00 hours on 14 June 2023, the SIO, Det Supt Sanders, provided attendees with information regarding the fail-to-appear warrant. I noted in my log at that time: "FTA warrant o/s – not arrested – from Sept'22." I also recorded that the SIO had briefed the group, but that he needed to understand the full sequence of events relating to the warrant, specifically why VC had not been arrested, to establish the facts and ensure the families were updated once clarity had been achieved.
643. At 10:00 hours on 15 June 2023, I attended a meeting with the FLA and the FLOs.
644. During that meeting, we discussed the need to inform the families about the warrant. It was agreed that, due to other activity taking place that day, it would not be appropriate to do so on that day. However, we were clear that this information must be shared, at the latest, before VC was charged, as the existence of the warrant would likely become public knowledge following any court appearance and I was clear that I would not wish for the families to learn things such as this from any external source. I

explained that we would need to disclose that the warrant was still outstanding and, at the very least, that there had been no recorded action taken since its issue in September 2022. Although not formally recorded at the time, I recall stating that any instruction regarding communication with the families would follow the usual established routes, namely, from the SIO via the FLA.

645. During the Gold Group meeting held at 12:00 hours on Wednesday 14 June 2023, it was noted in the actions section of the minutes that Det Supt Williams had completed the scoping exercise in relation to the fail-to-appear warrant. She reported that the warrant had been placed in the appropriate inbox for actioning but had never been acted upon. She identified that this raised issues of learning for the City Division senior management team. Although not recorded in the minutes, I recall Det Supt Williams informing me that the NPI responsible for managing that inbox had resigned from the organisation.

646. His resignation was unrelated to any matters concerning the warrant. He had joined the service as a direct entry Inspector, had not found policing to be a fulfilling career, and ultimately chose to pursue a different path.

647. The note recorded in the minutes was later supplemented by an email sent to me that evening by Det Supt Williams, which articulated this position relating to the FTA warrant in more detail. I now refer to that email chain, which had started with Det Insp Bradford, as URN: NGPF0007844.

648. The unexecuted warrant was understandably the subject of considerable discussion, both within and outside the Gold Group, in

murder investigation briefings, and more broadly across the force at the time. Although it was not formally recorded, I recall being informed, though I cannot remember when or by whom, that the officer in the case relating to the assault had been asked what action he had taken. I understood that he had requested support from other officers to arrest VC, but that this had not taken place. It is possible that I became aware of this information at a later stage, as I do not have a record of it.

649. From this point, I understood clearly that no substantive proactive action had been recorded by Nottinghamshire Police to execute the warrant, other than circulating VC as wanted on PNC and placing the warrant in the relevant tasking inbox. While I cannot entirely rule out the possibility that an officer, either serving or retired, may have proactively conducted address checks, I have not made any broader enquiry into this, and I consider it unlikely. I agreed with Det Supt Williams that this represented a systemic failure, and I subsequently asked Det Ch Supt Leona Scurr to review and address the matter.

650. During the first week after the killings, I issued a direct instruction to the SIO regarding family liaison matters, related to the disclosure of information about the outstanding warrant before or at the point of charging VC. I have already referred to this instruction briefly in paragraphs 472 and 473.

651. It is uncommon for a Gold Commander to issue instructions of this nature, because decisions about what information is shared with families during a homicide investigation fall within the remit of the SIO. However, I

retain the prerogative to do so, and in this instance, because I felt so strongly about the matter, I made the decision to issue the instruction.

652. I recorded in my Gold Log that several conversations had taken place between myself and the SIO on the afternoon of Friday 16 June 2023. During that time, I had placed pressure on the SIO to accelerate the charging decision, as I was becoming increasingly concerned about information being leaked to media outlets from within our organisation. It had become apparent that several sensitive matters had been disclosed throughout the week, including, notably, VC's visit to MI5, and that afternoon, it appeared that information about the warrant had also been leaked.

653. I was particularly concerned that if the existence of the warrant were to be revealed in the media before the families had been informed, it would undermine my clear objective of ensuring that they did not learn any details about the investigation from external sources. I had made it clear earlier in the week that the information about the warrant must be shared with the families before or at the point of charge, as there was a real risk they could otherwise hear about it during any announcement in court the following morning.

654. As I outlined in paragraph 469, considering the right time to share information with families is a challenging judgement. There is a balance to be struck between sharing information with families as early as possible, against reducing the risk of overwhelming them or compounding trauma. In my view, this was information the families needed to know that week. On the afternoon in question, there were conflicting pressures. Time was

limited, and there was growing media interest in the imminence of the story breaking.

655. I had already set a clear parameter: it should be shared no later than the point of charge, as that was when the warrant would likely become public through the court process.

656. To reduce the risk of the matter being reported in the media before the families were informed, I sought to accelerate the charging process. As part of that approach, on 16 June 2023, I instructed the SIO to direct the FLOs to inform the families about the existence of the warrant. This was to be done at the same time they were told that VC had been charged.

657. The SIO expressed understandable concern about this instruction, as it is highly unusual for a Gold Commander to direct an SIO in matters of family liaison. From my own experience as an SIO, I recognised that delivering sensitive information of this nature at such a critical point in the investigation, without the usual planning and preparation, was far from ideal. However, I weighed this against the risk of the families learning about the warrant through the media and concluded that it was the right course of action. I was later informed by Det Supt Sanders that the families had been briefed, and I recorded this in my Gold Log.

658. The next reference I made to the warrant was during a meeting held at 14:30 hours on 23 November 2023. This was a pre-Gold meeting media catch-up involving the SIO, Lyn Heath, and Matthew Jarram.

659. This meeting had been convened to discuss our communication strategy in preparation for the forthcoming criminal justice proceedings.

660. During that meeting, I noted, in my Gold log, the importance of ensuring that no information was shared with the media unless it had already been communicated to the families. Det Supt Sanders informed me that he had scheduled several meetings with the families, during which he intended to go through the timeline of previous police contact with VC. I do not recall whether I saw the timeline at that point, but I have certainly reviewed it since. It includes reference to the index offence, the service of the summons, and VC's failure to appear at court on 22 September 2022. I also noted "Info re W = shared". This was a note to myself to confirm that Det Supt Sanders updated me that information about the warrant had been shared with families.

661. I also noted my intention to be open in any media release regarding the warrant, including acknowledging that more should have been done to arrest VC. I planned to balance this by offering my professional view on the likely impact such an arrest would have had on his liberty.

662. At the time, it had been not my intention to explain to the public the specific information involved in managing that warrant, or more broadly, the failure within our warrants system. To do so would have required a detailed and potentially confusing explanation, one that included the fact that VC had been circulated as wanted on PNC, had not been stopped or checked by police in the period that followed, and that the warrant had subsequently been placed into a disorganised digital folder of outstanding work. While it appeared unlikely that any officer had actively attempted to locate VC, the condition of the system meant we could not say that with certainty.

663. I was contemplating saying that we should have done more to arrest VC, because I intended to acknowledge that our response in this area had not met the standard the public rightly expects. I will provide a full explanation of my approach and rationale regarding public communications in the media section later in this statement.
664. Later that same day on 23 November 2023, during the Gold Group meeting held at 15:30 hours, it was recorded in the minutes under agenda item 13 that all external communications were to be signed off by me. It was also noted that a draft communication was being prepared in relation to the warrant.
665. I made a further note in my Gold Log on 8 December 2023, recording that I had been informed by Det Supt Sanders that one of the scheduled family meetings had taken place the previous day, 7 December 2023, in Bristol. He explained that the meeting had involved both police and representatives from the CPS, and that the families had been taken through the timeline of previous police contact with VC, as well as aspects of his mental health history. I noted: "Minutes of meeting shared with families." It is unclear from my note whether I was referring to the minutes having already been shared or intending that they would be shared. I also recorded that Det Supt Sanders planned to brief the remaining families in the coming days.
666. On 9 January 2024, I made a note in my Gold Log during an update meeting regarding our communication strategy, which I attended with Matt Sharon and Lyn Heath. Although I did not record the time of the entry, I

know that the notes were made during the meeting itself, which, according to my calendar, commenced at 15:00 hours.

667. Within my notes, under the heading "Principles," I reiterated my intention to acknowledge publicly that we had not done enough in relation to the execution of the warrant. I also recorded my view that, while this failure should be recognised, in my assessment, VC would not have received a custodial sentence and would have been unlikely to engage meaningfully with mental health treatment.

668. On 16 January 2024, I made a note in my Gold Log indicating that I had been updated by Det Supt Sanders regarding the sharing of the prosecutor's opening note with the families. Although the log entry is untimed, I can trace its provenance to an email I received from Det Supt Sanders at 21:07 hours on 15 January 2024. Given that I was likely at home when I read the email, I believe I recorded the update in my log the following day.

669. In that email, Det Supt Sanders wrote: *"Please find attached the final version of our opening notes – case summary and legal. These also reiterate in written form many of the issues that we as a police team want to convey to the families.*

For the absence of any doubt, the families are aware that VC had a history of mental health, was known to the police and there was a warrant in existence for him for a FTA for assaulting an emergency worker (police officer). This was again reiterated by me to them in our conversations today (in addition to previous discussions – so they know)..."

670. This exhibit is referred to earlier in my statement as NGPF0007808.

671. On 18 January 2024 at 13:47 hours, Det Supt Sanders forwarded me an email originally sent to him by Det Insp Claire Gould. It contained a series of questions from one of the families, submitted via email to the FLO. I responded to Det Supt Sanders requesting the opportunity to review the email before any reply was issued, to ensure consistency with our planned media communications. I refer to this chain of emails as URN: NGPF0007822.

672. Later that day, I recall speaking with Det Supt Sanders, likely in the evening, and expressing that the questions appeared relatively straightforward and could be answered factually and simply. He advised that he would share the proposed response with me the following day, as we were scheduled to meet for a Gold Group meeting.

673. During the Gold Group meeting held at 13:15 hours on Friday, 19 January 2024, the warrant was discussed under the agenda item concerning our communications strategy. The minutes record that "ACC Griffin reviewed the issue raised with the warrant against the defendant." While I do not recall the precise wording of that conversation, my recollection is that I reiterated points previously made in earlier communications planning meetings.

674. The minutes of that meeting also reference the email from the family of Barnaby Webber (included in email chain NGPF0007822) to the SIO, which raised several questions, including one about the warrant. The minutes of the Gold Group meeting suggest that I agreed the responses to those questions in the meeting itself; however, I do not believe this is accurate. Although I recall a discussion taking place about this matter, I

also recall discussing the email later that same day during a meeting recorded in my Gold Log at 15:15 hours, where I noted: "Reply to email from Webber family." I therefore believe that I agreed the responses to the email in the later meeting, rather than in the Gold Group meeting. I refer to the final email response to Mrs Webber as URN: NGPF0002572.

675. The 15:15 hours meeting had been convened to further discuss our media communications approach. Present were Det Supt Sanders, Det Insp Claire Gould, and Matthew Jarram. During this meeting, I raised a concern about a question from Mrs Webber regarding the warrant, as I had previously been informed, on multiple occasions, that the families were already aware of its existence.

676. Det Supt Sanders confirmed that Mrs Webber had been informed. He did not say when precisely, but Det Insp Gould supported this by referencing entries in the FLO logs. Although I did not personally review the logs at the time, I was assured that the families had been informed about the warrant and that relevant entries had been made in the FLO logs.

677. I also recalled the email from 15 January 2024 from Det Supt Sanders detailed in paragraph 669, when he said, in reference to the warrant: *"..This was again reiterated by me to them in our conversations today (in addition to previous discussions – so they know)..."* This confirmed to me that the families had again been informed about the warrant during the meeting on 15 January 2024 referenced in that email, and that this had followed on from previous discussions about that same matter.

678. We concluded that Mrs Webber's question was likely a request for clarification, specifically regarding the date and the level of violence associated with VC.
679. Despite these reassurances, I remained concerned about the nature of the question, particularly the request for confirmation of the warrant's existence. I was reassured by both Det Supt Sanders and Det Insp Gould that the families had been appropriately informed, and I recorded this in my Gold Log, marking the entry to indicate the matter had been addressed.
680. Det Supt Sanders acknowledged that, on each occasion the warrant had been discussed, the families tended to shift the conversation toward matters they considered more pressing, most notably, their concerns about the Crown's acceptance of diminished responsibility and the resulting manslaughter charges. This led to a broader discussion about the families' understanding of VC's prior contact with agencies, particularly the police.
681. During this discussion, I expressed some frustration, having previously asked about the warrant and the timeline of prior incidents on several occasions and having been reassured that the information had been shared. Det Supt Sanders reiterated that the information had been shared but reminded me of the challenges involved in conveying complex information to families who are understandably focused on specific aspects of the case. He highlighted that most of the questions in the email related to VC's mental health, which I acknowledged.
682. The conversation became somewhat tense, and I reminded myself of the pressures I had faced as an SIO, particularly the expectation to ensure

all details were communicated to families. I recognised that expectations of Gold Command can sometimes be unrealistic and may not fully appreciate the sensitivity required when engaging with families during such difficult times. I also acknowledged that, following the conclusion of criminal proceedings, an inquest would likely take place, providing a further opportunity to explore these matters in greater detail, and importantly, that there would be opportunity to discuss them in fuller detail with all of the families in advance of that.

683. Det Supt Sanders confirmed that he had told families that the warrant had been outstanding since September 2022 and had not been actioned on several occasions. He stated that he had used words to the effect of, “we have not done enough to get him.” When I questioned this, he explained that he had not felt it appropriate at the time to delve into the complexities of the warrant system, the record of activity, the likely conclusions about inactivity and his circulation on PNC as being wanted. He believed his message had been sufficiently clear: VC should have been arrested but was not.

684. I asked whether my intention to publicly acknowledge that we should have done more in relation to the warrant would introduce any new information to the families. Det Supt Sanders assured me that it would not come as a surprise. Based on this, I concluded that if the existence of the warrant had been discussed with the families, it must have included some explanation as to why VC had not been arrested.

685. I also asked whether it would be helpful for me to meet with any of the families prior to the sentencing hearing to discuss these matters in more

detail. Both Det Supt Sanders and Det Insp Gould advised against this, expressing concern that such a meeting could be counterproductive. At that time, relationships between the families and the FLOs were strained, and the families were understandably focused, and in some cases angry, about the Crown's acceptance of manslaughter. Det Supt Sanders and Det Insp Gould both felt that introducing a senior officer who had not previously met with them could risk further damaging those relationships.

686. I acknowledged that it is unusual for a Gold Commander to meet directly with families, and that such engagement should only occur in exceptional circumstances. Following this discussion, I agreed that then was not the appropriate time.

687. We agreed to revisit the possibility of me meeting with the families after sentencing, if it was felt that such a meeting might be helpful. I recall discussing potential timings and suggesting that this might be something the Chief Constable would also wish to consider.

688. On the 29 of January 2024 the Chief Constable did write a letter to all families offering to meet with either her or me or both to listen to their concerns (NGPF0007810). Except for Elaine Newton this offer was not taken up.

689. I believe that some steps were taken to address the second concern, namely, the need to provide an open and transparent briefing about all circumstances relating to the warrant. I believe that the existence of the warrant and the broad headlines surrounding it, including the lack of action, were shared.

690. However, it is my view that these concerns were not adequately addressed, and we did not share sufficient information about the failure to arrest VC.

691. I think it is relevant to acknowledge the complexity involved in managing multiple families, particularly when navigating numerous, often sensitive pieces of information not only about the investigation but also about wider relevant circumstances, and the context in which this took place. The seven-month period between the offence and sentencing was relatively short, during which the families were experiencing profound grief while also having to engage with the criminal justice system. This included grappling with the complexities of mental health in the context of homicide, and more specifically, the legal implications of diminished responsibility and manslaughter. Given this, it is perhaps not surprising that the families had other matters they felt were more pressing than the warrant.

692. I also understand how difficult this was for the SIO and FLOs, who were working under considerable emotional and operational pressure. Nevertheless, I am now of the view that we should have made a more concerted effort to provide a comprehensive briefing that fully addressed the circumstances surrounding the warrant.

693. On reflection, the failure to execute the warrant was of such significance that I should have taken a more direct and intrusive approach. I had assumed that any conversation between the SIO and the bereaved families or surviving victims would naturally elicit questions and a conversation about why the warrant had not been executed. However, I now recognise that I should not have made that assumption. I should

instead have issued a clear instruction for this specific information to be shared and offered to join the SIO and FLOs in a meeting to do so.

694. By the time I realised that this information had not been fully conveyed, my offer to meet with the families and explain was too close to the sentencing hearing to be appropriate. I recognised that a better approach at that stage would be to arrange a meeting after the hearing and before any inquest.

695. On reflection, I also believe that all messages relating to the warrant should have been followed up in writing. This would have helped confirm that the information had been received and allowed for any follow-up questions, ensuring the matter was fully understood.

696. The concern in relation to the management of the warrant was referred to the IOPC on 30 January 2024 following the Gold Group meeting.

- General previous contact between police and the defendant:

697. I understood the concerns relating to previous contact between the police and VC to fall into two areas.

698. The first concerned perceived missed opportunities to intervene in a way that might have diverted VC's path and prevented the offences from being committed on 13 June 2023. These opportunities may have included arresting or prosecuting VC or sharing information with other agencies that could have enabled a more effective intervention.

699. The second related to whether the families had been fully informed about each of these prior contacts, particularly those that were relevant to the sequence of events, and whether the findings of any internal or

external reviews had been shared in a way that could help explain whether opportunities had been missed.

700. Again, I believe these two matters are closely connected. In relation to missed opportunities, any chance to intervene had, by that point, passed. This makes addressing the concern inherently difficult, as doing so would require undoing something that had occurred or taking action that had not been taken. Either scenario reflects an inadequate service. Any explanation offered is unlikely to fully resolve the concern.

701. I will address the issue of possible missed opportunities later in this statement, when I outline the reviews that were undertaken.

702. However, while missed opportunities cannot be reversed, their impact may be partially mitigated through a full and transparent explanation of each event. This is particularly important if such an explanation includes the full context: the agencies involved, the relevance of any mental health considerations and the duties on the NHS to address the same, and a detailed chronology to help contextualise each interaction. Providing this level of detail may help alleviate concerns or, at the very least, offer clarity around the appropriateness, or otherwise, of the actions taken by the police and / or other agencies.

703. The previous encounters have been subject to various reviews since June 2023 and are now under investigation by the IOPC, following a formal referral made on 30 January 2024.

704. I became aware of the previous contact between the Nottinghamshire Police and VC at an early stage in my leadership of Operation Hendrix.

705. The earliest recorded note of my knowledge regarding previous police contact with VC is found in the minutes of my second Gold Group meeting, which took place at 12:00 hours on Wednesday 14 June 2023. During the PSD update, Det Supt Williams informed me that there had been several prior interactions involving both Nottinghamshire Police and another force with VC. She cited one example in which VC had committed two assaults in Leicestershire and had not been circulated on PNC. Another example involved an incident where VC was believed to have taken someone hostage, resulting in that individual jumping from a window. No further action was taken in that case, reportedly because VC was deemed “too ill.” As I explained in paragraph 592 I now recognise that Det Supt Williams description of this incident is in fact a conflation of two separate incidents.

706. This update was provided in response to an action I had set during my first Gold Group meeting, instructing PSD to undertake a scoping exercise. Although the response was not fully articulated in the action matrix, I received an email from Det Supt Williams later that day, which I now refer to as URN: NGPF0007820, outlining the relevant incidents. During the meeting, and although not fully captured in the minutes, I recall Det Supt Williams explaining that the outcome of the scoping exercise had not identified any conduct matters, but she felt there was potential organisational learning. The minutes recorded: “It is felt that learning arising from this incident is important, i.e. with regards to a person with mental health that constantly avoids conviction but continues to reoffend.” This was the only specific incident referenced in the minutes, but I recall Det Supt Williams providing a brief analysis of several others.

707. I also recorded in my Gold Log that I had informed the Chief Constable of these other matters at 13:00 hours on 13 June 2023.
708. During the murder investigation briefing held at 18:00 hours on 14 June 2023, the SIO, Det Supt Sanders, provided a brief outline of VC's previous interactions with Nottinghamshire Police. I recorded in my Gold Log a reference to the assault of a police officer on 3 September 2021, and noted that on 28 September 2022, VC had been discharged from the Early Intervention Psychosis Team and returned to the care of his GP.
709. Within my notes, I also captured Det Supt Sanders' reference to there having been several encounters between VC, the police, and mental health services over a two to three-year period. He requested that an action be set to produce a composite timeline of those incidents and expressed his intention to take the families through that timeline at an appropriate stage in the investigation.
710. The next reference I made to previous contact was during a meeting held at 14:30 hours on 23 November 2023. This was a pre-Gold meeting media catch-up involving the SIO, Lyn Heath, and Matthew Jarram.
711. This meeting had been convened to discuss our communication strategy in preparation for the forthcoming criminal justice proceedings.
712. During that meeting, I recorded in my Gold Log the importance of ensuring that no information was released to the media unless it had first been communicated to the families. Det Supt Sanders advised that he had arranged a series of meetings with the families, during which he intended to talk them through the timeline of previous police contact with VC. While I do not recall reviewing the timeline at that point, I have since examined it

and, in my view, it accurately captures all relevant and significant interactions between the police and VC. I refer to the medical and police incident timeline as URN: NGPF0007824.

713. Later that same day, during the Gold Group meeting held at 15:30 hours, it was recorded in the minutes under agenda item 13 that all external communications were to be signed off by me.
714. On 8 December 2023, I made an entry in my Gold Log noting that Det Supt Sanders had informed me of a family meeting that had taken place the previous day, 7 December 2023, in Bristol. He explained that both police and representatives from the CPS had attended, and that the families had been taken through the timeline of prior police contact with VC, along with details of his mental health history. I recorded the phrase "Minutes of meeting shared with families," though it is unclear from my note whether I was referring to the minutes having already been distributed or intending that they would be. I also noted that Det Supt Sanders planned to brief the remaining families in the days that followed.
715. On 9 January 2024, I made an entry in my Gold Log during a meeting focused on our communication strategy, which I attended with Matt Jarram and Lyn Heath. During that meeting, I again emphasised one of the key principles guiding our approach: that no information should be made public unless it had first been shared with the families. Although I did not record the time of the entry, I am confident the notes were made during the meeting itself, which, according to my calendar, began at 15:00 hours.
716. On 16 January 2024, I made a note in my Gold Log that Det Supt Sanders had informed me the prosecution's opening note and sentencing

note had been shared with the families. In fact, he shared this update by email at 21:07hrs 15 January 2024 (NGPF0007808). It may be that I did not open or read the email and notes until the following day, hence the note on 16 January 2023.

717. The prosecution opening and sentencing notes refer to many of the previous contacts between VC and the police. I refer to the opening notes as URN: NGPF0007825, and the sentencing notes as URN: CPSE0000486.

718. I have extracted the relevant references from both the opening and sentencing notes:

- Paragraph 67: On 23 May 2020 D presented at A&E, believing he was having a heart attack. He returned to his apartment 13 hours later and knocked a door down to gain entrance to another apartment in the block: he was arrested for causing criminal damage. An assessment under the MHA in the Bridewell Custody suite by Liaison and Diversion psychiatric services concluded that he was psychotic but that the risk to others was low, and that he should be referred in the first instance to the Crisis Team for review at home, and he was released without charge.
- Paragraph 68: Upon his return to his apartment, an hour later, however, he knocked down another door to a different apartment in the block. He was arrested for criminal damage, and following a re-assessment was detained under the MHA and was admitted to inpatient psychiatric services at the Highbury Hospital on 25 May 2020. He was treated with an anti-psychotic medication and discharged on 17 June 2020 to the

care of the Nottingham City Crisis Team. He was advised to take the medication for a minimum of 6 to 9 months, and to seek medical advice if he wished to stop taking it.

- Paragraph 69: Between 14 and 31 July 2020 D was readmitted to Highbury Hospital under section 3 of the MHA following another instance of his forcing his way into a flat having stopped taking his medication. This was the third apartment in the same block to which he attempted to gain forced entry. The anti-psychotic medication was restarted and increased. Thereafter he was managed in the community by the Early Intervention in Psychosis team. His medication was increased twice.
- Paragraph 71: Elias Calocane describes how D became a student at Nottingham University, graduating in June 2022 having completed a degree in mechanical engineering. It was during the timeframe of D's degree studies that Elias became aware that D was suffering from mental health problems, believing that he was being spied on by his housemates and by MI6 and that his family was under threat.
- Paragraph 75: D subsequently evaded contact with the community team, and a section 135 MHA warrant was secured to gain entry to his property in order that an assessment could be conducted. The warrant was executed on 3 September 2021, on which occasion he assaulted a police officer. A bag of unused medication dating from February 2021 was discovered in the flat.

719. This incident is described in more detail in paragraph 67 (Vi) of the sentencing note:

- The Defendant was assessed at his flat on 3 September 2021. He assaulted a police officer using his fists, and it was necessary for a taser to be deployed to subdue him. He was admitted to inpatient services under section 2 of the MHA, where he was managed under sections 2 and 3 between September and October 2021
- Paragraph 77: In mid-January 2022 D was involved in an altercation with a flat-mate. An assessment under the MHA concluded that he could continue to be treated in the community, however he did not engage adequately with the Home Treatment Team.

720. This is described in more detail in paragraph 67 (vii) of the sentencing note:

- Following his discharge, in November and December 2021 he had limited contact with his community team, missing appointments and exhibiting paranoid and confrontational behaviour. In mid-January 2022 he assaulted a flatmate and prevented others from leaving. An MHA assessment concluded he could continue to be treated in the community, but he did not engage adequately with the team and had questionable compliance with his oral medication. Following a further assessment on 27 February (I believe this should read January) 2022 he was admitted to inpatient treatment under section 2 of the MHA, where he remained for three weeks. He refused to consider injected anti-psychotic medication and so continued to be prescribed aripiprazole. He was discharged on 24 February 2022 to the care of a community team.

721. I made notes of a meeting, which commenced at 15:15 hours 19 January 2024, that had been convened to discuss our approach to media communications. Present were Det Supt Sanders, Det Insp Claire Gould, and Matthew Jarram.
722. During that meeting we discussed the response to an e-mail that had been sent from Mrs Webber posing several questions to the FLO. This email is referred to earlier as NGPF0007822. Although I did not register it at the time, is perhaps relevant now to say that there were no questions about the previous contact between the police and VC other than in relation to the warrant which I have explained earlier in my statement.
723. During the meeting, we also discussed the previous contacts. Det Supt Sanders explained that, although he had reviewed the timeline, he had not been asked any questions about it. This did not surprise him, as the families were understandably focused on the distressing news that manslaughter was likely to be the outcome in their loved ones' case. When I asked him, he said he could not be certain that all the information about each event, and its relevance within the overall chronology, had been fully absorbed by the families.
724. I also noted that the two most recent reports to Nottinghamshire Police, prior to VC failing to appear in September 2022, did not appear in either the opening note or sentencing note. I was keen to understand whether the families were clear on the nature of those two incidents.
725. Det Supt Sanders said that he had shared the full content of the timeline which included those two incidents (on 26 April and 28 July 2022), but as he had previously explained, he could not be certain that all of the

incidents, and their full context, had been properly absorbed by the families.

726. As I have previously explained, we also explored whether it would be appropriate for me to meet with any of the families ahead of the sentencing hearing. Both Det Supt Sanders and Det Insp Gould advised against this, expressing concern that such a meeting could potentially be counterproductive. At that time, relationships between the families and the FLOs were strained, and the families were understandably focused, and in some cases deeply frustrated, by the Crown's decision to accept pleas of manslaughter on the grounds of diminished responsibility. It was felt that introducing a senior officer who had not previously engaged with the families might risk further damaging already fragile relationships.

727. I acknowledged that it is not typical for a Gold Commander to meet directly with bereaved families, and that such contact should be reserved for exceptional circumstances. Following our discussion, I agreed that it would not be appropriate to pursue a meeting at that stage.

728. We did, however, agree to revisit the possibility of a meeting after sentencing, should it be considered helpful. I recall discussing potential timings and suggesting that it might be something the Chief Constable would also wish to be involved in.

729. On 29 January 2024, the Chief Constable wrote to all families offering the opportunity to meet with her, with me, or with both of us, to listen to their concerns. Except for Elaine Newton, this offer was not taken up.

730. On my assessment, I believe that significant steps were taken to address the second part of this concern, namely the need to provide

families with information about previous contacts with VC. I believe we did provide details about those contacts and did put them into a contextual chronology.

731. However, I think it is difficult to objectively assess whether these concerns were adequately addressed because the perspective from the families is perhaps that they were not. I can see that efforts were made to inform the families and although not the purpose of the same, this was supplemented by the provision of the prosecutor's opening note and sentencing note dated 15th January 2024 to the families.

732. I have also reflected that managing communication with multiple bereaved families in the aftermath of such a serious incident presents challenges, particularly when dealing with a wide range of sensitive and complex information. This includes not only details of the investigation itself but also broader contextual matters. The period between the offence and sentencing, just seven months, was relatively short, and during that time, the families were navigating intense grief while also trying to understand and engage with the criminal justice process. A key part of that complexity was the legal framework surrounding mental health and homicide, particularly the concept of diminished responsibility and its application to manslaughter.

733. Considering these circumstances, it is understandable that the families may have prioritised other concerns over the precise detail and chronology of contact between VC and the police. I also recognise the pressure this placed on the SIO and FLO, who were working in a highly demanding and emotionally charged environment.

734. With the benefit of hindsight, we should have taken more intentional and careful steps to ensure that the families received a clear and complete account of the circumstances surrounding each previous interaction between police and VC. I say this with careful consideration of my experience both as a Gold Commander and as a former SIO. From a strategic position, it can be easy to suggest what should be shared with families and when. However, Gold Commanders do not have the same direct relationship with families that SIOs, and particularly FLOs, do. As such, I have always tried to manage my own expectations around what is reasonable and appropriately timed, and I recognise the importance of listening closely to the judgement of both the SIO and the FLA.

735. My view that more could have been done is not intended as a criticism, but rather as a reflection informed by hindsight. There is a clear distinction between making genuine efforts to share information with bereaved families and those efforts being sufficient fully to address the concerns raised. In conclusion, I would hope that the concerns relating to previous police contact were at least partially alleviated through the steps taken.

736. The matter concerning the management of the contact between the police and suspect was formally referred to the IOPC on 30 January 2024, following discussion at the Gold Group meeting.

- The report of an assault in Leicestershire in May 2023.

737. I understood the concerns raised in relation to the reported assaults in Leicestershire in May 2023 to be that this represented another potential moment where intervention with VC might have altered the course of events. Such intervention could have taken the form of arrest, prosecution,

or more effective information-sharing with partner agencies, potentially enabling a more coordinated and preventative response ahead of the tragic events of 13 June 2023.

738. I do not believe that the primary concern related to whether the families had been fully informed about the assaults in Leicestershire in May 2023, however, I felt it was important to reflect on our approach to communication in this regard. For completeness, I have considered the steps we took to inform the families and the nature of the conversations we had with them regarding this matter.

739. I can also see a clear connection between the failure to arrest VC and the informing of families of this fact. By the time concerns about the failure to arrest were being raised, the opportunity to intervene had already passed, which makes responding to them particularly challenging.

740. Addressing such concerns often involves reflecting on actions that were not taken or circumstances that cannot be changed, both of which point to shortcomings in the service provided. Any explanation offered in this context is unlikely to fully alleviate the sense of the concerns felt.

741. As I explained in paragraph 702, missed opportunities cannot be undone. However, their impact may be reduced by offering a clear and honest explanation, one that includes context, chronology, and relevant agency involvement.

742. I have not found any evidence of conversations having taken place between Nottinghamshire and Leicestershire Police regarding the May 2023 incident.

743. I have discussed this matter with colleagues, including the Chief Constable, the SIO, and the Head of Corporate Communications. It appears that each of us assumed someone else had initiated contact with colleagues in Leicestershire regarding the 13 June 2023 attacks and VC's arrest. We assumed that contact had been made because VC had been named as a suspect in an earlier incident in Kegworth in May 2023, for which he had not been arrested, and the fact that Leicestershire had not contacted Nottinghamshire at the time even though VC was circulated as wanted on a Nottinghamshire FTA warrant.

744. We now realise that that contact was not made, and it also transpired through discussion between me, the SIO, the Chief Constable, and our communications team that we had all also assumed that Leicestershire Police would have been aware of the matter through other channels. This assumption was based on the collaborative nature of major crime investigations across the East Midlands, which includes Leicestershire.

745. However, following the discussion (referenced in paragraph 743) with the SIO, Chief Constable and our communication team, we are now not sure if Leicestershire were aware of the arrest of VC for the Nottingham attacks and the relevance of the Kegworth incident. I accept responsibility for this oversight. At the very least, a Gold-to-Gold level conversation should have taken place, and I have no recollection or record of such a discussion about these matters occurring.

746. The assaults in Leicestershire in May 2023 are now subject to investigation by the IOPC, following a formal referral made by Leicestershire Police on 30 January 2024. I was informed of this during a

Gold Group meeting on that date by T/Det Supt Andy Reynolds. He advised that the referral had initially been declined on the basis that it did not meet the threshold. However, I was subsequently made aware that the IOPC had accepted the referral, and I understand that misconduct proceedings involving a number of Leicestershire officers are now underway.

747. The earliest recorded note of my awareness of the Leicestershire incident appears in the minutes of the second Gold Group meeting, held at 12:00 hours on Wednesday, 14 June 2023.

748. During the PSD update, Det Supt Williams informed me that VC had been linked to two assaults in Leicestershire approximately one month prior to the attacks on 13 June 2023. He had not been circulated as wanted for this offence on PNC.

749. This update was provided in response to an action I had set during the first Gold Group meeting, requesting PSD to carry out a scoping exercise.

750. Although the outcome was not fully captured in the action matrix, Det Supt Williams followed up with an email later that day (NGPF0007820), which outlined previous relevant incidents, including the Leicestershire assaults. In that document, she noted that officers from the Major Crime team had subsequently attended and obtained further victim accounts, which were recorded on the NICHE system.

751. The NICHE crime system is a comprehensive policing software system used by many UK police forces to manage and record operational information. It includes detailed records of reported crimes, associated investigations, custody processes, and other relevant data. In this context,

it served as the platform where victim accounts and investigative updates relating to the Leicestershire assaults were recorded and accessed by officers.

752. I also documented in my Gold Log that I had briefed the Chief Constable on these matters at 13:00 hours on 13 June 2023. I recall that our focus at the time was on both the FTA warrant and the Leicestershire incident, as they were the most recent and relevant incidents.
753. During the murder investigation briefing held at 18:00 hours on 14 June 2023, the SIO provided a summary of VC's prior interactions with policing. As he spoke about the Leicestershire assaults, I noted in my Gold Log: "2 x assaults in Leics – no action!"
754. I cannot recall exactly why I included an exclamation mark in that note, but it probably reflected my recognition of the significance of no action being taken in relation to an assault that occurred so close in time to the Nottingham attacks on 13 June 2023.
755. My notes also reflect that Det Supt Sanders set an action to compile a composite timeline of all previous incidents involving VC. He indicated his intention to share this timeline with the families at an appropriate stage in the investigation.
756. During a meeting held at 10:00 hours on Thursday, 15 June 2023 with the FLA and FLOs, I made a note in my Gold Log reflecting our discussion about the Leicestershire incident. I recall stating that the families must be informed about this matter prior to any charging decision being made in relation to the suspect.

757. Although this instruction was not formally recorded at the time, I remember making clear that any communication with the families should follow the established protocols, namely, that direction would come from the SIO via the FLA.
758. As described earlier in my statement at paragraph 652, on 16 June 2023, I discussed concerns with the SIO about potential media leaks and the importance of informing families about the warrant before any public disclosure. Although this direction was unusual, I felt it necessary to protect the families from learning sensitive and potentially upsetting details through external sources. The families were subsequently briefed, and I recorded this in my Gold Log.
759. Although I did not record it in my Gold Log, I recall, as part of that discussion, we also discussed the Leicestershire incident, during which I reiterated my view that the families should be informed prior to any charging decision. The SIO did not share this view, explaining that there had been no evidence of information leaks in relation to the Leicestershire (Kegworth) assaults, and that those Leicestershire assaults would not be referenced in the upcoming court hearing in any event, as they were not part of the charges. He felt that delaying disclosure of the Leicestershire assaults to the families would allow for a more considered and sensitive approach, which as explained earlier, would have been his preferred approach in relation to the FTA warrant.
760. Having reflected on his reasoning, I agreed, and concluded that the same urgency applied to the warrant did not extend to the Leicestershire incident. I agreed that unlike the warrant, details of the Leicestershire

assaults were unlikely to reach the families through external sources. I therefore agreed that this distressing information should be shared in the usual way, through a face-to-face conversation, once the Senior Investigating Officer and FLOs had had sufficient time to prepare and consider the best approach.

761. As previously outlined, I consistently emphasised the principle that no information should be shared publicly before it had been communicated to the families. I believe that this was evident in my handling of the warrant and previous contacts with VC, where I took steps to ensure the families were briefed ahead of any potential media coverage.

762. In the meetings and notes previously described, I consistently emphasised the importance of sensitive and timely communication with families, particularly in relation to the timeline of prior police contact with the suspect. I was reassured that the families had been taken through this timeline, which I later reviewed and believe accurately reflects all significant interactions.

763. While I do not recall making a specific note about the Leicestershire incident during this period, I regularly discussed our management of previous contact with VC, and the Leicestershire assaults were included within the timeline we produced.

764. On 16 January 2024, I recorded in my Gold Log that Det Supt Sanders had informed me that the prosecution's opening and sentencing notes had been shared with the families. Although the update was sent by email at 21:07 hours on 15 January 2024, it is likely I did not read it until the following day, which explains the timing of my entry.

765. I have already referred to this email as NGPF0007808. The prosecution opening and sentencing notes refer to many of the previous contacts between VC and the police. I have already referred to the opening note as NGPF0007825 and the sentencing note as CPSE0000486.

766. I have extracted the relevant reference from the opening note:

- Paragraph 83: On 1 May 2023 D started working in the Avarto Warehouse in Kegworth. On 5 May 2023 D attacked two employees. Following that incident efforts were made to contact D to tell him that he was not allowed back on the premises, but D never answered.

767. I have previously described the meetings and notes relating to our communication strategy and the timeline of prior contact with the suspect. On 19 January 2024, during a media planning meeting with Det Supt Sanders, Det Insp Gould, and Matthew Jarram, we revisited these issues. Det Supt Sanders noted that while the timeline had been shared with families, they had not asked questions, understandably, given their focus on the distressing news that manslaughter pleas had been accepted. He could not be certain that all details had been fully absorbed by the families.

768. We also discussed whether it would be appropriate for me to meet with the families ahead of sentencing. Both Det Supt Sanders and Det Insp Gould had advised against this, and as I have previously explained earlier in my statement at paragraph 507, I agreed that such contact would not be appropriate at that stage, though we left open the possibility of a meeting after sentencing.

769. I do not recall making a specific note about the Leicestershire incident during this period, but I regularly discussed our handling of previous contact with VC, and the incident was included in the timeline we produced.
770. On 29 January 2024, the Chief Constable wrote to all families offering the opportunity to meet with her, with me, or with both of us, to listen to their concerns. Except for Elaine Newton, this offer was not taken up. The Chief Constable and I met with Mrs Newton on 22 February 2024.
771. I have not seen any correspondence between Leicestershire Police and the families following 30 January 2024 and therefore cannot comment on any steps taken to address concerns since that date.
772. In my assessment, efforts were made to ensure that the families were informed about the Leicestershire incidents and their place within the broader chronology of police contact. This was primarily through verbal briefings, supported by the prosecution's opening note.
773. I believe the absence of clear dialogue between Nottinghamshire and Leicestershire Police in relation to the Leicestershire assaults was unhelpful and, in my view, contributed to delays in addressing the understandable concerns that the families had about the Leicestershire assaults.
774. Given that misconduct proceedings against the Leicestershire officers remain ongoing, and are of significant interest to the families, it seems reasonable to conclude that their concerns about this incident cannot be fully resolved until those proceedings are concluded.
- The investigation:

i. Toxicology

775. I understood that the issue relating to toxicology was a matter specifically raised by Dr Kumar. I understand that he had been concerned that intimate samples had not been taken from VC whilst he was in custody and because of this an opportunity had been missed to fully inform the assessments made later by psychiatrists when they were considering the prospect of diminished responsibility as a defence. I also understand that the concern extended to a perceived failure to take non intimate hair root samples, on the basis that these could accurately inform drug use.

776. The only written note that I have made in relation to this concern was on 8 December 2023 when Det Supt Sanders provided me with an update of a family meeting that had taken place the previous day. The note is not timed although it is dated. This written note is contained in my Gold Log (NGPF0007787) at page 21.

777. In that note I can see that I was updated that Mr Kumar had raised toxicology as an issue with the SIO and the CPS. I also noted "written response provided". I am not sure whether that meant that a written response had been provided or that a written response would be provided.

778. I do not have any further records of any conversations relating to toxicology in my Gold log nor in the minutes of my Gold Group meetings, until it was identified to me as a concern in the Gold Group meeting on 30 January 2024.

779. I was however alerted to this concern again via an e-mail sent to me at 21:45 hours 16 January 2024 from Det Supt Sanders. I refer to the entire e-mail exchange as URN: NGPF0007826.
780. The first e-mail at 21:45 hours on that day provided me with a chain of emails that had begun with one of the FLOs DC Gill Cutts, sending a note to Dr Kumar and Mrs O'Malley Kumar outlining forensic samples that had been taken from VC.
781. Included within the chain is a response from Dr Kumar, which is addressed to both FLOs for their family (DC Cutts and DC McVey), Samantha Shallow from the CPS, and Mr and Mrs Webber.
782. In his e-mail Mr Kumar expresses strong concern that non-intimate hair samples were not taken from VC in a serious case involving multiple homicides. He argues that such samples could have provided accurate evidence of drug use, which may have impacted the legal assessment of diminished responsibility. He also urges reconsideration of this decision, noting that hair sampling is still possible and could yield valuable forensic insight.
783. Mr Webber expressed surprise that potential drug use by VC had not been investigated more thoroughly, referencing media reports suggesting VC was evicted for drug use in 2022. He criticised the reliance on VC's own denial and cited a Daily Mail article as evidence.
784. Det Supt Sanders expressed strong frustration in his email to me (NGPF0007826), stating that he believed the views being circulated were factually incorrect. He shared a draft response and asked for my feedback. I replied that I would review the emails properly the following morning, and

I recall speaking with him by telephone on that morning. During that conversation, I accepted that decisions like this are exclusively for the SIO to make and not the Gold Commander, although we had not previously discussed the matter.

785. I counselled Det Supt Sanders against taking these emails as a direct criticism of either him or the investigation. I suggested that, given the profound grief and frustration felt by the families, particularly considering the Crown's decision to accept pleas of manslaughter, it was understandable that they might be seeking any avenue to challenge that outcome. I advised that while it was entirely appropriate to rebut suggestions that were not lawful, viable, or appropriate, the tone of the response should be measured and sensitive to the families' circumstances.

786. I thought it might be helpful to the Inquiry to explain the position regarding the taking of intimate and non-intimate samples from a person detained in custody. Intimate samples include blood, semen, urine, pubic hair, dental impressions, and swabs taken from any body orifice other than the mouth. These require authorisation from a police officer of at least the rank of Inspector, and the consent of the detained person. Without that consent, the sample cannot be taken.

787. It was my understanding that VC had refused to give consent, which meant that intimate samples could not be obtained.

788. Non-intimate samples, such as hair (excluding pubic hair), saliva, or fingerprints, are treated differently. If a person is detained for a recordable

offence, which includes murder, consent is not required to take non-intimate samples.

789. I believe that the subject of hair sampling is a complex one and is therefore not straightforward.

790. I fully understood Dr Kumar's perspective reflecting that hair samples can detect a range of illicit substances and provide approximate timelines of use, which could have been relevant to understanding VC's mental deterioration. I also reflected that, had the sample indicated long-term use of substances such as cocaine or certain forms of cannabis, known to influence or trigger psychosis, it might have added context.

791. However, I balanced this against the absence of any information, intelligence, or evidence suggesting VC used drugs. Det Supt Sanders confirmed this, explaining that he had reviewed all available material. He confirmed that there had been no drug residue or paraphernalia recovered during any of the searches. In that context, the decision to pursue hair sampling could be seen as speculative. While SIOs are trained to think laterally, they are also expected to base decisions on evidence.

792. I reviewed the referenced media article in Dr Kumar's email, which in my opinion did not clearly confirm drug use and presented conflicting accounts.

793. I also considered, as a further element to the balancing exercise, whether, in the absence of any indication of drug use, it would have been proportionate to use reasonable force to obtain a sample, in the event that VC refused his consent, such as physically restraining VC to remove hair. I concluded that such action would have been difficult to justify.

794. Additionally, and based on information from a forensic scientist consulted by Det Supt Sanders, I understood that hair sampling is an inexact science. I opined that this position would be exaggerated further if it were to be conducted months after the relevant period, as was now being suggested. Given that the sample would have been taken seven months after the incident, I agreed it would not be appropriate to do at that point.
795. I advised Det Supt Sanders to clearly explain his decision-making and rationale to Dr Kumar.
796. At 11:21 hours, 17 January 2024 Det Supt Sanders shared with me a copy of the final e-mail reply that he had already sent.
797. In that email, he explained that a forensic strategy was developed at the outset of the investigation and reviewed throughout in consultation with a Senior Crime Scene Co-ordinator and forensic scientists from Cellmark.
798. He also explained that details of the samples obtained, both intimate and non-intimate, had been shared with Mr Kumar by email on 9 December 2023, and discussed during the family meeting in Bristol, and subsequently re-sent on 15 December 2023.
799. He said he remained confident in the forensic approach taken, which was proportionate and informed by expert advice, and that the only means of obtaining a contemporaneous result would have been through blood or urine samples. VC, having received legal advice, declined to provide these, which was his right.
800. Det Supt Sanders acknowledged that whilst hair sampling is sometimes considered in other contexts, it was not a standard fallback in

these circumstances, and that national data supported this position. Moreover, taking a hair sample at the point of arrest would not have provided a reliable indication of drug use at that time, due to the biological delay in drug incorporation into hair.

801. Det Supt Sanders explained that, given the absence of any evidence of drug use from friends, family, associates, medical professionals, or previous agency contact, there were no reasonable grounds to pursue this line of inquiry. Even if a sample had been taken later, interpretation would have been complicated by potential contamination and the limitations of hair analysis in establishing precise timing of use.

802. Det Supt Sanders provided reassurance that the investigation did not rely solely on VC's account, and that all decisions had been based on the totality of verified information available.

803. The concerns raised by Dr Kumar, and later echoed by other family members, regarding toxicology are clearly deeply held and appear closely connected to the wider distress surrounding the Crown's acceptance of pleas to manslaughter on the grounds of diminished responsibility. Thorough steps have been taken to provide a full and transparent explanation of the rationale for not pursuing hair sampling, to address these concerns.

804. However, I do recognise that, given the strength of feeling and the context in which these concerns have arisen, such explanations have not fully alleviated the sense of frustration or address the depth of emotion involved.

ii. Searching / location of Slazenger bag:

805. This concern was briefly raised during the Gold Group meeting on 30 January 2024 by Det Supt Sanders, likely prompted by my request for attendees to reflect on any issues raised by families or reported in the media over the preceding weekend.
806. Specifically, the concern related to VC's possession of two bags, a small rucksack and a larger Slazenger sports bag, when travelling from London to Nottingham. I was aware that the sports bag had never been found by our investigation.
807. Det Supt Sanders had previously informed me that this issue had been raised during his meetings with the families, and it was my understanding that he had provided a full explanation of the addresses that police had searched and the reasons why the bag had not been recovered.
808. I believe the likely reason is that VC discarded the bag at some point between leaving the tram and arriving on Zulu Road. This area is densely populated, with terraced houses, alleyways, and bins lining the street. If the bag was deposited there, it would have been very difficult to locate, especially given the limited CCTV coverage of VC's movements in that area to inform any searches. The environment and lack of surveillance made it highly unlikely that the exact location of the bag could be identified.
809. I was aware that during at least one family meeting Det Supt Sanders had taken the families through the timeline of events over 12 and 13 June 2023 and as part of that had explained the background to not finding the Slazenger sports bag.

810. The timeline of events over 12 and 13 June 2023, which I refer to as URN: NGPF0007827, shows VC boarding an East Midlands train at St Pancras Station at 21:29 hours on 12 June 2023, arriving at Nottingham Station at 23:55 hours. He later walks towards Radford Road via Wilkinson Street at 00:23 hours. On each occasion, CCTV footage shows him clearly carrying the Slazenger bag. However, by 01:17 hours, as he is seen walking on Zulu Road towards Chard Street, the bag is no longer visible. His location between those two times is not known.

811. It may be for this reason that I did not record the concern in my Gold Log, as I understood it had already been addressed through previous briefings and investigative updates.

iii. General family updates:

812. The concern relating to “general family updates” was briefly raised during the Gold Group meeting on 30 January 2024, prompted by reflections shared by the FLA following media interviews that had been given by some of the families over the preceding weekend. Neither the FLA, the SIO, nor I fully understood the nature of this concern beyond what was mentioned during the Gold Group meeting itself about the other specific concerns relating to updates on specific matters.

813. As described later in my statement, the family liaison structure included comprehensive logs maintained by each FLO, detailing their contact with and updates provided to families. These were supplemented by a central log kept by the FLA, who coordinated the overall approach to family engagement.

814. I was surprised to hear that concerns had been raised about the general provision of updates. Since the referral to the IOPC on 30 January 2024, we have not been able to explore these concerns further with the families, which has limited our ability to respond to and address them directly.

- iv. A lack of what families perceive to be adequate referrals in terms of support:

815. Similarly, concerns regarding the adequacy of referrals for support were noted by the FLA as having been raised in family media interviews over the preceding weekend. This issue had never previously been brought to my attention, nor had it been raised in any formal or informal communication. As such, I had no record of any concerns being expressed in this regard and am not clear what these concerns are.

816. Until the final few weeks leading up to the sentencing hearing in January 2024, during which I acknowledge the relationship with the FLA became somewhat strained, the feedback I received via the SIO consistently reflected an apparently constructive and cooperative relationship between the FLOs and the families. Reports indicated that the support provided to families had not only met expectations but had been positively received by the families.

817. Since the referral to the IOPC on 30 January 2024, we have not been able to explore these concerns further with the families, which has limited our ability to respond to and address them directly.

- The prosecution:

- v. The concept of diminished responsibility:

818. I understood this concern related to the provision of an explanation of the meaning of diminished responsibility and that some families had not fully understood the significance to the case of the conclusions reached by the first defence psychiatric expert.
819. I was first formally notified that diminished responsibility was being considered as a realistic prospect on 9 October 2023, when the SIO informed me that the CPS had received a report from a defence-appointed psychiatrist raising this issue. In response, the CPS had begun the process of instructing their own psychiatric expert. I recorded this update in my Gold log on the same day, noting also that the families had been updated by the FLOs, and that the PTPH had been rescheduled to 28 November 2023.
820. On 23 November 2023, during a media planning meeting held at 14:30 hours, Det Supt Sanders informed me that the families were increasingly concerned about the possibility of a diminished responsibility finding and the implications this could have for the outcome of the case. I made a note of this in my Gold log.
821. Further, on 26 November 2023, I recorded an update from Det Supt Sanders indicating that the CPS had acknowledged the families' concerns regarding the psychiatric evidence and were reviewing the matter. Subsequently, on 28 November 2023, I noted that the CPS had agreed to commission an additional psychiatric report, resulting in the adjournment of court proceedings to 16 January 2024.
822. On 8 December 2023, I was informed by Det Supt Sanders of a meeting held the previous day (7 December), attended jointly by the police

and CPS, involving some of the families. I noted that during this meeting, there was significant challenge from the families regarding the psychiatric evidence, the issue of diminished responsibility, and the acceptance of a manslaughter plea. The families expressed clearly that they considered a murder conviction to be the only acceptable outcome.

823. On 18 December 2023, I was updated by Det Supt Sanders that the CPS had prepared letters for the families, formally notifying them of the Crown's acceptance of the manslaughter pleas. A plan was in place for these letters to be delivered via the FLOs.

824. On 20 December 2023, I recorded a further update from Det Supt Sanders noting that the Webber and O'Malley-Kumar families remained very unhappy with the decision to accept the manslaughter pleas. They had expressed intentions to meet with government ministers in the new year and to consult with legal counsel to challenge the decision. I also noted that the CPS had offered a further meeting to the families.

825. I am aware that several meetings took place between the families and representatives from the CPS, the SIO, FLOs, and, on occasion, Crown Counsel. These meetings were convened specifically to explain the CPS's position regarding diminished responsibility. I did not attend any of these meetings personally. Leading counsel Kharim Khalil KC was present in these meetings on (at least) 24 November 2023 and also 28 November 2023.

826. It was my understanding that considerable efforts were made to provide the families with information and context around the issue of diminished responsibility. I was informed that this included a briefing on 24

November 2023 delivered by Samantha Shallow, Head of the CPS Complex Case Unit, including a further explanation from Karim Khalil KC. I understood that these discussions were supplemented by written correspondence.

827. I later read His Majesty's Crown Prosecution Service Inspectorate ("HMCPsi") report of CPS actions in the VC case dated March 2024 – which I refer to as URN: NGPF0007828.

828. An analysis of the approach to explaining the concept of diminished responsibility is contained within pages 69-79 of that HMCPsi report, where the joint CPS and FLO approach prior to the first CPS meeting on 24 November 2023 is explained.

829. I have not repeated the whole of that section, but I summarise that section as follows:

830. The HMCPsi report explains that on 2 October 2023, the CPS received the first psychiatric expert report commissioned by the defence. On the same day, the FLO supporting Grace's parents updated the reviewing lawyer on the position of both Barnaby and Grace's families. It described how the CPS was informed that neither set of parents intended to attend the PTPH scheduled for 31 October 2023, as they felt unable to hear the details of the incident at that stage. The report noted that the FLO had advised that a meeting with the CPS after the PTPH would be more appropriate, as more information would be available by then, including any defences raised.

831. The HMCPsi report further explained how on 3 October 2023, the FLO for Grace's parents had informed them that the defence psychiatric expert

had raised the partial defence of diminished responsibility. Barnaby's parents were informed of this conclusion by their FLO on 4 October 2023, and Ian's son was informed by his FLO on 9 October 2023. All were advised that the CPS would now be instructing its own psychiatric expert. They were later informed that the PTPH had been rescheduled to 28 November 2023 to allow time for this further assessment.

832. The HMCPSI report says that later on 9 October 2023, Barnaby's father asked his FLO for clarification on what a partial defence of diminished responsibility meant. The review felt that this indicated that he did not yet fully understand the potential implications of such a defence for the outcome of the case. On 7 November 2023, Barnaby's mother raised the issue again with her FLO, seeking further explanation. It was evident that Barnaby's parents remained unclear about the significance of the defence and what might occur at the PTPH. Barnaby's mother subsequently requested, via the FLO, a meeting with the CPS to gain a clearer understanding.

833. The HMCPSI report stated that the FLO logs from 9 October 2023 record that Ian's son acknowledged the information provided, and indicated he was content to meet with the FLO and prosecution team at the PTPH for a further update.

834. Also, that on 24 November 2023, the CPS prosecution team met virtually with Barnaby and Grace's parents and informed them that the CPS would be accepting pleas to manslaughter on the grounds of diminished responsibility. Ian's son was informed of this decision by his FLO via telephone. The HMCPSI report said that during a meeting

between the Inspectorate and all bereaved families on 9 February 2024, they expressed that they had felt shocked and unprepared for the decision. This suggested that, up until the 24 November 2023 meeting, the significance of the defence psychiatric report received on 2 October 2023 had not been fully understood by the families.

835. The HMCPSI report found that the CPS did not provide specific guidance to the police on how to inform the bereaved families about the partial defence of diminished responsibility when the issue first arose on 2 October 2023. It concluded that, it is possible that, had the CPS provided suggested wording or guidance, this might have helped the families better understand the implications of the defence at an earlier stage. The inspectorate was unable to determine from the case records why, following Barnaby's father's request for clarification on 9 October 2023, the CPS was not contacted by the FLO.

836. The HMCPSI report commented that following Barnaby's mother's request for a meeting on 7 November 2023, the FLO informed the reviewing lawyer on 13 November 2023. The request was for a meeting with the CPS and counsel, ideally before the PTPH, so that Barnaby's parents could fully understand the partial defence and the potential outcomes of the hearing on 28 November 2023.

837. The HMCPSI report noted that the reviewing lawyer anticipated receiving the first prosecution psychiatric report by 22 November 2023 and sought to arrange a conference with prosecution counsel shortly thereafter. An email exchange followed between the CPS and the FLOs for Barnaby and Grace's parents to arrange a meeting before the PTPH. A

date of 24 November 2023 was agreed, based on the families' preference for a joint meeting.

838. The CPS prepared an agenda for the meeting, which was shared with Barnaby and Grace's parents by the FLOs on 23 November 2023. On the same day, the CPS, prosecution counsel, and police met and concluded that, considering the conclusions of two psychiatric experts, the defence of diminished responsibility was available and that pleas to manslaughter would be accepted.

839. The HMCPSI report described how the virtual meeting on 24 November 2023 was attended by Barnaby and Grace's parents, a family supporter, leading and junior counsel for the Crown, the reviewing CPS lawyer, the Senior District Crown Prosecutor ("SDCP"), the SIO, a FLA, and the FLOs. During the meeting, leading counsel explained the legal test for diminished responsibility.

840. The HMCPSI report found that there is no evidence that Ian's family was informed that a meeting was taking place on 24 November 2023 or that they were invited to attend. The only reference to Ian's family in this context is an email dated 22 November 2023, in which the Deputy Chief Prosecutor ("DCP") noted that the SIO had advised that Ian's sons did not wish to meet with the CPS specifically, but had requested a meeting with the SIO.

841. The HMCPSI report also found that there was no record in the logs to suggest that the FLO discussed the CPS offer of a meeting with Ian's sons between the first Crown Court hearing on 20 June 2023, when they met the reviewing lawyer and junior counsel, and 24 November 2023, when

Ian's son was informed by phone that the CPS was likely to accept pleas to manslaughter.

842. However, on 14 November 2023, the FLO contacted Ian Coates' son to advise that the prosecution psychiatric report would be completed the following week and that she would provide an update. She also offered a meeting with the SIO after the PTPH and asked him to coordinate with his brothers to identify suitable dates.

843. The HMCPSI report notes that on 21 November 2023, the FLO confirmed that the hearing on 28 November 2023 would proceed and again discussed a meeting with the SIO. Ian's son expressed interest in meeting the SIO, and on 23 November 2023 it was agreed that this would take place after the PTPH.

844. The HMCPSI report said that by this point, the CPS meeting with Barnaby and Grace's parents had already been arranged, but there is no record of this being communicated to Ian's family.

845. The HMCPSI report said that when they met with Ian's sons and the other bereaved families on 9 February 2024, Ian's son told them that had he known about the meeting on 24 November 2023, he would have wished to attend.

846. The HMCPSI report recommended that, where meetings are arranged with one or more bereaved families, the CPS should, where appropriate, ensure that other bereaved families are informed, via their FLOs, about the purpose of the meeting and the issues to be discussed. This approach would help families to make informed decisions about whether they wish to

attend and reduce the risk of any family later feeling that they were not given sufficient information to make that choice.

847. Prior to reading the HMCSI report, I was not aware of the specific timings of conversations between the FLOs, the families, and the CPS. I understand that these timings were taken from FLO and CPS logs. I also understand that the review did not include interviews with any of the FLOs or the FLA.

848. The explanation of diminished responsibility was, understandably, extremely difficult for the families to receive. Their response was shaped not only by the emotional weight and distress of the situation, but also by their strongly held belief that the psychiatric assessments were flawed. The news came as a significant shock, because it was their perception that the possibility of a diminished responsibility defence had not previously been clearly introduced to them, and they had not fully understood the concept or its potential impact on the outcome of the case.

849. I have personally seen several media interviews in which family members continue to express these concerns. Based on this, I believe it is reasonable to conclude that, despite the efforts made by Nottinghamshire Police and the CPS to explain and address the issue, the families' concerns have not been resolved.

vi. Consultation about murder vs manslaughter:

850. I understood this concern to be inextricably linked to the matters I have just addressed relating to diminished responsibility.

851. I understood the families disagreed with the CPS acceptance of psychiatric evidence, which ultimately informed the CPS decision to accept

a plea of guilty to manslaughter on the grounds of diminished responsibility, rather than pursue a conviction for murder. I understood one of the key issues to be that the families had not felt as if they had been adequately consulted on this decision.

852. A related concern involved the toxicology findings, which I have addressed earlier. A further associated concern related to the absence of a contemporaneous mental health assessment, both during VC's time in custody and in relation to the subsequent examinations conducted by forensic psychiatrists.

853. In my role as Gold Commander, I was not, nor would expect to be, present for any of the discussions that took place on this subject.

854. As previously noted, on 26 November 2023, I recorded an update from Det Supt Sanders indicating that the CPS had acknowledged the concerns raised by the families regarding the psychiatric evidence and were actively reviewing the matter. Following this, on 28 November 2023, I noted that the CPS had agreed to commission an additional psychiatric report. This decision led to the adjournment of the court proceedings, which were rescheduled to 16 January 2024 to allow time for the further assessment to be completed.

855. I made a note on 18 December 2023 that the CPS had by this time accepted guilty pleas to manslaughter based on diminished responsibility and that they had prepared letters for the families to explain this which would be provided to them by the FLOs the following day.

856. On 20 December 2023 Det Supt Sanders informed me that some of the families were profoundly unhappy with this decision and that the CPS had offered further meetings.

857. On 8 January 2024 I noted (in my Gold log) an update from Det Supt Sanders that the PTPH had been moved from 16 January to 23 January 2024 and also that a meeting had been planned with the Webber and O'Malley Kumar families for the 15 January 2024.

858. In the HMCPSI report, an analysis of the decision to accept pleas to manslaughter and of consultation with families after the first CPS meeting of 24 November 2023 is included within pages 80-98.

859. I summarise that section as follows:

860. The HMCPSI report explained that the bereaved families felt that the CPS's decision to accept guilty pleas to manslaughter had been made too quickly. Barnaby's parents described feeling "railroaded" by the process. Alongside Grace's parents and Ian's son, they voiced strong feelings of anger at the suggestion that they had been consulted about the decision. They were clear in stating that, rather than being involved in a consultative process, they were informed that a decision had already been made, which they described as a "fait accompli."

861. The HMCPSI report said It is entirely understandable that the decision to accept pleas to manslaughter, particularly in the context of such devastating and traumatic loss, was deeply distressing for the families. Regardless of when the decision was made or communicated, it was always likely to be extremely difficult for them to hear. However, they had been informed by the families that their distress was compounded by the

perception that they had been led to believe, up to that point, that the offender would be convicted of murder.

862. The HMCPSI report reaffirmed that it is regrettable that the families were only informed of the CPS's intention to accept manslaughter pleas four days before the PTPH. However, the timing of the decision was dictated by when the CPS received its first psychiatric expert report. Prior to receiving that report, the CPS could not make or communicate any decision regarding the acceptance of pleas. Once the report was received, and considering its conclusions, there were no grounds to delay the decision further.

863. The HMCPSI report stated that the CPS could not formally instruct its own psychiatric expert until the defence had served their report, as it is for the defence to first raise any medical issue that may affect a defendant's ability to enter pleas, stand trial, or present a defence. Until such a report is served, the prosecution cannot know whether a medical issue exists that would require expert assessment.

864. In this case, the HMCPSI report explained, the defence served their psychiatric report later than originally directed. A court order made on 20 June 2023 required the defence to serve their report by 15 September 2023. On 20 September 2023, the defence requested an extension to 29 September 2023, which was granted. A further extension to 2 October 2023 was then requested and approved.

865. Following receipt of the defence report, the CPS formally instructed its first psychiatric expert Professor Blackwood on 4 October 2023. Professor Blackwood interviewed VC on 14 November 2023. Given the expert's

existing commitments and the logistical challenges caused by VC's transfer between establishments, this timeline was not considered unreasonable. The CPS received Professor Blackwood's report on 21 November 2023, which concurred with the defence expert's conclusion that the partial defence of diminished responsibility was available in relation to all three murder charges.

866. The HMCPSI report articulates how, on the morning of 24 November 2023, just as the CPS was preparing to meet with Barnaby and Grace's parents, a second psychiatric report from the defence was received from Dr Shaffiullha. This report also supported the availability of the partial defence. With all three experts now in agreement, the HMCPSI report explains how the CPS concluded that there was no longer a realistic prospect of securing convictions for murder and decided to accept guilty pleas to manslaughter and attempted murder. The HMCPSI report stated that this decision was communicated to Barnaby and Grace's parents during the meeting.

867. The HMCPSI report also concluded that at the same time, Ian's partner and sons were informed of the CPS decision by their FLOs via telephone. The surviving victims were also contacted and updated.

868. The HMCPSI report describes how, in the days following the meeting, Barnaby and Grace's parents raised concerns about the decision. In response, the CPS commissioned a second psychiatric expert to provide an additional opinion, Dr Latham. The HMCPSI report explained that, at the PTPH on 28 November 2023, the prosecution did not accept the guilty pleas and informed the court that a further expert report had been

commissioned. The court directed that the report be served by 15 December 2023, and that the CPS confirmed its position by 22 December 2023.

869. The HMCPSI report goes on to describe that immediately after the PTPH on 28 November 2023, a meeting was held with Grace's parents, Ian's partner and sons, their FLOs, the SIO, the reviewing lawyer, the SDCP, and leading prosecution counsel. Following this meeting, the SDCP confirmed that the CPS would meet again with the families to explain the psychiatric reports in more detail, once they had had time to process the information shared.

870. The HMCPSI report details how the SIO later advised that Barnaby and Grace's parents had cancelled meetings scheduled for 30 November and 1 December 2023, indicating they needed more time to reflect on the developments at the PTPH.

871. The HMCPSI report details a further meeting was held on 7 December 2023 at Avon and Somerset Police Headquarters in Bristol with Barnaby and Grace's parents, the SDCP, the SIO, their FLOs, and the officer responsible for collating CCTV evidence. The HMCPSI report stated that meeting notes indicate that the SDCP clearly communicated that the CPS did not expect the second prosecution psychiatric expert's report to differ from the conclusions of the previous three reports, thereby preparing the families for the likelihood that the pleas to manslaughter would be accepted.

872. The CPS received their second prosecution psychiatric report from Dr Latham on 13 December 2023, which confirmed the conclusions of the

previous psychiatrists. The FLOs discussed the findings with Barnaby and Grace's parents on 13 December. The FLO for the Coates family was joined by Det Supt Sanders to discuss the findings with two of Ian's sons on 17 December 2023. During these discussions, the families were advised that the CPS was now expected to accept the guilty pleas to manslaughter.

873. The HMCPSI report explains that the final decision to accept the pleas was made by the CPS on 17 December 2023, over three weeks after the families were first informed that this was likely.

874. While the families felt the decision had been made too quickly, the HMCPSI report found that the CPS made its initial decision within three days of receiving its first psychiatric expert report. Prior to that, it could not make such a determination. It concluded that having listened to the families' concerns, the CPS delayed finalising the decision until a second expert report had been commissioned and received, ensuring that the decision was made with the fullest available information.

875. The HMCPSI report analysed the use of the word "consult" and found that the CPS used the term "consult" on several occasions when referring to its engagement with the families around legal decision-making in this case. It was also used by the prosecution during its opening address to the judge at the sentencing hearing. It also appeared in communications between the CPS and the police, where the CPS indicated that it would delay its decision to accept guilty pleas in order to allow further time to consult with the bereaved families. Additionally, FLO logs dated 27

November 2023 show that the term was used by the FLOs supporting Grace's parents and Ian's son.

876. The HMCPSI report found the use of the word "consult" may have contributed to a misunderstanding of the CPS's role and obligations. It said that while the CPS must ensure that victims and bereaved families are kept informed and provided with explanations, there is no legal obligation to consult them when decisions are made based on the evidential test set out in the Code for Crown Prosecutors. The use of the term "consult" in this context may have inadvertently led families to believe they would be actively involved in the decision-making process, which was not the case.

877. Any conversation relating to the acceptance of guilty pleas to manslaughter, based on diminished responsibility rather than the prospect of a murder conviction, was understandably extremely difficult for the bereaved families to receive. Their response was shaped not only by the profound emotional impact and frustration of the situation, but also by their firmly held belief that the approach to toxicology during VC's time in custody was flawed, and that the psychiatric assessments conducted by multiple experts were inadequate.

878. These concerns were further compounded by the families' perception that the decision had been made hastily, that they had not been properly consulted, and that they had not been forewarned that this outcome was a possibility.

879. I have personally seen several media interviews in which family members continue to express these concerns. Based on this, I believe it is

reasonable to conclude that, despite the efforts made to explain and address the issue, the families' concerns remain unresolved.

vii. Disclosure of psychiatric reports:

880. I understood this concern to related to a request from the O'Malley Kumar and Webber families for access to the psychiatric reports. I was aware that this request had been declined by the CPS, but I do not have knowledge of any specific steps the CPS may have taken to respond to or address the family's concerns. I am also not aware of whether any explanation for the decision was provided to the family, either verbally or in writing.

881. Although the reports themselves were not shared with the family, I understand that the FLOs did discuss the content of the reports with the families in some detail. However, I am not in a position to say whether the CPS's decision not to release the reports, or the FLOs' efforts to explain their contents, were sufficient in addressing the family's concerns.

viii. Sentencing:

882. I understood this concern to relate to the families deep frustration and distress regarding the outcome of the criminal proceedings. Specifically, their concern centred on the fact that VC was not convicted of murder and did not receive a life sentence with a whole life tariff. Instead, the court imposed a hospital order following a conviction for manslaughter, reflecting the findings in relation to VC's mental health.

883. I do recall one family member saying during a media interview that VC had made a mockery of the system and "he's got away with murder".

884. I do not know about any discussions that may have taken place between the CPS and the families in relation to this issue. Likewise, I am not aware of any measures that may have been taken to respond to or ease the concerns raised by the families. Therefore, I am not in a position to assess whether those concerns have been sufficiently acknowledged or addressed.

- ix. Unduly lenient paperwork submissions from the CPS to attorney general office following public complaints, none have been received from the families:

885. I do not fully understand the specific nature of this concern, but I was aware that one or more public referrals were made to the Attorney General's Office under the Unduly Lenient Scheme. I also understood that the CPS had independently referred the case to the Attorney General's Office, recommending that it be considered for onward referral to the Court of Appeal to review the sentence imposed.

886. I am not aware of what, if any, conversations took place between the CPS and the families regarding this matter. Similarly, I do not have knowledge of whether any steps were taken to help address or alleviate the families' concerns. As such, I am unable to comment on whether those concerns have been adequately responded to or resolved.

- Notifying families of the incident on the night.

887. A concern regarding the way in which some families were notified of the incident on the night of 13 June 2023 was raised by the FLA during the meeting held on 30 January 2024, because the FLA had seen mention of it in the media. While this had not previously been flagged to me as a formal

concern, I was aware of the circumstances surrounding the notifications, and I understood from the outset that this was something that had deeply troubled the FLA.

888. Although I do not have a formal record of our conversations on this matter, I was in the company of the FLA on several occasions across the 13, 14, and 15 of June 2023. I distinctly recall discussing the matter with her, as it was clear that the situation had caused her considerable distress.

889. She explained to me that she had made the decision to notify the Webber and O'Malley-Kumar families by telephone, an approach that, from a family liaison perspective, is generally avoided wherever possible due to the potential impact on the families. However, she felt that she had no viable alternative for reasons I will explain below.

890. By 10:00 hours on 13 June 2023, the FLA was acutely aware that the neither the Webber nor O'Malley-Kumar families had yet been informed of the incident.

891. Mr Webber had contacted the casualty bureau that morning, having seen coverage of the incident and grown concerned for his son, Barnaby. The Casualty Bureau is a structured system used by UK police forces during major incidents to manage information about people who may be involved, including those injured, missing, or deceased. It serves as a central point for receiving public calls, recording details, and coordinating with other agencies to support identification, family liaison, and public reassurance.

892. Mr Webber had been unable to reach Barnaby and had noticed that Barnaby's phone was tracking from Ilkeston Road towards a police station.

Mr Webber explained that they were away on holiday, and in light of this, Det Insp Gould instructed FLO Gina Farrell to notify him immediately by telephone and to make arrangements for an in-person meeting.

893. Det Insp Gould also described facing a similar dilemma with the O'Malley-Kumar family. Det Insp Gould's team had been unable to immediately obtain contact details for the family via the university and were increasingly aware of the risk that they might be informed by an alternative source, or that the Webber family might contact them, given the close friendship between the children. FLOs had already been dispatched to London, travelling towards their family home, when Det Insp Gould made the difficult decision to personally notify the family by phone. By this time students had begun to gather at the scene, the media were aware and in fact Dr Kumar had also phoned the Casualty Bureau. He explained that his family would be travelling up to Nottingham.

894. As an experienced FLA, Det Insp Gould was fully aware of the potential consequences of delivering such news by telephone. She explained to me how she had carefully weighed the risks of this approach against the possibility of the families learning of the incident through unofficial or less sensitive channels. In her judgment, a direct call from a trained FLA or FLO was the most appropriate and compassionate course of action under the circumstances.

895. I reassured her at the time that I believed she had acted appropriately and with great care. Until the meeting on 30 January 2024, I had not been made aware of any concerns regarding the method of communication used.

896. As with other concerns raised during that meeting, our ability to explore these matters further with the families has been limited due to the referral to the IOPC, which has restricted our capacity to respond directly.

- Police use of language (deceased):

897. A further concern was raised during the Gold Group meeting held on 30 January 2024, relating to the language used by an officer when communicating with one of the families on the night of the incident.

898. My understanding is that, during a conversation, the officer referred to the loved one as “deceased.” This concern had not previously been brought to my attention and, as with other matters raised during that meeting, it was identified by the FLA after viewing media coverage following the sentencing on 25 January 2024.

899. While I was not aware of this specific issue prior to the Gold Group meeting, I recognise the need for sensitivity of language used in such circumstances and the potential impact it can have on families. The use of terminology in moments of acute trauma must be handled with the utmost care, and I understand why this has been highlighted as a concern.

900. However, as with some of the other issues that were raised for the first time on 30 January 2024, our ability to explore this matter further with the families has been constrained by the referral to the IOPC, which has limited our capacity to engage directly and respond in detail.

- Protection of data, specifically the CCTV of the attack:

901. I understand that this concern relates to the inappropriate viewing or sharing of CCTV footage from the attacks on 13 June 2023.

902. It may stem from a specific case involving a Special Constable who resigned and then was later dismissed for accessing police body-worn video footage of the crime scenes, without a legitimate policing purpose.
903. This concern may also extend to the inappropriate viewing of other sensitive information, including incident logs associated with the attacks.
904. As I have explained earlier in my statement at paragraph 262, I was first made aware of the potential for staff not directly involved in the incident to be accessing incident records on police systems during the Gold Group meeting on 14 June 2023. This was raised under “any other business” by Det Supt Williams. She informed me that, while she had not planned to conduct a full audit of all systems, she recommended that departmental heads issue a clear reminder to staff about their responsibilities, specifically, not to access incidents or CCTV footage without a lawful and legitimate purpose. She felt this would be a pragmatic and proportionate response.
905. At that time, there was no suggestion that any staff had accessed CCTV footage. The discussion focused on preventative messaging, prompted by referrals to PSD indicating that some staff may have viewed incident logs inappropriately.
906. I agreed with her recommendation at the time. However, on reflection, I believe a more robust message from a Chief Officer would have been more appropriate. I should have taken that suggestion away for further discussion with colleagues to determine who was best placed to deliver such a message with the necessary authority and clarity.

907. This issue was discussed again during the Gold Group meeting on 20 June 2023, under the PSD update agenda item.
908. I was first alerted to an actual incident of inappropriate accessing of footage (the Special Constable case) in an e-mail from Det Supt Williams on 20 September 2023. I have already described this matter within my statement under paragraphs 480-496. I will also provide further commentary on the matter later in my statement, within the section that addresses my approach to unauthorised access issues.
909. In summary though, on 20 September 2023, the FLA and I were made aware, via email, about a Special Constable having viewed distressing footage, though no further detail was available at that stage. It later emerged, through email exchanges in December 2023, that information about the Special Constable case had not been passed on to the families as intended.
910. On 14 December 2023, Det Supt Sanders raised concerns about this case, and I confirmed the facts and repeated that, in my view, this case did trigger a duty of candour and that the affected family should be informed without delay.
911. However, following advice from FLOs, the SIO and the then Head of PSD (T/Det Supt Reynolds), and considering the families' emotional state and timing close to Christmas, I agreed to delay disclosure until the new year.
912. I later received confirmation that I had indeed authorised the disclosure of this matter back in September 2023, but that the SIO had delayed the process.

913. As of the Gold Group meetings in January 2024, I understood that the families had still not been informed about this matter.

914. I am aware that following the sentencing hearings, and matters being referred to the IOPC, the Chief Constable wrote to the bereaved families on 20 February 2024 and the surviving victims on 22 February 2024 outlining all the PSD investigations, including the disclosure of this case. Within that letter the Chief Constable made an apology for the failure to disclose this matter to any of the families.

915. This is the only matter relating to CCTV that I have been made aware of and besides the letters from the Chief Constable, am not aware of any other efforts to address any family concerns.

916. This concern is addressed more directly and, in more detail, both earlier and later in my statement, where I outline my involvement in the investigation into the accessing of information, and the steps taken to ensure that families were informed of any confirmed data breaches.

917. However, I acknowledge that this matter has not been adequately addressed, and I wish to repeat what I said in paragraph 482 above. On reflection, the way we managed the sharing of information regarding the PSD investigations was wholly inadequate. Looking back, I can see that our approach lacked coordination and clarity. As a result, the families were not given the information they should have received. I regret this and I extend an unreserved apology for it. I am also personally embarrassed by my oversight of the matter.

Reviews of previous Police encounters with the defendant.

918. I have also been asked to set out in detail the reviews that were carried out in relation to encounters that the police had with VC, as referenced in the Gold Group meeting on 30 January 2024. I have been asked to explain how the reviews were conducted and their conclusions, exhibiting relevant key documents including any final report.

919. It is accurate to say that during the Gold Group meeting held at 10:15 hours on 30 January 2024, I referenced internal reviews that had taken place in relation to previous police encounters with VC. This is recorded in the minutes under agenda item five. During the meeting, I explained to attendees that while every known police interaction with VC had been reviewed, I was not confident that all those reviews had been brought together or recorded in a single, centralised location.

920. I was aware that the relevant material existed in the form of various emails and documents, but these had not previously been collated or filed in a structured way within the Gold Group records. To address this, I created a new agenda item and tasked Det Supt Sanders and T/Det Supt Reynolds with gathering and consolidating the relevant documentation. I was aware that such material existed both within PSD and the Major Crime Unit.

921. For example, I knew that a physical folder existed within the Major Crime Unit in which reviews of previous encounters between Nottinghamshire police and VC had been collated. I had seen this folder myself and had discussed its contents on multiple occasions with colleagues in Major Crime, as I had been particularly focused on

understanding the nature and handling of those earlier interactions, something I will explain further in the next part of my statement.

922. The folder in question is a black ring binder, divided by tabs, each representing a separate encounter. It is referred to in the minutes of the Gold Group meeting under agenda item five, bullet point four, where it is recorded: "Andy to provide Neil document." While this description is not especially clear, I know I was referring to the ring binder I had previously seen and believed may have been in the possession of DC Neil Beddoe (now retired), a member of the investigation team working on the attacks of 13 June 2023.

923. In hindsight, it would have been more accurate to refer to it as the "Police Support Investigator ("PSI") Phil Cumberpatch document," as I believe PSI Cumberpatch was the officer who compiled it, and it was with him that I had discussed the reviews on several occasions. In any event, the ring binder has since been recovered from the incident room and is now referred to as URN: NGPF0007829.

924. The first review into previous police encounters with VC was initiated during the initial Gold Group meeting held on 13 June 2023. At that meeting, I set an action for Det Supt Williams to undertake a scoping exercise to identify any such encounters and assess whether there were any concerns relating to police conduct or misconduct.

925. This action was followed up at the second Gold Group meeting on 14 June 2023, during which Det Supt Williams provided an update. She identified three notable incidents: two assaults that had occurred in Leicestershire in May 2023; an incident involving a victim who had been

caused to jump from a window; and made a further reference to a fail-to-appear warrant, which she had already brought to my attention during the first meeting. This latter matter related to an assault on an emergency worker during an incident in which VC was being detained under mental health powers. While the specific details of this offence and its connection to the warrant are not recorded in the minutes of the 14 June 2023 meeting, the warrant itself is referenced, and I recall Det Supt Williams linking the two matters during our discussion.

926. This verbal update was supplemented by an email (NGPF0007820) which outlines most of the previous police contact with VC. In that email, Det Supt Williams identified various encounters involving VC prior to 13 June 2023.

927. I later learnt that there are thirteen relevant previous contacts with VC. To assist the Inquiry, I have allocated a sequential number to each of these incidents for ease of reference throughout the remainder of my statement. Det Supt Williams' scoping had missed the first incident, (which was on the same date as the second incident 24 May 2020), the fifth incident (5 July 2021) and the tenth and eleventh incidents (on 26 April 2022 and 28 July 2022) respectively.

928. Incidents 4 and 13 were not Nottinghamshire Police matters and were not subject to detailed review by the force. However, I considered it important to include them to present a complete chronology of police contact.

929. I have confined the description of each incident to the date, location, and a summary of the general nature of the matter, to serve as a key for

future reference. The descriptions I have attributed are not intended to be a full representation of the incident; they are merely constructed for ease of reference:

930. Incident 1: 24/05/2020, 12 Brook Court, Player Street, Nottingham. VC kicked and damaged a door to an empty flat. The door was kicked from its hinges, and VC was detained by police while he was attempting to get into another flat (number 11).
931. Incident 2: 24/05/2020, 23 Brook Court, Player Street, Nottingham. The resident of a flat has jumped out of her first-floor flat window after VC was kicking her front door, as a result of which she sustained a serious back injury.
932. Incident 3: 13/07/2020, 11 Brook Court, Player Street, Nottingham. VC forced entry into another flat in the same block and tried to assault someone inside before being detained by the occupants and the police were called. Nottinghamshire Police were not aware of this event until after 13 June 2023.
933. Incident 4: 31/05/2021, Thames House, Millbank, London (MI5). VC attended this location and asked the Metropolitan police to arrest him but appeared calm. No action was taken against him.
934. Incident 5: 05/07/2021, GRO-B 20 Middleton Street, Nottingham. VC grabbed his flat mate (Sebastian GRO-B) and pushed him against the wall inside the flat, saying "...people will be contacting you and in case that happens, then you should tell these people that I will contact them...." VC behaved very aggressively.

935. Incident 6: 03/09/2021, [GRO-B] Former Marquis of Lorne Pub, Junction Middleton Street (same location as incident 5), Nottingham. The police were supporting mental health services in the execution of a s.135 MHA warrant, during which VC assaulted a police officer, PC Pritchard.
936. Incident 7: 15/01/2022, Flat 15 Madison Court Derwent Way Nottingham. Following a disagreement over the cleaning of a shower, VC takes his flat mate (Christopher [GRO-B]) in a headlock, before punching him, and then waits for the police to arrive.
937. Incident 8: 19/01/2022, Flat 15 Madison Court Derwent Way Nottingham. Following a mental health referral from the University, after Incident 7 above, the police were requested to provide support to mental health services in the execution of an MHA warrant. VC was taken to Cassidy Suite, Highbury Hospital, via ambulance, escorted by police.
938. Incident 9: 28/01/2022, Flat 15 Madison Court Derwent Way Nottingham. The police received a further request to provide support to mental health services in the execution of an MHA warrant. VC was taken to Cassidy Suite, Highbury Hospital, via ambulance, and there was no need for a police escort on this occasion. Officers attended the scene, and spoke with VC, who accompanied them to the ambulance. There was no use of force.
939. Incident 10: 26/04/2022, Gymnasium, Nottingham Road, Basford, Nottingham. Sebastian [GRO-B] reports VC approaching him whilst at the Gym and then following him afterwards.
940. Incident 11: 28/07/2022, Northgate, Basford, Nottingham, Sebastian [GRO-B] reports VC following him again, after the gym.

941. Incident 12: 22/09/2022, VC fails to appear at Nottingham Magistrates Court for assaulting an assault emergency worker on 3 September 2021. A warrant (not backed for bail) was issued the same day.
942. Incident 13: 05/05/2023, Avarto Warehouse in Kegworth, Leicestershire. VC punched a male warehouse co- worker and pushed over a female worker who he believed had been talking about him because they were speaking in a foreign language (Romanian).
943. Following the first week of our response to the attacks of 13 June 2023, I recall distinctly and regularly reflecting on the previous incidents involving VC that we were aware of. During that initial week, I was informed that the SIO intended to review all previous incidents involving VC. I was not surprised by this, as such a review would be a reasonable and expected line of inquiry in any homicide investigation. VC's history is clearly relevant, not only in terms of evidential value but also in identifying any missed opportunities or matters of conduct that may warrant further scrutiny.
944. I was satisfied that the SIO's review of previous incidents was sufficient and would serve these several purposes. As mentioned earlier, I had ongoing discussions with PSI Cumberpatch, who by early September 2023 had begun compiling the ring binder containing documentation of these encounters (NGPF0007829) In the months that followed we regularly discussed and examined the various encounters.
945. Around that time, and over that same period (September-December 2023), I was also shown and began to study both the police incident timeline (which I refer to as URN: NGPF0007830) and the joint medical and police incident timeline (NGPF0007824).

946. The circumstances and consequences of the attacks on 13th June 2023 are tragic and the impact for the affected families are beyond human comprehension. The actions of VC on that day were atrociously violent.
947. What I am about to say, in relation to the previous incidents that VC was involved in, is upsetting and distressing. I know the families may well disagree with my assessment and I am acutely aware that it has the potential to upset them even further. I am profoundly sorry about that.
948. I am desperate not to make things any worse for them and have done my very best to articulate my views in as sensitive away as is possible. However, as difficult as it is, I am required by this public inquiry to put aside emotion and provide my opinions objectively, based on the evidence and information that is available to me and based on my thirty years of policing experience.
949. My focus on these earlier interactions stemmed from a deep sense of concern and professional curiosity. I found the nature of the case and the circumstances leading up to the attacks both troubling and difficult fully to comprehend. I questioned how someone responsible for the extreme violence of 13 June 2023 had never featured in our risk awareness, and how a person could move from committing low-level violent offences to acts at the most serious end of the spectrum.
950. As I studied, discussed, and learned more about the previous incidents, it became clear to me that, within the context of violence typically seen in Nottinghamshire, VC's earlier offences would not have reached the attention of divisional commanders, let alone a senior detective or someone at my rank as ACC Crime.

951. I have reflected deeply on this history of low-level offending and cannot see any clear signs of escalating violence. In fact, there were some signs of de-escalating violence. The offences VC committed were ones typically dealt with by response or neighbourhood officers, as they were all PIP 1 investigations.
952. The only incident involving serious injury was incident two, and even that was not caused directly by VC, but resulted from the victim's reaction to VC kicking at her door.
953. Given the circumstances of that case, and considering the assessment provided by Dr Seedat, which I will detail later, I believe it is highly unlikely that VC would have been convicted of a violent offence in respect of his behaviour.
954. In my professional opinion, based as I say on over 30 years of experience, much of which has involved serious crime investigation, I do not believe there was any clear indication that VC was likely to escalate his behaviour to the level seen on 13 June 2023.
955. In hindsight, it is clear that Incident 2 on 24 May 2020 where the female victim jumped out of a window, given the seriousness of the injuries sustained, should have been allocated to an accredited detective. It is clear that this was not considered at the time.
956. However, for the remaining incidents, the seriousness of the offences was such that they would not typically have warranted detective-led investigations. The incidents were generally low-level in nature: no weapons were used, injuries were either minor or non-existent, and VC typically remained at the scene.

957. There were also significant gaps between some incidents, for example, Incident 3 occurred in July 2020, and the next violent offence was not until July 2021 (Incident 5), which involved a minor assault with no injury.
958. Following VC's release from detention under the MHA after an incident of violence against his flat mate, Incident 7, the subsequent incidents which involved him following Sebastian [GRO-B] in April and July 2022 (Incidents 10 and 11) involved no physical contact or injury.
959. I acknowledge that VC may have had been medicated at this time, however, it was notable that his behaviour appeared to have de-escalated rather than escalated during this period.
960. After failing to appear in court in September 2022, the next time VC came to police attention was in May 2023 (Incident 13).
961. I do not seek to trivialise any of these incidents, nor do I claim expertise in criminal psychology, but I remain deeply concerned and surprised that an individual with this history could escalate to the level of violence seen during the attacks of 13 June 2023.
962. I did not keep notes of my ongoing assessment, which was primarily informed by documents shown to me and conversations with PSI Cumberpatch. Our review did identify several themes, and we agreed on the overall analysis of these events.
963. I believe part of the difficulty in reviewing VC's earlier police encounters lies in the fact that we now view them through the lens of what we know occurred on 13 June 2023, attacks marked by extreme and incomprehensible violence. It is understandably hard to resist looking back and thinking more could or should have been done. Throughout the

exercise of reviewing those incidents, I was careful to balance that natural instinct with a realistic understanding of what was known and available to officers at the time. These were relatively low-level incidents, and the circumstances presented to those attending them did not suggest the trajectory that later unfolded.

964. I have used the word *could/might* rather than *should* in some parts of this section of my statement, when reflecting on how the police approached certain incidents. This choice is deliberate. It reflects the balance I have described, between what we now know about the events of 13 June 2023 and what was realistically understood at the time of the previous encounters. With the benefit of hindsight, it is easy to conclude that more *should* have been done. However, a fairer assessment may be that more *could* or *might* have been done, and that is the distinction I am trying to convey.

965. PSI Cumberpatch and I reflected that there was no evidence that threat and risk were considered holistically in the decision-making around whether to arrest VC. While some decisions not to arrest were proportionate when considered in isolation, in hindsight, a broader view of VC's history might have justified a different approach. We thought that, had the officers considered the whole history of VC's behaviour, and certainly with the benefit of hindsight, he should have been arrested for Incidents 7 and 13.

966. PSI Cumberpatch and I also reflected that similar issues applied to information sharing with partner agencies, specifically mental health services and adult social care. In none of the cases we reviewed had

proactive information sharing with these partners taken place. While we recognised that officers are not mental health professionals, they are nonetheless trained to identify signs of vulnerability, including mental health concerns, and to make appropriate referrals. The responsibility to identify vulnerability applies both to the person reporting the incident, as well as the subject of that report, in this case VC.

967. The lack of identification of vulnerability and resultant referrals to partner agencies was particularly disappointing to me, because I had personally led the development and implementation of our vulnerability strategy in 2017 and believed that it was fully embedded as culture. This strategy remained in place at the time of all the incidents in question and continues to be current approach. The strategy, which was heavily publicised, carries a clear and simple message for officers, displayed on posters in every police station across the force: "Know it, Spot it, Stop it." That message encourages officers to understand what vulnerability is, recognise its signs, and take appropriate action, whether through intervention or information sharing.

968. I now refer to that strategy as URN: NGPF0007831. The strategy adopts for Nottinghamshire Police the national police definition of vulnerability: "A person is vulnerable if, as a result of their situation or circumstances, they are unable to take care of, or protect themselves, or others, from harm or exploitation."

969. Upon identification of a vulnerable person, an officer is required to submit a Public Protection Notice ("PPN"). This notice is submitted to the Multi Agency Safeguarding Hub ("MASH") which triggers a multi-agency

assessment of the information and instigation of an intervention if required.

I will explain this in more detail later in my statement.

970. PSI Cumberpatch and I reflected on whether VC met the definition of a vulnerable person. We felt that, while he may have been vulnerable in the broader sense of the word, he might not have met the formal criteria, specifically, someone unable to care for or protect himself from harm or exploitation. We thought this distinction is important when considering how vulnerability is assessed within policing contexts. An example of this is Incident 7. We reflected that VC's behaviour had indicated vulnerability in the ordinary sense of the word but could see that one might not have considered him as being unable to look after or protect himself.

971. PSI Cumberpatch and I also considered that there was a limited understanding within the workforce regarding how to manage suspects with mental health conditions within the criminal justice system. This was evident from Incident 2, and we reflected that this incident should have been referred to the CPS for consideration for prosecution.

972. Finally, PSI Cumberpatch and I concluded that supervisory oversight played a less prominent role in decision-making than we would have been expected.

973. I can see from an e-mail chain that, on 9 January 2024, I had been examining the timeline of contact again and asked some further clarification questions in relation to incidents eight and nine (Sebastian GRO-B).

974. My e-mail dated 9 January 2024 was addressed to the SIO and deputy SIO Clare Dean, and it triggered a dialogue which culminated in Det Ch

Insp Dean asking the force stalking lead (Det Insp Abi Goucher and Kate Reece) to undertake a further independent review of these two incidents, and for context, incident five. I refer to this e-mail chain as URN: NGPF0007832.

975. The response was provided to me by email, on 16 January 2024. In summary, Det Insp Goucher explained that they had reviewed three incidents involving VC and the reporting party, Sebastian GRO-B. She said, the first incident, on 5 July 2021, involved a low-level assault where VC grabbed Sebastian's T-shirt while speaking incoherently. Sebastian was not injured and did not wish to pursue a complaint, instead asking officers simply to be aware of the incident. Officers advised Sebastian to inform VC's mental health support team when they next visited, and no further action was taken. I will reflect on this response later in my statement.

976. Det Insp Goucher assessed the second incident, reported on 26 April 2022, involved Sebastian seeing VC at the gym and believing he was being followed home. After assessing the situation, it was determined that the behaviour did not meet the threshold for stalking. The incident was not given a crime number, and no positive police action was taken. Sebastian appeared uncertain about how he wished to proceed and had previously accepted social media contact from VC, which further complicated the assessment. I will also reflect on this response later in my statement.

977. In relation to the third incident, Det Insp Goucher confirmed this was reported on 28 July 2022, and again involved Sebastian reporting that VC had followed him home from the gym. Sebastian expressed increased anxiety and distress, stating that the behaviour was affecting his daily routine.

Although the incident was crimed, it was again assessed as not meeting the criteria for stalking, and Sebastian did not support a prosecution. Officers attempted to contact VC but were unsuccessful, and no further action was taken. I will also reflect on this response later in my statement.

978. Det Insp Goucher's review concluded that, based on the available information, there was insufficient evidence to determine that stalking had occurred. However, it was noted that further enquiries could have assisted in making a more informed assessment. These included clarifying the nature of the relationship between Sebastian and VC, understanding their shared accommodation history, and exploring whether Sebastian (or VC) had any vulnerabilities. Additionally, no checks were made with the gym, no CCTV or house-to-house enquiries were conducted, and no clear chronology of interactions was established.

979. It was also unclear whether Sebastian had been offered support services, and the Stalking Screening Tool, which became available in July 2022, was not used in the third incident. Overall, Det Insp Goucher's review highlighted missed opportunities to gather contextual information that might have helped determine whether VC's behaviour was persistent, fixated, or obsessive, and whether it constituted stalking.

980. I submitted this email response as part of my reply to the outstanding Gold Group action, that I had set on 30 January 2024, as part of my response. This action was later transferred over to Operation Chain Link under the leadership of the Chief Constable, meetings which had commenced on 6 February 2024.

981. The final evidence of review activity was generated by a further email sent by me to Det Ch Insp Nick Hall, on 28 February 2024, who was a Divisional Crime Manager at that time, working on the County Division, and with no previous involvement in Operation Hendrix.
982. I asked him to take a “fresh set of eyes” look at some of the incidents, an exercise he undertook and later emailed me his response on 6 March 2024.
983. I refer to this email exchange as URN: NGPF0007833.
984. The incident numbers Det Ch Insp Hall used in his email reply do not align with the numbers I have attributed to incidents within this witness statement. To help make sense of Det Ch Insp Hall’s review, I have replaced the numbers he used, with the number I have assigned in this statement.
985. Det Ch Insp Hall apologised for his email not being “particularly brief”, explaining he had undertaken a preliminary review of the incidents I had asked him to and that the review had provided some initial observations and highlighted several recurring themes.
986. In relation to Incident 1 on 24 May 2020, Det Ch Insp Hall said that the initial police attendance, arrest, and detention of VC appeared appropriate. However, questions remain regarding the mental health assessment conducted during detention and the decision not to detain him under the MHA. He explained that the police (I have assumed custody) records do not include the outcome of the assessment, making it difficult for him to evaluate whether the decision was justified. He said it was unclear what, if anything, changed in VC’s presentation between this incident and the

subsequent assault that led to his detention under the Act later that same day 24 May 2020 (Incident 2).

987. He noted that VC was deemed fit for interview, supported by both a solicitor and an appropriate adult, and was able to engage with officers, although he claimed to have no recollection of the incident. No PPN was submitted, and he thought it was possible that one would have been appropriate given the circumstances.

988. Det Insp Hall stated that at the time, this appeared to be an isolated incident, and it was VC's first recorded occurrence on NICHE. The custody sergeant did not identify any concerns during the pre-release risk assessment at 19:17pm on 24/05/2020. Det Insp Hall said that the decision to release VC under investigation ("RUI") or on bail, and to return him to the same address where the incident occurred, was difficult to assess without knowing his presentation at the time of release. Det Ch Insp Hall stated that with the benefit of hindsight, it would have been preferable not to return him to that location but acknowledged that officers had limited options available. Once the mental health assessment concluded that detention under the MHA was not required, release, either on bail or RUI, became inevitable.

989. Det Ch Insp Hall explained that even if the threshold for remand in custody had been met, which seemed to him to be unlikely, unless VC had significant antecedents outside the force area, it is probable that he would have been bailed back to his home address given the nature of the offence. Det Ch Insp Hall stated that while this may have prevented the subsequent offence, the underlying risk would have remained.

990. Det Ch Insp Hall concluded that on balance, and based on the information available at the time, it would not have been proportionate to bail VC away from his home address without alternative accommodation. He said that policy at the time may also have limited the use of bail in such circumstances, though further review of that policy would be required to confirm this. I believe he was referring here to the policy that had encouraged away from using bail and moved them towards releasing suspects under investigation, RUI.

991. Det Ch Insp Hall also acknowledged that the investigation was complicated by VC's subsequent sectioning and difficulties in obtaining cost estimates for the damage from the landlord. The attempt to resolve the matter through a conditional caution was well-intentioned but ultimately inappropriate, given VC's medical unfitness at the time of the offence. The case was closed with an Outcome 12 after VC declined the caution on 29 July 2021, supported by medical evidence (from Dr Seedat which is explained later) indicating he was unfit to prosecute. By that point, the offence was also several months out of time for summary proceedings.

992. Outcome 12 in UK police crime recording standards refers to cases where prosecution is prevented because the named suspect is considered too ill, either physically or mentally, to be prosecuted

993. In conclusion, Det Ch Insp Hall stated that Outcome 12 was a proportionate and appropriate resolution for this level of offence. As criminal damage is a summary-only matter, the police were entitled to determine that the evidential test was not met, and the medical letter dated 8 June 2020 provided a reasonable basis to close the investigation.

994. In relation to Incident 2, Det Ch Insp Hall explained this had occurred approximately two hours after VC's release from custody for Incident 1 and resulted in serious injury to the victim Feven. He said that although the complainant's initial statement was brief, likely taken before receiving medical treatment, it was sufficient to demonstrate that she apprehended immediate harm due to VC's actions and took steps to protect herself that she would not otherwise have taken. Her account of the door frame buckling, and the fact that it could not be secured by attending officers, supports the view that her actions were not unreasonable and did not break the chain of causation.

995. Det Ch Insp Hall found that the offence was initially recorded as Actual Bodily Harm ("ABH"), likely due to the absence of confirmed fractures at the time. However, Det CH Insp Hall stated that once the extent of the victim's injuries was known, the offence should have been reclassified as Grievous Bodily Harm ("GBH"). I believe Det Ch Insp Hall was referring to Section 20 GBH, which is GBH without intent.

996. Det Ch Insp Hall described how VC was reassessed in custody and subsequently detained under Section 2 of the MHA, before being transferred to Highbury Hospital for further assessment. VC was not interviewed, and the investigation was finalised with an Outcome 12 following receipt of a letter from Dr Seedat.

997. Dr Seedat had said: "*Dear Richard*

I can confirm that Mr Valdo Calocane, DOB: 04/09/1991, who is a university student at Nottingham university was admitted to Rowan one, Highbury hospital on a section 2 of the mental health act on the 25th of

May 2020. He currently remains an in-patient.

I can confirm that he presented with clear symptoms and signs suggestive of an acuter psychotic illness. He needed rapid tranquilisation at the very beginning of his stay but he has now settled and his mental health was somewhat improved.

He had no recollection of the events prior to his admission and it will be my view that he was not in touch with reality around the time of his admission nor around the time of the incident of causing damage to someone's door.

It was clear that his judgement and also awareness of his environment and actions was impaired due to experiencing an acute psychotic breakdown which was likely to have been precipitated by a combination of stress, sleep deprivation and social isolation. It will be my view that it was more than likely that he did not have the capacity to be responsible for his actions as this was not done in a clear conscious state.

Thank you.

Dr Seedat – Consultant psychiatrist , Rowan one, Highbury hospital "

998. Det Ch Insp Hall also said that there was no indication that consideration was given to a referral to the PSD or a DSI referral to the IOPC, possibly because the full extent of the injuries was only confirmed after hospital assessment.

999. Det Ch Insp Hall opined that the investigations into the criminal damage and the assault were not joined and were managed separately, with different officers in charge and separate supervisory oversight. He explained that, had VC accepted the conditional caution offered for the

earlier criminal damage, it would have created a perverse outcome, where the more serious assault was not pursued, but the lesser offence was.

1000. Det Ch Insp Hall had noted that the rationale for the Outcome 12 decision was not clearly documented, but it appears that the decision-maker, Sgt Sparks, concluded that the evidential threshold of the Full Code Test was not met, based on the medical letter. As GBH is not a police-chargeable offence, referral to the CPS should have been considered. VC was not interviewed, and no further formal mental health assessment was conducted in relation to the assault.

1001. Det Ch Insp Hall concluded that given the seriousness of the injuries, the appropriate course of action would have been to continue the investigation, interview VC, and seek early investigative advice from the CPS. CPS guidance makes clear that mental health conditions do not automatically exempt individuals from criminal liability. In serious cases, mental health may be more relevant to sentencing and disposal than to the decision to prosecute. A considered approach is required, including clarity on the evidential and public interest factors involved.

1002. Finally, Det Ch Insp Hall said, the decision to finalise the case via Outcome 12 effectively precluded the possibility of a conviction and any hospital or treatment-based disposal through sentencing. While it is not possible to say definitively whether the CPS would have reached a different conclusion, I believe that referral to the CPS would have ensured a more transparent and accountable process in a case involving significant injury.

1003. In relation to Incident 3 dated 13 July 2020, Det Ch Insp Hall noted that at this point the assault offence from 24 May 2020 had been refused charge and VC remained RUI for the minor damage to the door from the preceding incident on 24/05/2020.

1004. He explained that VC was detained at the scene by other residents and subsequently assessed by the Street Triage team and detained under S136 for assessment and conveyed to the S136 Suite. He observed that the previous incidents were identified and a note of this is on the log.

1005. Det Ch Insp Hall concluded that, on the facts known to the officers at the time, this was a proportionate response to the incident. No damage or injury was caused. Arrest options were potentially available, but Det Ch Insp Hall agreed that the proportionate response was to deal with this as a mental health incident. Det Ch Insp Hall rationalised that it was also a defensible decision not to record a crime, interpreting the officer's update to mean that, on the balance of probabilities, VC lacked the capacity to form the appropriate Mens Rea.

1006. Det Ch Insp Hall did pose one counter argument to this, explaining that if VC had been charged with a serious assault from the 24 May 2020 incident, and so had an impending prosecution, this may have influenced the attending officer's decision-making and may have had an impact (positively or negatively) on that prosecution. In Det Ch Insp Hall's view it was not impossible to make any solid, and therefore worthwhile, determinations on this point.

1007. Det Ch Insp Hall summarised Incident 5 (assault on Sebastian GRO-B on 5 July 2021) as a low-level Common Assault in which the complainant

did not wish to cooperate. He noted though that the victim had been sufficiently unnerved by the incident to make the report for the information of Police.

1008. Det Ch Insp Hall observed that the crime was finalised with the remark, "one word against another" which he inferred to mean that Sgt Price had assumed that VC would have denied the offence and noted that he could not see that he was given the opportunity to comment. Det Ch Insp Hall acknowledged that VC could have made admissions that could have led to a sanction commensurate to the offence, but accepted this was, perhaps, unlikely.

1009. Det Ch Insp Hall questioned the amount of research into VC that was conducted by the attending officer/supervisor. Det Ch Insp Hall noted that mental health had been mentioned in the initial call, and that a check of NICHE would have revealed the three incidents from approximately one year earlier on 24 May and 3 July 2020, and an intelligence report regarding the Thames House incident approximately two months previous. Det Ch Insp Hall said that this may have led to further consideration about using the term "low risk" on the closure report, though it is not explicitly clear what "low risk" had meant in this context nor how it was rationalised.

1010. Det Ch Insp Hall also noted that given that the victim and the suspect lived in same block he could not see any thought given to any re-occurrence or discussion with the local neighbourhood team but appreciated that both the officer in the case and supervisor may have been on that team at the time. He noted that there was no consideration for an adult PPN.

1011. Det Ch Insp Hall concluded that he did not believe that prosecution vs no prosecution was the issue here but rather the issue was the appropriate identification of potential risk and information sharing. Though there was little chance of a positive outcome, VC should have been interviewed before finalisation which may enabled further diversion/treatment options.

1012. Finally, in relation to Incident 6 (assault emergency worker on 3 September 2021 and the FTA warrant), Det Ch Insp Hall's review highlighted several procedural and investigative concerns.

1013. Det Ch Insp Hall thought that the initial file submission to the CPS was clearly deficient and was always likely to be returned. He considered it was notable that the initial CPS advice did not include a request for an interview with VC, which may have been influenced by COVID-related guidance in place at the time. The absence of medical evidence and corroborative non-police statements was a significant issue, particularly given that the incident arose from the execution of a Section 135 MHA warrant. Det Ch Insp Hall believed that this context contributed to the delay in progressing the case.

1014. Det Ch Insp Hall observed that another substantial delay occurred between the receipt of the initial advice on 22 November 2021 and the re-submission of the file on 26 April 2022. During this period, Det Ch Insp Hall noted that a change in the officer in charge suggests possible staffing or management issues. Even after re-submission, it appears that four months elapsed before a summons was issued, and the reason for this delay is unclear from the available records. Det Ch Insp Hall felt that a more

detailed timeline would likely require access to the file preparation functions within NICHE.

1015. Det Ch Insp Hall believed that a delay of approximately one year between the original incident and the first court appearance was excessive, particularly given the nature of the offence. Det Ch Insp Hall also commented on the fact that the medical practitioner involved, Dr Benjamin Lomas, declined to comment on VC's mental health due to doctor-patient confidentiality, which further complicated the evidential picture. Det Ch Insp Hall concluded by saying that the approach taken in this case was a contrast to the handling of the incident from 24 May 2020 and raised questions about consistency in prosecution strategy and engagement with the CPS. These delays and procedural gaps suggest that opportunities for earlier intervention and clearer decision-making were missed.

1016. Det Ch Insp Hall's overall commentary suggested that a key concern was the tendency to treat incidents involving VC in isolation, without sufficient consideration of VC's broader history or behavioural patterns. There also appeared to be inconsistent approaches to charging decisions where mental health was a factor, suggesting that further guidance or policy clarification for the workforce may be beneficial.

1017. These findings were broadly consistent with the review that Phil Cumberpatch and I had undertaken.

1018. Additionally, Det Ch Insp Hall's review raised questions about a culture of inadequate information sharing and the submission of PPNs. I took this to mean that he was concerned whether officers were being sufficiently

professionally curious and whether they considered VC's vulnerability and the potential need for mental health referrals. Any identified vulnerability in respect of VC's mental health would of course have been dealt with by MH services, not the police.

1019. In late winter 2023/2024, Nottinghamshire Police was subject to an inspection by His Majesty's Inspectorate of Constabulary and Fire & Rescue Services ("HMICFRS"). On 11 March 2024, the force was placed into Engage status, a formal phase of enhanced monitoring applied when areas of concerns are identified about a force's performance. One of the areas of concern highlighted for Nottinghamshire related to investigations, including supervisory oversight and suspect management.

1020. The themes identified by HMICFRS were consistent with what we had learnt from the review of the previous encounters with VC.

1021. As ACC with the crime portfolio, I was responsible for designing the recovery plan in response to this, which took the form of a 10-Point Investigation Improvement Plan, known as Operation Catalyst, which I now refer to as URN: NGPF0007834. This plan incorporated all the themes and learning identified during our internal review and was delivered to the entire workforce throughout 2024 via briefings and training. Within the 10-Point Investigation Improvement Plan, a particular emphasis was placed upon suspect management and vulnerability.

1022. On 18 March 2024 I combined the review undertaken by Det Insp Abby Goucher and Kate Reece with the review undertaken by Det Ch Insp Nick Hall, to create one composite document which I now refer to as URN: NGPF0007835. At the same time, I recall I created a second version of

this document (which I now refer to as URN: NGPF0007836), which I had intended might form part of the material that I was developing for my 10-point investigations plan. Vulnerability and Suspect management, including a specific input in relation to managing suspects with mental health, were key elements within that plan.

1023. I submitted what I thought was the complete composite document, via e-mail, to complete the outstanding Gold Group action. That document was embedded into the action matrix of the minutes of 15 March 2024. Because a further Operation Chain Link Gold Group did not take place, I never examined this document again, nor was it discussed within a future meeting.

1024. It was only whilst undertaking the exercise of completing this witness statement for the public inquiry that I had cause to revisit those minutes and embedded documents and realised immediately that I had submitted the wrong version. I had submitted the version that was intended to form part of my Operation Catalyst 10-point investigation plan, rather than the complete composite document.

1025. I can confirm that, while several reviews were undertaken in relation to previous contacts with VC, these did not culminate in a single, final consolidated report.

1026. On reflection, a single consolidated report outlining the approach to and findings from the various reviews would have been helpful. As I will explain later, commissioning an independent review, whether by the IOPC or another external party, could have offered greater objectivity and confidence in the process. However, the incidents themselves were

relatively straightforward, the issues were clearly identifiable, and as it transpired, the findings aligned with those of HMICFRS. There was therefore an established governance framework in place to oversee improvements. So, while I would have preferred independent scrutiny, I am, on balance and with hindsight, content with the approach taken to review.

What more could have been done to arrest the defendant and/or prevent the attacks.

1027. I have been asked to reflect on what more could have been done to locate and arrest VC and or prevent the attacks of 13 June 2023.

1028. Looking back over the three-year period preceding the events of 13 June 2023, I have come to view each encounter between VC and any agency as a moment of potential significance, a point at which, had something different been done, it may have altered the course of his pathway.

1029. That is not to say that I can assess with any certainty whether any particular intervention would have prevented what ultimately occurred. While it is conceivable that a different decision at any point in time, whether to act, to share information, or to intervene, might have influenced what followed, I do not believe it is reasonable to conclude that any one of those decisions would have necessarily prevented the attacks.

1030. That said, when I reflect on the various interactions VC had with the police and with mental health services, I can see that there were opportunities to have done things differently.

1031. There is no question that VC should have been arrested for failing to appear in court in September 2022, as I have already explained in paragraph 473 of my statement.

1032. In my view, the appropriate course of action would have been for the NPI to allocate the warrant to a designated officer or team within the relevant area, with the clear instruction to make all reasonable efforts to locate and arrest VC. At a minimum, this should have included visits to all known current and previous addresses linked to him. If those enquiries had not yielded results, it would have been proportionate, given his significant engagement with mental health services, to seek further information from those agencies to identify any additional addresses. It may also have been appropriate to make enquiries with the university and, where relevant, with family members. However, considering the nature of the offence for which the warrant was issued, I would not have expected more intrusive lines of enquiry to be pursued.

1033. Having reviewed Incident 2, which occurred on 24 May 2020 when VC forced entry into a neighbour's flat for the second time that day, I believe this matter should have been referred to the CPS, in line with the CPS Prosecution Guidance when dealing with Mental Health in respect of Suspects and Defendants, which I refer to as URN: NGPF0007837, for cases where mental health is a factor. While it seems unlikely that a prosecution would have been pursued, given the opinion of Dr Seedat, I nonetheless believe it would have been appropriate to refer the matter to the CPS for consideration. Had a conviction followed, it is possible that

agencies may have viewed VC differently when making subsequent decisions about him.

1034. Following Incidents 1, 2, and 3, the police did not formally submit a vulnerable adult or mental health referral to social care or mental health services. However, Incidents 2 and 3 were attended jointly with mental health professionals, and VC was detained under the MHA on both occasions. As such, the relevant information would have been known to those services.

1035. I have also considered whether VC's visit to MI5 in May 2021, had it been shared with mental health services in Nottingham, might have informed decision-making at that time.

1036. Reflecting on Incident 5, reported by Sebastian [GRO-B] in July 2021, I believe that, given the low-level nature of the assault and the victim's express wishes that VC was not arrested, the decision not to arrest was proportionate. However, VC was never seen by the police in relation to this incident, and had checks been made about his history, in my view he should have been. I also reflected on whether a different decision might have been taken had VC already been convicted in relation to the earlier incident involving the victim who jumped from a window. I also contemplate whether sharing information from this incident with adult social care or mental health services might have influenced decisions being made by those services at the time.

1037. Although it is difficult to judge, I wonder whether, had the MI5 and [Sebastian] assault incidents been shared with mental health services at the

time, a decision to seek a Section 135 Mental Health Act warrant might have been made before 3 September 2021

1038. On 3 September 2021, following Incident 6, VC was again detained under the MHA. One might consider that this represented a disruption to the chain of events, a moment at which his path was, at least temporarily, reset.

1039. I also reflect on the police response to Incident 7, reported in January 2022, involving an assault on a flatmate. It is possible that VC's path might have been diverted had the officer chosen to arrest him. I also wonder whether that decision might have been different had VC already had a criminal conviction e.g. for the second incident on 24 May 2020 or the 3 September 2021 assault on PC Pritchard. As previously noted, I believe that a formal referral to mental health services at this point might have influenced decisions taken by other agencies.

1040. Fortunately, the university did make a referral following this incident, and information was shared with mental health services. As a result, VC was again on 28 January 2022 detained under the MHA, and one might consider that his path was again reset.

1041. On 24 February 2022, VC was released from hospital for the final time. As with previous releases, I believe agencies should reflect on the robustness of the approach taken to his medication programme, although I do not consider myself qualified to comment on clinical matters.

1042. On 26 April 2022, the university made a further referral to mental health services after VC was found on campus on 21 April 2022 and provided a false name. He also revisited the flat where he had previously been

detained. This incident may have served as a trigger to reconsider his medication programme.

1043. Also on 26 April 2022, in Incident 10, Sebastian **GRO-B** reported that VC had followed him from a gym towards his home. The police did not visit VC on that occasion. While this may not have been an opportunity to arrest VC, it was certainly an opportunity to speak with him, assess whether mental health was a factor, and, if appropriate, make a referral to mental health services. Again, decisions taken at this point may have been different had VC's history been properly researched and understood.

1044. The same applies to Incident 11, reported by Sebastian **GRO-B** on 28 July 2022. The police did not engage with VC, and while it is difficult to assess in hindsight whether his behaviour amounted to stalking, it was nonetheless an opportunity to speak with VC and share relevant information with mental health services.

1045. On 22 September 2022, VC failed to appear in court and a warrant was issued (Incident 12). At the same time, VC was discharged from mental health services by the local mental health trust and placed under the care of his GP. There was no further contact between Nottinghamshire Police or mental health services and VC after this point. As I have already stated, there is no question that VC should have been arrested on the FTA warrant. While I am not qualified to comment on his clinical care, it seems clear that discharging VC from mental health services may have represented a missed opportunity. Any intervention following these events might have disrupted his path once again.

1046. Finally, in May 2023, an allegation of two assaults was made against VC at his workplace in Leicestershire (Incident 13). VC was not arrested for those offences. While I have not analysed those incidents in detail (since they are out of my policing area), it is my view that they presented a clear opportunity to intervene. Given that VC was circulated as wanted on PNC at the time, I believe he should have been arrested by Leicestershire Police.

Involvement in providing, managing or coordinating with the FLOs.

1047. I have been asked to set out in detail my involvement in providing, managing or coordinating with the FLOs.

1048. I wish to clarify that I did not have any direct involvement in managing or coordinating FLOs. This responsibility sits with the SIO, supported by the FLA.

1049. As Gold Commander, my role was to provide strategic oversight and direction to the overall response to these incidents. This included setting and monitoring progress against the strategic objectives, as described earlier in my statement at paragraph 142. The relevant objective in respect of family liaison was Strategic Objective Two: to ensure that effective engagement, communication, and support is provided to the affected families. My responsibility was to ensure that the appropriate structures were in place to deliver this objective.

1050. I placed particular emphasis on ensuring that the family liaison framework was established promptly and that FLOs were appropriately supported. In my view, the FLO role is one of the most demanding roles within any major investigation. The relationship between the investigation

team and the bereaved families is very important, requiring careful development at what is often the most profoundly difficult time in their lives.

1051. I believed that it was essential that families were treated with compassion and according to their individual needs. Where multiple families are involved, the complexity increases significantly, as those needs can vary widely. For this reason, I considered the early appointment of a FLA and FLOs to be a priority, and I made regular checks to ensure that this had been actioned.

1052. I recorded the requirement for an FLA in my Gold log at approximately 07:30 hours on 13 June 2023. Shortly thereafter, at 08:15 hours, the SIO confirmed the appointment of Det Insp Claire Gould to the role, which I also noted.

1053. During the SIO's murder investigation briefing at 20:20 hours on 13 June 2023, I was further assured that the family liaison framework was in place. This included the appointed FLA and a team of ten to twelve FLOs, with deployments also made to support injured victims.

1054. In a subsequent briefing at 09:00 hours on 14 June 2023, I was reassured by the appointment of a second FLA. This decision was made to provide resilience and support to Det Insp Gould, given the number of families and FLOs involved in the response.

1055. During Gold Group meetings, the ongoing deployment of both FLAs and FLOs was reaffirmed. I also confirmed that the SIO had developed a Family Liaison Strategy.

1056. The role of the FLA is to offer advice to the SIO, and to pass on instructions from the SIO to the FLO's and also to provide support to the FLOs. The SIO retains final decision-making authority over the tasks allocated to FLOs. As Gold Commander, I am of course able to check and confirm with the SIO the nature of those tasks, and I did so during the management of this incident. In exceptional circumstances, I may instruct the SIO to allocate specific tasks to FLOs, and I did this on two occasions during this operation.

1057. By the afternoon of Friday, 16 June 2023, I became increasingly concerned about the behaviour of the media, particularly the apparent leakage of sensitive information, including details about the warrant.

1058. In my assessment, information in the media about VC's FTA warrant or any other criminal or mental health matters could risk prejudice to the criminal proceedings by potentially influencing public perception and, more critically, the impartiality of any future jury. I considered that such disclosures may create a presumption of guilt, or an opinion of his mental health and undermine the defendant's right to a fair trial and compromise the integrity of the judicial process by introducing inadmissible or prejudicial material into the public domain.

1059. It was not just the information about the warrant I was concerned about, but also the revelation about other details relating to VC that could have a similar impact, and I was aware that media outlets were seemingly preparing to publish information.

1060. For example, in an email from the Sun newspaper to our communications team dated 14:14 hours on 16 June 2023, which I refer to

as URN: NGPF0005476, a reporter said (in summary): *"We are aware Nottingham attacks suspect Valdo Calocane was reported to police fir (sic) an attack on flatmate Chris GRO-B on or around January 15 and 16 2002 at Rayleigh Park student accommodation, Nottingham. In the days following this Nottinghamshire Police officers attended the property and escorted Valdo Calocane away. He received mental health intervention but was not charged with a crime. We have video of the attack and testimony that Valdo Calocane was known to others as "serial killer" because he regularly acted in such a threatening and intimidating manner...The relevant crime reference number for the case is 22000028303.....DEADLINE 4.30pm FRIDAY 16 JUNE 2023."*

1061. To mitigate this risk of publication of any such matters and thus the risk of prejudicing the criminal proceedings, I placed pressure on the SIO to accelerate the charging decision, knowing that once VC was charged, the media would be legally restricted from reporting further details, thereby reducing the risk of damage or prejudice. I have already described that matter earlier in my statement at paragraph 656, but will summarise it again here.

1062. During our conversation on 16 June 2023, I instructed the SIO to ensure that the families were immediately informed about the matter relating to the warrant. I was not prepared to accept the risk that they might learn of this information through the media. The SIO had already planned to inform the families of the warrant issue prior to charge, recognising that the warrant would inevitably be referenced during VC's first court appearance. We had committed to ensuring that information

would be shared directly with the families, rather than allowing them to learn of it through external sources.

1063. While the SIO expressed concern that this was not the ideal timing or method for delivering such sensitive information, I considered the greater risk to be the impact on the families' trust and confidence in us, should they learn of the matter through the media. I therefore took the decision to proceed with the instruction.

1064. The second occasion on which I issued a direct instruction to the SIO related to matters concerning PSD investigations and the accessing of information by members of the workforce. I set out the details of this matter both earlier and later in my statement.

1065. These instructions were given in the context of my strategic oversight responsibilities as Gold Commander and was consistent with my role in ensuring that the integrity of the investigation was maintained and that trust and confidence, particularly among the affected families, was safeguarded.

1066. During the initial phase of the incident response, I had some direct contact with the FLA, Det Insp Claire Gould, to support and oversee key aspects of the family liaison process. I considered this engagement essential, given the complexity and sensitivity of the role, and the importance of ensuring that the families' needs were met with care and consistency.

1067. Following the homicide investigation briefing that commenced at 20:20 hours on Tuesday 13 June 2023, I recorded in my log a conversation with Det Insp Gould. This followed an earlier discussion I had held with His

Majesty's Coroner regarding the families' wishes to release information about the identification of the victims. The challenge lay in reconciling these wishes with the formal identification process. In my role as ACC (Crime), I act as the strategic point of contact for coronial matters, and I recall speaking with the HM Coroner around this time to help facilitate a resolution.

1068. At 11:00 hours on Wednesday 14 June 2023, I noted a further conversation with Det Insp Gould, during which she provided updates on several matters including identification, photographs, press conference planning, vigil arrangements, preparations for the families to meet the Chief Constable, and the completion of homicide victim referrals.

1069. On Thursday 15 June 2023, at 10:00 hours, I attended a meeting organised by the FLA to brief the FLOs. This followed the SIO's briefing at 09:00 hours, which I had also attended alongside the FLA. Upon learning of the FLO briefing, I asked Det Insp Gould if I might join briefly to greet the officers, and she welcomed the idea. I made a note of the attendees, listened to the briefing, and took the opportunity to check on their welfare.

1070. During this meeting, I reiterated the importance of transparency and a "family first" approach, emphasising that families should never learn of developments in the investigation from external sources. Det Insp Gould outlined the key updates to be shared with families that day, which aligned with the SIO's earlier briefing. These included matters relating to MI5, the press conference, the IOPC referral, and a community solidarity statement. Additional updates included clarification that VC was neither an illegal immigrant nor an asylum seeker, and that his ethnicity would be

disclosed. It was also confirmed that any information intended for media release would be shared with families first. I noted these matters in my log at that time (10:00 hours 15 June 2023).

1071. The same entry in my log includes a discussion about the need to disclose information concerning the warrant and the Leicestershire assaults. I agreed that this disclosure was not necessary on that day due to other sensitive activities underway but expressed the view that it should be completed prior to charge.

1072. During the SIO's briefing at 18:00 hours on Wednesday 14 June 2023, I recorded a note under the topic "background" that the SIO acknowledged several relevant encounters between the police and VC over a two to three-year period. He recognised the importance of compiling a composite timeline, noting that while it was not a current priority, it would be shared with families in due course, likely with his involvement. He also emphasised the importance of clarifying the facts surrounding the warrant and committed to explaining these to families once established.

1073. At 19:24 hours on Thursday 15 June 2023, I had another conversation with Det Insp Gould regarding identification and the release of information about the victims. My recollection is that this discussion was interwoven with several conversations with His Majesty's Coroner, through which we were able to resolve the outstanding issues. Det Insp Gould also informed me of the families' wish to visit Ilkeston Road and asked whether I would support road closures to facilitate this. I agreed that this was an important request and confirmed my full support for any policing measures that could assist.

1074. Finally, on Wednesday 24 January 2024 at 08:30 hours, I met with the SIO, FLA, and FLOs to check on the welfare of the FLOs. I was acutely aware that supporting families through the sentencing hearing, which had commenced the previous day, would be emotionally demanding. I wanted to ensure that the FLOs had the necessary support to continue providing compassionate and professional care to the families, who were themselves facing an extremely difficult time.

Withdrawal of FLOs

1075. I have been asked to reflect on the minutes of the Gold Group meeting held on 30 January 2024 and to provide a detailed account of any concerns relating to the FLOs, including the background to those concerns, any steps taken to address them, and the rationale behind the decision to withdraw FLO support. I have also been asked to exhibit the plan referenced in those minutes.

1076. Up until 25 January 2024, the final day of the sentencing hearing, I was not aware of any concerns regarding the FLOs that would have warranted such a decision to be considered. A note in my log dated 20 December 2023 references an update from Det Supt Sanders, which appears to contain a contradiction: it states that the FLOs remained engaged and were providing updates, while also noting that some families were beginning to disengage, prompting welfare considerations. I do not recall any further detail about this conversation, which is probably because I did not register any significant concerns at that time regarding FLO engagement.

1077. On 9 January 2024, during a meeting with our communications team, I did inform them that some families had begun to disengage and that meetings had been cancelled. I noted that some families were deeply unhappy with the manslaughter decision and with the CPS, and that one family member had reportedly been rude to a FLO. This was shared in the context of communications planning, as families had indicated they did not wish to participate in media interviews or releases with the police and intended to manage their own communications.

1078. During a meeting on 19 January 2024, both Det Supt Sanders and Det Insp Gould informed me that there were some tensions between certain families and their assigned FLOs. However, we did not explore this matter in any significant detail. I understood the tensions to be linked to the upcoming sentencing hearing, particularly the families' frustrations with the CPS's decision to accept a plea of manslaughter on the grounds of diminished responsibility. At that time, nothing was shared with me to suggest that the withdrawal of FLOs was necessary.

1079. At the time, I reflected that such reactions, are not uncommon in the latter stages of criminal proceedings, particularly when outcomes are distressing for families. It did not appear unusual that meetings might be cancelled under such circumstances. Throughout the operation, I remained acutely aware of the emotional toll on both the families and the FLOs, and I know Det Supt Sanders shared this concern. We discussed it regularly.

1080. No further concerns regarding the FLOs were raised with me until the weekend of 27 and 28 January 2024 following the sentencing hearing.

During that weekend, Det Insp Gould informed both me and Det Supt Sanders that FLO's were very upset with what was being said in the media. These concerns were then formally brought forward during the Gold Group meeting on 30 January 2024.

1081. At the previous Gold Group meeting on 19 January 2024, no concerns were raised. The minutes noted that family engagement continued, that victim personal statements had been taken, and that constructive dialogue had occurred around sentencing arrangements.

1082. On 30 January 2024, family contact and FLO deployment were discussed as a specific agenda item. Det Supt Sanders and Det Insp Gould both expressed strong views that the FLOs should be withdrawn. They described the deployment as lengthy and complex, with significant impact on the FLOs' wellbeing, exacerbated by media coverage following the sentencing hearing. They referenced reports that were critical of the investigation and, more specifically, of the FLOs, including the nature and frequency of updates provided and the language used in a particularly sensitive notification to one family (a matter I have addressed earlier in my statement).

1083. Both Det Supt Sanders and Det Insp Gould were visibly affected by these developments. I agreed that it was appropriate to consider whether continued deployment of the FLOs remained suitable, given the reported loss of trust and confidence among some families and the welfare concerns for the officers involved. I emphasised that any decision must also take into account the ongoing need to support the families, and this balance was reflected in the recorded decision.

1084. We had a detailed discussion, and while the minutes do not capture the full extent of that conversation, I recall clearly the dilemma: the need to weigh the impact on FLOs and the loss of trust against the imperative to maintain meaningful support for families. The minutes suggest these two factors were to be balanced against each other, which may read confusingly. The discussion in fact centred on balancing both against the need for continued support.

1085. Det Insp Gould noted that the FLO relationships with Mr Coates' partner and the surviving victims remained effective and should be excluded from any withdrawal considerations.

1086. I concluded that restoring trust and confidence with families, while safeguarding the welfare of the FLOs, was paramount. I therefore tasked Det Supt Sanders and Det Insp Gould to develop a plan for the potential withdrawal of FLOs supporting the Webber and O'Malley-Kumar families. I was clear that this was a significant step and must be approached with care. I instructed that the national FLO advisor (Sian Lewis) be consulted, and that no final decision would be made until an alternative and adequate support offer was in place. I asked that options be developed for presentation to the families.

1087. I can confirm that these considerations continued over the following week and that no decision was finalised before the Chief Constable's first Operation Chainlink Gold Group meeting on 6 February 2024, which I did not attend. I understand that decisions were subsequently made by the Chief Constable, and I have not seen the final withdrawal plan.

CPS handling of the case

1088. I have been asked whether I hold any concerns regarding the way in which the CPS handled the case.

1089. In operations such as Hendrix, where a Gold Command structure is in place, it is essential that all involved maintain discipline and adhere to their designated roles. Engagement with the CPS falls within the remit of the SIO, which in this case was Det Supt Sanders.

1090. As Gold Commander, I did not have any direct interaction with the CPS during the course of this investigation. Should an SIO encounter any concerns or difficulties in relation to CPS involvement, it would be entirely appropriate for them to escalate those matters to the Gold Commander, either as part of a routine update or, if necessary, to seek strategic intervention.

1091. At no point did Det Supt Sanders raise any concerns with me regarding the CPS's handling of the case. I can therefore confirm that, from my perspective, I am not aware of any issues in this regard.

1092. I have, of course, read the HMCPSI report concerning the Nottingham attacks. However, I do not have personal insight into the matters discussed within that report and am therefore not in a position to comment further.

Statements to the Media

1093. I have been asked to outline my role in relation to media engagement during the Nottingham attacks, specifically in terms of responding to media queries and issuing public statements. This includes any changes in approach throughout the course of the investigation, charge, and trial.

1094. During the initial phase of our response, from the first call received on 13 June 2023 through to the point of charge on Friday 16 June 2023, the Chief Constable led all external communications and media responses. My role during this period was to act as a liaison between the investigative team, the various strategic and operational groups, and the Chief Constable, who was supported by our Head of Communications, Lyn Heath.

1095. As previously described, our daily briefing rhythm involved my early morning discussions with the SIO, followed by meetings with the Chief Constable and Lyn Heath to agree on communication priorities. These were followed by my attendance at the investigation briefing alongside a representative from the communications team. I then chaired the Gold Group meeting, which was regularly attended by either Lyn Heath, Matt Jarram, or both. I also chaired the SCG, while Lyn Heath participated in the communications cell subgroup. Throughout each day, further meetings with the Chief Constable took place, and attendance at the evening investigation briefing. This cycle was repeated daily.

1096. The following is noted in my Gold log (NGPF0007787):

1097. On 13 June 2023, I met with the Chief Constable and Lyn Heath at 08:15, chaired the TCG at 09:45, the Gold Group at 11:45, and reconvened with the Chief Constable and Lyn Heath at 15:00. I attended the evening investigation briefing at 20:00.

1098. On 14 June 2023, I met with the SIO at 07:00, followed by a meeting with the Chief Constable and Lyn Heath between 08:15 and 09:00. I attended the investigation briefing at 09:00, met again with the Chief

Constable at 10:30, chaired the Gold Group at 12:00, and the SCG at 13:30. We reconvened at 18:00 to attend the evening investigation briefing together, followed by a final debrief at 21:00.

1099. On 15 June 2023, I met with the SIO at 07:30, the Chief Constable and Lyn Heath at 08:30, and attended the investigation briefing at 09:00.

Further meetings with the Chief Constable and Lyn Heath took place at 11:00 and 14:30, with the Gold Group and SCG chaired at 12:00 and 13:30 respectively.

1100. On 16 June 2023, I met with the SIO at 07:30, the Chief Constable and Lyn Heath at 08:30, attended the investigation briefing at 09:00, chaired the Gold Group at 12:00, and the SCG at 13:45. A COT catch-up was also held at 16:00.

1101. On 16 June 2023, a final media statement was issued by the Chief Constable, confirming that a suspect had been charged in connection with the Nottingham attacks. I now refer to that statement, which was published on the Nottinghamshire Police website, as URN: NGPF0007930.

1102. Between 16 June 2023 and January 2024, I do not recall receiving many, if any, media inquiries specifically relating to the Nottingham attacks.

1103. On 9 October 2023, I was informed of a change to the court date. The PTPH was subsequently scheduled for 28 November 2023. This development prompted a conversation between the Chief Constable and I regarding future media engagement. Although I did not make a formal note of the discussion, I recall the Chief Constable advising that, given my role as Gold Commander and my detailed operational understanding, it would

be more appropriate for me to lead on any forthcoming media releases and interviews relating to the case.

1104. From that point onwards, and through to the plea and sentencing hearing, which took place between 23 and 25 January 2024, I led on our media approach. This included reviewing and signing off all media releases and undertaking all interviews related to the case.

Involvement in the Chief Constables announcement that Valdo Calocane had been charged on 16 June 2023

1105. My only involvement in relation to the Chief Constable's announcement that VC had been charged was to inform her that this had taken place. I did not contribute to the development of the media statement that followed.

1106. I may have been copied into email exchanges between the Chief Constable and the Communications Team regarding this media release; however, I do not recall receiving such emails, and I did not, to my knowledge, contribute to any discussions about its content.

1107. However, I was aware that the Chief Constable shared my concerns regarding the risk of unauthorised disclosures to the media and the potential prejudicial impact such leaks could have on the integrity of the criminal proceedings. I have already described these concerns earlier in my statement. We discussed these concerns on the day the charge was confirmed, 16 June 2023, and I note her subsequent warning about the posting of prejudicial information, as referenced in her own statement dated 16 June 2023.

1108. In light of these risks, I had instructed the SIO to accelerate the charging decision, as I have previously described. I had discussed the

approach with the Chief Constable explaining that this was a deliberate step to mitigate the possibility of further leaks and to safeguard the fairness of the judicial process.

Considerations regarding Nottinghamshire Police's Previous Interactions with Valdo Calocane in the Charging Announcement

1109. Due to my limited involvement in the Chief Constable's announcement on 16 June 2023 regarding the charging of VC, I am not aware of the extent to which, if at all, consideration was given to addressing Nottinghamshire Police's previous involvement with, or investigations into, matters relating to VC.

1110. Although I was not privy to any discussions on this point, I would not have supported the release of information concerning Nottinghamshire Police's prior encounters with VC at that stage. This type of information was precisely what I had sought to prevent from entering the public domain, for two key reasons.

1111. Firstly, the SIO had not yet had the opportunity to share details of previous contact with VC, aside from the warrant, with the bereaved families. Releasing such information publicly at that time would have conflicted with our "families first" approach to communications, which prioritised ensuring that families were informed directly and sensitively before any public disclosure.

1112. Secondly, the nature of the information, some of which related to criminal acts and a long-standing history of mental health, had the potential to be prejudicial to the now active criminal proceedings. Protecting the integrity of the criminal case was paramount, and I

remained concerned that premature or inappropriate disclosure could compromise that process.

Considerations regarding the accuracy and openness of the Chief

Constables 16 June 2023 charging announcement to the media.

1113. In my opinion, the Chief Constable's statement was accurate at the time it was made. VC, aged 31 and of no fixed address, had been charged with three counts of murder and three counts of attempted murder. He was scheduled to appear at Nottingham Magistrates' Court on Saturday 17 June 2023.

1114. In the witness statement of Lulian GRO-B who was a house mate of VC, he states that the landlord had given VC a definitive eviction date of 12 June 2023. From this point, and to my knowledge, that meant that VC was of no fixed address. I refer to the witness statement of Lulian GRO-B as URN: NGPF0002460.

1115. The charging of a suspect in connection with such serious offences, particularly those that had dominated both local and national media throughout the week, was a significant development. It marked a turning point for the affected families and communities, signalling that the individual believed to be responsible for these horrific events had been deprived of his liberty and that criminal justice proceedings had formally commenced. This type of development can offer reassurance to the public, helping to restore a sense of safety and stability. It also represents a vital first step in the process of securing justice for the victims and their families.

1116. This milestone was the direct result of an intensive and coordinated criminal investigation, supported by wider policing activity, which had taken place over a four-day period.

1117. Although VC had been arrested relatively quickly and his involvement seemed likely from the outset, the investigation required a thorough and methodical approach to progress from an initial position, where the sequence of events was not yet clear, to one where the CPS was satisfied that the evidence supported a coherent and detailed chronology. This chronology established clear evidential links between VC and each of the six attacks, and the CPS concluded that the threshold for prosecution had been met.

1118. An assessment of the investigation is documented in the Major Case Review Self-Inspection Report dated 22 June 2023 (NGPF0007817). This report followed a peer review conducted on 20 June 2023 by Stuart Prior, Head of the EMSOU Regional Review Unit, and Review Officer Paul Cottee. Both individuals are highly experienced in major crime investigations, and their assessments carry significant professional credibility.

1119. Having been present in the Major Investigation Room and having attended most of the SIO briefings, I can confirm that the assessment contained within the Major Case Review aligns with my own view of the quality of the investigation. This opinion is based not only on what I observed and heard during the response, but also on my professional experience as a former SIO and my understanding of what constitutes best practice in the management of major investigations.

1120. The review's findings reflect the structured and thorough approach that I witnessed firsthand. The investigative decisions, deployment of resources, and coordination across multiple crime scenes were consistent with the standards I would expect in a case of this complexity and seriousness. The review's conclusions, particularly in relation to the SIO's rationale, decision-making, and documentation, accord with my own assessment of the professionalism and diligence demonstrated throughout the investigation.

1121. The review confirmed that the on-call murder investigation SIO was notified at an early stage and responded immediately. According to the incident log for Incident 0065_13062023, Det Insp Pam Dowson was briefed regarding the initial calls to Ilkeston Road at 04:18 hours and was en-route to the scene by 04:25 hours. I refer to Incident Number 0065_13062023 as URN: NGPF0007846.

1122. The review found that the parameters set for the multiple scenes were appropriate and that scene logs were in place. It described the immediate investigative structure, including the appointment of the SIO, who in turn appointed Det Ch Insp Clare Dean as deputy, along with three further deputies to manage the respective crime scenes.

1123. Det Insp Clare Gibson was assigned to Ilkeston Road, Det Insp Kaz Smithson to Magdala Road, and Det Insp Kate Savage, who leads the specialist collision investigation unit, was assigned to both Milton Street and Parliament Street. A structured approach to scene examination was implemented, and forensic inquiries and evidence recovery were prioritised across eleven identified crime scenes.

1124. The SIO appointed Crime Scene Coordinator Tess Buxton to oversee all scenes, maximise forensic recovery, and assist in developing forensic strategies. Early forensic strategy meetings were held, and fast-track submissions were authorised, including hand swabs from the suspect, an item of his clothing, a blood-stained knife, and a sheath recovered from his rucksack.

1125. Three specialist search advisors were deployed, supported by licensed search officers, to conduct searches at and between scenes for evidence and/or victims. The SIO also instructed three post-mortems, all conducted by Dr Mike Biggs, with each attended by separate investigation teams.

1126. The review highlighted numerous fast-track actions undertaken by the SIO, including obtaining witness statements from VC's family members, deploying FLOs, identifying significant witnesses, reviewing key messaging, examining VC's property, and conducting CCTV trawls at the three main sites. The SIO also identified appropriate main lines of inquiry, which included family liaison and scene management, post-mortems, CCTV and intelligence inquiries, fast-track forensic opportunities, telephone data, liaison with counter-terrorism policing, processing the suspect, and establishing previous addresses to identify victims and recover evidence.

1127. The review acknowledged the significant resourcing support provided to the investigation, including murder investigators from across the region, detectives from Nottinghamshire Police, and contributions from counter-terrorism policing. It noted that CT staff were not as proficient in some roles, which led to occasional duplication of work.

1128. The review also observed that media activity during the first week was highly intrusive, with outlets conducting independent investigations, interviewing witnesses before police contact, identifying the suspect, and obtaining CCTV footage.

1129. The review confirmed that the SIO had appointed a FLA and deployed trained FLOs to both bereaved families and injured victims. Upon arrival in custody, VC's clothing was forensically recovered, and he was examined. I am aware that he refused consent to provide intimate samples, including blood. Dr Kumar raised concerns about the omission of recovering a hair sample for toxicology testing, which I have addressed earlier in my statement (paragraph 775). Dr Kumar also raised concerns about the non-recovery of a holdall VC was believed to have had earlier in the evening, which I have also commented on previously.

1130. The review noted that CCTV comparisons were conducted between footage from the scenes and dashcam recordings. The CPS was satisfied that the individual depicted in all footage was VC and that the images were consistent.

1131. The review referenced VC's mental health history and the issue that arose close to the charging decision, where I had instructed the SIO to expedite the process to mitigate the risk of media reporting potentially prejudicial information.

1132. One area identified for improvement related to the remote working arrangements of some intelligence functions, though ongoing support was being provided to the SIO.

1133. The investigation was managed on the HOLMES system, the appropriate platform for major investigations. All key roles required for its effective operation were appointed, and the SIO activated a Casualty Bureau, which received over 200 calls. This was recognised as good practice.
1134. The review concluded that a substantial number of resources had been deployed and that these were proportionate and sufficient to meet the demands of the investigation. The reviewer expressed high regard for the management of the investigation, describing it as well-structured and thoughtfully executed. Praise was given to the SIO's policy log entries, which demonstrated clear rationale and sound decision-making throughout.
1135. If the question regarding whether I considered the Chief Constable's statement to have been open and transparent at the time relates to whether any thought was given to providing more detail about Nottinghamshire Police's previous encounters with VC, then I hope I have already addressed this matter earlier in my statement.
1136. Upon reflection, and while acknowledging the concerns that have since been raised, particularly in relation to drug toxicology and the missing Slazenger holdall, it remains my view that the charges brought against VC were indeed the result of a thorough and diligent investigation into the events that occurred in the city that week. For the reasons I have already articulated, I continue to hold the opinion that the statement was open and transparent, and that it appropriately reflected the stage and scope of the investigation at that time.

Differences between the Operation Hendrix/if asked document and version published on the Internet.

1137. I have been asked to comment on and explain the differences between the Operation Hendrix release/if asked document (URN: NGPF0007928) and the version that was published on the Nottinghamshire website on 25 January 2024. I refer to a copy of the published article on the Nottinghamshire website as URN: NGPF0007935.

1138. To assist the inquiry, I will refer to the first document dated 16 January 2024 as “draft” and the version that was published on the website on 25 January 2024 as “final version.”

1139. I think it is both relevant and important to use these titles because that is precisely what they were.

1140. Where an incident or operation is being managed under a Gold Command structure, in the way the Operation Hendrix was, the standard approach when preparing media releases for the criminal justice phase of the operation is that a communications officer (in this case Matt Jarram) would meet with the SIO and the Gold Commander to discuss the case and approach. It is usual that there would be more than one of these meetings in the build up to the relevant hearing.

1141. The role of the communication officer is to talk to the officers about the case, elicit information, and combine that with information that they have absorbed throughout the course of the operation, particularly when they have been involved in it from the outset, and then go away and prepare a draft version or draft versions for a media release.

1142. Once that draft is complete it is normal for the communications officer to send the draft to the SIO, or the Gold Commander, or both, asking for it to be checked for accuracy and to provide feedback.

1143. This process can often involve a back-and-forth dialogue until eventually a final version is arrived at. The final version is not then published until it has been signed off by the Gold Commander.

1144. The content of the Operation Hendrix Press Release/ if asked document, which was sent to me by e-mail from Matt Jarram at 16:24 hours on 16 January 2024, was the first draft of the media release.

1145. I replied to that email at 16:52 hours on the same day to explain that I wanted to have a “proper read” of the draft and asked for my personal assistant to print it off for me, so that I could undertake that exercise. This is a standard approach for me as when I need to read documents thoroughly, particularly where accuracy is important and I am likely to be making amendments, my preference is to work on a hard copy rather than an electronic copy and to make notes with a highlighter or other pen.

1146. I am unable to point to specific changes made within the initial draft contained in the email, as that marked the beginning of a process which unfolded over the days that followed, culminating in my approval of the final version 9 days later on 25 January 2024.

1147. During that period, I recall having numerous in-person conversations with the communications team. I used my annotated hard copy of the draft, along with handwritten notes, to inform the development of subsequent versions. This was a fluid and iterative exercise, and I explain it in more detail in the next part of my statement.

1148. I refer to the combined email chain as URN: NGPF0007840. I refer to the initial email sent by Matt Jarram 16 January 2024 as URN: NGPF0007928. I refer to my approval of the final version 25 January 2024 as URN: NGPF0007929.

1149. I have also been asked to comment on several specific lines that appear in both the draft and final versions of the media release. Before addressing those points directly, I feel it is important to note that the final version of the release differed significantly from the draft. All changes made to the draft were made by me.

1150. My immediate observation upon reviewing the draft was that it lacked sufficient context for the statements being made. My primary aim in redrafting was therefore to introduce both context and chronology, to ensure the release conveyed a clearer and more informed narrative.

1151. When considering the content of this media release, I was mindful of balancing several important considerations. I was aware that the families were not fully sighted on all the details of the incidents in which we had engaged with VC. At the same time, I recognised that some of these incidents had been referenced in the prosecutor's opening note dated 15 January 2024, while others had not. I was conscious of not disclosing information that had not previously been shared with the families. I also felt it was important to provide the public with sufficient information to support a meaningful understanding of our prior contact with VC, and to ensure that the context of this case was clearly and accurately conveyed.

1152. The key message I sought to communicate in the final version was that, while there had been multiple encounters between the police and VC,

the vast majority of these were incidents that, within policing, would be classified as mental health related. In most cases, these encounters resulted in a mental health intervention either during or following police involvement. On some occasions, our attendance was specifically to support such interventions.

1153. I felt it was important to convey that VC's history of contact with the police was not characterised by persistent or serious criminal offending. Rather, his actions appeared to be closely linked to his mental health.

1154. I was also conscious of the importance of helping the public understand that what occurred was not connected to the broader issue of knife crime that has affected many cities across the country, including Nottingham. I was mindful that my words could directly influence how safe people felt in the city, and the level of trust and confidence that communities placed in Nottinghamshire Police and policing more generally. At the time, that trust was particularly fragile, not only due to national events but also because of more local incidents. In fact, just one week prior, on 7 June 2023, a 74-year-old man was tragically stabbed to death in Nottingham.

1155. To support explanation in this section of my statement, I think it would be helpful to refer again to the abbreviated timeline of thirteen encounters between VC and the police, that I have previously described in paragraphs 930-942. I hope this will assist the inquiry in understanding my analysis.

1156. While I have already described the thirteen relevant incidents earlier in my statement, I have repeated them here, and included additional

information that I felt was pertinent in illustrating the point about mental health.

1157. Incident 1: 24/05/2020, 12 Brook Court, Player Street, Nottingham. VC kicked and damaged a door to an empty flat. The door was kicked from its hinges, and VC was detained attempting to get into another flat (number 11). Whilst in custody for this matter, VC was assessed by a health care practitioner before being taken to the hospital due to concerns for his mental health.

1158. Incident 2: 24/05/2020, 23 Brook Court, Player Street, Nottingham. The resident of a flat jumped out of her first-floor flat window after VC was kicking her front door, as a result of which she sustained a serious back injury. This incident was attended by police officers and the mental health triage car, due to a reference in the incident log to an earlier event and its connection to mental health. The mental health triage car is a multi-agency resource comprising a police officer and an NHS psychiatric nurse, designed to provide a joint response to incidents where mental health is a factor. VC was sectioned under the MHA and transported to the Rowan Ward at Highbury Hospital.

1159. Incident 3: 13/07/2020, 11 Brook Court, Player Street, Nottingham. VC forced entry into another flat in the same block and tried to assault someone inside before being detained by the occupants and police called. This incident was also attended by the mental health triage car and VC was transported directly to the Cassidy suite at Highbury Hospital.

1160. Incident 4: 31/05/2021, Thames House, Millbank, London (MI5). VC attended this location and asked the Metropolitan police to arrest him but appeared calm. No action was taken against him.
1161. Incident 5: 05/07/2021, GRO-B 20 Middleton Street, Nottingham. VC grabbed his flat mate (Sebastian GRO-B) and pushed him against the wall inside the flat, saying "...people will be contacting you and in case that happens, then you should tell these people that I will contact them...." He behaved very aggressively. Although police did not actually attend this incident, and did not see VC on this occasion, Mr GRO-B told the Police that VC was regularly visited by NHS staff, which he believed to mental health nurses.
1162. Incident 6: 03/09/2021, GRO-B Former Marquis of Lorne Pub, Junction Middleton Street (same location as incident 5), Nottingham. The police attended this incident following a request to provide support to mental health services in the execution of a MHA warrant, during which VC assaulted a police officer, PC Pritchard.
1163. Incident 7: 15/01/2022, Flat 15 Madison Court Derwent Way Nottingham. Following a disagreement over the cleaning of a shower, VC put his flat mate (Christopher GRO-B) in a headlock, before punching him, and then waited for the police to arrive. A reference was made in the incident log to a previous mental health incident involving VC.
1164. Incident 8: 19/01/2022, Flat 15 Madison Court Derwent Way Nottingham. Following a mental health referral from the University, after Incident 7 above, the police were requested to provide support to mental

health services in the execution of an MHA warrant. VC was taken to Cassidy Suite, Highbury Hospital, via ambulance, escorted by police.

1165. Incident 9: 28/01/2022, Flat 15 Madison Court Derwent Way

Nottingham. The police received a further request to provide support to mental health services in the execution of an MHA warrant. VC was taken to Cassidy Suite, Highbury Hospital, via ambulance, and there was no need for a police escort on this occasion. Officers attended the scene, and spoke with VC, who accompanied them to the ambulance. There was no use of force.

1166. Incident 10: 26/04/2022, Gymnasium, Nottingham Road, Basford,

Nottingham. Sebastian GRO-B reported that VC approached him whilst at the Gym and then followed him afterwards.

1167. Incident 11: 28/07/2022, Northgate, Basford, Nottingham, Sebastian

GRO-B reported VC following him again, after the gym.

1168. Incident 12: 22/09/2022, VC failed to appear at Nottingham Magistrates

Court for assaulting an assault emergency worker. A warrant (not backed for bail) was issued the same day.

1169. Incident 13: 05/05/2023, Avarto Warehouse in Kegworth,

Leicestershire. VC punched a male warehouse co- worker and pushed over a female worker who he believed had been talking about him because they were speaking in a foreign language (Romanian).

1170. Drawing on this analysis, I will now address the questions in turn, and for clarity, I am responsible for all changes that resulted in the final version:

- **PART A - Draft Version:**

1171. *"I can confirm that Nottinghamshire Police previously engaged with the suspect while supporting our colleagues in the NHS."*

1172. This statement is factually accurate. However, in my assessment this sentence could be interpreted to mean that there had only been one such encounter, which would not have portrayed the full picture and prolonged period over which the police had worked, together with mental health services, in responding to incidents involving this defendant. Although I do not believe it was misleading or lacking in transparency, it did not effectively convey the message I had intended.

1173. *"In September 2021, we were requested to support a Section 135 warrant to section the suspect under the Mental Health Act."*

1174. This statement is also factually accurate and corresponds to Incident 6 as described above. While I do not believe it could reasonably be interpreted as misleading, it lacked the necessary context to support the message I was aiming to convey.

1175. *"We transported the suspect to Highbury Hospital and during this encounter he assaulted one of our police officers."*

1176. This statement is inaccurate. The officer was assaulted inside the flat prior to VC being removed from the scene. VC was then first taken to the Queen's Medical Centre, followed by a transfer to Highbury Hospital. While I do not believe the statement lacked transparency, given that it correctly notes the fact of the assault and the transfer to Highbury Hospital, it is a summary that does not accurately reflect the sequence of events in detail. Nor did this sentence help either with conveying the message that there had been several such encounters.

1177. Following my assessment of the draft version, I subsequently prepared and signed off the final version of the media release. I have not based these amendments on any other advice or source.

1178. Although I do not recall the precise stages through which this was completed, I am confident the process was undertaken in phases. The next relevant email correspondence I can locate is from Lyn Heath (URN: NGPF0007929), sent at 09:52 hours on 25 January 2024. In that message, Lyn Heath shared a further draft of the media release, noting that I had already signed off a previous version and that the communications team had now added a timeline of our contact with VC. I could see that this version differed from the original draft sent to me by Matt Jarram.

1179. I recall reviewing the timeline of contact at home on the evening of Thursday 18 January 2024, as noted in my log, in preparation for media interviews scheduled the following day.

1180. I also met with Matt Jarram on the afternoon of Friday 19 January 2024 specifically to undertake those interviews, and I recall discussing the timeline with him during that meeting. I also referred to the timeline in a note made during a meeting held at 15:15 hours that same day. My recollection is that, through these discussions, I identified some inaccuracies in the original draft and provided feedback to Matt Jarram accordingly.

1181. I also note a final email from myself at 11:13 hours on Thursday 25 January 2024, in which I amended the draft to produce the final version.

- **PART A - Final Version:**

1182. *“Nottinghamshire Police previously engaged with the defendant largely while supporting our colleagues in the NHS on a number of occasions.”*

1183. On reflection, the placement of "largely" and "on a number of occasions" in this sentence does create slight ambiguity when used together, which was never my intention. I do, however, believe the statement to be accurate, and certainly when one considers the message I was intending to convey, which was that our involvement with VC was primarily in relation to mental health incidents, and working with mental health colleagues.

1184. Based on my analysis of the incidents outlined above, there are eleven Nottinghamshire incidents, (excluding those involving the Metropolitan Police and Leicestershire Police). One of these relates to the execution of a fail-to-appear warrant. On three occasions, Incidents 5, 10, and 11, there was no engagement with VC at all.

1185. This means that Nottinghamshire Police engaged with VC on seven relevant occasions. At Incidents 2 and 3, Nottinghamshire Police attended alongside a psychiatric nurse as part of the mental health triage car. For Incidents 6, 8, and 9, police attendance was in support of the execution of an MHA warrant.

1186. I did not undertake a numerical analysis at the time to justify the use of the term "largely." Rather, it was an expression of my general understanding, informed by my knowledge of the history and the overall nature of our involvement with the defendant.

1187. Upon reflection, and when considered in the context of the full press release, I believe the sentence does convey the point that police

interactions with VC over the three years preceding the June 2023 attacks primarily related to behaviours stemming from his mental health.

1188. I acknowledge that the phrasing could have been more precise, particularly in clarifying that, on those occasions when we were working alongside our NHS colleagues, the nature of support was often mutual. In fact, in some instances, it is open to interpretation whether we were supporting them, or they were supporting us. In the case of incidents involving the mental health triage car, it is fair to say that we were supporting each other.

1189. I also acknowledge that a full and detailed chronology might have been more helpful for some, but it was never my intention to provide a comprehensive chronology of all police incidents involving VC. Rather, my aim was to offer the public a sense of the nature and context of the types of incidents in which he had been involved, whilst protecting my commitment not to over share information which might not yet be known to families.

1190. The key point I sought to convey was that, although there had been multiple encounters between the police and VC, the majority of these incidents would, within policing, be classified as mental health related. In most cases, these interactions led to a mental health intervention either during or following police involvement. On several occasions, our attendance was specifically to support such interventions.

1191. I felt it was important to emphasise that VC's history of contact with the police was not characterised by persistent or serious criminal offending. Rather, his behaviour appeared to be closely linked to his mental health.

1192. The purpose of changing this sentence was to make clear that we had engaged VC multiple times with mental health colleagues and to make clear that the incidents concerning VC were predominantly mental health related incidents. In the original draft version of this statement, it tended to indicate that this might have only happened once.

1193. *"We have helped transport the defendant to Highbury Hospital for treatment because he was sectioned under the Mental Health Act."*

1194. This statement is accurate, as is outlined in my analysis of the incidents. I do not think this sentence lacked openness or transparency because it was entirely true, with Nottinghamshire Police having transported or escorted EMAS carrying VC to hospital on at least four occasions. When one considers my intent, in relation to the message I was trying to convey, I think it was an appropriate thing to say.

1195. Again, the purpose of changing this sentence was to convey the message that VC had in actual fact been sectioned under the MHA, and that this was a significant intervention in the context of our dealings with him over that period. It was also intended to supplement the first revised sentence and help to inform the public that the police had played their part in transporting VC on more than one occasion, when he had been sectioned under the MHA.

1196. On reflection, and except for the small matters that have I have identified, I consider all five of the sentences to be accurate and for the reasons I have already articulated.

1197. Also, I consider the two additional sentences in the final version to be more open and transparent in terms of the message that I wanted to

convey which was to an almost exclusive extent the previous police interactions with VC had been because of his mental health and as part of that that we had worked together multiple times with colleagues from the mental health services to make appropriate interventions and played our part in his detention under the MHA.

- **PART B - Draft Version:**

1198. *“We also had two further encounters with the suspect on January 19 and January 28 2022, to again support a Section 135 warrant to section the suspect under the Mental Health Act. Again, officers supported by transporting the suspect to Highbury Hospital on both occasions.”*

1199. I consider the first sentence of this part of draft to be accurate. The sentence I am referring to here is the sentence that ends with the words “Mental Health Act”. Nottinghamshire Police did support the execution of a Section 135 MHA warrant in relation to VC on both 19 and 28 January 2022. These are referenced as Incidents 8 and 9 in my analysis above. It was also appropriate to use the word “again,” as these two incidents represented the second and third occasions on which police had supported the execution of an MHA warrant.

1200. However, the second part of the statement, *“officers supported by transporting the suspect to Highbury Hospital on both occasions”* is not accurate. On 19 January 2022, VC was conveyed to hospital via ambulance and was escorted by a police vehicle. On 28 January 2022, he was taken to hospital by ambulance without any police escort.

1201. In the context of my overall intended message, I believe the paragraph was open and transparent. However, its construction and placement within

the press statement did not assist in clearly explaining the chronology of events, particularly as there was no reference to the assault incident in January 2022, from which these two MHA warrant incidents stemmed.

1202. It was for this reason, and to ensure clarity and accuracy in the chronology, that I amended the wording for the final version of the release. Neither statement was based on information from another source or additional advice received.

- **PART B - Final Version:**

1203. *“In January 2022, we were called to an incident where the defendant is alleged to have assaulted a flat mate. We did attend this incident, but because police action was not supported, we did not arrest the defendant on this occasion. However, the resultant mental health referral did result in him being detained once again in a mental health establishment.”*

1204. I consider this statement to be accurate. Police were called to an incident on 15 January 2022 in which VC is alleged to have assaulted his flatmate, this is described as Incident 7 in my analysis above. The victim had indicated to the officer that he was not sure whether he wanted the police take any formal action and the officer elected not to proceed with an arrest. The victim later signed the attending officer’s pocket notebook entry to confirm that he did not wish for formal action to be taken against VC. I refer to this pocket notebook entry as URN: NGPF0007841.

1205. It is also accurate that a mental health referral was made following this incident. That referral led to the obtaining of a Section 135 MHA warrant, which was executed on 19 January 2022. Although VC was taken to Highbury Hospital on that occasion, he was released on the same day

following assessment. A subsequent reassessment resulted in a further Section 135 warrant being obtained and executed on 28 January 2022, which led to him being detained under the MHA.

1206. I acknowledge that I omitted a step in the process when describing this matter in the press release. I did not explain that the referral had been made by the University, and nor that following VC being taken to the hospital on the first occasion (19 January 2022), he was released on the same day. In fact, it took a further visit (28 January 2022) before he was sectioned. However, in my view, it remains accurate to state that the referral arising from the assault incident ultimately led to VC's detention under the MHA.

1207. I recognise that a fuller description of this incident may have been more helpful. Nonetheless, my intention was always to provide a broad overview of police interactions with VC and to contextualise the significant role that mental health played in those encounters.

1208. I also acknowledge that my reference to a "resultant referral" may, on reflection, be interpreted as suggesting that the referral was made by the police. That is not the case, and it was never my intention to create that impression.

1209. Taking these points together and particularly considering the overall purpose of the media release, I remain of the view that the paragraph was sufficiently open and transparent.

1210. Save for my earlier comments regarding the conveyance to hospital (in the draft version) and the other observations I have made, I consider both

versions of the statement to be accurate. In my view, they are also sufficiently open and transparent.

- **PART C - Draft Version:**

1211. *“He failed to appear and therefore a warrant was issued for his arrest in September 2022. We were unable to locate him due to his nomadic lifestyle...This case has now been discontinued.”*

1212. I consider the first part and last part of this statement is accurate. VC did fail to appear at court on 22 September 2022, and a warrant was issued for his arrest on that date.

1213. The assault on the police officer that gave rise to VC’s failure to appear at court was discontinued by the CPS in December 2023.

1214. The comment stating that we were unable to locate VC due to his nomadic lifestyle is inaccurate, which is why I removed it from the final version of the press release. Given its inaccuracy, I do not consider it meaningful to assess its openness or transparency. I knew at the time that this aspect of the draft statement was incorrect, and I remain of that view, and it was never published.

1215. I recall discussing this sentence with Matt Jarram shortly after he shared the draft with me on 16 January 2024. Although I do not have a recorded note of the conversation, it stands out in my memory as I was surprised to see the sentence included in the draft release. Matt Jarram explained that, over the preceding seven months, he had attended numerous briefings where there had been repeated references to whether VC had a fixed address. He recalled a conversation with the SIO, who he believed had once used that term “nomadic”, and remembered

discussions about the difficulty in locating the Slazenger bag VC had brought back from London, which had subsequently disappeared shortly before the attacks in Nottingham on 13 June 2023.

1216. Drawing on these recollections, he had assumed that the reason VC had not been arrested was due to difficulties in locating him. I explained that this was not the case and clarified that the police had not in fact made any proactive efforts to locate him. I had never heard anyone use the word “nomadic” in the context of Operation Hendrix.

1217. Matt Jarram appreciated the feedback, and the statement was amended accordingly. I cannot recall whether the changes were made by him, by me, or by another member of the communications team, but I take full responsibility for causing the amendment to be made. Nor can I recall whether the changes were submitted via email or by providing the communications team with a hard copy of the original draft that I had marked up with amendments. What I can confirm, however, is that when Lyn Heath sent me a further version of the draft at 09:52 hours on 25 January 2024, the amendments had already been made.

1218. In my view, this episode highlights the value of the collaborative and iterative approach we adopt when developing communication messages in the context of major incidents such as this.

1219. We amended the draft to ensure it accurately reflected what had occurred and to avoid perpetuating any misleading information.

1220. According to the information available to me at the time no attempts had been made by Nottinghamshire Police following the issue of the warrant on 22 September 2022 to locate VC.

- **PART C - Final Version:**

1221. *“He failed to appear on that occasion and a warrant for his arrest was issued in September 2022. He was never arrested for that warrant which was still outstanding at the point of his arrest in June 2023, when he brutally killed three people and seriously injured three others on the streets of Nottingham.”*

1222. I consider this statement to be accurate, and in my view, it is both open and transparent. That was my assessment at the time, and it remains my view now.

1223. As previously stated, a warrant had been issued for VC in September 2022, and he was never arrested in relation to that warrant, which remained outstanding at the time of his arrest in June 2023.

- **PART D - Draft Version:**

1224. *“He carried out no further offences in our city and county since our last interaction with him on January 28, 2022”.*

1225. When I read the draft, I immediately recognised that this sentence *might* be inaccurate. I recognised this because of my detailed knowledge of the timeline of police contact with VC which included the two reported incidents of potential stalking in April and July 2022 (Incidents 10 and 11). It is entirely possible that these two matters were not crimes at all, but since they had not been attended and fully assessed by the police, the possibility remained open and so I believed that this draft version of the statement *might* be inaccurate.

1226. Given its potential inaccuracy, the reason for which I have explained, I also assess that the sentence lacked openness or transparency in its

current iteration. It was possibly incorrect, certainly lacked openness and transparency and so I decided to remove it without delay.

1227. I do not recall discussing this specific point with anyone, and I attributed its inclusion to the drafter's lesser familiarity with the timeline compared to my own. I also do not recall the precise mechanism through which I removed the sentence, whether by email or by providing a marked-up hard copy of the draft. What I can confirm, however, is that when Lyn Heath sent me a further version of the draft at 09:52 hours on 25 January 2024, the sentence had been removed. In my email reply at 11:13 hours that same day, I authorised the final version, with a few additional minor amendments.

1228. The removal of this statement was my decision.

- **PART D - Final Version:**

1229. *Omitted from the 25 January document.*

1230. As is hopefully evident from the context above, the statement was omitted because it was possibly inaccurate and certainly lacked openness and transparency, which I recognised immediately upon reviewing the draft, and that assessment remains unchanged. On reflection, it seems likely that the statement was included in error, either through a misunderstanding or a lack of sufficient knowledge of the timeline.

- **PART E - Draft Version:**

1231. *"We had very little interaction with Calocane. Our main interaction with Calocane was supporting our NHS colleagues".*

1232. I believe it is important to clarify that this sentence was not part of the proposed draft press release. Rather, it was suggested to me as a

possible line to consider using during television interviews. This explains its omission from the final release, as it is abundantly clear from the email draft I received on 16 January 2024 that there was no intention for it to be included in any press release.

1233. As to whether the statement is accurate, I have above outlined thirteen contacts with VC between May 2020 and June 2023, two of which involved matters in another force area (London and Leicestershire). On an objective assessment, I would suggest that describing this as 'very little interaction' underrepresents the extent of our engagement. In that respect I acknowledge that this sentence lacked openness, but it was, of course, not included.

1234. Regarding the suggestion that our main interaction with VC was while supporting NHS colleagues, I would reiterate the observations I made in Part A above. The nature of those interactions was often collaborative, and in some instances, it is debatable whether we were supporting the NHS or they were supporting us.

1235. **PART E - Final Version:**

1236. *Omitted from the 25 January document.*

1237. As outlined above, this sentence was proposed to me as a potential response for use during immediate media interviews, rather than as content for the press release itself. Its omission from the final release is therefore unsurprising, as it was never intended for inclusion. The email draft I received on 16 January 2024 makes this clear. As such, no intervention was required to remove it, it simply was not part of the original draft.

- **PART F - Draft Version:**

1238. *“Our last interaction with Calocane was January 28, 2022 before he went on to kill three people and attempted to kill three others nearly a year and a half later.”*

1239. To provide context, this sentence was also put forward as a suggestion for use during media interviews and was not part of the draft press release. Its absence from the final version reflects that it was never intended for inclusion, as confirmed by the email draft I received on 16 January 2024.

1240. This statement is inaccurate, and is similar in content to that which was included within the draft version of the press release referred to above at Part D. The slight difference is that here the word “last interaction” is used, whereas in Part D above, the words used are *“He carried out no further offences”*. When I read this, I immediately recognised that this sentence was inaccurate. My understanding of the timeline of police contacts with VC made this apparent, particularly when considering the two reported incidents of potential stalking in April and July 2022 (Incidents 10 and 11).

1241. Given that the statement was inaccurate, I do not consider it appropriate to assess whether it demonstrated openness or transparency. It was clearly incorrect. That was my view at the time, and it remains unchanged. For that reason, as outlined above, the sentence was not included in any written press release.

1242. **PART F - Final Version:**

1243. *Omitted from the 25 January document.*

1244. I trust it has been made clear above that this comment appeared solely within the email of 16 January 2024 as a suggested response for media interviews. It was not proposed for inclusion in any press release, aside from the similar wording referenced earlier at Part D, and therefore its absence from the document issued on 25 January 2024 is entirely consistent with that intention.

Proposed changes to the timeline of contact with VC.

1245. I have been asked to confirm whether I made or proposed changes to the timeline of contact with VC, as set out in the version sent to me by email at 09:52 hours on 25 January 2024. I can confirm that I received this email from Lyn Heath, Head of Communications, and I now refer to it as URN: NGPF0007842.

1246. As previously described, I had earlier received an initial draft version from Matt Jarram on 16 January 2024. I reviewed that draft in hard copy, likely annotating it, and subsequently engaged in further discussions with members of the communications team regarding proposed amendments.

1247. It is now evident from email correspondence that I had been in dialogue about the 16 January 2024 draft with both Matt Jarram and Simon Cotton, Deputy Head of Communications. On the morning of 24 January 2024, a series of emails between myself, Matt Jarram, Simon Cotton, and Lyn Heath confirm that I met with both Jarram and Cotton to discuss the media release. Within that chain, I note an email sent by me to Lyn Heath at 09:55 hours on 24 January 2024, confirming that Simon Cotton and I had been working on the document. I refer to this email chain as URN: NGPF0007843.

1248. The version sent to me at 09:52 hours on 25 January 2024 reflected the discussions and amendments I had made from 16 January 2024 version, which I have detailed earlier in this statement. Following receipt of that version, I responded at 11:13 hours the same day, indicating that I was content with the first part of the press release, primarily concerning events on the night of 13 June 2023, but also noting that I had made several further changes to the latter section, namely the timeline.

1249. To assist the inquiry, I have compared the version sent by Lyn Heath with the version contained in my reply and have outlined the differences below.

1250. Paragraph one: Nottinghamshire Police previously engaged with the defendant largely while supporting our colleagues in the NHS on a number of occasions between 2020 and 2022. I made no changes to this paragraph.

1251. Paragraph two: On each occasion, we transported the defendant to Highbury Hospital for treatment after he was sectioned under the MHA. I amended this to read: We have helped transport the defendant to Highbury Hospital for treatment because he was sectioned under the MHA.

1252. I also added a further paragraph: On each occasion, he was released by mental health services and his mental health managed by them within the community.

1253. Paragraph three: In September 2021, we were again requested to support mental health services with a Section 135 warrant to section the suspect under the MHA. I removed the word "again". I removed this word,

because this was the first time the Police had supported the execution of a S135 MHA Warrant in relation to VC.

1254. Paragraph four: We transported the suspect to Highbury Hospital and during this encounter he assaulted one of our police officers. I made no changes to this paragraph. On reflection, I should have changed this paragraph, as in its current iteration it suggests that the assault had happened during the transporting of VC. This is not accurate. The officer was assaulted inside VC's flat, before he was taken to the hospital.

1255. Paragraph five: In August 2022, he was reported for summons and was due to attend court on 22 September 2022 for the assault on our officer. I made no changes to this paragraph.

1256. Paragraph six: He failed to appear on that occasion and a warrant for his arrest was issued in September 2022. He was never arrested for that warrant which was still outstanding at the point of his arrest in June 2023. I made no changes to this paragraph.

1257. Paragraph seven: The defendant had committed no violent incidents in our city and county, and none were reported to us since September 2021. I removed this paragraph because, as I have explained already, this was possibly inaccurate and certainly lacking in openness.

1258. I added the following paragraph into the release at this point: In January 2022, we were called to an incident where the defendant is alleged to have assaulted a flat mate. We did attend this incident, but because police action was not supported, we did not arrest the defendant on this occasion. The resultant mental health referral did result in him being detained once again in a mental health establishment.

1259. Paragraph eight: Our next involvement with the defendant was when he brutally killed three people and seriously injured three others on the streets of Nottingham in June 2023. I made no change to this paragraph. However, in the final version that was sent out by email by Lyn Heath at 12:04hrs on 25 January 2025, this paragraph was shortened and added onto Paragraph 7 above, so that it read: He failed to appear on that occasion and a warrant for his arrest was issued in September 2022. He was never arrested for that warrant which was still outstanding at the point of his arrest in June 2023, when he brutally killed three people and seriously injured three others on the streets of Nottingham.

1260. I did not make any further changes to the remainder of the version sent to me by Lyn Heath at 09:52 hours on 25 January 2024. That section of the document continued to read as follows:

1261. *“After the June 2023 attacks, we followed the Independent Office of Police Conduct’s guidance and, having shared details with them, we undertook professional discussions to establish whether the referral criteria was met over not executing the warrant for his arrest. Following advice that the criteria for referral was not met, we decided not to make a referral, but undertook an internal review of this matter ourselves.*

Assistant Chief Constable Rob Griffin, who has led the overall policing response to the events of June 13, said:

The devastating impact that the events of 13 June have had and continue to have for the families of those killed and those that survived these dreadful attacks are immeasurable.

I have personally reviewed this matter and we should have done more to arrest him. In my opinion it is highly unlikely that he would have received a custodial sentence for the alleged assault.

Of course, an arrest may have triggered a route back into mental health services, but as we have seen from his previous encounters with those services, it seems unlikely that he would have engaged in this process.

On June 13, we acted fast and efficiently to take this dangerous offender off the streets of Nottingham.

We referred ourselves to the IOPC after his arrest. This was because in the minutes before his arrest he was being followed by a police vehicle and ran over two pedestrians.

This is a standard procedure when a crime occurs while a defendant is being pursued by police. The IOPC investigated this matter and said we followed all relevant guidelines.

This was one of the darkest days in our city's history and our officers will continue to support all those families affected by this horrific crime."

Further clarification in relation to the timeline of contact with VC

1262. In addition to the points I have already made regarding the version of the timeline sent to me by Lyn Heath at 09:52 hours on 25 January 2024, I have been asked to provide further clarification in relation to three specific paragraphs contained within that document.

- **PART A:**

1263. As previously explained, I removed the following sentence from the draft version of the timeline provided by Lyn Heath:

1264. *“The defendant had committed no violent incidents in our city and county and none were reported to us since September 2021.”*

1265. The statement was omitted from the final version of the media release because it was inaccurate. I recognised this upon reviewing the draft, and that assessment has not changed. Accordingly, I removed it from the release.

1266. I attributed its inclusion to the drafter’s lesser familiarity with the timeline, particularly when compared to my own. Its inclusion had seemed somewhat surprising, given that the draft dated 16 January 2024 referenced an interaction with VC in January 2022, although I acknowledge that this reference did not include mention of a violent crime.

1267. I did consider whether the author intended to refer to September 2021. I considered whether it was more likely that the intended reference was September 2022, possibly to convey that following VC’s failure to appear at court, there had been no further reports of criminal behaviour within Nottinghamshire.

1268. I reflected that even if the intended date had been September 2022, it would have felt counterintuitive to suggest that no crimes had been reported in Nottinghamshire, when we were aware of allegations in Leicestershire. I was concerned that such a statement might be perceived as deflecting attention away from Nottinghamshire and towards another force area, which was never my intention and would not have aligned with my commitment to openness.

1269. Given the inaccuracy, I do not consider it appropriate to assess whether the statement demonstrated openness or transparency.

1270. I do not recall any specific conversation about this point. I removed the statement from the draft simply because it was incorrect.

- **PART B:**

1271. The following statement was included in both the draft version of the release that was sent to me in the e-mail from Lyn heath at 0952 hours 25 January 2024 and also in the final media release that was published on the Nottinghamshire Police website on the same date. I refer to a copy of the published article on the Nottinghamshire website as URN: NGPF0007936.

1272. *"I have personally reviewed this matter and we should have done more to arrest him. In my opinion it is highly unlikely that he would have received a custodial sentence for the alleged assault."*

1273. I have been asked to describe the nature of the review that I undertook.

1274. The review I commissioned into the warrants process developed in two distinct phases. Initially, the focus was on a specific warrant relating to VC. However, it became clear that there were broader systemic failures in how warrants were managed within Nottinghamshire Police.

1275. The first phase of the review, establishing what action had been taken in relation to the specific warrant, was relatively straightforward and lasted only a few days.

1276. I was first made aware of the existence of the warrant during the initial Gold Group meeting at 11:45 hours on 13 June 2023.

1277. In response, I tasked Det Supt Williams, Head of PSD, to review the individual case and determine why VC had not been arrested.

1278. This was recorded as an action within the Gold Group, and Det Supt Williams provided an update during the next meeting on 14 June 2023.

1279. The action tracker noted that the warrant had been placed in a NICHE inbox titled "Notts Wanted City Centre" in September 2022 but had not been actioned. Det Supt Williams suggested that there may be learning for the City Senior Management Team. I now understand that the inbox name was recorded with a typographical error and should have read "Notts Wanted City Central." I also distinctly recall being informed that VC had been circulated as wanted on PNC.

1280. The NICHE police system is a comprehensive records management system used by many police forces across the United Kingdom, including Nottinghamshire Police. It serves as the central platform for managing a wide range of policing functions and operational data. Through NICHE, officers and staff can record and manage crime reports, conduct investigations, assess intelligence and vulnerability, handle custody and detainee processes, manage voluntary attendance and property, and prepare electronic case files with integrated workflow management.

1281. A NICHE inbox functions as a digital filing cabinet where documents can be stored and tasks or actions assigned. Each geographical area within the force has its own NICHE inbox, which serves as the central location for managing operational items. Each area also had a NICHE inbox for outstanding warrants. Those requiring action are placed into the relevant inbox corresponding to the geographical area, ensuring they are directed to the appropriate team for follow-up and actioning.

1282. The City Senior Management Team, led by Supt Kathryn Craner, was present at the meeting. Although not formally recorded in the minutes or action tracker, I recall further discussion with the group about the management of warrants. Supt Craner briefly explained that warrants were indeed managed through NICHE, with each area having its own inbox where warrants were lodged for actioning. Responsibility for managing these tasks lay with the NPI for the relevant area. I was already aware that NPIs were responsible for overseeing the execution of warrants allocated to their areas, and this remains the case today. Supt Craner noted that the NPI for the relevant area had recently resigned, and a new NPI had only just taken up the post. As I explained earlier, his resignation was unrelated to any matters concerning the warrant. He had joined the service as a direct entry Inspector, had not found policing to be a fulfilling career, and ultimately chose to pursue a different path.

1283. As I also explained earlier in my statement in paragraph 648, the unexecuted warrant was a topic of considerable discussion across the force, including within the Gold Group and investigation briefings. Although not formally recorded, I recall being told, though I cannot recall when or by whom, that the officer in the assault case had sought support to arrest VC, but the arrest did not occur. I may have learned this later, as I have no record confirming when it was shared.

1284. I also remember being informed that the warrant had been sent to VC's previous address, which did not surprise me, as we were aware that he had not returned to the location where the offence had occurred and from which he had been sectioned in September 2021.

1285. From this point, I understood clearly that no substantive proactive action had been recorded by Nottinghamshire Police to execute the warrant, other than circulating VC as wanted on PNC and placing the warrant in the relevant tasking inbox. While I cannot entirely rule out the possibility that an officer, either serving or retired, may have proactively conducted address checks, I have not made any broader enquiry into this, and I consider it unlikely.

1286. Later that day, at 19:06 hours on 14 June 2023, I received an email from Det Supt Williams (NGPF0007844), which had been sent to her earlier that day by Det Insp Louise Bradford of PSD. This email provided further detail arising from the review of VC's warrant and raised concerns about the wider warrants process. It highlighted a lack of clarity around who was responsible for monitoring the inboxes where warrant circulation tasks were sent. It explained that since 2017, warrants had been managed through NICHE, but the current process appeared fragmented and poorly monitored.

1287. Det Insp Bradford explained that once a court issued a warrant, it was entered onto NICHE by warrant officers and sent to PNC to ensure the individual was circulated as wanted. It was then tasked back to the warrant officers to distribute to the relevant departments or individuals. However, the warrants officer reportedly did not know who monitored the NICHE inboxes, and completed tasks were rarely returned, likely due to a lack of oversight or follow-up.

1288. One NICHE inbox, "Notts Wanted City Central", which is where VCs warrant was lodged, contained 282 live warrant circulation tasks, with the

oldest dating back to 2017. This suggested that the inbox may not have been actively monitored since the transition to NICHE. While some tasks may have been actioned by officers managing individual cases, many appeared not to have been finalised in the system. In the worst-case scenario, all 282 tasks could represent outstanding warrants.

1289. Further review of NICHE inboxes for other geographical areas, revealed similar issues, with some containing dozens or even hundreds of live tasks, many dating back several years. The warrants officer reportedly had over 1,000 initiated tasks, warrants sent out for others to action and had previously been advised to leave them as they were too numerous to manage. Det Insp Bradford recommended that someone be assigned to review the backlog and determine the status of these tasks, as the situation may mean that over 1,000 warrants were outstanding.

1290. From the early stages of Operation Hendrix, I was therefore aware that VC had failed to appear at court, that a warrant had been issued and sent to an outdated address, that he had been circulated as wanted, and that the warrant had been placed in the appropriate inbox for actioning. However, no action had been recorded, leading to the most likely position being that no proactive steps had been taken to arrest VC. In my view, this is a completely unacceptable position and falls far below what the public would expect.

1291. As previously stated in paragraph 473, when I reflect on the matter now, I wish to state that this resulted from a serious systemic operational failure on the part of Nottinghamshire Police. I am profoundly embarrassed

by this and wish to offer an unreserved apology. The warrant should have been executed, and VC should have been arrested.

1292. During the Gold Group meeting on 14 June 2023, I discharged the action and remitted the matter of the warrants system to be addressed outside of the Gold Group by Det Ch Supt Scurr. On 15 June 2023, Det Ch Supt Scurr was formally tasked with reviewing how warrants were managed through NICHE. A review was undertaken both within the force and with regional NICHE forces.

1293. Throughout June 2023, Det Ch Supt Scurr led this review and tasked Det Ch Insp Kim Binns to benchmark practices with other forces outside the region and to make recommendations for improving the management of warrants in Nottinghamshire. By 7 July 2023, Det Ch Insp Binns presented her findings, while the overall system for managing warrants was flawed, the process of allocating them to Neighbourhood Policing Teams was effective. Det Ch Insp Binns recommended that responsibility for managing and executing warrants should remain with NPIs, with records maintained on NICHE occurrence enquiry logs. However, Det Ch Insp Binns also found that due to flawed system and the volume of warrants, they were not easily identifiable in NICHE queues, which significantly hindered prioritisation and management.

1294. Det Ch Supt Scurr set priority actions to cleanse all current warrant records in NICHE, ensuring that executed warrants were properly finalised and associated tasks closed. Warrants were to be graded A, B, or C, in line with National Police Chief's Council ("NPCC") guidance, according to the index offence to assist with prioritisation. A Power BI dashboard was to

be developed to support oversight of warrants. Additionally, "Operation Final Score" was implemented to re-examine all warrants allocated to workflows where the subject was believed to be outside the force area or where enquiries had been exhausted.

1295. Between July and October 2023, Det Ch Supt Scurr established a Warrant Working Group to deliver these actions, with progress reported into my Strategic Criminal Justice Board. The overarching objective was to redesign the end-to-end process for managing warrants within the force through NICHE, and that revised process has now been fully implemented.

1296. At the time I made my statement to the media, I was aware that VC had failed to appear at court, that a warrant had been issued and sent to an outdated address, that he had been circulated as wanted, and that the warrant had been placed in the appropriate inbox for actioning. However, no recorded action had been taken, which led me to conclude that no proactive steps had been undertaken to arrest VC.

1297. What ought to have occurred is that the NPI should have allocated the warrant to a specific officer or team within their area and instructed them to undertake all reasonable efforts to locate and arrest VC. As a minimum, this should have included visiting all known current and previous addresses associated with the individual.

1298. Had those enquiries proven negative, it would have been reasonable, in my view, given VC's significant engagement with mental health services, to seek further information from that agency to identify any additional addresses. It would also have been proportionate to make enquiries with the university and, where appropriate, with family members.

1299. Considering the nature of the offending, I would not have expected more intrusive lines of enquiry to be pursued.
1300. At that time in Nottinghamshire, there was no strategic guidance in place specifying for NPIs the expected timeframe for executing a fail-to-appear warrant. This was a further organisational failure, as the NPCC guidance provides such timeframes. It was, however, understood that NPIs were responsible for prioritising the arrest of individuals subject to outstanding warrants, alongside other operational demands such as recalls to prison and suspects wanted for substantive offences.
1301. While I would not have expected the NPI to prioritise the arrest of VC, given the relatively low-level nature of the assault involved, I would nonetheless have expected that some activity aimed at effecting his arrest would have been initiated within a reasonable period. Although it is difficult to define precisely what constitutes a reasonable timeframe, I would have considered a period of 21 days to be appropriate in the circumstances.
1302. I think it is important to acknowledge that, while I held certain expectations of the NPI role, their ability to meet those expectations was significantly constrained by the systems in place at the time for managing warrants. The system was entirely deficient at this time.
1303. As described by Det Insp Louise Bradford, I fully recognise that when an NPI accessed their warrants inbox, they were likely met with a confusing and unclear picture. It would not have been immediately apparent which entries represented live warrants requiring action, and which were simply updates on tasks, some completed, some not.

1304. I accept that this lack of clarity would have made it very difficult for an NPI to quickly establish a reliable overview of outstanding work. In turn, this would have hindered their ability to prioritise effectively and take timely action.

1305. In the final version of the media release, I can confirm that there is reference to two separate assault cases. The first related to the assault on the police officer, an offence which had taken place whilst the officer had been supporting mental health colleagues to execute an MHA warrant. The second related to the alleged assault by VC on his flatmate in January 2022.

1306. When I expressed my view that it was highly unlikely that VC would have received a custodial sentence for the alleged assault, I was referring to the first case, the case of the assault on PC Pritchard on 3 September 2021.

1307. I expressed this view because I believed it was consistent with the overall message I had been trying to convey, that the encounters between the police and VC did not arise from him being a career criminal or a repeat and persistent violent offender but were instead closely connected to his mental health.

1308. In that context, I felt it was important for the public to understand that the offence for which he failed to appear at court was one of those types of offences, linked to his mental health, and not one that would ordinarily have led to a lengthy custodial sentence. I recognised that some may have thought that arresting him on the warrant might have resulted in him being imprisoned and therefore not at liberty in June 2023 to commit the tragic

offences that occurred. My intention was to clarify that this was not the likely outcome at the time, and that the nature of the offence did not suggest such a result.

1309. I also felt it was a question the public would reasonably have; namely what outcome VC might have faced at court in relation to this offence.

1310. In forming this view, I felt it was important to supplement my professional judgement, shaped by (then) over 28 years of policing experience and extensive work within the criminal justice system, with some additional research.

1311. On the evening of 18 January 2023, I recorded an entry in my log reflecting my analysis of the potential outcomes had VC been arrested on the outstanding warrant.

1312. My analysis began with consideration of the circumstances surrounding any such arrest and initial detention. I noted that mental health concerns could have been identified at either stage, and that an arrest might even have led to a further detention under the MHA.

1313. If VC had been deemed fit for detention, he would likely have been held for the next available court appearance. At that point, I considered it relevant whether he had legal representation and how he presented in terms of his mental health, with or without a solicitor.

1314. I anticipated that a criminal defence solicitor, upon learning that the alleged assault occurred during the process of being sectioned under the MHA, might challenge whether it remained in the public interest to pursue the case. Subject to VC's instructions, I considered that a solicitor may have sought to have the case discontinued. This view was later echoed by

the CPS lawyer in November 2023, who proposed discontinuance of the assault charge.

1315. I also considered whether VC would have been fit to give instructions.

If not, I believed he would likely have been released on bail for psychiatric assessment. If he had been fit and wished to plead guilty, the matter would have proceeded directly to sentencing.

1316. In the event of a not guilty plea, particularly if based on mental health grounds, I considered it likely that he would have been released on bail pending trial and further psychiatric evaluation.

1317. I did not believe that a remand into custody would have been likely, given that the warrant had been issued to an outdated address, and it was probable that VC was unaware of it.

1318. Psychiatric evidence obtained in the 2023 case confirmed that VC had experienced recurring episodes of psychosis, specifically paranoid schizophrenia, since 2020, and was suffering from this condition at the time of the 2021 assault. I considered that this would have been a significant factor in any sentencing decision, likely resulting in a reduced sanction.

1319. It may also have provided grounds for the CPS reconsidering whether the offence should be pursued at all, given that his mental illness appeared to be either the direct cause or a substantial contributing factor in the commission of the offence.

1320. I next turned to the Magistrates' Court sentencing guidelines to consider the question of sentence in the event of either a conviction following trial or a guilty plea.

1321. I began with Step One, which involves determining the offence category. I reviewed the factors listed under culpability and harm. Under culpability, I noted that none of the indicators of high culpability were present. However, one of the factors listed under lesser culpability, namely, the presence of a mental disorder linked to the commission of the offence, was applicable. I therefore assessed the case as falling within Category B for culpability.

1322. In terms of harm, I considered the number and severity of injuries and concluded that this would likely place the offence in Category 2.

1323. Proceeding to Step Two, which sets the starting point for sentencing, I assessed the case as most likely falling within category B2. This would suggest a starting point of a low-level community order, with a range extending up to a high-level community order. Even if the case were assessed as B1, which I considered unlikely, the starting point would be a medium-level community order, with a range from low-level community order up to 16 weeks' custody.

1324. I then considered statutory and other aggravating features. Among the statutory factors, I noted that VC had no previous convictions and was not on bail, but that the offence was committed against a public servant. None of the other aggravating features, such as spitting, biting, domestic context, presence of children, or abuse of power, appeared to apply.

1325. I also considered factors that might reduce the seriousness of the offence or reflect personal mitigation. These included the absence of previous convictions and the presence of mental health concerns, while being mindful not to double-count the latter.

1326. Under Step Three, I acknowledged that the offence was aggravated by virtue of being committed against an emergency worker, which would attract a sentence uplift. However, if assessed at B2, this would likely result in a more onerous sanction of the same type identified for the basic offence.

1327. Taking into account the overall circumstances of the offence, including the context in which it occurred and the available body-worn video footage, I concluded that it was highly unlikely VC would have received a custodial sentence for this offence.

1328. I have been asked to consider whether both sentences in this part of the press statement are accurate, open, and transparent.

1329. In relation to the first sentence, where I stated that I had personally reviewed the matter, I believe this to be an accurate and transparent reflection of my involvement. On reflection, I acknowledge that a lay person might interpret that phrase to mean I had independently reviewed all systems and information relating to the case myself. However, I think it is more likely that they would understand it to mean that, as a senior officer with overall command of the operation, I had directed others to carry out reviews on my behalf, received information from them, and then read, considered, and discussed that information. In the context of a large organisation such as Nottinghamshire Police, and given the position I held within the COT, I believe it is both reasonable and sufficiently transparent to state that I personally reviewed the matters relating to the warrant.

1330. I also consider it factually accurate to say that we should have done more to arrest VC, for all the reasons I have previously outlined. I

acknowledge that I could have provided more detail about the circumstances surrounding the failure to arrest VC on the warrant.

1331. However, at the time, it was never my intention to explain to the public the complexities and challenges surrounding the management of that warrant, or more broadly, the poor state of our warrants system. Attempting to describe the circumstances in which VC had been circulated as wanted on PNC and yet had not been stopped or checked by police in the period that followed, even after a further offence in Leicestershire, would have required a lengthy and confusing explanation. I believed the confusion would have been added to by attempting to explain that the warrant had been placed into a disorganised digital folder of work. While it was highly unlikely that any officer had actively attempted to locate VC, the poor condition of the system meant we could not say that with certainty.

1332. In expressing the view that we should have done more to arrest him, I intended to acknowledge that our response in this regard had fallen short of what we should have achieved. I believed it was important to be honest about that, recognising that it reflected a serious failure in our processes. My aim was not to assign blame, but to be transparent about the limitations that existed at the time, and to support a better understanding of the context in which decisions were made.

1333. I also reflected that because the full extent of this issue had not already been shared with the families, it limited my ability to go further in any event. Nonetheless, I felt it was important to say enough to make clear to the public that the police service had not met the standard expected in this regard.

1334. Regarding the second sentence, where I stated that in my opinion it was unlikely VC would have received a custodial sentence, I recognise that this is a difficult question to assess in terms of accuracy, as it was an expression of professional judgement rather than a statement of fact. I have already explained the basis on which that opinion was formed. It was my view at the time, and it remains my view. I believe that expressing such an opinion publicly, with appropriate context and explanation, is consistent with being open and transparent.

- **PART C:**

1335. The following statement was also included in both the draft version of the release that was sent to me in the e-mail from Lyn Heath at 09:52 hours 25 January 2024 and in the final media release that was published on the Nottinghamshire Police website on the same date.

1336. *“Of course, an arrest may have triggered a route back into mental health services, but as we have seen from his previous encounters with those services, it seems unlikely that he would have engaged in this process.”*

1337. I expressed this view because I wanted to make clear that I fully acknowledged there may have been other potential benefits arising from an intervention with VC, had he been arrested. While I had already stated my view that it was highly unlikely his arrest would have led to him being detained in prison, I was nonetheless mindful that such an arrest might have created an opportunity for re-engagement with mental health services, whether at the point of arrest, during detention, or through the court process.

1338. I was also seeking to convey a sense of concern, and to some extent frustration, about the cyclical and arguably ineffective nature of the systems approach that had been taken in managing this individual over a period of three years.

1339. It was clear to me that a pattern had emerged: VC would commit an act, be detained, sometimes initially in police custody, sometimes directly into a mental health care setting, and ultimately be released back into the community under a treatment plan that he did not adhere to. This would then lead to further deterioration and repetition of the cycle.

1340. My intention was to highlight the complexity and difficulty of managing individuals with this type of illness, and to reflect that the current arrangements across public services were not, in my view, sufficiently robust or joined up to meet the needs presented.

1341. My overall message was that, even if VC had been arrested, it is unlikely he would have been detained in prison custody. It is also unlikely he would have been detained in a mental health care setting in the long term. More probably, he would have remained at liberty in the community, and, based on previous patterns, would not have engaged with his prescribed medication. This would have left his condition less controlled and his behaviour at risk of further deterioration.

1342. To form this opinion, I reviewed the medical and police incident timeline that had been compiled as part of the case papers submitted to the CPS (NGPF0007824). I was also briefed on the content of VC's RiO records, a comprehensive record of his mental health care. These records span 273 pages; while I did not read them in full, a cursory review made clear VC's

inconsistent engagement with his prescribed medication. I also considered the prosecutor's sentencing note dated 15 January 2024, which provided further summary insight into VC's attitude toward treatment.

1343. The medical and police incident timeline (NGPF0007824) offered a helpful summary of key events. It showed that VC was first detained under Section 2 of the MHA on 25 May 2020, following two incidents involving damage to property within his flat complex. He was discharged on 17 June 2020, with follow-up care assigned to the crisis team and local mental health services.

1344. A second detention occurred on 13 July 2020 after a similar incident, and he was again discharged on 31 July 2020 under the care of community mental health teams.

1345. On 29 May 2021, VC's mother contacted the crisis team, expressing concern that he was unwell and had not been taking his medication for two to three weeks. This was followed by a missed review appointment on 28 June 2021.

1346. A home visit was conducted on 8 July 2021, and by 9 August 2021, after another missed clinic appointment, it was suspected that VC was relapsing. A doctor visited him at home on 10 August 2021 and reported that he was compliant with medication at that time.

1347. However, a series of missed visits and calls followed, and due to concerns about disengagement, an MHA warrant was obtained and executed on 3 September 2021, resulting in a third MHA detention. VC was discharged on 22 October 2021 with continued monitoring.

1348. On 15 January 2022, VC assaulted his flatmate. A referral from the university followed, and due to ongoing disengagement, another MHA warrant was executed on 19 January 2022. VC was taken to Highbury Hospital but not detained. Upon release, VC was advised to engage with services and adhere to his medication.
1349. A further review on 27 January 2022 led to another MHA warrant, executed on 28 January, resulting in a fourth detention. He was granted short periods of release during February and discharged on 24 February 2022.
1350. Reports of unusual behaviour were made by VC's former flatmate in April and July 2022. On 22 September 2022, VC failed to appear at Nottingham Magistrates' Court, and a warrant was issued. The following day, on 23 September 2022, the mental health team discharged him back to the care of his GP, having been unable to locate him.
1351. The prosecution's sentencing note added further context to this timeline and reinforced the view that VC's engagement with mental health services had been inconsistent and problematic over a sustained period:
1352. Paragraph 67 (iii) - VC reported to Dr. Blackwood that in October 2020 he had stopped taking his medication, at the direction of the voices. However, in December 2020 he told his doctor that he was compliant with his medication. His medication was increased again in February 2021 (at §§27-28 p.8). Subsequently discovered unused medication suggests he ceased taking his medication at this time.
1353. Paragraph 67 (iv) - In May 2021 his family became concerned about his mental health again. On 11 July 2021 the voices were telling him his

family would die, and he drove to see them, sleeping in the car because he refused to go into the house, and returning to Nottingham the following morning. He did not refer to this in a clinic review on 10 August 2021, but instead told the assessing psychiatrist that the voices were faint and that he was content to continue his medication. It is clear that he was actively and deliberately concealing the symptoms of his psychosis and 'compliance with oral medication was unlikely'.

1354. Paragraph 67 (v) - On 31 August 2021 VC disclosed that he had stopped taking his psychotropic medication, stating that he believed he had never been mentally unwell. He evaded subsequent contact with his treating team.

1355. Paragraph 67 (vii) - Following his discharge, in November and December 2021 VC had limited contact with his community team, missing appointments and exhibiting paranoid and confrontational behaviour.

1356. Paragraph 70 - The Prosecution acknowledge that VC's inability to accept the respective diagnoses of his condition was and is a consequence of that mental illness.

1357. Paragraph 71 - The Prosecution observe, however, that VC was aware he had committed previous acts of violence. He was told on multiple occasions, of the need to take his medication. He continued to fail to take his medication and hidden and lied about that fact with care.

1358. In relation to this statement, I recognise that this was a matter of professional judgement rather than an objective fact. I have already outlined the reasoning that informed that view, and it remains my considered opinion. While it is not possible to determine with certainty

what the outcome would have been, I believe that offering a reasoned opinion in this context, supported by analysis and experience, represents a fair and transparent contribution to the public understanding of the case.

ITV News interview – 25 January 2024

1359. I have been asked to reflect on two statements I made during my interview with ITV News on 25 January 2024. Specifically, I have been asked whether I considered those statements to be accurate, open, and transparent at the time they were made, and whether my opinion in respect of either has since changed. If my view has changed, I have been asked to explain when and why that change occurred.

1360. I believe it is important to provide some context to these statements, as they were made in response to direct questions during the ITV News interview.

1361. As part of my preparation for this witness statement, I re-watched the ITV News interview, which was broadcast in full at the time.

1362. To assist the Inquiry, I have included additional narrative drawn from the transcript of that interview, which I hope will help to clarify the circumstances in which the statements were made and provide the appropriate context for understanding them.

1363. I refer to the transcript of this interview as URN: NGPF0007845. I will take each statement in turn.

1364. For clarity, I believe it is evident that the interview was specifically focused on police activity on 13 June 2024. All my responses were given directly in relation to that line of questioning and were intended to describe

what took place on that morning and address whether anything could have been done differently.

1365. To be clear, I was not asked about, nor did I provide, any commentary or information relating to events prior to that date.

- Statement one:

1366. *"I am absolutely confident that there is nothing we could have done, we couldn't have changed the way we responded at any point that would have stopped any of those incidents".*

1367. To support a clearer understanding of the context in which this statement was made, I have included both the full question that was put to me and my complete response. I have also identified the specific part of my answer (which I have highlighted in bold type) that the Inquiry has asked me to address.

1368. At 00.02.00 into the interview, I was asked:

1369. *"I mean, this is kind of very fast-moving event, tragically, you know, three people lost their lives in awful, awful circumstances. Are you kind of confident that everything that you as a force did on that day, was done to try and stop Valdo Calocane while he was doing things? Are you content that you couldn't have done anything more, or you did everything you could do?"*

1370. At 00:02:24 I replied (with my emphasis added):

1371. *"Yes, I think the first thing to say is that three people lost their life, but three other people nearly lost theirs too. It's about six victims and not three. But each dreadful, dreadful cases. And you know, we look back and I look back. I've led this policing response from the night on June the 13th*

and we've looked back and poured over. I'm absolutely confident that there was nothing that we could have done. It, it, we couldn't have changed the way that we responded at any point that would have stopped any of those incidents happening on that night."

1372. Before I deal with the question on accuracy, I would firstly like to say, that I have reflected on the tone and impact of this statement and now regret responding in that manner. In the context of a TV interview, especially one involving such sensitive matters, it is now my view that this statement is likely to come across as overly definitive and potentially dismissive of public concern or scrutiny, even though that was emphatically not my intent.

1373. It was something I said during a fast-paced media interview and if I could do the interview again, I would choose very different words: "Absolutely confident" leaves no room for nuance or reflection, which I can see would likely be perceived as defensive. Saying "nothing we could have done" might sound dismissive to those affected or seeking accountability. The phrasing does not acknowledge the emotional weight of the incidents or the public's need for reassurance.

1374. In hindsight, I believe a more appropriate way to express it would have been to say: "Based on everything I know, and the actions taken on the night, I believe our response was appropriate. With the benefit of hindsight, it's always right to reflect on whether anything could have been done differently, but I am not aware of any specific point where a change in our approach would have prevented those incidents."

1375. Not only would this have been more understated, sensitive and empathetic, I believe it would also have reflected the fact that at that time of the interview, we had not undertaken a forensic analysis of police activity between the attacks of Barnaby and Grace and the subsequent attacks.
1376. It may also be difficult to determine the accuracy of my remarks, as they reflect my personal perspective and opinion at the time. That opinion was informed by my close familiarity with the events of that night.
1377. In preparation for the interview, I revisited the incident logs documenting the calls made to police on 13 June 2024, as well as the sequence of events chart (NGPF0007827) compiled by the major crime investigation team and submitted to the CPS as part of the prosecution file.
1378. I also reflected again on the Operation Hendrix debrief report which had been published in October 2023.
1379. I refer to the main incident log NGPF0007846.
1380. I refer to the main incident log for the attacks that commenced on Milton Street (Incident 0077_13062023) as URN: NGPF0007847.
1381. I refer to incident log for the attack on Magdala Road (Incident 0079_13062023) as URN: NGPF0007848.
1382. I refer to the Operation Hendrix debrief report as URN: NGPF0007690.
1383. The opinion I expressed was that I did not believe there was anything we could have done on that night to prevent the sequence of events from unfolding as they did. By the time of the interview, I was aware that VC's actions lacked any discernible logic or pattern. He had no known

connection to the victims, the attacks occurred at different times and locations, and each was carried out in a markedly different manner.

1384. The attacks on Ilkeston Road appeared to be entirely without motive.

While robbery was initially considered, no theft had taken place. The subsequent attempt to enter Seely Hirst House, followed by seemingly gratuitous violence on Ian Coates and the theft of a van, culminating in further harm to others, presented a deeply confusing and fragmented picture that was extremely difficult to piece together in real time.

1385. The attack on Grace and Barnaby occurred at approximately 04:00 hours, with VC leaving the scene by 04:02 hours. The first call to police was received at 04:04 hours, and officers arrived at the location by 04:08 hours.

1386. According to the incident log (NGPF0007846), by 04:07 hours, the FCR had already considered the 'golden hour' principles, those immediate actions officers are advised to take upon attending a serious incident. These included activating body-worn video, obtaining initial accounts from victims and witnesses, conducting early CCTV enquiries, searching for any weapons, securing the scene, and passing early observations regarding any suspects. Consideration was also given to avoiding cross-contamination, meaning officers who attended the scene would not be used to arrest the suspect, to preserve forensic integrity.

1387. At 04:09 hours, a dog unit was deployed to assist in locating the offender. At that time, the description available was limited to "black male, wearing all black, with a black bag."

1388. The initial priority for attending officers is always to preserve life, locating any victims and administering first aid. I have spoken with several officers involved in this task, who described to me the truly harrowing scene they encountered. Barnaby and Grace had suffered multiple, catastrophic knife wounds, injuries of such severity that many of the officers had never witnessed anything comparable in their careers. They recounted how they fought to save them, attempting CPR under conditions that were both traumatic and deeply distressing.

1389. At 04:09 hours, an update was added to the log indicating that someone had been robbed. The caller added to the suspect's description, noting he was wearing a hoodie and had left the scene heading towards the city centre.

1390. Simultaneously (at 04:09 hours), a call was received from an off-duty police officer who had been awoken by a female screaming near the Cathedral on Derby Road. Officers responded to this incident, and a more thorough search of the area was instructed, once a potential connection was considered between this and the attacks on Ilkeston Road.

1391. It was unclear on the night where VC had gone after his attacks on Grace and Barnaby. However, through the investigation that followed in the weeks and months afterwards, we learned that by 04:05 hours, three minutes before the first officer arrived, he had already travelled along Hopedale Close and Rifle Street, crossed Denman Street, and was near Hartley Road. By 04:13 hours, he was on Player Street, walking towards Alfreton Road.

1392. At 04:14 hours, the incident log recorded that although the Local Authority CCTV cameras had not captured the attacks, the operator was actively reviewing available footage to determine whether any relevant material had been recorded. The CCTV system was also being utilised to assist in locating the suspect.

1393. I know this area well, having worked in the city for many years. Along the route he took, there are numerous alternative roads and alleyways, making his exact path from Ilkeston Road to Player Street difficult to determine.

1394. I reflected on how unusual it was that he appeared to be walking so casually away from such a dreadful crime. Having reached Player Street, VC no longer stood out. He was, in many ways, the opposite of what officers might have expected to be looking for. One might have expected a person who had just committed such a violent and atrocious crime to be running or at least skulking in the shadows or alleyways. At 04:38 hours VC was casually strolling along a main road, along the pavement of Gregory Boulevard.

1395. An update on the log at 04:13 hours indicated the offender was running away, and an area search had commenced.

1396. I was aware that the Det Insp Pam Dowson had been informed of the attack on Grace and Barnaby at 04:18 hours and was en-route to the scene by 04:25 hours.

1397. At 04:22 hours, a further description was added to the log: a black male, of fat build, dressed in black with his hood up, last seen turning left, possibly towards Hopedale Road. We now know that by this time, VC had

crossed Alfreton Road, walked down Thurman Street, crossed Birkin Avenue, and was walking along Holland Street towards Radford Road, which is more than half a mile away.

1398. At 04:30 hours, another incident log update noted that the suspect was no longer believed to be carrying a man bag and was wearing grey jogging bottoms.

1399. By 04:41 hours, officers had reviewed ring doorbell footage and obtained an image of VC, clarifying that he did not appear to be of fat build. A minute later, potential CCTV footage (I believed from an address on Ilkeston Road) of the incident was discovered, and images were uploaded to the log by 04:50 hours. At 04:53 hours, intelligence operatives confirmed that the facial images were not clear enough to support an automatic facial recognition search.

1400. By this time, VC was likely in the vicinity of Mansfield Road. We know that at 04:38 hours, he was walking along Gregory Boulevard towards Mansfield Road, and by 05:01 hours, he had arrived at Seely Hirst House on Mapperley Road in the Mapperley Park area, which is two miles away from the scene of the attacks on Grace and Barnaby.

1401. VC was seen moving back and forth from this location between 05:01 and 05:11 hours, before leaving and walking along Mapperley Road towards Woodborough Road.

1402. The first call regarding the incident on Milton Street was received at 05:25 hours, reporting that a black male in a white van had deliberately driven over another male and fled towards Parliament Street. By 05:30 hours, a police officer was following the van and observed it mount the

pavement and strike two pedestrians. At 05:31 hours, an officer still had sight of the vehicle on Alfreton Road as it travelled away from the city. At 05:32 hours, the officer reported the van passing the junction of Forest Road, turning onto Bentinck Road, and by 05:35 hours, the van had stopped, and VC was detained at the junction of Bentinck Road and Maples Street.

1403. I have reviewed the body-worn video footage of VC's arrest and spoken with the officers involved. In my view, their conduct was calm and professional, particularly given the highly pressurised circumstances they were operating under.

1404. In my analysis, the attacks on Ilkeston Road occurred without any warning or discernible build-up. There had been no preceding incidents that might have enabled anyone to anticipate or judge that VC was about to carry out such appalling actions.

1405. From the moment police were alerted to the attack on Grace and Barnaby at 04:04 hours, there was, in theory, a window of opportunity to intervene and prevent the subsequent attacks on Magdala Road, Milton Street, and Parliament Street.

1406. Before expressing my opinion in the interview, I had carefully considered whether any realistic opportunity existed to prevent further incidents following the initial attacks on Grace and Barnaby. That window, I concluded, extended from 04:04 hours, the time of the first call to police, until approximately 05:14 hours, when screams were heard on Magdala Road.

1407. However, given that the incident on Magdala Road was not reported until after the attacks on Milton Street and Parliament Street had already occurred, I found it extremely difficult to envisage any realistic scenario in which intervention could have taken place after the Magdala Road incident in time to prevent those subsequent events.

1408. At 04:04 hours, the identity of VC was unknown. He could not have been detained at Ilkeston Road, as the first call was made after he had already left. There were no viable or realistic lines of inquiry that could have led to his identification in the immediate aftermath of the attack. The only practical means of locating him was through an area search.

1409. I reflected on the complexity of coordinating a search under such circumstances. Multiple calls had been received regarding a serious incident, and it was unclear where VC had gone, whether he was alone, on foot, or using a vehicle or other mode of transport. His description was relatively vague. Not only had he left the scene before the first call was made, but the attending officers were rightly focused on preserving life, administering first aid, understanding what had occurred, and gathering initial information. By the time these critical actions were underway, VC had gained a significant head start.

1410. VC had travelled via multiple side streets and likely alleyways, moving into a different area of the city. From reviewing his movements, it was evident that he did so in a calm and composed manner. Once he had left the immediate vicinity, and certainly by the time he reached Gregory Boulevard at 04:38 hours, I would not have expected officers to be

searching in that area. Even if they had been, I am not convinced VC would have drawn their attention.

1411. From the information now available to me, it is clear that coordination of the search activity was limited, although officers, including dog handlers, were actively searching for VC in the area. This task would have been extremely challenging given the circumstances I have previously outlined. VC's route was unpredictable, and he did not stand out in a way that would have drawn attention: he was a Black male in a racially diverse area of Nottingham, wearing dark clothing that concealed any visible blood staining, walking calmly, and not carrying a weapon.

1412. On reflection, search efforts should have been better coordinated. However, even with improved coordination, I believe, based on all the facts now known, that locating VC along the route he took would still have been a very difficult task.

1413. On this basis, as a result of everything I have considered at this time, I do not believe it would be fair to suggest that any other reasonable or realistic steps could have been taken to detain him before the attack on Ian Coates in Magdala Road.

1414. I also considered whether the incidents at Seely Hirst House might have presented an opportunity to prevent further attacks. Had we responded to that incident while VC was still present, even without identifying him as the individual responsible for the earlier attack on Ilkeston Road, it is possible VC might have been arrested in connection with that incident alone.

1415. Having reviewed the available records, it is clear that the only call made in relation to the incident at Seely Hirst House was by witness [GRO-B] [GRO-B] at 06:16 hours (i.e. long after VC's arrest), following a conversation between him and Sergeant James Bravant, who had by now responded to the call to Magdala Road.

1416. It appears that during the incident at Seely Hirst House, a conversation had taken place between [GRO-B] who was resident there, and a security guard Ivan [GRO-B]. This conversation followed a fellow resident [GRO-B] having confronted VC when he had tried to access [GRO-B] window, which [GRO-B] had seen on CCTV.

1417. [GRO-B] had been woken by tapping noises and shortly after heard knocking on another door. Upon speaking to [GRO-B] and learning that neither he nor [GRO-B] had called the police, and after hearing sirens nearby, [GRO-B] went outside, encountered Sergeant Bravant, and was asked to report the matter. He did so via a 101 call at 06:16 hours.

1418. The information regarding Seely Hirst House was received after the call concerning Ian Coates, which was made at 05:37 hours (police incident 0079_13062023, NGPF0007848). No calls were made at the time of the Magdala Road incident itself. As such, it transpired that the Seely Hirst house incident had not presented as an opportunity for the police to intervene with VC.

1419. The call made by [GRO-B] at 06:16 hours was treated as a duplicate incident and attached to incident 0079_13062023 as a contact record, reference CR0172_13062023. I now refer to contact record CR0172_13062023 as URN: NGPF0007850.

1420. I refer to the statement of GRO-B as URN: NGPF0007851.

1421. While it is not possible to assert the accuracy of my opinion as a matter of fact, I believed it to be a fair and informed view at the time. As noted earlier, although I recognise that I did not express my view as I would have preferred, it was based not only on the evidence and information available to me, but also on my professional experience in managing responses to incidents of this nature.

1422. The opinion was expressed in response to a direct question, and I answered in a manner I considered to be open and honest. I believe the statement I gave was transparent and reflected my genuine assessment at that time. My view on this has not changed.

- Statement two:

1423. *"I am really confident that everything we did was thorough and professional, I wouldn't have looked to have change anything".*

1424. Again, to assist with context, I have included the full wording of the question I was asked, along with my complete response. Within that response, I have highlighted the specific statement (with my emphasis added) that I have been asked to address, to help the Inquiry understand the circumstances in which it was made.

1425. At 00:02:55 I was asked: *"(Inaudible) I mean Such as, I mean it was so spread across some of the parts of the city to you as well, I mean trying to sort of piece all that together and follow a chain and, and stop whatever might have been going on again. It would have been hard I guess?"*

1426. At 00:03:07 I responded:

1427. *“Well, it was desperate yes, in terms of geography, but also in terms of time. So, the attacks on Barnaby and Grace 4:00 AM. And then the defendant walks away on foot and for all intent and purposes disappears. And the next time you see him is almost a mile away and an hour later. And then the incidents on Milton St and Parliament St and later we learned on, on Magdala Road, you know, they were a long way away in terms of time. And as I say, geography, so very difficult you know to have done anything differently, but as I say, we constantly debrief these types of operations. We’ve poured over the detail. We’ve poured over the way that we responded, the way that we started that investigation from the outset, and you know **I’m really confident that everything that we did was thorough and professional. I wouldn’t have looked to have changed anything** and tragically, we couldn’t have stopped any of what happened, happened on that night. And let, let’s not forget, you know, he was arrested really quickly. So, the Ilkeston Road killings of Grace and Barnaby around about 4:00 AM and not long after 5:30, we’d arrested him. So, you know, I think it was actually, it was, as you say, fast moving. But we arrested him just as quickly as we could.”*

1428. I have also reflected on the tone and impact of this statement, and I regret responding in that manner. I now recognise that the tone may have come across as overly definitive and lacking in empathy, particularly given the sensitivity of the events of 13 June 2023, and the perspective of bereaved families and surviving victims. I understand how such wording could unintentionally suggest a lack of reflection or an unwillingness to

learn and improve, potentially conveying a closed mindset. That was never my intention. My aim was solely to offer reassurance.

1429. To address the question about accuracy I would like to say the following.

1430. Alongside the sources of information I had accessed and the analysis I undertook in preparation for this interview, as I have described already, I also reflected on the Operation Hendrix debrief report as part of that preparation.

1431. The Operation Hendrix debrief report, (NGPF0007690) reflects on organisational learning and process improvement following the major incident in Nottingham. Overall, it reported that Operation Hendrix demonstrated strong preparedness, commitment, and multiagency collaboration, while also highlighting areas for improvement in communications, welfare, debriefing culture, scene management, and coordination.

1432. It said that Nottinghamshire Police demonstrated preparedness and training, with the demands of the incident falling within the scope and capability of the organisation and its supporting services. Individuals across the force showed exceptional commitment to public service, often going above and beyond their duties.

1433. The report further details the effectiveness of the initial incident response, scene management, coordination groups, investigation, welfare provisions, communications, and the CT policing network.

1434. Each area is assessed for good practice and areas for improvement, with recommendations provided to address identified gaps. In preparing

for the interview, I concentrated on the initial response section, as the questions I was being asked focused specifically on how we responded on the night and whether there was anything we could have done differently to prevent any of the attacks. The debrief revealed the initial response benefited from good interoperability between services and prioritisation of first aid, but some officers felt they lacked sufficient information regarding their roles and deployment expectations when they were deployed to the City to provide resilience. It also said that scene management was flexible and resourceful, but officers were sometimes on scene for extended periods without adequate welfare support or approved communication statements.

1435. When reflecting on my interview statement, I recognise that I was responding to a question about our ability to understand and respond to the events as they unfolded that night, and whether anything further could have been done to prevent them.

1436. In forming my view, I had personally reviewed body-worn video footage from the scene at Ilkeston Road, CCTV footage capturing the incidents on Milton Street and Parliament Street, and the body-worn footage of VC's arrest. Having seen how officers conducted themselves in each of these scenarios, I was able to observe their actions directly. In my professional opinion, their behaviour throughout was both thorough and measured, and I assessed their performance as being of a high standard.

1437. The opinion I expressed was that, based on the information available at the time and the analysis I have already outlined, I do not believe there were reasonable or realistic steps we could have taken to alter the

outcome that night. My assessment is rooted in what could sensibly have been done in the circumstances as they presented themselves, rather than with the benefit of hindsight or information that only became available in the days and weeks that followed.

1438. For example, had we known in advance the precise route VC would take, we would, of course, deployed officers to those areas. However, this was not information we could reasonably have known at the time, and it would not have been realistic to expect officers to search those specific locations. My view is that our response was appropriate given the circumstances and the information available to us at the time.

1439. As with the first statement in my ITV interview that I have explained earlier, while I cannot assert the accuracy of my opinion as a matter of fact, I believed it to be a fair and informed view at the time. As mentioned earlier, I recognise that I did not express my perspective as clearly or as thoughtfully as I would have preferred. Nonetheless, my view was shaped by the evidence and information available to me, as well as my professional experience in managing responses to incidents of this nature.

1440. The opinion was given in response to a direct question, and I answered in a way I believed to be open and honest. I have reflected on the point about the coordination of search activity, which in my view should have been better. Aside from that point, I remain of the view that the statement reflected my genuine assessment at the time, and I continue to stand by that assessment.

Reflections on Media Communications

1441. I have been asked to reflect on my involvement with police communications during Operation Hendrix and to consider whether there are any aspects I would have approached differently, or any lessons I have learned.

1442. One of the first reflections I would offer is that I likely underestimated the scale and intensity of the media interest that emerged around the sentencing hearing. While there had been significant media scrutiny during the first week of the operation in June 2023, the period between then and January 2024 was relatively quiet, with minimal media engagement. By the time January 2024 arrived, I had perhaps lost sight of the intensity of that initial period, and as a result, our preparations for media engagement were not as timely or robust as they should have been.

1443. Closely linked to this, I believe I should have considered much earlier how best to align our communications with the families alongside our communications with the media. Communicating with families is inherently complex, even in straightforward cases. In this instance, we were supporting six families, each navigating unimaginable grief, and each with their own experiences and perspectives. The case also involved three years of multi-agency contact with VC, which, while not necessarily relevant to the legal outcome, was understandably of interest to the families.

1444. Our communications needed to cover not only the events of June 2023 and the subsequent investigation, but also the historical context of prior incidents and agency involvement. Sharing this breadth of information in a way that was digestible and meaningful for families, at a time of profound

emotional distress, was a significant challenge. It required sensitivity, time, structure, and a tailored approach for each family.

1445. In hindsight, I believe it would have been beneficial to offer families the option of receiving written updates alongside verbal briefings. It is well recognised that grieving families may struggle to absorb detailed information in real-time conversations, especially when information is only provided verbally. Written updates can provide a reference point, allowing families to process information at their own pace and formulate any follow-up questions. We did not provide written updates in this case, and on reflection, I believe doing so would have been helpful, not only to reassure me as Gold Commander that key information had been shared and to know what had been shared, but more importantly, to support the families in understanding the complexities of the case.

1446. Had we taken this approach, it would have also supported a more structured external communications strategy. I would have had greater confidence in what information had been shared with families, could have sought their consent to share relevant elements with the media, and then provided a comprehensive briefing to journalists.

1447. In that context, I believe a non-reportable media briefing, delivered several weeks ahead of the sentencing hearing, could have been an effective way to share background and context. While there are risks associated with such briefings, including potential leaks and the risk of prejudicing proceedings, I believe these can be mitigated with careful planning. The College of Policing's Engagement and Communication Approved Professional Practice supports the use of such briefings to

provide context and facilitate dialogue with the media on sensitive policing matters.

1448. An alternative approach could have been to consider a pre-trial briefing, embargoed until the start of proceedings. This is sometimes used in high-profile or complex cases to help ensure accurate reporting. While this would have required agreement with the CPS, it is an option I now recognise could have been explored.

1449. Bringing these reflections together, I believe that providing structured written updates to families would have supported both their understanding and our ability to communicate effectively with the public. It would have enabled me to deliver a non-reportable briefing that ensured both families and the wider public were fully sighted on the circumstances of the case, including any missed opportunities, an objective I had always intended to achieve.

1450. I have also reflected on several specific comments I made to the media during either television interviews or in written format via media releases.

1451. In relation to my ITV interview, I have already acknowledged in my statement how my approach to this should have been different. The comments were made during a fast-paced media interview, and with the benefit of hindsight, I recognise that my choice of words, particularly phrases like “*absolutely confident*” and “*nothing we could have done*”, are likely to have come across as overly definitive and lacking in empathy.

1452. I now appreciate how such language could be perceived as dismissive, especially in the context of such a sensitive matter and from the perspective of bereaved families and survivors. At the time, we had not yet

conducted a detailed forensic analysis of police activity between the attacks, and a more measured and reflective response would have better acknowledged both the complexity of the situation and the public's need for reassurance.

1453. My intention was never to close off reflection or learning, but simply to offer reassurance based on what was known at the time.

1454. In relation to the written media releases there are two statements that I have reflected extensively on. The first statement is when I said I did not believe VC would have received a custodial sentence had he been arrested on the FTA warrant.

1455. The second statement was that, if his arrest on the FTA warrant had in fact triggered a route back into mental health services, that I thought it was unlikely he would have engaged with any treatment programme.

1456. For clarity, although both statements represented my honestly held view at the time and that has not changed, I do not now believe it was appropriate to express those views publicly at that time. Had I adopted the approach outlined above, providing written updates and structured briefings, I would not have felt the need to make those comments in the media.

1457. Throughout my engagement with the media, I sought to strike a careful balance between providing context to help the public understand the facts of the case and being sensitive and empathetic towards the families. In these two comments, I now believe that I did not achieve that balance, which I very much regret.

1458. On reflection, I do not believe I was sufficiently thoughtful of the likely impact these two statements could have on bereaved families and surviving victims. In hindsight, it seems clear that they may have been interpreted as suggesting that earlier intervention *could* not have made a difference, something I did not intend. I now recognise that I did not strike the right balance between providing factual information to the public and showing the empathy that is so vital in supporting those affected by such distressing circumstances. I regret that my message was not conveyed with the sensitivity I had hoped.

Unauthorised access issues

1459. I have been asked to outline the steps I took, if any, to safeguard the integrity of sensitive data and materials, and to uphold the dignity and privacy of victims, survivors, and bereaved families.

1460. The first time I became aware of concerns regarding inappropriate access to material was during the second Gold Group meeting on Wednesday 14 June 2022. Under “any other business”, Det Supt Williams informed the group that the PSD had received referrals indicating that some staff members, who were not directly involved in the incident, had accessed information about it on internal systems. She explained that, at that stage, there was insufficient capacity to conduct a full audit across all systems to determine the scale of the issue. Instead, she proposed a proportionate response: that Ch Supts should cascade a clear message through their commands that officers must not access incident information or view CCTV unless they had a lawful and legitimate purpose to do so.

1461. At the time, I considered this to be a proportionate and effective course of action. It struck a balance between protecting sensitive material and avoiding disruption to the investigation at a critical early stage. I tasked the three Ch Supts with delivering this message and was reassured at the following meeting that this had been completed. I therefore considered the action discharged.

1462. The issue was raised again at the Gold Group meeting on 20 June 2022. Det Supt Williams reiterated concerns about unauthorised access, this time specifically referencing CCTV footage. She emphasised that curiosity was not a justification and that maintaining the trust and confidence of the families was paramount. I shared her concern and expressed disappointment that the initial message had not had the intended effect. I acknowledged that further reinforcement was necessary.

1463. Det Supt Williams proposed that a message should now be issued jointly by the Head of PSD and the staff associations. Her intention was to encourage openness and honesty among staff, and to create a form of amnesty. Officers and staff would be encouraged to speak with their line managers if they had accessed material without a legitimate purpose. Line managers would then assess whether a referral to PSD was necessary. Det Supt Williams was clear that this approach was intended to support those who may have acted without malice but needed guidance, while also making clear that anyone found to have shared information inappropriately would not be eligible for amnesty and would be subject to formal action.

1464. I have explained earlier in my statement why I considered this approach to be appropriate, at paragraph 334.

1465. An action was set for Det Supt Williams to work with the staff associations to develop and disseminate this message, clarifying the lawful basis for accessing incident material, including CCTV. I was informed that this action had been completed during the Gold Group meeting on 23 June 2023.
1466. The group also discussed whether, in future, the organisation should consider restricting access to incident material from the outset of a major investigation. While I recognised the reassurance this might offer to families, I also raised concerns about the potential impact on operational effectiveness, particularly in the early stages of an investigation. More fundamentally, I expressed concern that such restrictions might reflect a lack of trust in our workforce. I stated, on record in the Gold Group minutes, that if we reached a point where we felt compelled to restrict access to prevent misconduct, it would be a troubling reflection of our organisational culture.
1467. I viewed this as a cultural and leadership issue. I stressed the importance of senior leaders modelling the standards we expect and fostering a culture where staff understand and respect the boundaries of appropriate access.
1468. On reflection, I acknowledge that I should have taken more robust steps to protect sensitive material, particularly CCTV and body-worn video footage from the scenes. While I remain concerned that restricting access could have impeded the investigation, I accept that clearer and more decisive action may have been warranted. I make this observation in the context that I was not fully sighted on the extent of the unauthorised

access, nor was I involved in the PSD investigations, which I will address later in my statement.

1469. I was aware, through discussions with the COT and separately with Det Supt Williams, that PSD-led investigations were underway in relation to a potential “leak of information” from within the organisation. However, updates on those investigations were not reported into the Gold Group.

1470. In hindsight, I believe that either I or another member of the COT should have taken direct responsibility for communicating with the workforce. The message should have been more explicit in setting expectations and less focused on support.

1471. At the Gold Group meeting on 19 July 2023, no issues of unauthorised access were reported. Similarly, at the meeting on 23 November 2023, I was informed that all IOPC and PSD matters were closed.

1472. On 20 September 2023, I received an email from Det Supt Williams highlighting two specific cases identified by PSD: one involving a police officer PC Gell who had accessed material and sent inappropriate WhatsApp messages, and another involving a special constable SPC Skenderaj. I instructed that these matters be shared with the families, which I have explained earlier in my statement and will provide further detail later in my statement.

1473. Beyond these cases, I was not informed of any wider issues or investigations relating to unauthorised access.

1474. At the Gold Group meeting on 19 January 2024, we discussed what had by then become three PSD cases with the addition of the Front

Counter Clerk Rutherford case. However, I received no further updates or reports of broader concerns.

1475. In summary, the steps I took to protect the integrity of sensitive data and materials were limited to authorising two messages to the workforce, making clear that unauthorised access was unacceptable. The first message was via the three Ch Supt's and the second via Det Supt Williams. I did not impose technical restrictions on access, for the reasons I have outlined. However, I fully accept that the messages issued to the workforce should have been more direct, more frequent, and delivered by someone in a position of senior authority.

Involvement in investigations into unauthorised access issues

1476. I have been asked to outline my involvement in the investigations concerning the accessing of sensitive data, information, or material, including any relevant telephone or messaging communications.

1477. I can confirm that I had no direct involvement in these investigations. They were led and managed entirely by the PSD and fell outside the scope of the Gold Group I chaired. I did not have oversight of, nor did I influence, any decisions made in relation to those matters.

1478. In hindsight, this separation of responsibilities presented certain challenges, which I will expand upon later in my statement, particularly in relation to how we provided updates to families. It is my view that a more integrated approach, whereby these investigations were brought within the remit of the Gold Group, would have allowed for greater strategic oversight and alignment with the broader investigation into the homicides and attacks.

1479. All decisions relating to the PSD investigations were taken by the Head of PSD. I had assumed that these were being reported to the DCC, who holds overarching responsibility for PSD. However, it became apparent that decisions were being made at Supt level. Under normal circumstances, it is entirely appropriate for investigations led by the PSD to be conducted independently of other investigative processes. However, given the seriousness and sensitivity of the case, it may have been more appropriate for those decisions to have had Chief Officer oversight.

1480. On reflection, both I and the DCC should have had a clearer discussion to establish a defined command protocol, ensuring clarity around roles, responsibilities, and oversight. The absence of such a protocol contributed to a lack of strategic coordination in the oversight of these PSD investigations.

1481. Although representatives from PSD attended the Gold Group meetings, as can be seen from the summary of minutes I have previously provided, discussions or updates regarding the investigations being undertaken by PSD were not brought into the Gold Group forum, except for the specific matters I will address later in this statement. On reflection, I believe PSD may have viewed the arrangements in the same way I did: that the management of those investigations sat outside the scope of the Gold Group.

1482. As I have previously mentioned, I became aware that PSD had initiated an investigation into the potential leaking of information. I was not involved in the commissioning of that investigation, nor was I sighted on its scope or parameters.

1483. During two of the Gold Group meetings I chaired, on 14 and 20 June 2023, Det Supt Williams made me aware of reports concerning members of the workforce potentially accessing information inappropriately. She sought my support in communicating messages to the workforce, as I have previously described. However, she did not request, nor did I provide, any direction regarding the conduct or management of the investigation itself.

1484. Beyond that, and the updates I received regarding three specific investigations: the Special Constable Skenderaj case, the Front Counter Clerk Rutherford case, and the case involving PC Matt Gell (who was investigated for both accessing information and sending inappropriate WhatsApp messages), my involvement was limited. My role was confined to helping ensure that affected families were appropriately informed, and I did not participate in the investigative process itself.

Steps taken to inform survivors and families of unauthorised access issues.

1485. I will now describe my involvement in the steps taken to ensure that survivors and bereaved families were appropriately informed regarding any data breaches and the actions taken in response.

1486. At the outset, I must acknowledge that the organisational approach to this task was wholly inadequate. The steps taken were, in my view, sub-optimal and did not meet the standards that should have been expected in such a sensitive and high-impact context.

1487. I will repeat what I said earlier about this matter (in paragraph 482), which is that, on reflection, the way we managed the sharing of information

with families regarding the PSD investigations was wholly inadequate. Looking back, I can see that our approach lacked coordination and clarity. As a result, the families were not given the information they should have received. I regret this and I convey an unreserved apology for it. I am also personally embarrassed by my oversight of the matter.

1488. I believe the limitations in our approach stemmed from two key factors. First, there was a lack of clarity and coordination around roles and responsibilities, particularly in relation to strategic oversight and decision-making. Second, the approach adopted at the time by the PSD regarding the identification of interested persons and the process for ensuring they were appropriately updated contributed to the shortcomings.

1489. To assist the Inquiry, I thought it would be helpful to first set out what the relevant regulations require in terms of disclosure and engagement with interested persons, before going on to describe what occurred during Operation Hendrix.

1490. Under Section 21 of the Police Reform Act 2002, the appropriate authority has a duty to identify and keep informed any person who qualifies as an interested person in relation to a complaint or conduct matter. This includes the individual who made the complaint, anyone who has suffered serious injury as a result of the conduct, the relatives of someone who died or was seriously injured due to the conduct, and any other person whom the IOPC or the appropriate authority considers to have a sufficient interest in the case. The appropriate authority is the officer with delegated responsibility for managing any such PSD investigations.

1491. PSD have a statutory and ethical responsibility to keep interested persons informed throughout the investigation process. This duty is outlined in the IOPC Statutory Guidance. The investigator (who works beneath and independent from the appropriate authority) is responsible for ensuring that the interested person is kept updated at least every 28 days and they will have agreed a preferred method of contact.

1492. In June 2023, within Nottinghamshire Police's PSD, it became apparent that there was no formal step within the case management process requiring consideration of who might be deemed an interested person in relation to an investigation. This absence of procedural clarity meant that the identification and engagement of interested persons was not systematically addressed.

1493. This issue was further compounded in cases where PSD had not undertaken a formal severity assessment. In such instances, where conduct was being managed outside of the formal misconduct regulations, such as through informal interventions, there was no requirement, nor apparent practice, to consider whether any individuals, including survivors or bereaved families, should be recognised as interested persons. As a result, those most affected by the conduct under investigation were not always appropriately identified or informed.

1494. A severity assessment is a structured evaluation of the potential impact, seriousness, and implications of the reported conduct or incident, considering factors such as risk to public trust, operational integrity, legal exposure, and reputational harm. It helps determine the appropriate level

of oversight, urgency, and resource allocation required for the investigation.

1495. In some cases, PSD might decide that a formal severity assessment is not required, but instead the conduct identified can be addressed through a more informal approach known as an intervention. An intervention is where an input or direction is provided to an individual that falls outside the formal procedures and governance set out in the Police Reform Act 2002 and associated regulations.

1496. Although I was not aware at the time, I now understand that as part of the ongoing Operation Hendrix PSD investigations, assessments were undertaken regarding individuals identified as having accessed information inappropriately. Several interventions were made with individual staff members. Because these matters were dealt with by way of informal intervention rather than through formal misconduct proceedings, no consideration was given to identifying interested persons. As a result, I am now aware that the bereaved families were not informed about any of these matters.

1497. When a PSD investigation intersects with a criminal investigation, the responsibility for updating bereaved families generally falls to the FLO, under the guidance of the SIO. The FLO acts as the primary point of contact for families and determines the most appropriate way to provide updates.

1498. Determining the extent to which a conduct matter is linked to the criminal investigation can be complex, and this directly affects whether a family is considered an interested person. Furthermore, a family is only

formally recognised as an interested person if a conduct or complaint investigation is initiated. Consequently, if a matter is assessed as not meeting the threshold for a conduct or complaint investigation, the family would typically not be informed or updated.

1499. I was first notified of any conduct investigations on 20 September 2023, when I was copied into an email from Det Supt Williams to the FLA. I recorded this in my log, as described earlier in my statement at paragraph 480. The email was copied to me, "from a Hendrix Gold Group perspective" and formed part of a wider chain initiated by Det Insp Gould, who was updating the FLOs regarding a suspected media leak in the early stages of the investigation.

1500. In her message, Det Insp Gould explained that although no media outlet had been identified, it had been confirmed that PC Matthew Gell accessed investigation materials without a policing purpose and disclosed information via WhatsApp to (i) his wife, a serving officer in West Midlands Police, and (ii) a friend outside policing. She noted that a criminal and misconduct investigation had taken place, and while no evidence of a media leak was found, the officer would face a Gross Misconduct hearing. The hearing was to be held in private, and Det Insp Gould recommended informing the families to avoid future concerns about transparency. She indicated that the most serious potential outcome was dismissal, although a Final Written Warning was also possible. She advised against sharing the WhatsApp message due to its insensitive content and clarified that the disclosed information did not include details about VC. She stated that the

timing of disclosure to the families would be coordinated with Supt Williams.

1501. Det Insp Gould then emailed Det Supt Williams to seek guidance on when the information could be shared. In her reply, Det Supt Williams agreed with the proposed wording but suggested referring to "an officer" rather than naming PC Matthew Gell, given the intention to hold the misconduct hearing privately before the criminal trial, meaning the officer's name would not be released publicly. Her email also addressed potential questions from the family, noting that attendance at the private hearing might be possible with the chair's agreement. She explained that while the investigator had chosen not to seek family statements prior to the hearing, it might be appropriate for the family to provide input at the sanction stage if the case was proven. Det Supt Williams confirmed that the timing of disclosure was at the discretion of Det Insp Gould and the Hendrix SIO, assuming the officer had been informed of the hearing.

1502. Additionally, Det Supt Williams referenced a separate case involving a Special Constable who had admitted to unlawfully accessing distressing footage and had subsequently resigned. She explained that this case would likely proceed as an Accelerated Misconduct Hearing, although the Investigating Officer's report was not yet complete. She advised that consideration should be given to whether both matters should be addressed together or separately.

1503. In response to the email, I thanked Det Supt Williams for sharing the update and expressed a strong preference that the family be informed of such matters directly by the team, rather than learning about them through

other channels. I noted that Det Insp Gould appeared to have received approval to proceed and confirmed that the timing of disclosure was at her discretion, provided it aligned with the principle of ensuring the family hears it from the appropriate source. I stated: "Really keen to ensure that the family always find out about these types of issues from us, rather than anywhere else..."

1504. From that point, I assumed that arrangements had been put in place, as per the dialogue within the email chain, to inform the families about these cases. This email chain is exhibited as NGPF0007813.

1505. I do not recall receiving any further updates on this matter following the email of 20 September 2023, nor would I have expected to. During the subsequent Gold Group meeting held on 23 November 2023, the issue was not discussed. In fact, I was informed by T/Det Supt Reynolds that the IOPC/PSD matters were closed. By this point, I believe I had likely forgotten about the earlier email from 20 September 2023.

1506. The next time this matter was brought to my attention was via an email from Det Supt Sanders at 14:11 hours on 14 December 2023. I have described this email exchange, which is exhibited as NGPF0007814, earlier in my statement at paragraph 483.

1507. In summary, Det Supt Sanders informed me that on 12 December 2023 he had met with T/Det Supt Reynolds, who was copied into the email, along with the FLA. Det Supt Sanders explained that in his meeting with T/Det Supt Reynolds, he had been informed that on 11 December 2023, the Chief Constable, at an Accelerated Misconduct Hearing, had declared that a Special Constable would have been dismissed, had he not already

resigned, for unauthorised access to police information and systems. This included material related to Operation Hendrix and viewing of body-worn video footage from the initial attack site. The adjudication from the Chief Constable was that the families should be informed.

1508. Det Supt Sanders expressed that this outcome had come as a surprise to him, as the PSD investigation had previously been unknown to the inquiry team. He also noted that the timing was particularly difficult for the families, who were already dealing with the emotional strain of psychiatric reports and CPS considerations surrounding the acceptance of pleas for manslaughter.

1509. The email also reiterated the three PSD investigations linked to Operation Hendrix: PC Matthew Gell (Operation Glint), who had been arrested and was due to face a Gross Misconduct hearing in January 2024 for unauthorised access to police data; Special Constable Skenderaj, who had been dismissed under misconduct regulations for unauthorised access to body-worn video footage; and a police staff member, Sarah Rutherford, who had accessed police material without a policing purpose, including content related to Operation Hendrix.

1510. The email raised several important considerations. It emphasised that, should families be informed, they must be provided with full details of each case, specifically, who accessed what information, when, and whether any data was shared. It also highlighted the importance of consistent messaging, particularly given that families often communicate with one another and expect updates collectively. The need for organisational safeguards to prevent future breaches was noted, along with the

expectation that FLOs would require a formal statement from senior leadership to deliver to families. Additionally, it was suggested that a senior representative from PSD or the COT should be available to address family concerns directly.

1511. The email also noted that outcome and appeal notifications for Special Constable Skenderaj had not yet been sent, pending decisions by the COT. The FLOs expressed the view that updates should be delivered as a complete package rather than piecemeal, to support family wellbeing. A concern was also raised about how to manage cases that may conclude with no further action, and whether it would be more appropriate to wait until all PSD matters were resolved before informing families. Finally, the email suggested that if families were considered interested parties, they may be entitled to severity assessments, investigation officer reports, and Regulation 62 Chief Constable adjudications. Det Supt Sanders recommended that the COT provide final direction and sign-off on these matters.

1512. I now recognise, although I had not realised at the time, that the description of the PC Matthew Gell case in this email differed from earlier communications. Specifically, it did not include any reference to the WhatsApp message. Following receipt of this email, I met with T/Det Supt Reynolds to discuss the matters raised, and he described the cases in line with the content of Det Supt Sanders' email. I acknowledge that I had previously been informed of the PC Matthew Gell case by email in September 2023, and that communication did reference the WhatsApp message. I recorded this in my log at the time. However, by the time of the

December 2023 email exchange and my conversation with T/Det Supt Reynolds, where the WhatsApp message was not mentioned, it is clear to me that I had forgotten this detail. This is confirmed in the email reply I sent to both T/Det Supt Reynolds and Det Supt Sanders.

1513. I replied to their email at 17:13 hours on the same day 14 December 2023. In my response, I acknowledged the complexity of the issues raised and confirmed that the understanding of the three PSD investigations was accurate. After careful consideration, I concluded that neither Operation Glint nor the Skenderaj case required disclosure to the families, as both involved inappropriate access to police records without direct relevance to the victims. I explained that these cases appeared to involve officers or staff reviewing police records about the Hendrix incident, with no direct focus on any of the victims. One case, in fact, focused primarily on VC.

1514. However, I viewed the Special Constable case differently, as it involved unauthorised viewing of images of one of the deceased. In my view, this triggered an immediate duty of candour, and the affected family should have been informed without delay, ideally within a few days and with full context provided by PSD. I recognised the difficulty of delivering this message, particularly given the wider circumstances, and offered support, either personally or via T/Det Supt Reynolds, in delivering the message. I recommended informing only the family directly affected, while acknowledging the risk of wider dissemination. I also stated my expectation that PSD provide details on organisational safeguards to prevent similar incidents in future. I invited further questions and confirmed my commitment to clarity and transparency.

1515. In a short follow-up email exchange, I clarified with Det Supt Sanders that the case requiring immediate disclosure was the Special Constable case, which I realised from my earlier email was in fact Skenderaj.

1516. On reflection, I acknowledge that our approach to this matter was flawed. It is apparent that I had forgotten the notification I received in September 2023 regarding some of these issues. Had I remembered, I would have questioned why the information had not been shared at the time I requested it. Furthermore, had I recalled the matter relating to the WhatsApp messages, my decision regarding informing the families would have been different. They should, of course, have been informed.

1517. I cannot explain why the WhatsApp message was not referenced in the email from Det Supt Sanders or in my subsequent conversation with T/Det Supt Reynolds, but it was not and it is clear that I had forgotten this detail at the time. I also cannot explain why the question of whether the families ought to be considered interested persons in respect of the PC Matthew Gell case did not arise, but it plainly did not, and in hindsight, this omission did not help matters.

1518. Even without recalling the WhatsApp issue, I now believe that, based on the information available to me at the time, I should have made a different decision. The right course of action would have been to inform the families of all relevant PSD matters. I regret this error, and I apologise unreservedly for it. As I have previously explained, the Chief Constable wrote a letter of explanation and apology to bereaved families on 20 February 2024 and to the surviving victims on 22 February 2024.

1519. On 19 December 2023 at 09:59 hours, Det Supt Sanders sent me a further email following a meeting he had held the previous day with T/Det Supt Reynolds and the FLOs. This was part of an email chain which I now refer to as URN: NGPF0007931. This included a chain of correspondence in which they had agreed a form of words that could be provided to the families. However, both expressed the view that it was not the appropriate time to deliver this message. Det Supt Sanders and T/Det Supt Reynolds supported the FLOs' position that it would be inappropriate to go against the families' wishes simply to retrospectively acknowledge a PSD outcome. They agreed that families should receive information at a time when they are best placed to process it, and not alongside other distressing updates. While the final decision rested with Gold, they strongly encouraged me to take the FLOs' perspective into account when determining the content and timing of any communication.

1520. In my reply, I confirmed that I had reviewed both emails and fully agreed with the advice given, including that of the FLOs, regarding the timing of disclosure. I acknowledged the sensitivity of the matter and the potential emotional impact on the families, particularly given the prevailing circumstances. While recognising that the duty of candour remained, I explained that it would be counterproductive to deliver this message at that time, especially as the families had withdrawn from planned meetings for understandable reasons. I therefore confirmed the decision to delay disclosure until after Christmas, with a review to follow thereafter.

1521. The next discussion regarding informing families about these matters took place during the Gold Group meeting on 19 January 2024. During the

PSD update, the three matters described above were referenced, and it was noted in the minutes that the families had been notified of appropriate updates to date. I believe this discussion followed an email sent by Det Supt Sanders at 21:07 hours on 15 January 2024, in which he stated: *"...I have informed them that we have strict safeguards in place. That even police officers who access this material without a policing purpose will be subject to the strictest of outcomes. I have informed them that a Special Constable who did just that (access case materials) before Christmas has been sacked for accessing case material without a policing purpose at a misconduct hearing. I have also informed the other family members (Ian Coates) of this in my face-to-face meetings with them..."* This email is referred to as NGPF0007808.

1522. I remember that I was not satisfied that the families had been provided with sufficient information regarding the Special Constable Skenderaj case, and Det Supt Sanders acknowledged that a fuller briefing was still required. I set this as an action, allocated to Det Supt Sanders, to ensure that this was completed.

1523. My final discussion relating to the disclosure of data breaches to bereaved families took place during the Gold Group meeting on 30 January 2024. This discussion occurred during the PSD update, which I have previously described in my statement at paragraph 426. In summary, T/Det Supt Reynolds provided an update on each of the three cases I have outlined earlier. The group then discussed what information should be shared with families regarding misconduct hearings, and how that should reflect the needs and views of the families.

1524. Following this discussion, I set an action for myself to meet with T/Det Supt Reynolds to determine what needed to be shared with families and to reflect on the organisational learning arising from this operation, specifically in relation to how officers behave when accessing sensitive material. Ultimately this action was addressed through the letter sent to bereaved families and victims that I referenced earlier.

1525. I also reflected, as recorded in the meeting minutes, that I had agreed (during the Gold Group meeting on 19 January) to a further delay in fully informing the families about the details of the Special Constable case due to its proximity to sentencing. However, I expressed the view that this disclosure should have occurred in September, when the organisation first became aware of the matter.

1526. I accepted responsibility for the additional delay that followed the Gold Group meeting on 19 January. I explained that, while the delay was regrettable, it was important that communications with families on these matters were now handled in the right way, at the right time, and by the right person.

Potential improvements to the process for communicating with victims and families in similar circumstances.

1527. As a result of my experience managing Operation Hendrix, I recognise that there were significant improvements to be made in how victims and bereaved families are informed about data breaches and related conduct matters during the management of major or critical incidents. In my current role as portfolio holder for the PSD, I have been able to ensure that these improvements are now fully embedded within Nottinghamshire Police.

1528. Any operation subject to Gold Group oversight now includes PSD representation at the meeting. More importantly, the PSD representative is provided with clear direction and guidance regarding their role within the Gold Group. In addition to offering tactical advice to the Gold Commander, particularly on whether conduct issues may arise in connection with the incident itself or any relevant precursor events, the PSD representative is now expected to contribute to forward-looking strategic oversight. This includes ensuring a clear connection between the Gold Group's management of the incident and its oversight of any conduct matters that emerge subsequently.

1529. This revised approach ensures that the Gold Commander has visibility of conduct issues arising before, during, or after the incident under their command.

1530. To support this, a new process has been introduced: at the point a severity assessment is conducted by PSD, the assessment template now includes a dedicated section for the Appropriate Authority to consider who may be identified as interested persons. Furthermore, when the terms of reference are set for the investigating officer, responsibilities relating to interested persons are now explicitly defined.

1531. In the context of major incidents, even where matters are dealt with outside of the formal misconduct regulations and a severity assessment is not undertaken, the Appropriate Authority is now expected to consider whether any such matters should be shared with families. These decisions are brought to the Gold Group for discussion and ratification.

1532. This new approach ensures that the PSD representative brings forward information to the Gold Group about any identified interested persons in cases progressing through misconduct investigations. It also enables discussion about whether families should be treated as interested persons in cases managed through informal intervention, even where the regulations do not require it.

1533. With the PSD representative's role now clearly defined, the Gold Commander can make informed decisions about what information should be shared with families, whether through FLOs in cases where they are deployed, or through other appropriate mechanisms. The Gold Commander can also set specific actions and maintain oversight of when, where, and how that information is shared.

1534. Recognising that some PSD matters may be too sensitive for discussion in the wider Gold Group forum, a process has been established to allow such issues to be addressed in closed-door sessions at the start or end of the meeting, or within a designated sub-group of the Gold Group.

1535. This is the approach I have adopted as Gold Commander for Operation Perth, the ongoing corporate manslaughter investigation into incidents within the maternity services at Nottingham University Hospitals NHS Trust.

1536. Had this framework been in place during Operation Hendrix, the families would have been identified as interested persons at a much earlier stage. I would have been notified of the interventions that were handled outside of the regulations and would have been able to ensure, through the FLOs, that timely and appropriate information was provided. I would

also have been able to exert influence to ensure that this happened proactively, rather than, as ultimately occurred, trying to achieve the same outcome at a point when it was already too late.

IOPC referrals

1537. I have been asked to outline my involvement in any referrals made to the IOPC. As noted earlier in my statement (paragraph 218), my first engagement with this process was during the initial Gold Group meeting held on 13 June 2023. At that meeting, I sought clarification from Det Supt Williams to ensure that a referral was made in relation to the latter stages of the attacks, specifically, the incident in which VC struck two pedestrians while being followed by a police vehicle. This discussion is recorded under item 6 (“PSD update”) in the meeting minutes. The referral was confirmed during the subsequent meeting on 14 June 2023, and I refer to this as URN: NGPF0007852.

1538. I also recall raising the possibility of referring the matter concerning the warrant, although this is not reflected in the meeting record. On 14 June 2023, following PSD’s scoping exercise, we held detailed discussions about previous contact, including the warrant. We considered whether it met the threshold for referral to the IOPC and concluded at that time that it did not.

1539. That decision remained a concern for me, and I know I revisited it with PSD colleagues at a later stage, most likely around 11 August 2023. I am confident of this because at 12:10 hours on that date, Det Sgt Neil Allsop sent an email to the IOPC, addressed to Andrew Mellor and copied to Det Supt Williams and T/Det Supt Reynolds, which I understand was prompted

by my expressed concerns. In that email he explained:

"Thank you again for taking my call and for offering to obtain some guidance in regard of my request for advice.

To clarify this was discussed on the day and a decision was made not to refer to the IOPC however Nottinghamshire Police ACC Mr Griffin has questioned whether this was the right decision at that time and therefore the reason for me contacting you directly....."

1540. Mr Mellor replied at 15:39hours 14 August 2023:

"Thanks for the email – I appreciate your engagement with us on this issue.

Apologies for my delay in coming back to you. I have discussed the below email with both my line manager and the Head of IOPC Assessment Unit who deal with incoming referrals. Our view is the below is clearly a process issue that you have identified and will no doubt address and does not strictly meet the referral criteria to us. The only way that we can see this becoming referable is if one of the families become aware and complaint or a conduct matter is recorded for an individual. I note you mention that you do not know who is responsible for monitoring the inboxes and therefore it would be hard to say that there is a possible breach of standards by any one individual. Our Head of Assessments has suggested you complete a learning exercise, address the issue so it does not happen again and keep the conduct under review. I hope your position on this matter assists – please come back to me if you require anything further."

1541. This position was consistent with the advice I had received from Det Supt Williams at the time, and on that basis, I did not pursue the matter further at that stage.

1542. My final involvement in referrals to the IOPC occurred on 30 January 2024. As recorded in the Gold Group minutes, I informed the group that I had decided earlier that morning to refer all previous police contact with VC in the lead-up to the events of 13 June 2023. During that meeting, T/Det Supt Reynolds confirmed that the referral was being submitted that morning (NGPF0007811).

1543. This decision followed reflection on the public commentary that emerged after the sentencing hearing on 25 January 2024. In the days that followed, families expressed concerns in the media regarding various aspects of the police response, not only to the attacks themselves but also to earlier incidents involving VC.

1544. Although no formal complaint had been made, I felt that, viewed objectively, the matters being raised publicly were tantamount to a complaint. I discussed this extensively on 29 January 2024 with several colleagues, including the Chief Constable and the (then) PCC Caroline Henry. After reflecting overnight, I made the decision the following morning to proceed with the referral.

College of Policing review

1545. I have been asked about the commissioning of a College of Policing review.

1546. I can confirm that former PCC Caroline Henry announced publicly on 30 January 2024 that she would commission the College of Policing (“the

College”) to conduct an independent external review (“the College Review”) into Nottinghamshire Police’s response to the killings and attempted murders committed by VC on 13 June 2023 (published PCC ‘Notice of Decision’ DR 2024.044 refers – which I refer to as URN: NGPF0007853).

1547. I can also confirm that the College Review has not taken place.

1548. I understand that the College Review was paused by PCC Henry on 23 April 2024 when concerns were raised by the IOPC about the College Review potentially undermining the IOPC’s investigations if they occurred concurrently.

1549. Dr Sanjoy Kumar (representing the bereaved families) also wrote to PCC Henry on 23 April 2024 asking for a pause to the College Review. PCC Henry replied to all that she had already asked the College to pause its Review that day, while the College and the IOPC held discussions.

1550. As a result of the PCC elections on 2 May 2024, Gary Godden became PCC for Nottinghamshire on 9 May 2024.

1551. Discussions then took place between the Chief Executive of the College and the Director General of the IOPC to explore a Memorandum of Understanding (“MoU”), setting out how the College Review and IOPC investigations might continue concurrently to fulfil different purposes.

1552. Despite progress on a planned way forward, the bereaved families made it clear to PCC Godden at a meeting he held with them on 5 August 2024, that they still did not want the College Review to commence until the IOPC investigations had all concluded.

1553. During August 2024, PCC Godden confirmed with the three surviving victims that they shared this view. On 2 September 2024, the PCC became aware that the Home Office had met with the College in relation to their Review, the IOPC investigations and a proposed public inquiry.

1554. Thus, PCC Godden has not lifted the pause to the College Review, and it has remained in place ever since – a position PCC Godden intends to revisit at the conclusion of the IOPC investigations, although such a revisit will now be affected by the work of The Nottingham Inquiry.

Reflections and conclusions

1555. When I look back, I believe there are additional actions that the police could have taken in respect of the response to the 13 June 2023 attacks.

1556. While there were many strengths in the multi-agency response to Operation Hendrix, there are several areas where we could have acted differently to improve outcomes for all partners and the affected community.

1557. One of the most significant areas for improvement relates to the timeliness and clarity of notifications by the police to some partners and other agencies. There were delays in activating the Resilience Direct response page and issuing METHANE reports, which resulted in some partners being out of the loop during the critical early stages of the incident. Earlier and more consistent use of established notification procedures, including direct phone calls and prompt updates to all relevant agencies, would have ensured that partners such as the Integrated Care Board, universities, and local authorities were better informed and able to respond more effectively.

1558. Communication between agencies, particularly within the health sector, was another area where improvements could have been made. The lack of prompt alerts and coordinated messaging led to confusion and hindered situational awareness. Ensuring that all organisations have up-to-date emergency contacts and that notification cascades are regularly tested would help to streamline communication in future incidents.

1559. Information sharing also presented challenges. Some partners felt unable to share sensitive information within wider meetings and would have benefited from having designated police contacts to facilitate secure exchanges. Additionally, information sometimes reached the public domain before being shared with partners, highlighting the need for more robust media management and earlier activation of the Multi-Agency Communications Cell.

1560. Resource management and meeting logistics were also identified as areas for development. The timing and frequency of Tactical and Strategic Coordinating Group meetings could be improved, with consideration given to convening initial meetings virtually to start conversations and escalation, followed by more formal sessions as information becomes available. Separating the roles of Gold and Silver Commanders from SCG and TCG Chairs, where resources allow, would help to ensure effective leadership and participation. Out-of-hours provision for multi-agency planning was also identified as an area for improvement.

1561. I believe a review of the joint response also emphasises the importance of reviewing and updating plans, training, and protocols across all agencies. This includes incorporating lessons learned into emergency

planning, ensuring clarity around scene naming, and fostering stronger relationships between key roles such as National Inter-agency Liaison Officers and Armed Response Units. Nottinghamshire Police major incident plan was written and first published on 19 February 2024 as a direct response to operation Hendrix. To supplement this plan our emergency planning team also developed a SharePoint site where all relevant information is now held.

1562. I believe scene management also presented challenges. Officers were required to preserve multiple scenes for extended periods, sometimes without adequate welfare support or clear communication statements to manage press interest. The provision of welfare resources, such as refreshments and weather protection, was sometimes delayed, and the use of gazebos and external support could have been actioned sooner. Improved training in scene management and the use of smarter technologies for resource mobilisation would have supported officers more effectively.

1563. Welfare provision for officers and staff was mixed. While some praised the response, others felt support was slow or inconsistent, and there was an over-reliance on peer support rather than specialist health care. A force-wide welfare trigger plan, clearer abstraction of welfare coordinators, and increased use of occupational health resources would have ensured more robust support for those affected.

1564. During the first week of the response, the communications team managed significant demand, balancing public reassurance with investigative needs. However, excessive press intrusion and capacity

issues meant that daily business was impacted, and some staff did not receive sufficient information to handle media queries. Earlier activation of the LRF communications cell, might have been helpful in this respect.

1565. I recognised that the debriefing culture within our organisation was identified as needing improvement. While written debriefs and structured sessions captured valuable feedback, there was a lack of 'hot' debriefs immediately after the incident, and no formal debriefing process was in place for many teams. Adopting College of Policing debrief training, improving technological support for debriefs, and centrally coordinating organisational learning has helped us to embed a culture of continuous improvement.

1566. In relation to the management of the investigation during the first week, one of the most prominent areas for improvement was the collaboration between major crime and CT teams.

1567. I am aware that the link between the two was "clunky," with major crime investigators not fully understanding the function or value of fusion cells, and the CT intelligence flows into the major incident room were disjointed and siloed. This lack of coordinated intelligence sharing led to duplication of effort and differences in approach between teams, as officers operated with differing priorities and parameters. For example, evidence and intelligence gathering were approached differently, and the lack of a clear briefing and tasking mechanism for resources sent into the major incident room further complicated matters. Training and knowledge inputs for staff at tactical and operational levels could have helped ensure all parties were

aware of the capabilities and support available from the CT policing network.

1568. Another area for development was the clarity around available resources to Counter Terrorism Intelligence Units (“CTIU”s). Even though there was early engagement at a strategic level, it was not clear from the outset what support the North East region would provide, and that contingency arrangements between buddy regions would benefit from a formal MoU outlining roles, responsibilities, and resourcing arrangements.

1569. The operation was challenged at times from a lack of clarity regarding whether the investigation was CT led, or Major Crime led. The absence of a PIP4 coordinator with an understanding of both major crime and CT was a gap here. A review recommended that CT exposure be introduced into PIP4 training to ensure that those in strategic roles can coordinate across all parts of an investigation.

1570. From the outset, I considered the appointment of a PIP4 accredited strategic advisor. I discussed this with the Chief Constable at 08:15 hours on 13 June 2024, making a note of it in my log. At that time, the force did not have any PIP4 accredited SIOs, other than the Chief Constable and me. We explored the possibility of seeking regional support but ultimately decided not to pursue that route.

1571. Our decision was based on a view that the approach we had adopted to managing the flow of information, outlined earlier in my statement, was delivering the key functions typically associated with a PIP4 role. These included stakeholder engagement, media management, and community liaison. The plan was for support to the SIO and investigation team to be

provided through the Det Ch Supt, Head of Crime, Det Ch Supt Leona Scurr.

1572. On reflection, however, the presence of a PIP4 strategic advisor may have added value, particularly in coordinating between the CT and major crime elements of the investigation. In the later stages, such support might also have enhanced the management of communications with families and, subsequently, with the media, as referenced earlier in my statement.

1573. I also acknowledge that communication between Counter Terrorism Policing Headquarters (“CTPHQ”) and the regional CT head was an area where improvements could have been made. The CT head was inundated with calls and requests for updates, which could have been streamlined by prioritising the dissemination of a single brief to all relevant parties and establishing a single point of contact on both ends to avoid duplication and overload.

1574. For balance, I believe there were also many areas of good practice, such as the effective initiation of the Counter Terrorism Intelligence Cell (“CTIC”) and the handover to fusion, which followed established plans and benefited from experienced staff and clear communication. A fusion cell in the context of CT is a multi-agency intelligence coordination unit designed to bring together key partners to ensure a unified and consistent understanding of the intelligence picture during the incident.

1575. The professionalism of staff in a rapidly developing situation was impressive, and the use of guidance and physical resources (such as grab bags for CTIC stand-up) contributed to the success of these elements.

1576. The actions required of the PSD representative within the Gold Group structure could also have been different, as I have described above. As part of our revised approach, all Gold Groups now include a PSD representative whose role is clearly defined. They provide tactical advice to the Gold Commander on potential conduct issues, whether arising from the incident itself or preceding events, and contribute to strategic oversight, ensuring alignment between incident management and any emerging conduct matters.

1577. To support this, the severity assessment template now prompts the Appropriate Authority to consider potential interested persons. Additionally, when setting terms of reference for an investigating officer, responsibilities around interested persons are explicitly outlined.

1578. In major incidents, even where formal misconduct processes are not triggered, the Appropriate Authority is expected to assess whether any issues should be shared with families. These decisions are brought to the Gold Group for discussion and agreement.

1579. This structure ensures that the PSD representative can raise relevant conduct matters and support decisions about whether families should be treated as interested persons, even in informal cases. It also enables the Gold Commander to direct how and when information is shared, including through FLOs where appropriate.

1580. Where sensitive PSD issues arise, a mechanism is in place for these to be addressed in closed sessions or sub-groups of the Gold Group.

1581. Had such action been taken during Operation Hendrix, families would likely have been identified as interested persons much earlier, and I would

have had the oversight needed to ensure timely and proactive communication.

1582. Upon reflection, I recognise that I did not fully grasp the meaning and implications of the term "interested person" at the time. While, in my capacity as Gold Commander, it is not within my remit to receive severity assessments or determine the designation of interested persons, I do consider it essential to maintain a broader engagement with this subject. It is important that I exercise appropriate oversight and scrutiny regarding decisions that affect when and how families are informed of matters relating to PSD.

1583. As I have already previously described, more action should have been taken to ensure the families and later the media, were fully sighted on all previous encounters between the police and VC. I believe that structured written updates for families from the SIO, would have enhanced both their understanding and our ability to communicate transparently with the public. It would have allowed me to deliver a non-reportable briefing that ensured families, and, by extension, the wider public, were appropriately informed about the important context and background to this case, including any missed opportunities. This had always been my intention.

1584. Looking back, I believe I could have taken a firmer stance with the IOPC in the early stages of the operation regarding referring the management of the outstanding warrant. I also recognise that I might have considered referring all previous incidents at that time. Doing so would have reinforced our commitment to openness and transparency and may have pre-empted concerns that we had not disclosed sufficient detail

about earlier encounters. A full IOPC investigation would inevitably have brought those matters into sharper focus and referring them proactively could have helped avoid any perception of omission.

1585. When I reflect on this point, I acknowledge the importance of understanding and applying the technical requirements of the relevant regulations. However, I also believe it is equally important to step back and apply a common-sense perspective. I recognise that both PSD and the IOPC are required to adhere to specific criteria when considering referrals. That said, I now believe that, as Gold Commander, it is incumbent upon me to look beyond the technicalities, to apply sound judgement, and to consider what is right and appropriate in the circumstances.

Structural Issues

1586. I have been asked to consider whether there are (and I have included, were) any structural issues (regarding police policies, procedures, methodology, training etc) which contributed to any issues I have identified.

1587. In reviewing the management of previous encounters with the defendant by Nottinghamshire Police, I have identified several structural issues that contributed to the issues outlined in my witness statement.

1588. One area relates to the approach taken regarding the submission and onward assessment of PPNs.

1589. Prior to February 2022, when an officer attended an incident and identified an individual as potentially vulnerable due to mental health concerns, but where the circumstances did not meet the threshold for Section 136, A&E attendance, or Street Triage involvement, a PPN would

be submitted. These PPNs were sent to the MASH, where they were assessed alongside other adult safeguarding referrals. If deemed appropriate, the MASH would refer the case to adult social care or a local mental health team. However, these referrals were not always assessed holistically, nor were they routinely reviewed in the event of subsequent referrals involving the same individual.

1590. In February 2022, a new process was introduced with the establishment of the Street Triage High Intensity Team (“HIT”) within the wider Mental Health Street Triage team (“MHST”), based in the police vulnerability hub.

1591. The HIT team, comprising a Mental Health Safeguarding Officer (“MHSO”) and a High Intensity Mental Health Practitioner (“HIP”), was created to jointly identify individuals with unmet mental health needs who may be at risk of harm to themselves or others. The team’s remit includes those individuals currently open to services, those previously known to services, and those who may be falling through gaps in provision.

1592. With the introduction of this team, the process for managing mental health-related PPNs changed. While PPNs continued to be sent electronically to MASH, police officers within MASH began to review and share mental health concerns directly with the HIT, via the MHST team’s email inbox.

1593. The HIT team’s workload is largely generated by PPN referrals but also includes referrals relating to repeat callers to the control room and online submissions. The mental health street triage car, which responds to live incidents, also identifies cases requiring further management.

1594. Upon receipt of a PPN or other referral, the HIT team considers a range of outcomes. These include taking no further action where no ongoing need is identified, signposting individuals to primary care for low-level concerns, escalating urgent cases to the Street Triage Team or HIP for immediate action, sharing information with healthcare partners, or considering a proactive visit in collaboration with the HIP. Decisions are recorded on a secure internal system, with rationales documented. Where there is uncertainty, the MHSO consults with colleagues such as the Street Triage Team Sergeant, nurse, or HIP.

1595. Guidance is provided for closing a PPN referral as 'No Further Action' ("NFA"), such as when the individual has already been assessed by health services or there is insufficient information to act upon. There is also guidance for when to consider a proactive visit, particularly in cases of acute mental health need, lack of engagement with services, or where risks may increase without intervention. Both the MHSO and HIP maintain records of their decision-making in line with organisational policy.

1596. I highlight this matter because, as noted earlier in my statement at paragraph 1018, there were instances where PPNs were not submitted following incidents attended by officers. I do not suggest that this change in process would necessarily have altered the outcome in VC's case, but I consider it a relevant structural issue during the period in question.

1597. A related structural issue concerns the existence and operation of the Police Liaison Operations Group ("PLOG").

1598. Prior to the Covid-19 pandemic, Nottinghamshire Police held regular PLOG meetings attended by the Police MHST team and representatives

from the NHS Mental Health Teams. There is no statutory requirement for these meetings, and they ceased at the onset of the pandemic, only being re-established in April 2023. Since then, meetings have taken place weekly (on a Tuesday), with the first Tuesday of each month focusing on community mental health care and the remaining Tuesday meetings in that month, addressing inpatient plans. These meetings are chaired by the Mental Health Care Group Safety and Security Manager for Nottinghamshire Healthcare Trust.

1599. During PLOG meetings, cases are discussed collaboratively, with both police and NHS incidents reviewed and multi-agency attendees working together to determine appropriate courses of action. Police officers support the Mental Health Team in developing contingency plans to ensure alternative strategies are available if initial approaches are not successful.

1600. In summary, PLOG provides a forum for reviewing mental health-related incidents, planning multi-agency interventions for individuals with repeated police contact, and documenting decisions regarding the use of powers such as Section 136 or referrals to Street Triage. These meetings also facilitate coordination with health partners to ensure continuity of care and reduce repeat incidents.

1601. It should be noted that PLOG meetings did not take place between March 2020 and April 2023. While it is difficult to assess whether the existence of effective PLOG meetings would have made a difference in the case of VC, I consider this a potentially relevant structural issue.

1602. I have also identified issues relating to the general approach to crime investigation within Nottinghamshire Police between 2020 and 2022.

These issues are broadly consistent with the findings of HMICFRS during their 2023 inspection, which resulted in the force being placed into enhanced monitoring status in March 2024. One significant area of concern highlighted was the management of investigations.

1603. In response to these findings, I developed and implemented a ten-point improvement plan for investigations, delivered under the banner of Operation Catalyst. This plan adopted a back-to-basics approach and was incorporated into the basic training for all new officers, as well as being delivered to existing officers and staff involved in investigations through face-to-face briefings and training packages. Additionally, a half-day training session was provided for every sergeant.

1604. The plan began with three “Whys,” emphasising the rationale behind the initiative. This focus on the “Why” was intended to address a dilution in leadership emphasis within Nottinghamshire. The first “Why” centred on improving outcomes for victims and witnesses, which is one of the three strategic objectives for the force; the second explained the connection between investigations and the identification and management of vulnerability; and the third articulated the alignment of investigations with the codes of ethics, specifically the importance of conducting thorough investigations.

1605. The fourth element of the plan addressed the “What”, namely, the effective investigation of crime.

1606. The remaining six points focused on the “How,” to address the structural issues. These included the use of appropriate crime management systems, completion of thorough investigation updates,

victim needs assessments and regular updates, effective suspect management (including how to deal effectively with cases involving mental health), robust supervisory oversight, and accurate attribution of outcome codes.

1607. As described elsewhere in my statement, the issues addressed within this plan stem from those identified by HMICFRS and were also evident in the approach taken during police encounters with the defendant. We recognised that a culture had developed in which the quality of investigations had lost some of its necessary focus. This was attributable to several interconnected factors that collectively impacted our approach.

1608. The Covid-19 period (2020/21) coincided with unprecedented recruitment levels as part of the government's national uplift programme. Officers were recruited at a rapid pace, and training was delivered remotely, with less emphasis on the quality of investigations. During this time, officers were also encouraged to make only necessary arrests and followed a period in Nottinghamshire where a proportionate approach to investigations had been promoted.

1609. The result was a workforce that was disproportionately junior in experience, less well trained, and had developed a culture less focused on the quality of investigations and proactive suspect management.

1610. Although not specifically highlighted by HMICFRS, our reviews of previous encounters with the defendant identified a lack of thorough understanding regarding the management of suspects within the criminal justice system where mental health concerns are present. To address this,

the suspect management element of the ten-point plan incorporated specific reference to mental health and the relevant CPS guidance.

1611. The Investigation Standards Accelerated Plan Action Tracker documents our progress and management of efforts to improve investigation standards, including benchmarking best practices, refining victim care, and implementing a monthly investigation quality audit regime.

I now refer to the action tracker as URN: NGPF0007854.

1612. We also created a SharePoint site with investigation guides and delivered regular meetings and force-wide engagement.

1613. To improve investigation plans, we clarified what should be investigated, who is responsible for writing and reviewing the plan, and the required content. We ensured alignment with APP and reasonable lines of inquiry.

1614. The suspect management input addressed a range of issues, including the necessity test for arrest, engagement with suspects, assessment of antecedents (including mental health considerations), comprehensive case management, quality handovers, bail management, and the use of correct NICHE flags for outstanding suspects.

1615. Within the training packages is a specific reference to the guidance from CPS for police in relation to the prosecution of offenders where mental health is a factor.

1616. In May 2025 following several revisits, smaller re-inspections and presentations to the National Police Performance Oversight Group (“PPOG”) we were removed from HMICFRS Engaged status.

1617. I also consider the approach taken by Nottinghamshire Police to the management and scrutiny of FTA warrants to be a relevant structural issue in the context of this case.

1618. Warrants fall under the remit of the Criminal Justice (“CJ”) department. Historically, the warrants team was located near the City custody suite, but a departmental review in 2020 resulted in the relocation of the warrants team to the same site as the PNC team within the CJ building. During this review, the PNC unit was transferred to the Intelligence Unit, moving away from CJ management.

1619. This change led to a loss of coordination and synergy between these closely linked areas of business. Following a post-implementation review in 2022/23, it was determined that the PNC unit aligned more effectively with CJ, and both the unit and its management structure were returned to the CJ department.

1620. Warrants are notified to the force by both Magistrates and Crown Courts, Magistrates Court via the Libra/Bichard Portal and Crown Court directly. These are then manually entered into both NICHE and PNC by the PNC/Warrants team. The national protocol for categorising warrants (A, B, C), which is based on offence type, was adopted in Nottinghamshire to determine prioritisation.

1621. However, around 2022, the warrants team altered their process, categorising Crown Court warrants as Class A and Magistrates Court warrants as Class B, rather than applying the warrant matrix across all warrants.

1622. All warrants are shared with local teams relevant to the offence location and any specialist teams supporting that area.

1623. In September 2022, when the warrant for VC was issued, there was no performance management framework in place. The national categorisation was not being effectively applied, and no additional risk matrix was used to overlay offence determination, resulting in ineffective prioritisation. Officers had discretion to move warrants between NICHE inboxes and decide whether all opportunities to execute the warrant had been exhausted, with limited supervisory oversight.

1624. Warrant management and performance were left to local management structures, with the NPI for the area responsible for prioritising and allocating warrants. Monitoring was rudimentary, conducted through Divisional Operational Performance reviews, and there was no formal structure for accountability in executing warrants. The inboxes became disorganised, making it difficult to determine outstanding work, progress, and prioritisation.

1625. Following the attacks in June 2023, a comprehensive review of the warrant system was commissioned. As a result, a more sophisticated system was introduced.

1626. Upon receipt of a warrant, the warrants team now applies the national offence categorisation code, followed by a gravity matrix, and a manual search across crime and intelligence systems. Depending on the defendant's footprint, this can escalate the categorisation.

1627. Once the warrant reaches the local inbox, it is automatically captured through a business intelligence platform (Power BI), enabling all relevant

parties to access and update warrants easily. The system also draws on available intelligence about the subject and applies the Cambridge Harm Index, assigning a numerical score in addition to the categorisation that has already been applied (A, B, C) to each warrant.

1628. The Cambridge Harm Index (“CHI”) is a data-driven metric designed to assess the severity and societal impact of criminal activity, rather than simply counting the number of offences. It assigns weighted scores to different crimes based on their starting point within sentencing guidelines, allowing for a more nuanced understanding of harm.

1629. While local ownership and management of warrants remain with the NPI and Divisional Commander, scrutiny is now applied daily through daily management meetings, tactical forums, and ultimately the strategic CJ Board.

1630. It is fair to say that the previous systemic failures have been addressed, although the effectiveness of the system still relies on human intervention and leadership to drive activity and the desire to arrest wanted individuals.

1631. According to NPCC guidance for grading FTA Warrants and Warrants in First Instance, VC’s warrant would have been graded as B (aim to arrest within 21 days). Since the review, Nottinghamshire Police has determined that assault on an emergency worker aggravates the categorisation, so VC’s warrant would now be graded as A (aim to arrest within 14 days).

1632. However, based on the CHI, VC’s score (had he been subject to this assessment, which he was not) prior to 13 June 2013 would have been 2.

The highest scoring individual on all our outstanding warrants as of 26 September 2025 is 4015.

Recommendations

1633. I consider there are several recommendations that could help prevent some of the issues I have identified.

- **Recommendation 1:**

1634. I recommend that national policing bodies review and, if necessary, revise the current definition and operational guidance on vulnerability to ensure that mental health vulnerability, particularly among suspects, is explicitly recognised and considered in all policing contexts.

1635. While the current national definition of vulnerability, “A person is vulnerable if, as a result of their situation or circumstances, they are unable to take care or protect themselves or others from harm or exploitation” is broad and inclusive, in practice I believe there is a risk that it is not automatically interpreted to include mental health.

1636. It is often the case that individuals suffering with mental health issue are entirely capable of taking care of and protecting themselves.

1637. Even though the national strategy states: “In addition to this broad approach to vulnerability, this strategy recognises that some groups are always considered as vulnerable.” Included within that wider parameter are children and young people between the age of 18-24, and adults who are identified under the Care Act 2014 as at risk and receiving care in the community.

1638. The Care Act defines those who need support as “any person aged 18 years and over who is or may be in need of community care services by

reason of mental health issue, learning or physical disability, sensory impairment, age or illness or who is or may be unable to take care of him/herself or unable to protect him/herself against significant harm or serious exploitation”.

1639. In my opinion, this is still not sufficiently clear and could result in officers overlooking or under-recognising mental health vulnerability, especially where individuals do not meet statutory thresholds for care or support.

1640. I would therefore recommend that the definition of vulnerability, and all supporting guidance, should explicitly reference mental health as a key factor, regardless of whether the individual is a victim, witness, or suspect. Training and operational materials should include practical examples and scenarios illustrating how mental health vulnerability may present in suspects, and how it should influence decision-making, safeguarding, and referral pathways. Police Forces should ensure that officers are equipped to identify and respond to mental health vulnerability at all levels of severity, not just where Care Act criteria are met.

1641. I believe that if adopted, this recommendation would ensure that mental health vulnerability is consistently recognised and addressed in all policing activity, reducing the risk of missed opportunities for intervention and improving public safety for individuals and communities.

- **Recommendation 2:**

1642. I would encourage a recommendation that national policing bodies, in partnership with the CPS, review and reinforce the training and operational guidance provided to officers, particularly those conducting PIP1 (priority

and volume crime) investigations, regarding the CPS guidance on the prosecution of cases where mental health is a factor.

1643. My experience, as set out in this statement, has highlighted that there is often a lack of awareness or understanding among frontline investigators of the guidance and its practical implications for case building, charging decisions, and safeguarding. I also discovered that opportunities to refer cases for early CPS advice, or to ensure that mental health considerations are properly documented and presented, are sometimes missed, potentially affecting both outcomes for victims and the management of vulnerable suspects.

1644. I believe the complexity of mental health issues in criminal investigations requires clear, accessible guidance and a culture of early consultation between police and CPS, and this is particularly so for new and frontline officers.

1645. I would therefore recommend that all officers involved in PIP1 investigations receive specific training on the guidance, including practical scenarios and decision-making tools, and that police Forces ensure the guidance is embedded in local policy, investigation templates, and supervisory oversight processes.

1646. I believe this would help to ensure that mental health is consistently and appropriately considered in all relevant investigations and that officers are confident in seeking early CPS input where needed.

- **Recommendation 3:**

1647. To ensure that families receive coordinated, clear, compassionate, and consistent communications in cases where the legal concept of diminished

responsibility is engaged or likely to be a significant issue, I would recommend that the CPS and police forces review and strengthen their joint working arrangements with FLOs.

1648. What became apparent during Operation Hendrix is that the concept of diminished responsibility is often misunderstood and can be deeply distressing for bereaved families and survivors. FLOs are generally the primary point of contact for families in homicide cases but may not always have direct, or immediate access to CPS legal expertise or up-to-date information about psychiatric evidence, or plea considerations.

1649. This recommendation could include the CPS and police reviewing protocols for joint briefings with families and information-sharing with FLOs in all cases where diminished responsibility is or is likely to be a feature. Additionally, that written materials and guidance on diminished responsibility are reviewed by CPS and police and made available to FLOs and families at the earliest appropriate stage.

- **Recommendation 4:**

1650. When several families are affected by an investigation, there is a risk of inconsistency, confusion, or distress if communication is not carefully planned and coordinated. Decisions about whether to meet families jointly or separately, how meetings are facilitated, and how information is shared, can have a significant impact on families' understanding, trust, and wellbeing.

1651. Of course, families should still be consulted about their preferences for joint or separate meetings, and their wishes respected wherever practicable.

1652. However, I would recommend that policing develops a secure and reliable mechanism for providing information simultaneously to multiple families in major investigations. The current approach, often relying on individually phoning or visiting families in the hope that messages are received at the same time, can lead to inconsistencies and distress.
1653. Forces could consider implementing secure digital platforms (such as a dedicated family portal or encrypted messaging system) to deliver important updates to all families at once, with appropriate safeguards for privacy and support.
1654. This approach would help ensure consistency, transparency, and equity in communication, and reduce the risk of families learning sensitive information at different times.
1655. I also believe there is a need for national policing bodies and the CPS to develop clear, joint protocols for engaging with multiple bereaved families and survivors in major investigations and prosecutions. These protocols should provide specific guidance on whether meetings and communications should be conducted jointly, separately, simultaneously, or through a combination of approaches, ensuring that arrangements are carefully planned, consistently facilitated, and responsive to the needs and preferences of each family.
1656. In future I believe that planning for family engagement should be embedded as a separate standing agenda item in Gold Group meetings and SIO case management meetings, with clear roles and responsibilities for both police and CPS representatives. As I have previously explained, written communications would also support improvement in this area.

- **Recommendation 5:**

1657. I believe a recommendation, urging national policing bodies, in consultation with the IOPC and relevant stakeholders, to review and clarify the role of PSD in major crime investigations, particularly in relation to the effective identification and management of “interested persons” as defined in the Police Reform Act 2002 and associated regulations, could be helpful.

1658. My experience during this investigation highlighted that the current regulations and guidance do not always provide sufficient clarity on when and how individuals, especially bereaved families and survivors, should be formally identified as interested persons in the context of PSD investigations running alongside major crime inquiries.

1659. There is a risk that, without clear protocols, important information may not be shared with those most affected, or that families may not receive the updates and support to which they are entitled.

1660. The interface between the operational investigation and PSD processes can be complex, and the absence of clear, joined-up guidance can lead to confusion, missed opportunities for engagement, and, ultimately, a loss of trust.

1661. I would propose that the relevant regulations and statutory guidance are reviewed to ensure they provide clear, practical direction on the identification and notification of interested persons in the context of major and critical incidents.

1662. That review should include examining whether the role of PSD in supporting Gold and SIO command structures is clearly defined, and

consider explicit responsibilities for advising on interested persons, severity assessments, and the timing and method of family engagement.

1663. The review should also ensure that training and operational guidance is updated to reflect these changes, ensuring that all forces adopt a consistent, transparent, and victim-focused approach.

1664. I believe this would help to ensure that, in future, families and survivors are always identified promptly as interested persons where appropriate, are kept fully informed throughout, and that the responsibilities of PSD and operational teams are aligned and clearly understood.

- **Recommendation 6:**

1665. I recommend that Police Liaison Operations Groups (“PLOG”s), multi-agency forums for reviewing mental health-related incidents and planning interventions for individuals with repeated police contact, should be adopted as standard practice across all police forces in the UK and placed on a statutory footing.

1666. My experience has shown that regular PLOG meetings, attended by police, NHS Mental Health Teams, and other relevant partners, provide an effective forum for:

- Collaborative review of cases involving mental health vulnerability.
- Joint planning of interventions and contingency strategies.
- Ensuring continuity of care and reducing repeat incidents.
- Documenting decisions regarding the use of police powers (such as Section 136) and referrals to Street Triage.

1667. The absence of a statutory requirement for PLOGs means that their existence and effectiveness can be inconsistent, as seen during the Covid-

19 pandemic when meetings in Nottinghamshire ceased and were only re-established later. To ensure that all forces benefit from this structured, multi-agency approach, and that vulnerable individuals do not fall through the gaps, I recommend that PLOGs be mandated nationally, with clear guidance on their operation, membership, and frequency.

1668. Placing PLOGs on a statutory footing would help embed best practice, improve information sharing, and ensure a consistent, joined-up response to mental health vulnerability across policing and partner agencies. This group should be MH led as is the case in Nottingham.

- **Recommendation 7:**

1669. Aligned to the implementation of PLOG's, I would also support a recommendation that all agencies involved in managing risk to individuals and the public, including police, health, and social care partners, adopt a consistent and systematic approach to risk assessment and management. This should include clear, shared processes for identifying, assessing, and mitigating risks, and for documenting the rationale behind key decisions.

1670. The police have robust systems in place where risks arise, which are embedded as part of the organisational culture (including use of the NDM and the process of testing planned actions against threat assessments and working strategy).

1671. Where a person is identified as presenting a potential risk to themselves or others, all agencies should ensure that the full range of available options and interventions are considered, and that actions are taken in a timely and coordinated manner. This includes, for example, the use of Community Treatment Orders (CTOs) or other statutory

mechanisms, where appropriate, to protect both the individual and the wider public.

1672. It is also important that all agencies are held to comparable standards of accountability and scrutiny in their risk management practices. Establishing consistent governance, reporting mechanisms, and transparent decision-making processes will help ensure that responsibilities are clear, that actions are subject to appropriate oversight, and that public confidence is maintained.

1673. The aim should be to foster a culture of shared responsibility, where agencies work collaboratively to manage risk, protect the public, and ensure that individuals receive the support and interventions they need, while upholding the rights of all involved. It is crucial that the rights of the individual are fully balanced with the need for public protection, using effective risk management processes, which are consistent across all agencies.

- **Recommendation 8:**

1674. Associated to recommendation 7, I would also encourage a further recommendation that focussed specifically on Community Treatment Orders (CTOs).

1675. That recommendation might include that national and local mental health services, in partnership with policing and other safeguarding agencies, ensure that the option of a CTO is always properly considered as part of the risk management process for individuals admitted under the MHA, particularly where there are identified risks to personal or public safety.

1676. While the forthcoming Mental Health Bill might introduce changes to CTO criteria, it remains essential that clinicians and multi-agency partners are supported to use CTOs appropriately and consistently in cases where they may help mitigate risk, balancing the rights of the individual with the need to protect the public. I am aware that any changes will need to be cognisant of the issue relating to disproportionality in the use of CTOs, and the impact for black and minority ethnic patients.

1677. NHS England commissioned Themis Consulting Ltd to carry out an independent investigation into the care and treatment provided to VC by NHS services prior to the tragic events of 13 June 2023. This independent review, which was published in January 2025, highlighted that, during admissions under Section 3 of the Mental Health Act, there was an opportunity to discharge the individual under a CTO, which would have allowed for conditions such as medication compliance and recall to hospital if necessary. The use of Section 2, rather than Section 3, inadvertently removed this option, underscoring the importance of accurate application of Mental Health Act powers.

1678. I would urge the recommendation to include that all relevant agencies review their policies and training to ensure that the use of CTOs is fully understood and considered wherever appropriate. Additionally, the recommendation might include that decision-making processes regarding the use of Section 2 versus Section 3 admissions are robust, well-documented, and subject to regular review.

1679. If this recommendation were to be implemented, I believe it would help to ensure that all available legal and clinical tools are considered and used

appropriately to manage risk, support recovery, and protect both individuals and the wider community.

- **Recommendation 9:**

1680. I believe that any recommendation that helps to widen and strengthen Multi-Agency Public Protection Arrangements (MAPPA) and Potentially Dangerous Persons (PDP) frameworks would help address some of the issues I have identified throughout my statement.

1681. MAPPA and PDP frameworks provide a structured, multi-agency approach to risk assessment and management, bringing together police, probation, NHS, mental health clinicians, social services, housing, and third sector partners. These arrangements enable improved information sharing, dynamic risk assessment, and coordinated use of legal and protective tools to reduce the risk of serious harm or homicide.

1682. At present, the criteria for MAPPA referrals are relatively prescriptive, which can limit the ability to refer individuals such as VC. Currently, MAPPA referrals are generally restricted to:

- Registered sexual offenders (subject to notification requirements).
- Violent offenders sentenced to imprisonment for 12 months or more for a violent offence, or those detained under hospital orders for such offences.
- Other offenders who, by reason of offences committed or their behaviour, are considered to pose a risk of serious harm to the public.

1683. In each of these categories, a conviction is typically a prerequisite for referral. This means that individuals who present a significant risk but do

not have qualifying convictions may not be eligible for MAPPA oversight, potentially leaving a gap in multi-agency risk management.

1684. The eligibility criteria for PDP is wider than this and includes individuals that do not meet the MAPPA criteria, but for whom there is credible intelligence or evidence that the person's behaviour indicates a present or potential risk of serious harm to the public, a particular individual, or to known groups. The risk may be based on a pattern of concerning behaviour, threats, or incidents, even if these have not resulted in a conviction, and the risk is significant enough that it requires a coordinated, multi-agency response to manage and mitigate it.

1685. PDP status is not dependent on a criminal conviction.

1686. Importantly, MAPPA and PDP processes ensure that mental health clinicians become a formal part of the risk management structure, supporting professional accountability and helping to prevent individuals from falling through the gaps, especially when someone is not detainable under the MHA but continues to pose a risk to themselves or others. These forums also facilitate the identification of risks to specific individuals and enable timely notification and safeguarding measures.

1687. The recommendation might include that a review of MAPPA be undertaken to consider widening its scope, so that individuals who present a significant risk of serious harm, particularly those with complex mental health needs, can be more readily included, even in the absence of qualifying convictions.

1688. In addition, further work should be done to encourage and enhance the use of the PDP process. All agencies involved in the management of

individuals who, because of their complex mental health needs, pose a risk of serious harm, should ensure that referrals into PDP processes are actively considered as part of risk management planning, especially where MAPPA criteria are not met.

1689. I believe this would help ensure that no high-risk individual falls through the gaps due to restrictive eligibility criteria, and that robust, multi-agency risk management frameworks are available and consistently applied for all those who present a risk to the public, regardless of conviction status.

- **Recommendation 10:**

1690. To optimise the impact of any change that results from implementing recommendation 9, while it will remain essential that information is shared and risk is managed within established governance processes, it is equally important to recognise that information needs to be shared both ways (i.e. police to MH, but also MH to police).

1691. I would suggest a recommendation that national and local health partners, including GPs, community mental health teams, psychiatrists, pharmacies, and social care, develop and implement robust protocols for timely information sharing when a patient with serious mental illness fails to collect prescribed antipsychotic medication or demonstrates non-compliance with a treatment plan. This should apply also to where a medical practitioner has a concern about the risk a patient might present at the point they are due to be released into the community.

1692. Non-collection of medication or non-compliance is often an early warning sign of relapse or increased risk, and failure to share this information has been a factor in several serious case reviews and

preventable incidents. Effective information sharing enables early clinical intervention, such as medication review, home visits, mental health act assessments, or welfare checks, and can trigger multi-disciplinary meetings to consider the full range of legal and safeguarding options (including the MHA, MAPPA, safeguarding frameworks, and CTOs).

1693. I would urge that the recommendation includes that GPs and other health professionals are supported and encouraged to promptly notify relevant partners, such as the Community Mental Health Team, Crisis Team, Pharmacist, Care Coordinator, or Social Worker when concerns arise, and the police where risk of harm is identified. This should be embedded in local protocols and supported by secure communication systems. The implementation of PLOGs would support this recommendation.

1694. I think it is also relevant to say that the police should not be viewed as the default agency for providing access to mental health services, particularly when a patient is already under the care of health professionals. The principle remains that individuals with mental health needs should receive appropriate care and intervention from health partners, with police and other agencies working collaboratively to support public safety.

1695. The recommendation should serve to reduce delays in recognising crisis, prevent missed opportunities for proactive intervention, and ensure that individuals at risk receive timely, coordinated support from all relevant agencies.

- **Recommendation 11:**

1696. This final recommendation follows a brief review of lessons learnt from two earlier mental health homicide cases [GRO-C]

[GRO-C]

1697. I refer to the lessons learned from [GRO-C] as URN: NHSE0000278.

1698. I refer to the lessons learned from [GRO-C] as URN: NGPF0007933.

1699. I compared these with the findings and recommendations from the NHS England-commissioned Themis Consulting independent investigation into the care and treatment of Valdo Calocane prior to the Nottingham attacks on 13 June 2023, which I now refer to as URN: [NHSE0000298]

1700. The similarities across these three cases highlight repeated systemic issues. I believe they show the urgent need to ensure that recommendations are not only made, but also robustly followed up to prevent future tragedies.

1701. Across the three cases, there are striking similarities in the nature of the recommendations, particularly around risk assessment, discharge planning, medication adherence, and interagency communication. The recurrence of these themes over time suggests that while lessons have been identified, they have not always been fully embedded into practice.

1702. In reviewing the tragic cases of VC [GRO-C] and [GRO-C] a pattern of recurring failures emerges, failures that have been documented across decades yet continue to resurface.

1703. A central theme is the failure to conduct robust and dynamic risk assessments. In all three cases, risk was either misunderstood, poorly documented, or inadequately communicated. VC's risk profile was

minimized despite clear warning signs; **GRO-C** was released during a mental health relapse due to fragmented knowledge of his history; and **GRO-C** was supervised by inexperienced staff with insufficient oversight.

These failures point to a need for risk assessments that are not only thorough but continuously updated and shared across agencies.

1704. Equally concerning is the lack of effective discharge and release planning. VC was discharged into the community with limited follow-up, and **GRO-C** was released twice within 48 hours without full assessment. **GRO-C** release decisions were similarly flawed, with insufficient ongoing management despite a known history of violence. These cases show that discharge must be treated as a critical transition point requiring assertive outreach and coordinated oversight.

1705. Medication adherence, a cornerstone of managing psychosis, was another area of repeated concern. VC's refusal to take medication was well-documented, yet long term options were not pursued. **GRO-C** case also reflected poor treatment planning and supervision. While **GRO-C** review was less explicit on this point, the gaps in care during psychotic episodes suggest that medication management was not adequately prioritized. Assertive strategies to address non-compliance must be considered, including the use of depot medication where appropriate.

1706. The quality of record keeping and interagency information sharing was consistently poor. VC's treatment history and risk details were often missing or omitted; **GRO-C** release decisions were made without access to full clinical records; and **GRO-C** case highlighted the need for better communication across agencies. These failures underscore the

importance of integrated systems that ensure all relevant information is available to decision-makers.

1707. I would therefore urge the inquiry to develop a mechanism to ensure that that all recommendations arising from this Inquiry are not only documented but robustly followed up. This means embedding them into operational practice, auditing their implementation, and ensuring accountability across all agencies.

1708. Without sustained implementation and oversight, there is a real risk that the same failures will continue to repeat, with tragic consequences.

Statement of Truth

I believe the content of this statement to be true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed:

GRO-B

Dated: 28 November 2025

Index to First Witness Statement of DCC Rob Griffin

No.	URN	Document Description
1	NGPF0007786	Timeline of phone calls
2	NGPF0007787	Gold Commanders Log
3	NGPF0007927	TCG Meeting Minutes
4	NGPF0007788	SCG Meeting Minutes

5	NGPF0007789	SCG Meeting Minutes
6	NGPF0007790	SCG Meeting Minutes
7	NGPF0007791	SCG Meeting Minutes
8	NGPF0007792	TCG Meeting Minutes
9	NGPF0007793	TCG Meeting Minutes
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19	NGPF0007803	Gold Group 7 Minutes
20	NGPF0007804	Message to workforce
21	NGPF0007805	Gold Group 8 Minutes
22	NGPF0007806	Gold Group 10 Minutes
23	NGPF0007807	Gold Group 12 Minutes
24	NGPF0007808	Email from DSUPT Sanders 15/01/2024
25	NGPF0007809	Gold Group 13 Minutes
26	NGPF0007810	Letter from CC Meynell to the Families Jan 24
27	NGPF0007811	IOPC Referral on 30/01/2024
28	NGPF0007812	Gold Group 14 Minutes

29	NGPF0007813	Email chain with DSUPT Williams 20/09/2023
30	NGPF0007814	Email chain with DSUPT Sanders 14/12/2023
31	NGPF0007815	Letter from CC Meynell to the Families Feb 24
32	NGPF0007816	LRF Debrief report
33	NGPF0007817	Major Case Review Self-Inspection Report
34	NGPF0007818	Email re PSD looking into unactioned warrant
35	NGPF0007819	Email from DSUPT Reynolds 25/01/2024
36	NGPF0007844	Email from DSUPT Williams 14/06/2023 re FTA Warrant
37	NGPF0007820	Email from DSUPT Williams 14/06/2023 re scoping exercise
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47	NGPF0007830	Police Incident Timeline
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51	NGPF0007834	Op Catalyst 10-Point Plan
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53	NGPF0007836	Combined document version 2

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55	NGPF0005476	Email from the Sun 16/06/2023
56	NGPF0002460	Statement of Iulian GRO-B
57	NGPF0007840	Email chain re: draft of Op Hendrix press release
58	NGPF0007928	Op Hendrix press release
59	NGPF0007929	Updated Release
60	NGPF0007841	PNB of officer attending on 15/01/22
61	NGPF0007842	Timeline of Contact with VC
62	NGPF0007843	Email to Lynn Heath 24/01/2024
63	NGPF0007930	Press Release from 16062023 at 1636pm
64	NGPF0007845	Transcript of ITV News Interview
65	NGPF0007846	Incident Log 0065_13062023
66	NGPF0007847	Incident Log 0077_13062023
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75	NHSE0000278	Lessons from GRO-C
76	NGPF0007933	Lessons from GRO-C
77	NHSE0000298	NHS England-commissioned Themis Consulting independent investigation

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79	NGPF0007936	Internet Article 25 Jan 2024 Timeline of previous contact with VC