THE INQUIRIES ACT 2005

BEFORE HH DEBORAH TAYLOR

THE NOTTINGHAM INQUIRY

WRITTEN CLOSING SUBMISSIONS OF THE CHIEF CONSTABLE OF LEICESTERSHIRE POLICE

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1. These submissions are provided to the Inquiry on behalf of the Chief Constable of Leicestershire Police, pursuant to the Chair's directions dated 26 May 2026. They are structured as follows:
   a. Introduction.
   b. The care of people with mental illness who pose a risk of serious harm to others.
   c. Multi-agency working.
   d. Information sharing.
   e. Risk assessment.
   f. Leicestershire Police's actions following the incident at Arvato Ltd's premises on 5 May 2023.
   g. Causation.
   h. Lessons learned.

Introduction

2. On behalf of Leicestershire Police, Temporary Chief Constable Sandall's deepest condolences to the families of Barnaby Webber, Grace O'Malley-Kumar and Ian Coates, and recognition of the suffering of Wayne Birkett, Sharon Miller and Marcin Gawronski are repeated. So too is T/CC Sandall's acknowledgement of the terrible impact on all those whose lives have been profoundly affected by VC's horrific offending on 13 June 2023.[1]
3. It is hoped that the Inquiry provides the answers that the Families were searching for. It is also hoped that the Inquiry is a catalyst for real change, something that the evidence heard by this Inquiry strongly indicates is needed.

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[1] WITN0001001_0030 at [101].

4. Leicestershire Police is grateful for the opportunity to participate in this important Inquiry. These submissions cover matters within the scope of the Inquiry that are relevant to policing generally (beyond Leicestershire Police's immediate involvement) and are made to contribute to the Inquiry's consideration of those matters.

The care of people with mental illness who pose a risk of serious harm to others

5. The Chief Constable agrees with the Ritchie Inquiry into the Care and Treatment of Chrisopher Clunis at [43.0.1] that "it is important to emphasise ... that the vast majority of mentally ill patients are living safely in the community. Furthermore the vast majority of those who suffer from schizophrenia are also living safely in the community. But there are other patients who are not receiving the care and treatment that they require to ensure that they are safe, and that the public are protected."[2]
6. The central question for this Inquiry is how it was that VC, a man with paranoid schizophrenia and a history of violence to others, was in a position to carry out the homicidal acts he did on 13 June 2023.
7. A similar question has been central to many, many, inquests and NHS homicide reviews, and was the focus of the Ritchie Inquiry. In many of these investigations, the following themes have arisen:
    a. Risk assessment[3] including in respect of decisions about detention;
    b. Quality of monitoring in the community;[4]
    c. Concordance with medication / engagement with treatment or services;
    d. Information sharing (within and between agencies).[5]
8. Given the number of homicides attributed to people with mental illness (2,468 since 1993 according to Julian Hendy (Mr Hendy, 28th May 2026, 12/7-9 INQT0000100),[6] and the no-doubt greater number of non-fatal attacks, this Inquiry might consider it appropriate to return to fundamentals.

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[2] DHSC0000160_0120.
[3] Ritchie Inquiry 'important failing' 4: 42.2.1: DHSC0000160_0118.
[4] Ritchie Inquiry 'important failings' 5 – 7: 42.2.1: DHSC0000160_ 0018.
[5] Ritchie Inquiry 'important failing' 1: 42.2.1: DHSC0000160_ 0117 – _0118.
[6] Mr Hendy's Hundred Families website (RLIT0000093) now puts the figure at 2,496: https://www.hundredfamilies.org. It is noted that there is debate around the precise figures. Professor Sir Louis Appleby notes that between 2005 and 2015 there were 32 homicides annually committed by people with schizophrenia, 20 of whom were recent patients, and 59% of whom were not in receipt of care as planned: WITN0069007_0007 at [29] – [30].

9. In her evidence, Dr Smith said:[7]

> "In 1974, it was decided that the asylums, which, you know, would be, you know, dissolved, there was deinstitutionalisation. At that point 40% of NHS beds were for mental health and learning disability patients. Since then, our beds have reduced by 85%. The expectation was that the money that was saved, because asylum care is expensive, the money that was saved from the asylums would be pumped into and ploughed into community services. Unfortunately, as ever, the money didn't really follow, which has meant that community services have been -- there were occasionally there's injections of money and funding and resources, but generally, they are, you know, they're just not properly resourced, and because they're not properly resourced, it means that they've got thinner and thinner and they can produce a crisis response, but often not good enough in certain places."[8]

10. The basis upon which deinstitutionalisation took place is assumed to be that the benefits to patients in terms of autonomy and quality of treatment in the community outweighed any increased risk to the public. That risk / benefit analysis appears to have been undertaken on the assumption that care in the community would be sufficiently well resourced. It may be that the decision to deinstitutionalise would not have been reached had it been known that care in the community would be insufficiently resourced.

11. The Chief Constable is <u>not</u> calling for a return to institutionalisation – far from it. Rather, he is submitting that care in the community should be sufficiently well resourced and efficacious to minimise to an acceptable level the risk from those with mental illness who pose a risk of serious harm.

12. This cohort of patients was of particular interest to the Ritchie Inquiry, which described it as the 'Special Supervision Group of patients who need special care' ("SSG") in chapter 47 and made the following findings (emphasis added):[9]

> "47.0.1. We emphasise again that the vast majority of those people who suffer from schizophrenia live safely in the community. However as indicated at the beginning of our Report we have been very troubled by the fact that during the period of our investigations there have been repeated

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[7] Dr Smith, 1st June 2026, p.51/1-18 (INQT0000103).

[8] Mr Hendy referred to a "severe shortage of psychiatric beds", which are down from 150,000 in 1954 to 18,000 today: Mr Hendy, 28th May 2026 PM, 44/1-4 (INQT0000100).

[9] DHSC0000160_0126 – _0127.

reports of serious and violent acts committed by a very small number of patients who suffer from severe mental illness. Christopher Clunis is one of such patients. In our view, the serious harm that may be inflicted by severely mentally ill people on themsleves [sic] or on members of the public is a cost of care in the community which no civilised society should tolerate. There will always be some risk that harm will be inflicted. However we are concerned that such a risk should be reduced in so far as is possible.

47.0.2. In addition to those patients we have referred to in the previous paragraph, we have come to the view as our Inquiry has progressed that however good the care in the community that can be provided and however all embracing, there will always remain a small group of seriously mentally ill people who are at risk of falling through the net of care. We feel that they too need very special care and treatment involving especially close supervision and support.

47.0.3. In days gone by all such patients were confined within mental institutions so that they and the public were safe. If a similar degree of safety is to be provided when care is provided within the community then, in our view, it can only be provided by exceptional means. We consider that if the needs of that small group are not properly met, care in the community will be discredited and may be perceived as a policy which has failed. We do not think that as a society we can afford to let that happen. We are convinced, as we felt was every witness from whom we received evidence, that care in the community is the right approach for caring for the mentally ill and we have no wish to return to the days of locked, impersonal, dehumanising and undignified institutional care.

47.0.4. We have called that group of patients who need special supervision, the Special Supervision Group. We suggest that patients who suffer from mental disorder and who are assessed by their Consultant Psychiatrist to require close supervision and support, and who meet 2 of the following criteria, would fall into that group:

(a) patients who have been detained in hospital under the Mental Health Act 1983 on more than one occasion;

(b) patients who have a history of violence or of persistent offending;

(c) patients who have failed to respond to treatment from the general psychiatric services;

(d) patients who are homeless.

47.0.5. We consider that the Special Supervision Group needs to be cared for by a specialist multi-disciplinary team who have a limited and protected case load. The patients we are trying to identify are those who are difficult to care for, and need to be followed up intensively, with assertive and close supervision.

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47.0.9. From all we have heard during our Inquiry, we consider that a Special Supervision Group should be targeted for special care. It is also clear that existing mental health budgets could not provide for such Specialist Teams. The clear evidence is that such a service should be separately funded, with an arbitrator ensuring that such funds are used as intended.

47.0.10. We envisage a special role for Community Psychiatric Nurses specialising in the care of Special Supervision Group, often as key worker. They would work exclusively for the specialist team in caring for the Special Supervision Group and would have no other duties."

13. The Chief Constable considers that the SSG (a term adopted herein for convenience) should be managed by the NHS on a mandated, consistent and adequately funded pathway. The SSG should also be the subject of a bespoke multi-agency pathway, enhanced information sharing, and common assessment of risk (as to which, see below).

14. The Chief Constable has no fixed view on whether the Ritche Inquiry's criteria for inclusion in the SSG at [47.0.4][10] remain sound, but considers those criteria should be:

a. Underpinned by a criterion that the patient poses a risk of serious harm to the public, including should they relapse; and

b. Supplemented with a criterion that captures patients who are at high risk of relapse or non-compliance with anti-psychotic medication.

15. The Ritchie Inquiry's recommendations in respect of the SSG were taken up with the roll out (or at least a boost in the uptake of) of Assertive Outreach. Assertive

[10] DHSC0000160_0127.

Outreach teams gained national coverage by 2002, but were scaled back from 2010.[11] Dr Dissanayaka's evidence was that now, in England, there is only an estimated 32% coverage of Assertive Outreach provision (with a significant variation in fidelity).[12] Whatever the reasons for the decline in Assertive Outreach, funding appears to have played a major part in it.[13]

16. The Chief Constable respectfully agrees with Dr Dissanayaka's observation that this specialist cohort requires particular management and assessment of risk on an ongoing basis,[14] and that all patients who require Assertive Outreach should have access to it.[15]

17. The value of Assertive Outreach was clear on the evidence gathered by the Ritchie Inquiry and it is no less clear on the evidence gathered by this Inquiry. For instance, data gathered by the National Confidential Inquiry ("NCI") suggests a strong relationship between schizophrenia and homicides (accounting for around 6% of all convictions despite a population prevalence estimated to be around 0.5-1%). The NCI's data also emphasises the importance in terms of prevention of: (i) co-existing alcohol or drug misuse; and (ii) not receiving treatment as planned through loss of contact or treatment refusal. Because of these findings, the NCI's reports have consistently supported Assertive Outreach teams and Community Treatment Orders.[16]

18. The decline in the use, consistency, and quality of Assertive Outreach, and the apparent absence of an equally effective alternative model of care in the community for the SSG is a matter of real concern.

19. Whether the Inquiry is attracted by the Assertive Outreach model or a different model, it is submitted that:

    a. There should be a single NHS model for managing the SSG that NHS bodies are required to apply. A single model will promote consistency of care and supervision of the SSG across the country (noting that patients move across health area borders, as VC did), and consistency in multi-agency working. A requirement is needed because otherwise NHS bodies in different areas will either not adopt, or in due course deviate from any merely recommended

[11] Dr James, 21st May 2026 PM, 88/4-8 (INQT0000094).
[12] WITN0412001_0010 at [20].
[13] See e.g. Dr Dissanayaka, 15th April 2026 AM, 79/8-23 (INQT0000051).
[14] Dr Dissanayaka, 15th April 2026 AM, 80/3-6 (INQT0000051).
[15] WITN0412001_0035 at [54].
[16] WITN0069007_008 at [36].

national model (e.g. due to money or ideological differences within psychiatry),[17] as most did after the initial uptake of Assertive Outreach post-Ritchie.

b. The pathway should be separately funded from existing mental health budgets, as the Ritchie Inquiry recommended. The Ritchie Inquiry's rationale was that specialist teams to care for the SSG could not be provided for from existing mental health budgets. While this presumably remains the case, there is another reason for ring-fenced funding. If care under the pathway is funded from general mental health budgets, it is susceptible to the overall pressures on those budgets and therefore to cuts, money being re-allocated, or staff / services being expected to take on additional work. This appears to have been essentially what happened to Assertive Outreach teams. Professor Morgan's evidence was that "… the philosophies that underpinned crisis services, based on Assertive Outreach teams, have been lost through the asset stripping of these teams to cut costs".[18] Had the Ritchie Inquiry's recommendation for separate funding been followed, this would not have been possible.

c. There should in any event be sufficient funding to enable NHS bodies properly to manage the risk posed by the SSG, including through the use of inpatient beds where necessary, and in particular to prevent patients reaching the stage of crisis where risk to the public is higher and compulsory detention is more likely.

Multi-agency working

20. No witness who gave evidence to the Inquiry doubted the importance of multi-agency working. Its importance includes:

    a. Gaining a common understanding of risk;

    b. Ensuring that all relevant information is shared for assessing and managing risk;

    c. Ensuring that all relevant agencies are involved, and understand their role (and the role that other agencies are playing), in managing risk;[19]

    d. Reducing the likelihood of gaps in care;[20] and

    e. Ensuring that vulnerable individuals do not fall through gaps in the system.[21]

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[17] Dr Dissanayaka, 15th April 2026 AM, 79/8-23 (INQT0000051).
[18] Professor Morgan, 20th April 2026 PM 8/19-22 (INQT0000056).
[19] Sir Andy Marsh, 14th April 2026 PM, 91/17-21 (INQT0000050.
[20] Professor Morgan WITN0058001_0011 [57].
[21] As observed by Sir Andy Marsh WITN0349001_023 at [79].

21. No witness who gave evidence to the Inquiry suggested that the current arrangements for multi-agency working, or how they were operated, was adequate in the case of the SSG.[22]
22. Part of the problem likely to be that there is no bespoke multi-agency structure for managing the risk (or at least the long term risk) posed to the public by the SSG.
23. The existing multi-agency structures (primarily MAPPA, Prevent, and PDP) do not apply to many patients in the SSG.
24. Multi Agency Public Protection Arrangements (MAPPA) only apply in cases where the person concerned is, per s.325(2) of the Criminal Justice Act 2003:
    a. A relevant sexual and violent offender;
    b. A relevant terrorist offender;
    c. Another person who, by reason of offences committed by them is considered by the responsible authority to be a person who may cause serious harm to the public, and
    d. Another person who has committed offences and is considered by the responsible authority to be persons who may be at risk of involvement in terrorism-related activity.
25. Not all patients in the SSG will fit this definition, because not all will have committed an offence.
26. The Prevent programme has referral criteria which do not include all patients in the SSG. Most will not have demonstrated any material terrorist ideology or a vulnerability to being drawn into terrorism. Some may be intent on inflicting serious violence such that they come within the ambit of the Prevent programme (e.g. because they have an obsession with massacre, but many are likely to pose a more general risk of harm. As Sir Adrian Fulford recognised in the Southport Inquiry Phase 1 report at [56][23], Prevent's current statutory remit does not extend to all forms of risk of harm to others.
27. The Potentially Dangerous Persons ("PDP") pathway was established by the College of Policing's APP Major Investigation and Public Protection.[24] It is designed for persons not managed under MAPPA, but in respect of whom reasonable

[22] The "challenge" of multi-agency working, despite its importance, was noted by Professor Morgan WITN0058001_0017 [78].
[23] RLIT0000094
[24] INQY0000027. The PDP is a non-statutory multi-agency pathway.

grounds exist for believing that there is a risk of them committing an offence that will cause serious harm.

28. It is clear from the APP that the PDP is not designed to include all patients in the SSG, and is not suitable for their long-term management.
    a. The "examples of PDPs" include "where a community psychiatric nurse (CPN) or other mental health worker shares information with the police that a patient with mental ill health has disclosed fantasies about committing serious violent offences. The patient is not cooperating with the current treatment plan, and the informant believes serious violent behaviour is imminent".[25] This is a very high threshold.
    b. Under "Managing PDPs" it is stated: "PDP cases should not be managed indefinitely and should be considered and recorded on a case-by-case basis, up to a maximum of eight weeks." [26] The SSG requires long term, and potentially life-long risk management.
    c. In his evidence, Sir Andy Marsh agreed that the PDP (as described in the APP) is not an appropriate pathway for managing long term, and potentially life-long, risks posed by some individuals: Sir Andy Marsh, 14th April 2026 PM, 116/8-12.

29. In the Southport Inquiry Phase 1 report[27], Sir Adrian Fulford considered how multi-agency working should be structured in terms of those who pose a real risk of killing or causing serious harm (including 'violence fixated' individuals) and recommended at [56]:

> "... I consider that there should be a single, dedicated agency or structure with responsibility for monitoring and co-ordinating any necessary information sharing or gathering and any intervention, providing direction, and holding the relevant agencies to account. The form will be a matter for consideration, but it could be through a mechanism for the appointment of a pre-existing agency as the 'lead agency'; the expansion or creation of a dedicated multi-agency structure (for example MAPPA or akin to MAPPA); or the creation of a new agency."

[25] INQY0000027_0001.
[26] INQY0000027_0005.
[27] RLIT0000094

30. This is being considered in Phase 2 of the Southport Inquiry[28] (Phase 1 recommendation 1 being that "Phase 2 should consider what single agency or structure should be appointed or established to record, monitor and co-ordinate interventions for children and young people who present a high risk of serious harm....").

31. In his evidence, Sir Andy Marsh agreed that there would be benefit in establishing a new pathway for managing the long-term risk posed by those who have mental illness, have been deemed at some point to pose a serious risk to the public, but who only pose that risk immediately when they are not taking their medication (in other words, SSG patients).[29] Dr Dissanayaka expressed a similar view.[30]

32. The Chief Constable submits that a new statutory multi-agency pathway should be created to manage the risk posed by the SSG.[31]

33. This could be achieved in various ways, including by creating a new pathway based the MAPPA model. The Inquiry may wish to consider the proposal made by the Southport Inquiry in its Phase 2 report (in respect of those who pose a real risk of killing or causing serious harm) should the report be available in time. But in respect of the SSG, simply expanding the MAPPA criteria would be inapposite *inter alia* because the 'responsible authority' in respect of MAPPA is police, the Probation Service and the Prison Service acting jointly (see s.325(1) of the Criminal Justice Act 2003). For the SSG, the responsible / lead authority, with primary responsibility for assessing and managing risk, and for co-ordinating multi-agency work, should be an NHS body.[32] It is the NHS which has the most apposite expertise, capability and experience in the assessment and management of risk posed by mentally ill persons. In any event the Probation Service and Prison Service will not need to have any role unless the patient has served a custodial sentence.

34. It is further submitted that:

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[28] RLIT0000094

[29] Sir Andy Marsh, 14th April 2026 PM, 116/13-25 (INQT0000050).

[30] Dr Dissanayaka, 15th April 2026 AM, 106/2-12 (INQT0000051).

[31] For the avoidance of doubt (noting the Chair's question of T/CC Sandall on 11th March 2026 PM, 73/14 – 24 (INQT0000021)), it is not submitted that this new pathway should apply to all those with mental illness, or all those with mental illness who pose any risk of harm to others. This would be unmanageable, which is why there are not multi-agency pathways for all members of the public who pose a risk of harm to others. The proposed new pathway only relates to members of the SSG.

[32] Dr Dissanayaka, 15th April 2026 AM, 105/23-25 (INQT0000051), accepted that health services would be the lead agency.

a. As with MAPPA, there could be levels of management associated with different degrees of multi-agency activity (MAPPA has three such levels).[33] This would enable the pathway to operate flexibly depending on the level of risk posed by the person at a particular time and other relevant considerations. At the lowest level, the risk would be managed solely by NHS bodies, but there could be information sharing expectations on other relevant agencies (or direct access to those agencies' systems, as to which, see below). At the higher levels, there could be more intensive multi-agency work including review meetings etc.[34]

b. There should be dedicated government funding for the police to participate in this multi-agency pathway (given the additional work involved),[35] including funding for police personnel in each force to manage information sharing (both the sharing of police information to relevant partner agencies, and disseminating information received from partner agencies internally).

c. Consideration should be given to there being a national co-ordinator of local multi-agency pathway groups. The benefits of such a role would include identifying and sharing best practice and ensuring the co-ordinated management of patients in the SSG who move across health authority and police boundaries.

Information sharing

35. There can be no doubt that data protection is an (unnecessarily) complex area of law. The UKGDPR is 149 pages long. The Data Protection Act 2018 is 354 pages long. The focus of this legislation is on protecting the rights of data subjects by erecting barriers to information sharing, not protecting the public by ensuring the free flow of information. In addition to the legislation, there is a significant volume of guidance from the Information Commissioner's Office ("ICO") and from organisations including the College of Policing and the Department of Health, and jurisprudence from the First Tier Tribunal and the courts.

36. Mr Arnold of the ICO accepted that "the law is complex, and when viewed in isolation and attempting to interpret without specialist experience, it is challenging. But regulators, the sector, the data protection profession are there to bring the legislation

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[33] HOMF0000065_0045 - _0046.

[34] In MAPPA Level 2 cases, review meetings are held at least every 16 weeks. In MAPPA Level 3 cases they are held at least every 8 weeks: HOMF0000065_0074.

[35] Sir Andy Marsh, 14th April 2026 PM, 88/2-8 (INQT0000050).

to life and help ensure it is applied proportionately and reasonably".[36] The availability of guidance from the ICO, or specialist data protection advice within an organisation, to distil or interpret this complex area of law, may be of little comfort to front line police officers and NHS staff having to make quick-time decisions about data sharing amongst their other responsibilities.

37. Even where there is a potentially lawful basis to share data, the barriers to doing so in policing include:

    a. The bureaucracy involved, in particular the forms that need to be filled in.[37]

    b. The need to obtain specialist advice due to the complexity of the law.

    c. The professional consequences of inappropriate data sharing: Confidentiality is one of the Standards of Professional Behaviour in Schedule 2 to the Police (Conduct) Regulations 2020. The College of Policing's 'Guidance for ethical and professional behaviour in policing'[38] states that officers "will protect... police information in line with the General Data Protection Regulations (GDPR) and the Code of Practice on police information and records management" (the latter being a 32 paged document).[39]

    d. The consequences for the Chief Constable as the data controller of inappropriate data sharing, namely damages claims (including the costs of defending them), as well as complaints to the ICO and the associated enforcement action.

    e. The need for all data sharing to be proportionate due to the data minimisation principle in Article 5(1)(c) of the UKGDPR and the third data protection principle in s.37 of the Data Protection Act 2018 (as Mr Arnold accepted).[40]. The same is so under Article 8 ECHR – for the inevitable infringement of the data subject's Article 8(1) ECHR rights occasioned by the processing of their personal data to be lawful under Article 8(2), it must be *inter alia* proportionate. Even if all the other conditions for data sharing are satisfied, the proportionality requirement means that each piece of information or document needs to be examined to ensure that it does not contain data which is excessive to the purpose for which it is being shared. Practically, that involves considering whether a document needs to be redacted or summarised before it is shared.

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[36] Mr Arnold 26th May 2026 AM, 9/14-16 (INQT0000095).
[37] T/CC Sandall 11th March 2026 PM, 57/14-20 (INQT0000021).
[38] RLIT0000105
[39] HOMF0000041.
[40] Mr Arnold, 26th May 2026 AM, 8/15-18 (INQT0000095).

This is a time consuming process. The requirement to undertake a granular proportionality assessment of this kind is a requirement imposed by the legislation. It is not something that can be addressed by clearer guidance from the ICO etc.

38. It is fair to observe that there are unlikely to be negative consequences for a police or NHS data controller where information is shared in an emergency or in a scenario where there is an obvious overriding public interest – although the issue of proportionality will remain. Moreover, data sharing is more straightforward when it is reactive to a direct request for data made by another public body, which request will usually set out the reason why the information is required.

39. The nuanced question for this Inquiry is likely to be in respect of proactive data sharing about patients who have long term mental illnesses, at times when there is not an emergency or an immediate / obvious overriding public interest.

40. Proactive information sharing:

    a. Provides all multi-agency partners with the fullest information relevant to the assessment and management of risk; and

    b. Enables the relevant multi-agency partner(s) to identify and manage emerging risk by intervening with preventative action before an individual reaches a crisis point when they are more likely to cause serious harm. Earlier sharing increases the prospect of meaningful, and potentially lower level, intervention.

41. The Inquiry will no doubt consider police information sharing with NHS bodies, who will (properly) say that information held by the police is relevant to completing risk assessments and formulating treatment plans. The Inquiry is also invited to consider NHS information sharing with the police. For instance, what (if anything) did the relevant NHS bodies share with the police when VC was discharged from detention under the Mental Health Act 1983, or discharged from care, or known to be non-concordant with medication / not engaging with services? If the information sharing was inadequate, why was this? Was it due to excessive priority being given to patient confidentiality over the public interest / safety?

42. The Chief Constable confines his submissions in respect of recommendations to information sharing about patients in the SSG. The Inquiry received evidence from police and healthcare witnesses alike that there needs to be better information sharing.[41]

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[41] Sir Andy Marsh's recommendations WITN0349001_0024 at [80]; [82]; Dr Dissanayaka 15th April 2026 AM, 105/18-21; 107/13-25 (INQT0000051).

43. The primary submission is that, given the rich source of information required by clinicians to undertake risk assessments and formulate treatment plans,[42] relevant persons in the NHS (and other multi-agency partners) should be given limited access to police systems. Leicestershire Police is already giving such access in this way to the Probation Service on a trial basis.[43] The benefits of this approach are that:
    a. Information sharing is timely;
    b. Information sharing is complete – there are no issues with the police having to work out, and potentially failing to appreciate, what particular information may be of value to the NHS (and other partner agencies).
44. This approach may require a change in the law (i) to provide an explicit lawful basis for the processing; and, in any event (ii) to exempt this category of information sharing from the proportionality requirement, which might not be satisfied where information is shared *en bloc*.
45. The additional submission is that relevant NHS bodies should be required to do two things in respect of patients in the SSG.
46. First, NHS bodies should be required to share sufficient information about an SSG patient to allow partners agencies to make contribute to and/or make their own assessment of risk, risk management plans, and plans for responding to any incidents they are called to with respect to the individual.[44] This information should be understandable to a lay person and might include patient's condition, that they are at risk of relapse, the warning signs of relapse, the NHS's assessment of risk, and any significant developments.
47. Second, NHS bodies should be required specify (i) precisely what information the NHS is interested in (e.g. the patient displaying particular warning signs of relapse); and (ii) precisely how and with whom that information should be shared.[45]
48. Specifying what information is required is crucial, because it will not always be obvious (to police) that something may be relevant in the clinical context, including to a patient's potential relapse and risk of harm.
49. The Inquiry received some good examples of the idiosyncratic early warning signs of relapse:

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[42] See e.g. Professor Morgan WITN0058001_0005 - _0006 at [27] – [31].
[43] T/CC Sandall, 11th March 2026, 72/21 – 73/7 (INQT0000021).
[44] On the importance to health services sharing relevant information with the police, see Sir Andy Marsh, 14th April 2026 PM, 112/22 – 114/4 (INQT0000050).
[45] T/CC Sandall, 11th March 2026, 72/16 – 20 (INQT0000021).

a. Dr Smith said "So for example, I had a patient who has, you know, has a cat, you know, he is someone who had perpetrated very serious violence in the past. We'd managed to treat him, he'd got very, very much better but he was now a very isolated individual. His cat was incredibly important to him. Everything was fine as long as that cat was alive. If anything happened to that cat, then that -- we knew that then his risk profile would change and we would have to do something about that."[46]

b. Dr Dissanayaka said "I think it's really important and I think that knowledge of the person is really important as well. These things get lost in the mists of time and that continuity we have in our service is really important. So I might get a call from, you know, the team that says that one of our patients has been out scratching cars, and to some people that without seem like a really innocuous thing for that person to be doing, but within the team, what we know, because we have this much more longitudinal in-depth approach, is that that happened before. That happened because of the number plates of the cars and the meaning that those number plates had for that patient. It also happened in the context of increased drug use. It was also associated with the sharp escalation and significant violence that followed. It also happened because that person was carrying a bladed instrument with them that they used to scratch the car. So all of that comes in to understanding. It doesn't necessarily understand why he had the idea, you know, he might have had the idea that, you know, that meaning was there, but it does help us to understand what the risks might be."[47]

c. Professor Morgan gave examples of early warning signs of relapse, stating that "[e]ach one will be individual to the patient, but often will be quite characteristic of an imminent risk." He said that the plan for a patient "should specify what to look for".[48]

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[46] Dr Smith, 1st June 2026, 14/12-20 (INQT0000103).

[47] Dr Dissanayaka, 15th April 2026 AM, 67/16 - 68/12 (INQT0000051).

[48] Professor Morgan, 20th April 2026 PM, 37/1-17 (INQT0000056). This is consistent with the Ritchie Inquiry report at [44.0.3] "(viii) All members of the team should be alerted to signs and symptoms in the patient which may indicate that the patient is likely to relapse. Such signs and symptoms may be identified by the doctors but may also be identified by the patient himself or his relatives or friends." There is no reason in principle why the same recommendation should not be extended to the police (and other multi-agency partners) who may at particular times have more frequent contact with the patient than members of their treating team / have contact with the patient

50. Apparently innocuous information about a person's cat being missing, or about low level offending such as scratching a car, is vanishingly unlikely to be recognised by a police officer as an early warning sign of an individual's relapse (even if there is a marker on police systems to indicate that the individual has a history of mental illness). Realistically, the significance of this kind of information will only be recognised by the police if it is (i) communicated by the NHS; and (ii) placed on police systems as a prompt for officers.

51. The Ritchie Inquiry concluded as follows:[49]

> "48.0.1. In our view, if care in the community is to be provided properly by a multi-disciplinary team, then there has to be a sharing of information about the patient between members of that team.
>
> ...
>
> 48.0.2. We are impressed by the view that if there is a risk that the patient may harm himself or others, everyone who may provide any service to the patient, for example those who may provide housing, occupational therapy, or financial benefits, needs to know about this risk. The question of confidentiality is not an easy subject and it is beyond our remit to try and resolve the conflicting issues. But we feel that it is a vital matter which needs to be addressed and resolved urgently now that the Care Programme Approach is required for care in the community."

52. Information sharing is within the scope of this Inquiry. It is submitted that, in respect of the SSG, where there is information that may be relevant to the risk posed by a patient, public safety[50] must take clear priority over patient confidentiality and data rights. Routine proactive sharing of information by multi-agency partners should be permitted and promoted by new exemptions to various requirements of UKGDPR and the Data Protection Act 2018, including as to proportionality.[51]

53. Finally, it is submitted that:

    a. Information sharing should be undertaken by means of automated and integrated arrangements wherever possible, to avoid resource intensive

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in settings where the signs and symptoms of relapse are more likely to manifest themselves: DHSC0000160_0121.

[49] DHSC0000160_0129.

[50] Sir Andy Marsh, 14th April 2026 PM, 57/2-4 (INQT0000050).

[51] While this may be considered to be a bold submission, it would be limited to the data of patients in the SSG, and to the sharing of that data with multi-agency partners who (as submitted above) would be working together pursuant to a statutory multi-agency pathway.

processes that are prone to human error.[52] These arrangements will need to be developed, and it may not always be possible to use them e.g. in an emergency.

b. Where information sharing takes place, there needs to be clarity between multi-agency partners as to where the responsibility lies for any additional risk assessment or management that is required. One multi-agency partner should not satisfy themselves that their own responsibilities in terms of risk assessment and management have been satisfied merely by sharing information.

Risk assessment

54. There should be a common tool for assessing the risk posed by the SSG.[53]

55. In the Southport Inquiry Phase 1 report at [61], Sir Adrian Fulford found there to be "an urgent need for a method of assessing risk which 'talks' across social care, mental health, education, policing and the criminal justice system".[54]

56. Sir Andy Marsh recommended that all agencies involved in managing risk to the public should adopt a consistent and systematic approach to risk assessment and management.[55]

57. In the case of the SSG, the main risk will arise from mental health, and primary responsibility for the risk assessment will be always rest with NHS bodies.

58. No submissions are made on the effectiveness of the NHS's current risk assessment tools. It is however observed that an effective risk assessment tool for the purposes of public protection would be one:

    a. focussed on the risk to the public;

    b. that addresses the risk associated with contingencies (e.g. non-concordance with medication) and the likelihood of those contingencies arising;

    c. that involves multi-agency partners, following the sharing of relevant information;

    d. that 'talks' across partner agencies so that the nature of the risk and the role that those agencies might play in managing it is properly understood.

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[52] See the observations of Sir Andy Marsh, 14th April 2026 PM, 90/24 – 91/3 INQT0000050).

[53] Even within the healthcare setting there are multiple tools: see e.g. Professor Morgan WITN0058001_0007 [34] *et seq.*

[54] See also [62] – [63]. This matter is being taken up by the Southport Inquiry in Phase 2.

[55] WITN0349001_022-023 at [77].

Leicestershire Police's actions following the incident at Arvato Ltd's premises on 5 May 2023

59. As was the case when this Inquiry opened, there is (still) an outstanding misconduct process in respect of Police Constable ("PC") Taylor, PC Amos-Perkins, and one of their supervisors, Temporary Police Sergeant ("T/PS") Mark Read. The practical impact of the misconduct process being outstanding is that those three officers are separately represented in this Inquiry. It also has the effect of limiting the representations that the Chief Constable is able to make at this stage[56] because:
    a. The investigation is being carried out independently by the Independent Office for Police Conduct ("IOPC"), rather than by Leicestershire Police; and
    b. The Chief Constable will have a statutory role[57] in the misconduct process once the IOPC's investigation has concluded, including being responsible for bringing any misconduct proceedings that the officers may face.
60. The Chief Constable repeats his apology for the shortcomings that the three officers have already accepted:
    a. PC Taylor not saving her body worn video footage ("BWV") of the police attendance at Arvato's premises as 'evidential',[58] meaning that it no longer exists. PC Amos-Perkins (as PC Taylor's tutor constable) not directing PC Taylor to do so or checking that she had.[59]
    b. PC Taylor not searching on the NICHE database for, or giving sufficient consideration to, VC's offending history and any outstanding criminal matters, and not conducting searches for VC on the PNC or PND systems.[60] PC Amos-Perkins for not reminding PC Taylor to do so or double checking that she had.[61]
    c. T/PS Read not conducting the required 28-day supervisor's review of PC Taylor's investigation.[62]
    d. PC Taylor not having a better strategy for obtaining witness statements from the two victims, be that (i) obtaining statements while the officers were at Arvato (subject to a Romanian interpreter being available via telephone / video

[56] The Chief Constable would welcome the opportunity to make further, more detailed, submissions when the misconduct process has concluded should that be before the Inquiry's report is finalised.
[57] Under Part 2 of the Police Reform Act 2002 and the Police (Conduct) Regulations 2020.
[58] WITN0009001_007 at [23].
[59] WITN0010001_005 at [17].
[60] WITN0009001_0016 – _0017 at [59] – [60]; _0024 at [97]; [100]; _0026 at [103].
[61] WITN0010001_007 at [22] – [23]; _0009 at [29].
[62] WITN0010001_005 at [16].

call and it being possible to complete the statements before the officers were diverted to another grade 1 call at 18.56);[63] (ii) fixing an appointment while the officers were at Arvato for the two victims to give their statements at a time when they and a Romanian interpreter were available, rather than leaving the arrangements to be made later;[64] and/or (iii) making more sustained efforts to contact the victims to try to obtain their statements, including returning to Arvato when those efforts stalled.[65]

61. There are three matters about the Arvato incident and investigation which arose in the evidence that the Chief Constable makes short submissions on.

62. First, during the evidence it became apparent that there were potential discrepancies between the accounts of the officers and the accounts of the Arvato staff as to:

    a. Whether VC was displaying what might be described broadly as signs of mental illness;

    b. Whether, after the Arvato staff intervened following VC's attack on the victims, VC had been looking on the floor where there was a safety knife which staff kicked away because they were concerned that VC might use it as a weapon.[66]

63. Two questions need to be addressed: (i) whether the Arvato witnesses are correct in their recollections; and, if so, (ii) what the Arvato witnesses told the officers.[67]

64. In *Gestmin SGPS SA v Credit Suisse (UK) Ltd* [2013] EWHC 3560 (Comm)[68] Leggatt J set out principles for the assessment of evidence including at [22]:

> "…the best approach for a judge to adopt in the trial of a commercial case is, in my view, to place little if any reliance at all on witnesses' recollections of what was said in meetings and conversations, and to base factual findings on inferences drawn from the documentary evidence and known or probable facts. …"

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[63] WITN0009001_006 at [19].
[64] WITN0009001_006 at [18]; WITN0110001_005 at [18].
[65] WITN0009001_0024 at [96]; PC Taylor, 11th March 2026 AM, p.52/1-5.
[66] The most precise first-hand account the Inquiry has of the presence of a knife is from Volodimir in his statement dated 23 September 2025: WITN0057001_002 at [8].
[67] PC Taylor's evidence is that there was no mention of a knife being used in respect of the assault by anyone, and it is not mentioned in her notes: WITN0009001_006 – _007 at [21] – [22]. She did not enter anything under 'Weapon used' on the NICHE OEL: LEPF0000004. PC Amos-Perkins could not remember being told anything about a knife: WITN0010001_005 at [16] (INQT0000020).
[68] RLIT0000082

65. *Gestmin* was a document heavy commercial case, but the *Gestmin* principles have been applied, for instance, in personal injury litigation *AB v Pro-Nation Ltd* [2016] EWHC 1022 (QB)[69] at [30] *et seq*.

66. It is in any event, *"testing recollection against contemporaneous documents is a useful and important exercise because it gives the court an opportunity to compare a near contemporaneous version of events (subject to no or little reconstruction) with a re-constructed version of events": Evans v Secretary of State for Health and Social Care* [2024] EWHC 496 (KB)[70] at [37(f)] citing *Jackman* [2021] EWHC 1461[71] at [13]; *Bannister* [2020] EWHC 1256 (QB)[72] at [77]; *Sloper* [2016] EWHC 483 (QB)[73] at [60].

67. In this case, the best evidence is the audio visual / documentary evidence, namely:
    a. The 999 call made by Louisa;
    b. PC Taylor's pocket notebook (which she wrote in while she was at Arvato)[74], which was used to complete her nearly contemporaneous NICHE OEL entry;[75] and
    c. Arvato's contemporaneous internal records and email communications with Sky Recruitment.

68. That is the best evidence because (i) it is recorded / written; (ii) it is the most contemporaneous evidence, subject to little reconstruction; and (iii) crucially, it is not a reconstructed version of events after the witnesses became aware of VC's horrific offending on 13 June 2023, the reporting of which made it plain that VC appeared to be mentally ill, and had used a knife in the attacks.

69. In these contemporaneous materials:
    a. There is no reference to VC displaying signs of mental illness;[76]

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[69] RLIT0000083
[70] RLIT0000084
[71] RLIT0000085
[72] RLIT0000086
[73] RLIT0000087
[74] WITN0009001_004 at [13]; PC Taylor, 11th March 2026 AM, 7/24 – 25 (INQT0000020); pocket book WITN0009002.
[75] LEPF0000004_0004 – _0005.
[76] There was no reference to VC displaying signs of mental illness described by Louisa stated in her witness statement dated 19 January 2026 WITN0373001 *viz* to "extremely strange" behaviour [22]; to VC "showing no acknowledgment or recognition that [she] was there" and "staring completely blankly at GRO-B, through [her], and his eyes were glazed over" [22]; to it being "incredibly bizarre" [22]; to VC having a "strange presentation" and "not seeming 'right'" and being "potentially dangerous" [36]; to VC's persona being "so strange" and that VC "didn't appear to be 'there'" [38]; to VC having an "expressionless look" and a "glaze over his eyes" [49]; or to VC being

b. There is no reference to a knife being involved, or more specifically to VC looking at the ground where there was a knife, after he had attacked the victims.[77]

70. If VC had been displaying signs of mental illness and/or a knife had been involved in the incident in any material way, given the significance of that information the Chair might consider that, in the ordinary course of events:
    a. This information would have been given by Arvato staff to the police;
    b. The police (here PC Taylor) would have recorded it;[78]
    c. This information would have been recorded internally by Arvato;
    d. This information would have given by Arvato to Sky Recruitment, at least out of concern for workers at businesses that Sky might place VC with in the future.

71. Second, the offence which VC was alleged to have committed at Arvato was one common assault. The victims were in pain. The female victim had the feeling of a bruised knee and been given an ice pack. Louisa's evidence is that both victims had red marks and bruising.[79] The officers' evidence was that they did not see this.[80] The victims declined PC Taylor's offer of medical attention.[81]

72. The incident was described by CTI in questions to PC Taylor as serious and violent and reference was made to people being upset, distressed, appalled and disgusted by it. The Chief Constable has no doubt that VC's actions were deeply unpleasant both for the victims and the witnesses. VC's actions were unacceptable – even if he had been (or thought he had been) pushed, as he apparently said to Volodimir and

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"not 'with it'" and appearing "to be mentally unstable" (or to the similar averments made in Louisa's oral evidence, or in Matthew's statement WITN0056001_0003 at [9] – [10] and his oral evidence (INQT0000019).

[77] It is accepted that, on 13 June 2023, after the Nottingham attacks, when officers visited the Arvato warehouse, Ali Parvez told them that "Staff members state that [VC] was looking on the floor for which he states was his 'glasses', but staff members believe he was looking for a knife, specifically a safety knife that they use in the warehouse" : LEPF0000004_0012.

[78] As PC Taylor confirmed, in respect of any mention of a knife: PC Taylor, 11th March 2026 AM, 16/21 – 24 (INQT00000020).

[79] WITN0373001_008 at [30].

[80] PC Taylor recorded on the NICHE OEL "male victim injury just pain - female victim has a feeling of a bruised knee": LEPF0000004; PC Amos-Perkins' evidence was that he "could not see any bruising or other injuries to either victim": WITN0010001_004 at [13]; PC Amos-Perkins, 11 March 2026 AM p.5 – 7 INQT0000020 (he acknowledged that their injuries could have developed over time).

[81] WITN0009001_004 at [14]. They had also declined Louisa's offer to go to A&E and for an ambulance to be called: WITN0373001_008 at [30]. They did subsequently seek medical attention and described bruises and swelling (female victim) dizziness and swelling (male victim): ARVS0000008; ARVS0000009; ARVS0000039.

Matthew when they intervened.[82] But that does not alter the fact that a common assault is, objectively, a relatively low level offence. It is a summary only offence, and the lowest level of offence against the person. In managing threat and risk, the police inevitably treat offences such as common assault with less priority than assault occasioning actual or grievous bodily harm, sexual offences etc.

73. Third, the Inquiry is respectfully reminded about the importance of avoiding hindsight reasoning: see e.g. *Goodenough v Chief Constable of Thames Valley Police* [2020] EWHC 695 (QB)[83] where Turner J said at [45]:

> "The Court must take care not to judge the actions of the officers by unrealistic standards of detached reflection and retrospective analysis …".

74. The question is what the officers were expected to do in responding to a fairly routine report of common assault. The question is not what the officers could or should have done had they been aware that VC was someone who was likely to do the terrible things he did on 13 June 2023. The officers' actions should not be scrutinised through that retrospective lens.

Causation

75. In terms of Leicestershire Police's involvement in the chronology leading up to 13 June 2023, the question of causation arises in two ways.

76. First, if the chain of causation was already complete by 5 May 2023, any failings by Leicestershire Police in respect of the Arvato incident will not be causally relevant. For instance, if the Inquiry concludes that VC should have been treated differently by healthcare providers such that he would either have been medicated (e.g. by depot injections) or detained under the Mental Health Act 1983 by 5 May 2023, the Arvato incident would probably never have occurred.

77. Second, assuming that the chain of causation was incomplete by 5 May 2023, the Inquiry will need to explore the causal significance of Leicestershire Police's actions or omissions. The Inquiry will need to explore whether it is likely that, but for those acts or omissions, VC would have been in custody, in mental health detention or medicated by 13 June 2023, and therefore unable or unlikely to offend.

78. There are two main acts / omissions that were explored with the Leicestershire Police witnesses in questioning.

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[82] WITN0057001_0002 at [8]; WITN0056001_002 at [7].
[83] RLIT0000104

79. The first alleged omission was not to 'caution' / invite VC for voluntary interview sooner.[84] T/PS Read confirmed that the urgency of arresting VC for the Arvato incident alone "would be a lower level".[85] This action would, in any event, not have been possible before VC's name had been provided to Leicestershire Police by Sky Recruitment on 24 May 2023.[86] It is anticipated that the Leicestershire Police officers will maintain that it was a sound operational decision to wait for the victim's statements before seeking to question VC. Had the officers interviewed VC before obtaining victim statements, the CPS would have been likely to require victim statements in any event before a charging decision.[87] And a second interview with VC may have been required to put the contents of the victims' statements to him.

80. The possibility of inviting VC for voluntary interview depends on Leicestershire Police (itself or with the assistance of other police forces) being able to locate VC. There is no clear evidence as to where VC was residing between 24 May 2023 and 13 June 2023,[88] less still that he would have been present when officers attended his address to invite him to a voluntary interview. Even assuming that VC had been located and attended a voluntary interview at which he had made a full admission to the allegation, it is vanishingly unlikely (i) that VC would have been remanded in custody with respect to a common assault allegation alone; or (ii) that VC would have been charged and had a custodial sentence imposed on him by 13 June 2023.

81. In the premises, even if it were an omission not to attempt to voluntarily interview VC earlier, the potential causal significance of that failure is not that it would have removed the opportunity for VC to carry out the 13 June 2023 attacks of itself. Rather, it is that the process of attempting to voluntarily interview VC would have been likely (and it is accepted that it would have been likely) to have resulted in officers noticing that there was an outstanding warrant in respect of VC. In terms of causation, the first alleged omission therefore collapses into the second.

82. The second alleged omission (and it is accepted that this was a failing) was to recognise that there was a warrant for VC's arrest in respect of his failure to appear.

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[84] PC Taylor explained why a voluntary interview would be a realistic possibility rather than an arrest: WITN0009001_022 at [88]; PC Taylor, 11th March 2026 AM, 83/17– 84/3 (INQT0000020). Under s.24 of the Police and Criminal Evidence Act 1984 an arrest must be 'necessary'.

[85] T/PS Read, 11th March 2026 PM, 10/17-18 (INQT0000021).

[86] LEPF0000004; WITN0009001_0015 at [52].

[87] WITN00011001_007 at [21].

[88] The last known address for VC is understood by those representing Leicestershire Police to be the Derby address provided to PC Taylor by Sky Recruitment on 24 May 2023: LEPF0000004_0009.

This information was available for PC Taylor to see on 24 May 2023. She ought to have noticed it – her evidence is that she missed it.

83. Leicestershire Police's position as to what should and would have happened is as follows:

    a. First, because the warrant was for failure to appear at Court in respect of an offence investigated by Nottinghamshire Police, Leicestershire Police should have contacted Nottinghamshire Police to inform them that VC – who had a warrant out for his arrest in respect of a Nottinghamshire offence – had been responsible for the Arvato incident.[89]

    b. Second, because VC was apparently living in Derbyshire,[90] contact would be made (probably by Nottinghamshire Police, because the warrant was in respect of a Nottinghamshire offence) with Derbyshire Police, in relating to executing the warrant.

    c. Third, a decision as to <u>when</u> to execute the warrant would have been made by Nottinghamshire and/or Derbyshire Police (not Leicestershire Police, in circumstances where VC's immediate arrest for common assault was not necessary).

    d. Fourth, <u>if possible</u>, VC would have been arrested pursuant to the warrant (probably by Derbyshire Police) and taken into custody, because the warrant was not backed for bail.

    e. Fifth, <u>if possible</u>, VC would have been interviewed by Leicestershire Police officers in respect of the Arvato incident while he was in custody pursuant to the warrant.[91]

    f. Sixth, VC would have been brought before the Court (the day after being arrested pursuant to the warrant) when a decision would have been taken by the Court as to whether VC should be remanded in custody.

84. Detailed submissions on causation in respect of the warrant are likely to be made by Nottinghamshire Police. Leicestershire Police makes the following submissions:

    a. As to the <u>third</u> step above, T/PS Read observed that, assuming Leicestershire Police had contacted Nottinghamshire Police "we can't dictate what their levels

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[89] See T/PS Read's evidence: WITN0001001_006 at [18]. T/CC Sandall gave evidence about the means of contacting another force in respect of an outstanding warrant: T/CC Sandall, 11th March 2026, 77/20 – 78/4 (INQT0000021).

[90] On 24 May 2023 Sky Recruitment provided PC Taylor with VC's name and his address, which was 37 Milton Street, Derby, Derbyshire: LEPF0000004_0009.

[91] PC Amos-Perkins, 11th March 2026 AM, 121/1-5 (INQT0000020).

(sic) of response is, based on their demand at the time....it would be down to them to determine when they could actually effect that arrest...".[92] Given that the warrant had been outstanding since 22 September 2022 and Nottinghamshire Police had around 1,000 outstanding warrants at the time,[93] there is nothing to suggest that the warrant in respect of VC would suddenly have attracted a high priority. That is so even if, objectively, the warrant *ought* to have been executed promptly.[94] There is no reason to suppose that VC being suspected of common assault would have changed the priority given by Nottinghamshire Police in 2023 to the execution of a warrant for failure to appear in respect of a more serious offence.

b. As to the fourth step, there is no evidence that the warrant would have been executed successfully. As set out above, it is not clear where VC was residing between 24 May 2023 and 13 June 2023, less still that he would have been present when officers attended his last known address.

c. As to the fifth step, even if it had been possible for Leicestershire Police officers to interview VC in respect of the Arvato incident while he was in custody pursuant to the warrant, and he had made a full admission to the allegation, it is vanishingly unlikely (i) that he would have been remanded in custody with respect to the common assault (had he not already been remanded by the Court); or (ii) that he would have been given a custodial sentence on the common assault charge by 13 June 2023.

d. As to the sixth step, it is far from clear that the Court would have remanded VC in custody, even taking the Arvato incident into account. It appears that the reason why VC had failed to attend Court on 22 September 2022 was not that he was attempting to escape justice, but because he did not receive the summons.[95] For completeness, it is also vanishingly unlikely that VC would have stood trial or, if he had pleaded guilty, been sentenced for the underlying offence of assaulting PC Pritchard by 13 June 2023. Even if he had been sentenced, a custodial sentence would be unlikely given that the offence was

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[92] T/PS Read, 11th March 2026 PM, 10/1-7 (INQT0000021).

[93] NGPF0007820; T/DCC Griffin, 23rd March 2026 AM, 34/7-18; 42/6-18 (INQT0000036).

[94] It plainly ought to have been, as was accepted on behalf of Nottinghamshire Police, eg. FCC Meynell, 20th March 2026 AM, 25/2-8 (INQT0000034).

[95] The summons to appear at the Magistrates' Court on 22 September 2022 was sent to VC on 24 August 2022 to Flat 15, Madison Court in Nottingham NGPF0000017_0039, which had ceased to be VC's address on 8 February 2022: UNIN0001304.

committed while a s.135 warrant was being executed on 3 September 2021 due to VC's mental illness, for which he was detained under the Mental Health Act 1983 for over a month.[96]

85. In summary, even if the Leicestershire Police officers had recognised in late May 2023 that there was a warrant outstanding in respect of VC and contacted Nottinghamshire Police, it appears unlikely that VC would have been remanded in custody and therefore unable to offend on 13 June 2023. The failure to notice the outstanding warrant after 24 May 2023 was a missed opportunity – but it was a missed opportunity to prompt Nottinghamshire Police to execute the warrant. It had no other causal significance.

86. It is understood that an alternative hypothesis is that VC being taken into custody would have resulted in healthcare intervention. The history of VC's interaction with healthcare bodies does not support a conclusion being reached with any confidence that VC would have been detained under the Mental Health Act 1983, or made subject to any compulsory treatment / requirement for a depot injection, such that he would have been medicated by 13 June 2023. Rather, the likely outcome of any healthcare intervention is that VC would have been left to manage his own medication. There is little or no evidence to support a conclusion that VC would have become concordant with his medication by 13 June 2023.

Lessons learned

87. Leicestershire Police strives to improve continuously and had identified various lessons before this Inquiry began. The force will consider very carefully any further recommendations made by the Inquiry, and will implement any changes made at a national level e.g. by the Home Office or the College of Policing.

88. In its original investigation into the three Leicestershire Police officers, the IOPC did not make any 'organisational learning' recommendations.[97] Should the IOPC make any such recommendations in its re-opened investigation these will be considered robustly by Leicestershire Police. The investigative materials held by the IOPC will also be examined by Leicestershire Police once they are available to identify any lessons.

89. The Inquiry asked T/CC Sandall to give evidence about Leicestershire Police's:

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[96] VC was discharged on 21 October 2021: NHFT0000168_0164-0194.
[97] WITN0001001_0025 at [81] - [82].

a. policies, procedures and criteria in various areas;[98] and

b. training.[99]

90. The errors that occurred in respect of the investigation into VC's offending at Arvato were not attributable to failures in policy, procedure or criteria, or in training. Indeed, the three officers gave evidence that their errors were attributable to human error, demands on their time,[100] and inexperience in PC Taylor's case,[101] rather than fundamental failures in policy, procedure or training.

91. In his evidence T/CC Sandall explained that the following steps have been taken by Leicestershire Police:

a. Strengthening arrangements for supporting Student Officers following their transition to operational activity, including giving additional training to Tutor Officers and updating the previous student development co-ordinator role.[102]

b. Developing a new data tool enabling supervisors to have immediate, contemporaneous visibility of pending and overdue victim updates, and enabling command teams to monitor adherence to the Victims' Code.[103]

c. Improving officers' understanding of access to interpreting services. The language services offered by a service provider under contract with Leicestershire Police are referenced throughout Student Officer training, but consideration is being given to ensuring a continued awareness of the services across the Force.[104]

d. Launching Operation Forefront to strengthen service and high standards, including investigation standards. This includes tools, training and guidance for officers.[105]

e. Launching an Assessment Investigation Unit to support frontline policing and investigations, and introducing scheduled video response and rapid video response services. These allow officers, in appropriate circumstances, to

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[98] WITN0001001_0005 – 0018 at [21] – [62].
[99] WITN0001001_0018 – 0024 at [63] – [78].
[100] At a force level, May and June 2023 were extremely busy for Leicestershire Police by reference to 999 calls: T/CC Sandall, 11th March 2026 PM, 67/19 – 68/5 (INQT0000021).
[101] e.g. PC Taylor WITN0009001_0025 at [101]; PC Amos-Perkins WITN0010001_0009 at [29]; T/PS Read WITN0011001_005 at [16].
[102] WITN0001001_0025 [84].
[103] WITN0001001_0026 [86] – [88].
[104] WITN0001001_0026 [89].
[105] WITN0001001_0027 [90] – [92].

secure reasonable lines of enquiry and engage with victims in a timely manner via video calls.[106]

f. Introducing Crime Managers and Performance Managers across all policing areas, ensuring strengthened levels of supervision and accountability to maintain high standards of service being delivered to victims of crime.[107] These two new roles were explained by T/PS Read. He confirmed that, as a result of their creation, his role as a response sergeant had become less demanding, allowing him significantly more time to conduct regular crime reviews, and to deal with the day-to-day running of a shift.[108]

g. Introducing a leadership course (licensed by the College of Policing) to all tiers of management to ensure that they continue to have the support and skills necessary to be effective leaders.[109]

h. Introducing a computer system to identify outstanding warrants, how long they have been outstanding for and what grade they are. This allows an inspector to review, on a weekly basis, how many warrants have been issued, how many recalls to prison have been made, how they are going to be actioned and what resources are going to be allocated to action them, with appropriate prioritisation based on assessment of risk.[110]

i. In terms of BWV retention, before an officer ticks 'non-evidential', the system now states in terms that the footage will only be retained for 31 days (if marked as 'non-evidential') to emphasise this consequence.[111]

92. Regardless of the improvements that Leicestershire Police has made, and makes, there are three fundamentals that it is important to emphasise will limit the ability of officers consistently to complete the highest quality and/or the timeliest investigations:

a. First, the police's primary responsibility is to preserve life. If the police are called to an emergency, risk is prioritised and officers may need to be diverted from investigations to responding to emergencies.[112]

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[106] WITN0001001_0028 [93].
[107] WITN0001001_0028 [93].
[108] WITN0001001_008 at [26] – [28].
[109] WITN0001001_0028 [94].
[110] T/CC Sandall, 11th March 2026 PM, 39/8-16 (INQT0000021).
[111] T/CC Sandall, 11th March 2026 PM, 53/5-10 (INQT0000021).
[112] T/CC Sandall 11th March 2026 PM, 47/19-25 (INQT0000021).

b. Second, the high level of demand on policing in terms of the number of 'calls for service' (on average 1,500 per day)[113] and the complexity of those matters.[114]

c. Third, the reduction in police funding, and therefore officer numbers. In Leicestershire Police in 2026, there are less officers (and staff and PCSOs) than there were in 2010. Between 2023 and 2026, £23 million was taken out of the organisation. A further £4 million must be removed in 2026, and a further £6 million in 2027.[115]

93. Any recommendations that the Inquiry makes that involve the deployment of additional police resources will therefore only be effective if they are backed by additional government funding. Leicestershire Police already has insufficient resources to meet the demands that is faces.[116]

JAMES BERRY KC

Serjeants' Inn Chambers

13 August 2026

[113] T/CC Sandall, 11th March 2026, 51/19-20 (INQT0000021).

[114] T/CC Sandall, 11th March 2026, 50/8-12 (INQT0000021).

[115] It was £9 million at the time when T/CC Sandall gave his evidence: 11th March 2026, 50/9-19. The figure changes depending on pay awards, inflation, decision making by the Home Office and the Police and Crime Commissioner etc.

[116] T/CC Sandall, 11th March 2026, 68/14-20 (INQT0000021).