THE NOTTINGHAM INQUIRY

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TPS MARK READ

CLOSING STATEMENT

Introduction

1. These are the written closing submissions on behalf of the three individual named Leicestershire police officers who have core participant designation.

2. Nothing in these submissions detracts from what was said in the Opening Statement on behalf of the three officers, and otherwise. This is not the time however for further and repeated expressions of empathy: as the evidence has emerged, the necessity of this Inquiry has become obvious. It is time to confront some uncomfortable realities; for hard-edged analysis; and equally hard-edged practical solutions. The Inquiry process must be an extraordinary – and continuing – test of endurance for victims and survivors and their families and friends. Much of the detail of evidence is recognised to have been of even greater concern than was predicted from an already high level of concern.

3. Aside from individual poor decision-making, fundamental questions arise as to how society – through multiple State agencies – manages those with mental health conditions such as paranoid schizophrenia which, if not actively managed, produce significant risk of serious harm and death to members of the public. These questions do not arise for anything like the first time. Any changes in the law, or procedures, or resources – all would appear necessary – will need to be coupled with changes in culture within organisations, and between organisations, as to the management of this species of risk. Policies existed that were wholly explicit as to the fact that, even if mental health was the reason a crime may have been committed, this did not justify a diversion away from the criminal justice system to mental health services. That, however, was clearly the operative culture within both policing and mental health services, even with repeat offending and when serious injury had been caused. Powers that would have been available on sentence were accordingly not engaged. Perceived legal impediments to information-sharing as to risk between agencies were imagined

rather than real: this was a chronic and damaging cultural failure of understanding. The law as to this needs reform: and, whatever the law is, agencies need to re-set operational norms. The cultural failure reduced the effective assessment and management of the serious risks to the public from those with acute paranoid schizophrenia. Within mental health services, the interests of the person with the mental health condition were –without obvious exception – elevated, again as a matter of culture, above those of the significant risks to the public. On repeated occasions, this cultural bias has proved fatal. This cultural failure must be gripped to avoid it recurring under the new statutory provisions. The language of the Mental Health Act 2025 appears to promote repetition of this cultural bias, and requires review as to the threshold tests applied as to risk.

4. On behalf of the individual officers, and whilst there is some limited wider commentary integrated to these submissions in relation to potential recommendations, and certain events from the 5 May 2023 incident at Arvato to 13 June 2023 will inevitably contribute to any timeline, within the Terms of Reference the closing submissions are essentially limited to a narrow element of [4].[1] That narrow element is the investigation into the incident at the Arvato warehouse on 5 May 2023, and whether any omissions or failures in that investigation may be characterised as causative of the unlawful killings on 13 June 2023.

5. The Inquiry is not addressing the matters within the IOPC-led misconduct investigation into the police investigation. Given the bases of questioning, however, a short analysis of the objective merits of the investigation is included within these closing submissions. Some operational mistakes were made, and have been both acknowledged and apologised for. The Inquiry must however maintain an objective and proportionate approach to what was under investigation, and what was investigated: although obviously a deeply unpleasant experience for the victims – most assaults are – by the objective nationally-applicable CPS charging standards the conduct amounted to two suspected batteries/common assaults.

6. Further, it is contended that any finding as to causation, most specifically from the failure to identify the outstanding warrant on the date VC's identity – despite repeated requests – was established on 24 May 2023, would be wholly speculative, and the evidence points the other way. The factors include that Nottinghamshire Police would have had to prioritise this warrant ahead of the hundreds of others it had; VC's whereabouts would have had to be established in order to execute the warrant; once produced at court, the merits of his failure to attend would have been considered, including whether he had been served with notice to attend court originally, and/or had failed to do so without reasonable excuse; even assuming this was established, a remand in custody pending trial would

[1] '4. Review the understanding, assessment and management of the risk of VC to others and his risk of offending between 2019 and 13 June 2023, to identify and address any issues with regard to decisions, actions or omissions of agencies, professional bodies or individuals relevant to the treatment of VC, and the management of his risk to others including whether the relevant guidance was followed appropriately. (Understanding, assessment and management of risk)'.

have been highly improbable (conditions of bail could have been imposed, e.g. as to residence with family and/or initiating a mental health assessment); and any use of section 37 of the Mental Health Act 1983 on conviction (for the assault of a police officer on the section 135 detention, and/or the Arvato common assaults) would only have lasted for as long as the registered medical practitioners deemed necessary.

7. These factors are addressed in greater detail below: stated shortly, the answers do not justify a finding of causation.

The Arvato incident and investigation

What did VC do?

8. The starting point must be to establish what actually happened at the Arvato incident on 5 May 2023. This evidence would have determined what offence VC was charged with, and the probable sequence and timing of events through the criminal justice system. The Inquiry – as any other decision-maker – needs to differentiate the direct evidence from hearsay reports and, in particular, what witnesses are now saying (informed by the widely-reported details and (intimidating) photographs of VC after 13 June 2023) from what they did or did not say at the time.

9. The Inquiry has each of the attending officers' notebooks, IOPC interviews, statements to the Inquiry, and transcripts of evidence to the Inquiry. This is not repeated. Some of the questions at the Inquiry do not reflect the direct evidence given by others of what they saw, rather they reflect inaccurate and inconsistent hearsay reports from others of what the other person said they saw. Such hearsay is not admissible in criminal proceedings.

10. As to context, VC had been recruited through an agency and undertaken an induction (which is not clearly documented) approximately two days before this incident. He was known to each witness who dealt with him as 'Val Mendez' or just 'Mendez', not VC. There was nothing on his conduct prior to 5 May 2023 that was remarkable.

11. The best direct witness of fact as to this is Volodimir, in his original witness statement to the Inquiry (23 September 2025 [WITN0057001]), and in evidence ([10 March 2026, 30/16 to 33/12] URN INQT0000019). He was VC's direct operations supervisor. He is consistent as to some important details.

12. On his account, and as to VC's preceding conduct, it was wholly unremarkable. At [6] and [7] of his witness statement, he said:

> 6. He started with us a couple of days before the incident and was assigned to my team working on preparing items in advance of the Zelda launch. Promotions like this involve lots of merchandise other than the game, for example, special editions of Monopoly are produced and are popular with collectors. After a couple of days, he needed a safety knife to carry out his tasks - opening boxes etc. I remember giving him a cheap plastic knife used across the warehouse and said to him "That's a hundred quid knife don't lose it" as a joke, but he looked at me as if he did not understand and I found this a little strange.
>
> 7. My next interaction with him was when he approached me to ask if he could do something other than the task assigned to him because he was bored so suggested he swap to order picking.

13. In evidence he added further detail ([10 March 2026, 32/14 – 33/12] URN INQT0000019):

> MS LANGDALE: You tell us that after a couple of days he needed a safety knife to carry out his tasks.
> A. Yes.
> Q. What did he need he knife for, and when did he get the knife?
> A. So he was asking for a safety knife to open boxes. So are giving him cheap plastic fish knife, and then – and tell him "Just do not lose, this is a hundred quid" like a joke, but he was looking on me, and repeats the joke and I say "Yeah, it's a joke", and he was "ha-ha". He was little bit strange.
> Q. Did many people use that plastic knife? We've seen what it looks like. Did many people use that knife in the warehouse?
> A. Yes, we just allowed to use just fish-type knife for that moment.
> Q. You tell us he then asked you another time if he could change the job he was doing?
> A. Yes.
> Q. What was that about?
> A. Just say he was bored, can he do something else? So I suggest him if he wants to start picking to learn how to pick, so he was willing to learn and he start doing this.

14. None of this is remotely suggestive of acute mental illness: the opposite is the case. It also indicates that VC was given (by Volodimir) a plastic fish-type knife, rather than either of the other types of knife described in evidence. As addressed below, there is no evidence he ever had other than this plastic fish-type knife.

15. As to the violence itself, this is described broadly consistently by the direct victims and other witnesses (Volodimir [WITN0057001]; Matthew [WITN0056001]; Louisa [WITN0373001], all INQT0000019) who witnessed the latter part of it. The male victim appears to have been hit – hard – twice to the left side of the head. The female victim appears to have been forcibly pushed aside and fallen, possibly after impact with a table, to the floor. VC appears to have been in the vicinity, and to have had some kind of unresolved conversation immediately preceding the violence with the male victim.

16. The direct witness accounts are again instructive.

17. Volodimir stated (witness statement 23 September 2025 [WITN0057001] at [8], added emphasis):

> On 5 May whilst l did not see the start of the incident, I soon became aware that there was something wrong in the warehouse. There was an unusual amount of shouting and screaming and I ran towards the source of the noise. I was about twenty metres away. I saw two workers on the ground (a man and women) with Valdo Calacone punching the man in the face and side of the head, whilst his wife was trying to protect him. I told Valdo to stop and approached him to intervene. He was a big guy and was saying that he had been pushed. He was agitated and looking at the floor, saying he had lost his glasses. I looked at the floor and saw a safety knife on the floor. Given his state of agitation (he was extremely aggressive) I decided to kick the knife away from him. I was concerned he might use it as a weapon. Other colleagues kicked the knife further away and it ended up under a conveyor belt some distance from where we were stood.

18. Further, in evidence, he elaborated that the knife kicked away was not that being used by VC ([10 March 2026, 38/2 – 38/24]; URN INQT0000019):

> Q. What happened to that knife?
> A. I'm not sure. Because I was showing the police, they check the area but they didn't remove that knife.
> Q. So you see VC looking for, he says, his glasses.
> A. Yes.
> Q. Then you see that knife and kick it out of the way.
> A. Yeah, I just -- not far from him. Just notice on the floor because there was a lot of mess, because (unclear) is on the side, you know, when they was having this punches and everything.
> Q. What knife had he been using to cut the boxes? The one that you'd said it cost £100 or something like that?
> A. Yeah, it was like fish, like cheap plastic one.
> Q. So not like that?
> A. Not like that.
> Q. Something else. But he was using the one you gave him in the warehouse.
> A. Yes.
> Q. So you had never seen this other knife --
> A. No.
> Q. -- that was on the floor, and you never saw it after that incident?
> A. No.

19. Similarly, Matthew ([WITN0056001_002 [7]) states that VC was looking for his glasses after the incident:

> Whilst Louisa attended to [male victim] and [female victim] my focus was on Valdo. I stood between him and the couple and asked what was going on. I was worried that he still seemed intent on attacking [male victim]. All he could say was "I was pushed" and for whatever reason I concluded he meant pushed in a verbal as opposed to physical way. He was looking around the floor and I asked him what he was looking for and he said he was looking for his glasses.

20. The hearsay account from Ali Parvez – given after 13 June 2023 to the vastly better resourced homicide investigation – ([LEPF0000004_0012]) is broadly consistent with this, albeit the description of the knife is different:

> 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 within the warehouse.

21. There is accordingly simply no evidence either (1) that VC had taken this Stanley-style knife to the scene of the violence, or that he had ever touched it; or (2) that he ever reached down as if to use it. It was kicked away in case he did, but not because he did. If this is what the police were told at the scene, it is accordingly unsurprising if it is not remembered. VC had neither used a knife, reached for a knife, nor threatened to use a knife as part of his violence. Witness accounts (from Louisa ([WITN0373001]) and Matthew ([WITN0056001])) that he had are no more than inaccurate hearsay based on what they say there were told by others (i.e. Volodimir ([WITN0057001])).

22. Further – and consistent with what the police were told at the scene – he had said he was looking for his glasses on the floor following the violence.

23. From the perspective of any investigation, VC's claim that 'he was pushed' would have required more detailed consideration. That is not to say that any such claimed provocation would have represented a defence to his violence, rather that the claim could either have been discredited on investigation or, to a (limited) degree, provided mitigation. Even if sufficient evidence existed to arrest/interview under caution without such formal statements, in operational terms this promoted the value of detailed witness statements from the victims before any interview of VC so that he could be questioned on an informed evidential basis. No prosecution could have proceeded without them. Evidence would also have been required from them as to the final level of injury.

Seriousness of allegation

24. To repeat: this was a significant assault and required police investigation. It was traumatic for the victims, and disturbing to staff that witnessed it. As to intrinsic seriousness within the criminal justice system, however, these factors do not alter the objective classification that must be applied: they are factors going to 'harm' under the statutory Sentencing Guidelines.

25. Under the CPS Guidance[2] relating to assaults, including battery/common assault, is the following:

> **1. Start by determining the level of injury**
>
> In the first instance it should be possible to determine whether the injury is of GBH, ABH or battery level.
>
> This must be considered with reference to the victim, i.e. the person's age, health or any other relevant factors. In *Bollom* [2003] EWCA Crim 2846 the court said 'To use this case as an example, these injuries on a 6-foot adult in the fullness of health would be less serious than on, for instance, an elderly or unwell person, or someone who was physically or psychiatrically vulnerable or, as here, on a very young child. In deciding whether injuries are grievous, an assessment must be made of, amongst other things, the effect of the harm on the individual. We have no doubt that in determining the gravity of these injuries, it was necessary to consider them in their real context.'
>
> Examples where the injury is most likely to amount to common assault or battery include (this is not an exhaustive list):
>
> grazes
> scratching
> abrasions
> minor bruising
> swelling
> reddening of the skin
> superficial cuts
>
> Examples where the injury is most likely to amount to ABH as it is more than transient or trifling include (this not an exhaustive list):
>
> damaged teeth or bones
> extensive or severe bruising
> cuts requiring suturing
> loss of consciousness

26. The next section of the same Guidance starts as follows:

> **2. Take a step back and considering all of the circumstances, select the appropriate charge**
>
> The appropriate charge should be identified by applying the principles set out in the Code for Crown Prosecutors, in particular paragraph 6.1 which states:
>
> Prosecutors should select charges which:
>
> - reflect the seriousness and extent of the offending
> - give the court adequate powers to sentence and impose appropriate post-conviction orders;
> - allow a confiscation order to be made in appropriate cases, where a suspect has benefitted from criminal conduct, and

[2] https://www.cps.gov.uk/prosecution-guidance/offences-against-person-incorporating-charging-standard

- enable the case to be presented in a clear and simple way.

This underlines that the level of injury is not determinative and prosecutors must consider all the circumstances of the offending.

27. It continues:

> However, in all cases it is necessary to consider whether the charge reflects the seriousness and extent of the offending. For instance, use of a weapon, a particularly serious way of committing an assault (e.g. kicking on the floor, headbutting), a vulnerable victim, repeated conduct, the making of threats, multiple incidents, significant pre-meditation, or a relevant past history may mean the more serious charge is appropriate.

28. Applying this Guidance, and reflecting the reality of the criminal justice system, the injuries are demonstrably those consistent with battery/common assault. VC had no previous convictions. There was no planning. No weapon was used, or threatened to be used. He left the premises when challenged afterwards and did not threaten anyone else. The incident was spontaneous. He may – albeit mistakenly – have felt provoked ('pushed'). If charged as battery/common assault, the court's sentencing powers would have been wholly adequate (up to 6 months' imprisonment under section 39 CJA 1988), and a custodial sentence (even a suspended custodial sentence) highly unlikely. The relative vulnerability of the victims (based on size and age) does not alter this.

Operational decisions at the scene

29. It is appreciated that the officers' conduct at the scene is primarily a matter for the IOPC investigation rather than the Inquiry. Nonetheless, and given some of the themes developed in questioning, some headline submissions are made.

30. The starting point is that the original call from Arvato was graded as a Grade 1 response, meaning 'Emergency' with an 'Attendance aim' of 15 minutes and 'Key Triggers' 'Danger to life, serious injury, threat or use of violence, serious crime in progress, detained offender posing risk, serious RTC'. The response time achieved was reasonable, and used emergency equipment. By the time of arrival, the suspect was believed to be off premises (as he was, without incident) and he was not seen en route to the warehouse.

31. The responding officers – PC Amos-Perkins and PC Taylor – were part of a finite resource of response officers. Response work is intrinsically reactive, and officers are entitled to take decisions that will balance the needs of an investigation at a scene against the necessity to be available for deployment. That basic proposition is clearly illustrated in the immediate case by the simple fact

that they left Arvato in response to another Grade 1 call. That was a wholly justified operational decision.

32. PC Taylor correctly engaged her body-worn camera in order to record what was said by witnesses at the scene, and the scene itself. The operational error arose when she did not subsequently preserve this as evidence: she has recognised that this was a mistake, and the product of her then inexperience in classifying such material (as the Inquiry well knows, 5 May 2023 was only her 12th operational shift. Even by 24 May 2023 she was wholly inexperienced).

33. The officers do not recall being told about any knife, beyond PC Taylor (witness statement 3 October 2025 [WITN0009001_006] at [21]) saying 'The manager of the warehouse mentioned at some point that each staff member had a safety knife/box knife, which was used for opening cardboard boxes and other operational work. I do not recall the context of this comment, but I can say that there was no mention of a knife being used in respect of the assault.' In questioning by the Chair ([11 March 2026, 89/1 – 7]; URN INQT0000020) she confirmed she was referring to Louisa.

34. As stated above, given the fact it was simply kicked away as a precaution, and this is what Volodimir saw and would have told anyone at the time, this is not surprising.

35. The officers correctly offered first aid/transfer for treatment, which was refused. They had accounts of punches to the side of the head, and saw the victims receiving treatment, but do not recall specific reddening. They accept that this reddening may have evolved later. As set out above, and even when fully developed, the injuries were at a level of battery/common assault.

36. They did not take detailed witness statements at the time, nor seek to engage (assuming it would actually have been available in the time they were at Arvato, which is not a safe assumption) a telephone-based translation. This was an entirely justifiable operational decision for multiple reasons.

37. Firstly, the victims were in shock and accordingly unlikely to provide their best evidence: this principle is cemented into basic operational practice, e.g. as to those reporting a rape or sexual assault that has just occurred, or for police officers following an incident under College of Policing and IOPC Post-Incident Management procedures. Under the approved approaches, detailed accounts should wait at least 48 hours for the memory to settle and shock to reduce.

38. Secondly, the officers were and remained operational as part of the response team and may have had to deploy to another Grade 1 (which Arvato was not at point of departure) at any point in time. That is exactly what happened. In summary, they had been deployed at 17:55; arrived at 18:13; and re-deployed to a Grade 1 incident at 18:56 relating to a male walking (dangerously) on the A6. This departure would have meant an unsatisfactory interrupted process for the victims.

39. Thirdly, the officers reasonably concluded that the subject matter of the investigation involved a battery/common assault. Their memory of visible injuries, insofar as they had developed as injuries by the time they left, is broadly consistent with what Louisa reported in the 999 call ([NGPF0001860_008]).

40. Fourthly, the officers had no reason to predict that the process of obtaining statements would subsequently evolve as it did, and the challenges arranging it experienced by PC Taylor with Arvato.

41. Fifthly, there was no reason to believe that witnesses would not be available to provide statements in the immediate future. It may be observed that having an interpreter physically present, rather than engaging by telephone, is more satisfactory in all respects unless the detailed witness statement is needed urgently, or unless there is an urgent operational need (e.g. a real and immediate risk to the public). Neither applied here.

42. Sixthly, there is no corroboration for any claim that VC's mental health was raised as a factor by any witness at the time. This includes the 999 call; what was noted by the police following the visit; and the Arvato and Sky Recruitment internal documentation. Statements as to perceptions of VC's mental health, based on how he looked following the violence – it may be observed, not a reliable basis to reach any clinical conclusions – only followed his arrest and publicity associated with his appalling violence on 13 June 2023. This includes the repeatedly- and widely- used photograph of his face in which his appearance is striking. These factors are contended to have produced – subconsciously at least – a re-construction in the minds of witnesses as to what they recall. On any view, and whether it was their impression at the time or not, it was not reflected in any account until after 13 June 2023.

43. Questions that would have been asked of Louisa on behalf of the three individual officers include: the limited extent of the injuries she witnessed and reported in the 999 call, and that the injury to the male victim had aggravated a pre-existing one ([NGPF0001860_0007 and _008]); that she understood the female victim to have been pushed out of the way to get at male victim, and then left alone, and that there were no reports of random violence against anyone ([IOPC0000082_0001]); that by the time of her IOPC statement of 20 March 2024 she had seen much media, including the much-used photograph of VC ([IOPC0000082]); whether viewing this material caused her to reconstruct how VC appeared on 5 May 2023; if she was so concerned about VC's mental health and/or the speed of the police response, why not escalate within Arvato or directly with police when they contacted her ([ARVS0000015] and [LEPF0000004]); why there was no greater urgency escalating the response to the police; why no reference to a safety knife or mental health until her statement to IOPC; to confirm the police did take details, and said they would make arrangements to come back and get statements through an interpreter; and she never suggested to her internal

management or to the police that the investigation was not being taken seriously enough ([LEPF0000004]).

44. Further, that the contemporaneous entries by PC Taylor demonstrate that Louisa was the designated point of contact within Arvato throughout or, as a minimum, when this was asserted by PC Taylor in communications no contradictory message, or the identity of whoever was the point of contact, was sent back. As an absolute minimum. PC Taylor was entitled to believe Louisa was the point of contact throughout.

45. The Inquiry is invited to examine the documented history of communication between PC Taylor and Louisa on the contemporaneous police investigation log, and Arvato's and Sky Recruitment's internal correspondence and documentation, on these points. Without being critical of any Arvato or other witness, they are contended to support PC Taylor's account.

46. The officers' decision to leave Arvato to respond to a different Grade 1 call was reasonable. It was also operationally reasonable – that is to say, within the range of decisions an operational officer could justifiably make – to seek to arrange the formal date for taking witness statements to a later date. Whilst fixing this could in principle have been done at the time, to ensure it was effective PC Taylor would have had to know (1) her operational availability (as the designated OIC); (2) that of the witnesses; and (3) that of an independent translator. Co-ordinating these three variables was reasonably to be done from the police station. PC Taylor was not to predict that future liaison with the witnesses would prove to be so challenging.

The progression of the investigation to 24 May 2023

47. The officers have provided detailed witness statements to the Inquiry documenting the history of this investigation from 5 May 2023 to 13 June 2023. Within the period the critical date for the Inquiry's purposes is probably 24 May 2023, when VC's identify was finally provided through Arvato/Sky Recruitment.

48. Events on 24 May 2023 are addressed separately, below.

49. The critical documents for any objective analysis of the investigation are (1) the original OEL ([LEPF0000004]); (2) PC Taylor's witness statement of 3 October 2025 ([WITN0009001); (3) her evidence to the Inquiry ([11 March 2026, 1/1 – 90/8]; INQT0000020). Related to these are the witness statements and evidence of PC Amos-Perkins (witness statement 3 October 2025 [WITN0010001], evidence [11 March 2026 90/16 – 148/25]; INQT0000020) and TPS Read (witness statement 3 October 2025 [WITN0011001], evidence [11 March 2026 pm 01/1 – 31/15]; INQT0000021).

50. In terms of context, there is a wealth of evidence (1) that all response officers within Leicestershire Police were operating at or beyond capacity at the time (for example, both PC Taylor and TPS Read were routinely performing police work when off duty, and unpaid); (2) that the level of experience on the force generally for operational policing was low, and officers relatively young (see Sandall [CC Sandall, 11 March 2026, 69/23 – 70/12]; INQT0000021) TPS Read [TPS Read, 11 March 2026, 27/24 – 28/7; 28/23 – 29/29/7]; INQT0000021); (3) that PC Amos-Perkins, although a tutor, was himself both objectively young and inexperienced to have that role; and (4) PC Taylor was only on her 12th operational shift on 5 May 2023, and required to complete certain tasks in order to pass this stage of her training.

51. Self-evidently, operational mistakes should be avoided. Equally self-evidently, and once they are discovered to have been made, it is easy to contend they were obvious. But it is also equally true that all human beings make operational mistakes in whatever field of work they are involved in, or in their private conduct and administration. And the probability of such mistakes increases directly when work is having to be done under acute pressures of time and resourcing, and further still when the person concerned is inexperienced. The Inquiry is invited to bear such factors in mind in its assessment of what the three individual officers did, and did not, do. Insofar as there were admitted operational errors, none has sought either to avoid them or to blame others. Each is a committed police officer.

52. Of most direct relevance to the period between leaving the Arvato warehouse and 24 May 2023 is contended to be PC Taylor's witness statement at [19] – [48] and associated OEL entries. These are contended to speak for themselves. On a fair reading, they are contended to demonstrate (1) the reality of PC Taylor's reactive operational responsibilities at the time (it is common ground that theoretical duty ('protected') time to catch up was impracticable because of lack of resources, and/or cancelled at short notice on a reactive basis); (2) that repeated attempts were made to arrange a convenient date and time to obtain witness statements; (3) that this was done both direct, and through Louisa; (4) that Louisa was and remained the designated Arvato point of contact up to and including the last communication from PC Taylor on 10 June 2023; and (5) that the obvious necessity of Arvato and/or Sky Recruitment providing VC's full identity was delayed – despite requests of them – until 24 May 2023.

53. There is no lack of commitment by PC Taylor to progressing the investigation: quite simply, on a fair reading, she was not getting the basic information back that she had requested. Her entries on the OEL are competent and clear, even if on occasion reflecting inexperience with some police jargon/systems (e.g. the use of 'DP' when VC was not detained). It is also observed – given the language of one entry was said to 'lack empathy' – that these and equivalent police records are intended to be practical, concise and informative. Recording information in a factual manner does

not lack empathy, any more than a clinician simply recording reported symptoms in a medical record lacks empathy. They are working professional records.

54. In her correspondence with the public she is clear and appropriate: for example OEL entry 22 on 3 June 2023, reflecting an email sent on 2 June 2023:

> Contacted Louisa
>
> Email.
>
> Hello Louisa.
>
> This is PC Taylor
>
> I am contacting you in regards to 23*273031. Can you pass on our sincere apologies that we have not been to visit [named victims]. We have been extremely busy. I hope they can understand. Are you able to provide me with their shift for the next 2 weeks maybe, just so that we can come and see them, and if possible we can utilise an interpreter at your workplace just to explain where we are at with this investigation. All that we need from [named victims] is what they would like/expect out of this investigation, what injuries [named victim] had medical attention for and whether they would like to like a formal complaint. I will attempt to call you on 03/06/2023 when I am back on shift if you don't get back to me on email.
>
> Have a great day, Thankyou

55. An email on similar lines was also sent on 6 June 2023 direct to the victims in English and Romanian ([WITN0009003_001]).

> Hello [named victims]
>
> This is PC Taylor
> I am contacting you in regards to 23*273031.
> Our sincere apologies that we have not been to visit, We have been extremely busy. I hope they can understand
> Are you able to provide me with your shifts for the next 2 weeks maybe, just so that we can come and see them, and if possible we can utilise an interpreter at your workplace just to explain where we are at with this investigation.
> All the questions are that we are going to ask you both are:
> - What would you like out of this investigation
> - Are you still wishing to pursue this complaint of common assault
> - Are you willing to make a formal complaint (would require statements, injury descriptions
> from hospital etc)
> - What injuries was [the female victim] treated for at the hospital

56. There were further, unanswered, attempts to contact Louisa documented on 4 ('as she has agreed to be the point of contact for the two victims due conversation to the language barrier …' (sic)) and 10 June 2023: OEL entries 23 and 24. The 10 June 2023 email was sent direct both to one of the victims and Louisa, again with no reply, setting a deadline of 15 June 2023 or else the investigation would be sent for filing. Objectively, these efforts were proportionate and reasonable.

57. Similarly, it was a reasonable approach to continue to progress concurrent attempts to identify VC and to arrest/interview him.

Events on 24 May 2024 following identification of VC

i. Obtaining witness statements

58. PC Taylor finally obtained the requested identity details from Sky Recruitment on 24 May 2023. These were entered to the OEL at 23:46 (OEL entry [20]). The entry reads:

> Ali Parvez from Sky Recuitment (sic) has confirmed the details of the suspect:
> Name — Valdo Mendes Calocane
> Date of Birth — 04 09 1991
> Phone number [VC phone number 2]
> Home address – 37 Milton Street Derby DERBYSHIRE DE22 3PA UNITED KINGDOM

59. Technically, CTI is correct in questioning on the premise that the police could have acted in the absence of victim and other eye-witness accounts based on the content of the bodyworn video. This pre-supposes that VC was both identified, and his whereabouts established, in order to arrange either a voluntary interview (absent the outstanding Nottinghamshire Police warrant, the most likely procedure, since if he co-operated no arrest would be necessary)[3] or to arrest and interview him, in either case under criminal caution. It is also observed that TPS Read, an experienced operational officer, assessed that in relation to the Arvato incident in isolation, the priority of arrest '… would be at a lower level' ([TPS Read, 11 March 2026, 10/17 – 18]; INQT0000021) even once identity was established.

60. Whatever the technical position, however, operationally it was entirely legitimate – in reality, the correct decision at the time – to seek to obtain formal eye-witness statements first. There are some obvious reasons for this, including (1) that it enables the interviewing officers to know the detail of the incident they are interviewing about, in order to explore and challenge any answers given by the interviewee; (2) this would enable an immediate charging decision at the conclusion of interview (including the necessary evidence as to the level of injury) and/or the identification of other lines of investigation; (3) it makes it less likely that the interviewee would elect to answer no comment when questioned (the risk of an adverse inference from silence would increase); (4) it would have enabled use of this formal evidence in court for other purposes (for example, had VC been arrested on the

[3] Under section 24 PACE 1984, an arrest must be 'necessary'. PC Taylor assessed that a voluntary interview would have been the likely approach: WITN0009001_022 at [88]; PC Taylor [11 March 2026 83/17 – 84/3]; INQT0000020

outstanding warrant, as to considerations of remand/bail). As matters stood, any legal representative for VC would have been likely to advise (i) there were no witness statements to enable advice to be given; (ii) that the victims/eye witnesses had not even confirmed they wanted to proceed, and had not answered repeated police requests to provide statements; and (iii) there was no CCTV of the incident, and no medical evidence, so such witnesses were essential.

61. It is trite that no prosecution may be based wholly or mainly on an adverse inference from not answering questions when interviewed. The more specific the detail of the case put in interview, the stronger the basis of the adverse inference will be. Where an interviewee is advised by their lawyer to answer no comment when questioned, the likely strength of any adverse inference is reduced. The legal direction associated with when an adverse inference may arise, and the weight to be attached to it if it does, substantially reduces – or eliminates – its relevance in most cases. For those that either investigate crime, and/or conduct criminal cases, this will be an uncontroversial analysis. An adverse inference only arises if there is compelling evidence of guilt. If witness statements were not required before interview, they would have been required afterwards, and – in reality – before charge. Absent considerations relating to the circumstances of the outstanding Nottinghamshire Police warrant, VC would either have been released under investigation (the most likely, to enable completion of the basic eye-witness and medical evidence required for file and to determine the correct charge), or on bail.

62. Either way, he would probably have been in the community and, in terms of his mental health, simply discharged back to his GP following non-engagement with mental health services.

Access to the NICHE record for VC by PC Taylor

63. The forensic evidence as to the use of NICHE by PC Taylor is and remains unsatisfactory: the IOPC failed to retain it in its original form, and protracted attempts to rebuild it have proved unsuccessful. The evidence as to its use from the IOPC was served on 9 March 2026 and is part of a document entitled 'Operation Penhallow – Analytical Report' ([IOPC0000133]).

64. In material part, this Analytical Report relies on the interpretation of NICHE audit data by Brian Gardner from Leicestershire Police. His contribution is being treated uncritically by the IOPC (and, from the form of questioning by CTI, it appears the Inquiry), as to what was done and potentially visible to PC Taylor. No expert declaration accompanies either Mr Gardner's analysis, or that of the author of the IOPC's Analytical Report (who expressly disavows expert status). The Inquiry is respectfully encouraged to be cautious: for example, CTI and other counsel questioned PC Taylor as to the significance of the 'running man' icon next to the outstanding 'wanted warrant' entry. The

premise was that this indicated a man 'on the run': quite simply, it does not. Every entry in the NICHE system has the same icon.

65. Based on what is declaredly a reconstruction of the NICHE system based on how it looks now – no data having been obtained when the IOPC's Operation Penhallow started – the intrinsic limitations of what was happening are summarised at [10] of the Analytical Report:

> Please note that at the time Officer Y expanded the involved occurrences, only the first 6 would have been displayed (not 8 as in the image above). The image above is not taken from 2023 but has been taken from the live system and edited to show the wording that would have been present at the time on the warrant entry only. The location of the `wanted warrant' entry would have been the second one down in the list.
>
> The image above reaffirms that on 24/05/2023 [VC's] involvement in occurrence 22000554223 was [Wanted Warrant]. Whilst the above shows what was available to view at the time, it cannot show how this was displayed on screen, for example, how large the screen was, how large this particular window was on screen, whether it was made smaller, minimised, covered by another window, the speed at which this list of occurrences was scrolled through by the Officer or whether the Officer was physically looking at the screen or reading the words on it.
>
> It is inferred from looking at the PMS data that Officer Y also had Outlook and potentially MSEDGE and Explorer open on screen, as the data shows these three systems were accessed in the space of 1 minute and 12 seconds prior to her adding [VC] as a suspect.

66. Both PC Taylor and PC Amos-Perkins have provided clear evidence as to what they now remember of the circumstances of this short moment of routine operational policing.

67. To start with PC Amos-Perkins, his position was – as is PC Taylor's now, with the benefit of greater operational experience – that entering a suspect's name onto NICHE will automatically require consideration of anything else of immediate relevance held on the system about him. Both accept that the information that he was 'Wanted warrant' and 'Nottingham Magistrates' Court complex Summary first incident warrant not backed for bail issued on 22nd September 2022', in relation to an alleged assault of an emergency worker, would have been relevant in terms of investigative strategy and, if absorbed, would have triggered certain actions. Without more, the fact these actions were not triggered demonstrates any available information was not absorbed by PC Taylor at the time. It was not mentioned to PC Amos-Perkins. Neither had any reason not to take appropriate investigative steps had they been aware of it: after all, in all other respects they were conscientiously seeking to progress the investigation.

68. His evidence as to what he is likely to have said to PC Taylor is instructive. To the Inquiry he said as follows to CTI ([11 March 2026 112/18 – 113/3]; INQT0000020):

> Q. If we go to number 20 which is on page 9, we see on 24 May PC Taylor finally gets the key details for the suspect. Was that a bit of a eureka moment? You've got the suspect's details, you can go and find out what you need to know.
>
> A. It was sort of like a "Finally we've got it." I can remember there being a mention that she'd got a name, but there was not anything significant that had been mentioned at that point. So it was "I've got a name" and it was sort of "Add him on to the NICHE occurrence and we'll go from there."

69. It can be seen that, if the 'sort of' language of 'Add him on to the NICHE occurrence and we'll go from there' was used, then an officer as inexperienced as PC Taylor may have taken the instruction/advice over-literally. Implied in it, from PC Amos-Perkins' perspective, is a review of other material on NICHE. This is obvious to PC Taylor now, but not then.

70. There is no basis to conclude that PC Amos-Perkins was either told about, or saw on PC Taylor's screen, the relevant warrant as to this outstanding warrant. Had he known about the warrant he would have done something about it. Further, at the time it happened he had his own duties and to address, and a significant list of his own investigations to process on police systems. To suggest he was looking at PC Taylor's screen is pure speculation. He had no reason to.

71. From the perspective of PC Taylor, and assuming the evidence is accepted that the entry was on screen as reflected in the Gardner analysis, intrinsic to the same analysis are the multiple factors that may have led to PC Taylor not absorbing the information that was available. The size of that window, amongst multiple other open windows (see Gardner, above) is only one of a number of such factors. Reflecting what the Chair asked/observed in questioning PC Taylor, there is every possibility PC Taylor – working under pressure, with multiple screens open – simply got distracted. Reviewing the detail of suspect backgrounds and other information when entering information to NICHE was not yet in her police officer muscle-memory: it is now.

72. This is consistent with the fact that no PNC or PND checks were conducted by either officer. PC Amos-Perkins assumed PC Taylor had reviewed NICHE: his assumption was on the premise that to him this was automatic. It was not to her at the time: he accepts he should have double-checked.

73. Similarly, the investigation continued on the same bases as before. As PC Taylor said in questioning from the Chair ([11 March 2026, 87/11 – 19]; INQT0000020):

> I think what I mean by that is if I'd have seen he was wanted on warrant, I'd have asked advice, and we'd have discussed that further about what the next steps were to do because that would have been my first time dealing with it, as well. So what I mean by that is, you know, speaking to him: how do we progress this forward if he's wanted on warrant, what does that mean and how do we get in contact with Nottinghamshire and progress it further with them as well?

74. There was no such discussion: she had not seen it.

75. As PC Taylor has explained, the OEL entry of 7 June 2023 ('Unable to make arrest attempts this set due to: …', which appears rushed) makes no operational sense and appears to be a mis-typed form of words. There had been no discussion of any plan to arrest VC, or any contact with Nottinghamshire or Derbyshire Police. Necessary witness statements were still being chased in the same period. Planning an arrest strategy is something that would inevitably have involved PC Amos-Perkins – PC Taylor had not done anything equivalent before, even within Leicestershire Police – and he knew nothing of it.

76. Similarly, in her regulation 17 response (undated, but after 6 March 2024, so a minimum of 9 – 10 months later, and as to which she was inevitably and reasonably questioned) she said (from memory, and with no NICHE analysis report [LEPF0000433_0003]):

> I had to ask my tutor for help in how to add the suspect's details to NICHE, what classification to record him as. I believe that when I did this I had a look at some of the previous investigations linked to him.
>
> I recognise and accept that at the time I did not complete PNC or PND checks on the suspect. I did not know that this needed to be done. I am now aware of this and know how to do this.
>
> I know that by doing this that it would show any warning markers, his previous offending, any outstanding offences.

77. Demonstrably, 'I believe' – 9 to 10 months later – is not the same as a concrete memory. There is no memory of what was absorbed, if anything, of the outstanding occurrence log ('the previous investigations linked to him'). The emphasis is on 'recording' a 'classification' of a suspect's details. The point remains as above: even if open, she did not absorb it, whether through it being concealed on a busy, multi-window single screen, or some distraction. Had she seen and absorbed it, operational consequences would have followed.

TPS Read

78. As for TPS Read, his evidence speaks for itself. Such operational errors as he made were, on any fair and objective analysis, the direct product of the reality of his relentless working responsibilities.

Causation, and the likely series of events had the outstanding warrant been recognised

79. Assuming the outstanding warrant had been recognised by either PC Taylor, or PC Amos-Perkins, or the lack of suspect background checks on OEL identified on a 28-day review by TPS Read, the Inquiry has to make a realistic assessment of the probable series of events that would have followed. This inevitably involves a degree of assumption as to operational policing; the operation of different parts of the criminal justice system; and/or the reality of how mental health services were likely to have managed VC had he been referred to them as he had on multiple previous occasions.

80. The Inquiry will consider evidence as to each of these – and doubtless other – factors in greater detail than is attempted on behalf of the three individual Leicestershire police officers. On their behalves, a headline approach is adopted, and the conclusions the Inquiry is invited to reach.

Executing the warrant

81. The presumed line of argument as to causation is that if the outstanding Nottingham warrant had been identified by officers from Leicestershire Police, they would have alerted officers at Nottinghamshire Police, who – potentially in liaison with Derbyshire Police, given Derby was VC's last known address – have (1) prioritised this outstanding warrant ahead of others as a matter of risk-assessment; (2) identified where VC was now living; (3) executed the warrant; (4) taken VC to Nottingham Magistrates' Court; (5) proved the breach; and (6) he would have been remanded in custody, and/or somehow made subject to a mandatory requirement in terms of medication (whether as punishment for the breach, and/or pending trial on either or both of the outstanding criminal investigations (i.e. the assaulting an emergency worker allegation, and/or Arvato)) such that he would not have had acute paranoid schizophrenia on 13 June 2023, or secured at some facility if he did.

82. It is contended that any one or more – or all – of these are unlikely to have occurred.

Nottinghamshire Police: executing outstanding warrants

83. The evidence as to this is extensive, and Nottinghamshire Police have formally accepted that their operational performance at the relevant time was seriously deficient. The backlog of warrants was extensive and, even insofar as there was a system of prioritisation based on risk, it is unlikely that the outstanding warrant relating to VC would suddenly have been treated as a priority. Even if the warrant should – as, in an ideal world, it would – have been executed expeditiously, the operational

reality at the time was that Nottinghamshire Police had c. 1000 outstanding warrants at the time (T/DCC Griffin witness statement 28 November 2025 [WITN0074001]; reflected in evidence [T/DCC Griffin, 23 March, 34/7 – 18, 42/6 – 18]; INQT0000036) and others would have taken priority over this. Nothing in the evidence substantively changes what was stated by CTI in Opening (INQT0000001 138/6-15).[4]

84. The Inquiry cannot safely conclude that a referral on 24 May 2023 would have led to any attempt by Nottinghamshire Police to execute the warrant by 13 June 2023, i.e. only 20 days later.

VC's address(es)

85. The Inquiry has the evidence as to VC's address. Even had a decision been taken by the police to execute the warrant, it cannot be assumed that VC would have been at the Milton Street address in Derby as shown on the information given to PC Taylor by Sky Recruitment and/or the NICHE system. Family members did not have a clear understanding of where he was. Further investigation may have been required. How long it would have taken to establish his address is speculative.

Executing the warrant

86. Assuming an up-to-date address, VC would have had to be present. Given his reported lifestyle, that he would have been so is again is intrinsically speculative. Executing the warrant may have involved operational liaison between two, if not three, police forces. The reality of timescales for this is speculative.

Taking VC to court/proving the breach

87. Assuming VC was arrested, he would have been taken straight to court (or the next day). To prove the breach, it would be necessary to prove (1) that he had received the summons to attend; and (2) that he failed without reasonable excuse to attend. Neither of these are straightforward: as to (1), his address at the date of the summons was not where it was originally sent. The summons was sent to VC at Flat 15, Madison Court, Nottingham on 24 August 2022. He had last lived at this address on 8 February 2022 ([WITN0032001_0014] at [45]; [UNIN0001304]). As to (2), he was previously

[4] As opened by CTI (Opening Statement INQT0000001, 138/6-15) 'VC was summonsed to attend Nottingham Magistrates Court on 22nd September 2022 (at a time when he was in hospital). He failed to appear and a warrant was issued for VC's arrest. The warrant was flagged to PC Myers (at least by 20th January 2023) but came through the NICHE computer system as a 'low' priority. PC Myers will describe his belief that the warrant would be taken forward by another team.'

(unsatisfactorily) discharged on 21 October 2021 (chronology [NHFT0019588]), but the evidence appears unclear as to where he was, and why, at the date of the 22 September 2022 hearing.[5]

88. Were there any factual dispute about any of this, the breach hearing would have been likely to have been adjourned in order for enquiries to be made. In reality, VC would have been granted bail for any such adjournment. This may or may not have had conditions of residence, potentially with his family.

89. Unless he was presenting as acutely mentally unwell, he would not have been remanded in custody, and/or compulsorily detained under any provision of the Mental Health Act 1983 on the information that would have been available to the prosecution or court. Questioning of former CC Meynell (and others) as to the probable series of events presupposes that on any such hearing VC would have presented as acutely mentally unwell, and requiring compulsory admission under the Mental Health Act 1983, since he presented that way on 13 June 2023. This is not a safe assumption: VC's presentation on earlier dates may have been different, and he is documented on repeated occasions to have had the capacity and intelligence to mask symptoms from even trained clinicians, still less untrained lawyers and magistrates. Further, a high proportion of defendants in the criminal justice system have histories of chronic and acute mental illness. Without compelling evidence to justify it, they are not either remanded in custody or sectioned for assessment on this precautionary basis. If they were, there would be wholly insufficient capacity in terms of secure psychiatric units to accommodate them: the system operates at or beyond full capacity as it is.

Conditions of bail/release

90. Accordingly, and unless he was presenting as acutely mentally unwell – again speculative, especially as he was so accomplished at masking his mental state – it is (highly) unlikely that he would or could have been made subject to mandatory assessment or depot medication.

Conclusions as to causation

91. In opening ([INQT0000001, 142/4-11]), CTI posed the question that the Chair:

> '…may want to consider whether the assault at Arvato was a serious missed opportunity, whether an arrest of VC under the existing warrant or in respect of this assault, might have triggered a different chain of events. The Inquiry will investigate how such errors can be

[5] See fn [4]. If he was in hospital on 22 September 2022, this would have inevitably have been stated at any initial court appearance, and would almost certainly have represented a reasonable excuse even were the summons been shown to have been effectively served. It may be the Inquiry has resolved this in evidence since opening.

avoided in the future and how best to ensure that all relevant crime and mental health information is available to those investigating offences.'

92. As to ensuring greater access in future to mental health information for investigating officers, this is supported by the three individual Leicestershire Police officers: see below. As to what the 'missed opportunity' was, it was to inform Nottinghamshire Police of the outstanding warrant, and the probability that there had been further offending at the level of battery/common assault. As to the reality of whether it would have triggered a 'different chain of events', the analysis is as set out above.

Wider themes and suggested recommendations

93. The Inquiry is considering a vast amount of material, and has as one of its defined objectives the production of evidence-led practical recommendations. The three individual Leicestershire police officers do not seek to address, in any detail, subjects beyond their immediate role in these events.

94. A number of themes are however highlighted on behalf of these operational police officers, and through them as proxies for many tens-of-thousands of other operational police officers. The context for this Inquiry is well-understood: time and again, wholly innocent members of the public have been caused serious injury, and killed, by those with acute mental health disorders who, by any objective diagnostic criteria, should have been treated and managed on the basis they represented a significant risk to the public if not adequately treated and managed. Given the data, such cases are not to be characterised as 'exceptional'.

95. Whilst the documented violence is repeatedly against members of the public selected at random (albeit reflecting paranoid and delusional thinking), emergency workers, including but not limited to police officers, are those required to confront such acutely dangerous individuals. They are entitled to expect that the management of risk of such individuals will give appropriate weight to that risk: history demonstrates however that the interests of the patient have assumed a cultural domination over the risks to the public and emergency workers.

96. The following observations made on behalf of the three Leicestershire Police officers in opening ([INQT0000002, 78/9 – 24]) are maintained:

> In the immediate Inquiry, questions include whether organisations with information about Valdo Calocane shared it as they could have done and, if not, why not and with what effect? Should such organisations be entitled – or even required – to share more information with each other in future in order to ensure appropriate mitigation of risk from those with recurring mental disorder is put in place? If so, according to what criteria? Is there a risk that the centrality of patients' rights in the 2025 Mental Health Act legislation will relegate – as a matter of clinical culture, if not the law itself – the importance of the protection of

the public from the significant risk of serious violence if a specific mental health condition is not adequately gripped by the assessing clinicians?

97. In making recommendations, the Inquiry is invited to reflect the necessity of forcing cultural change. Without limitation, the evidence has established – notwithstanding policies to the contrary that existed – an entrenched cultural failure within policing to charge suspects where they may have acted in consequence of a mental health condition (even where, as here, serious injuries have resulted, and there is repeat offending); that the management of high-risk paranoid schizophrenics was chronically flawed in terms of risk (one example, from many that could be highlighted, is that decision to discharge VC to his GP in September 2022 following repeated non-engagement was extraordinary, and the GP left in an invidious and barely-informed position);[6] the failure to obtain a CTO and/or implement a regime of depot medication or even assertive outreach does not reflect any justifiable assessment of risks to the public of non-compliance relative to the clinical needs of the patient.

98. The accuracy, and force, of the evidence of Dr O'Malley-Kumar on this point is surely incontrovertible (Dr O'Malley-Kumar [25 March 2026, 76/1 – 15]; INQT0000040):

> … a point I've been making from the beginning is that psychiatry is the only medical speciality where poor treatment, lack of treatment, failure to treat or negligent treatment, or refusal of the patient to take treatment, can result in the death of a third party. And I think people need to understand that.
>
> The Royal College of psychiatrists need to understand the job that they have and the role that they have in keeping the public and the patients safe for that matter. And the psychiatrists let us down. They risk assessed for their own staff and their own staff could only visit VC in pairs with a male, yet they were happy to discharge him back to the GP without any treatment.

99. The following matters are highlighted for consideration as to recommendations:

    1. Necessary changes in the law, and inter-agency protocols, as to sharing and accessing information for those members of the public with mental health conditions such as paranoid schizophrenia. This is almost too obvious to state, and a feature of multiple public inquiries including, but not limited to, the Bichard Inquiry Report in 2004. It is an almost invariable feature of many hundreds of serious case reviews across different sectors. Even within policing, it is surely unacceptable that there is – in 2026 – no single nationally-accessible database equivalent to NICHE for operational police

[6] *Per* CTI Opening ([INQT0000001, 136/17 – 24]), 'Dr Timothy Baker, the senior partner at VC's GP practice, fairly observes in his statement that: "No information with regards to his current risk or risks when not taking medication was shared with the Practice at the point of discharge." There was no explanation of any risk he posed, no advice on management, medication needs, or concerns as to non-concordance. There was no explanation of any care plan.'

officers. The Bichard Inquiry identified the barriers to accessing intelligence even between neighbouring police forces, and the catastrophic effect of these barriers: in 2026, these barriers to policing information being accessible remain between most forces. The PNC and PND contain far less operational information, and not everyone is trained to use PND. In future, the accessible data should reflect the full history of arrests and outcomes (including as to whether mental health was a consideration and, if so, how) such that informed decisions can be taken with live investigations;

2. The necessity of accessible data for people of qualifying risk – i.e. those assessed as of 'significant' (meaning, 'sufficient' or even 'more than minimal') risk of causing (a qualifying level of) harm if not managed (see [3], below) – because of a diagnosed mental health condition between clinical and policing services, is equally obvious. The evidence demonstrates that, in diagnostic terms, conduct that may appear insignificant to the police could be highly relevant to a psychiatrist (see e.g. Dr Smith (Dr Smith, [1 June 2026, 14/12 – 20]; INQT0000103) re the significance of the death of a cat; Dr Dissanayaka (Dr Dissanayaka, [15 April 2026, 67/16 – 68/12]; INQT0000051) re scratching cars), and the corresponding necessity of the police sharing such evidence with managing clinicians;

3. As to the threshold of risk that should be required before any mandated intervention (CTO/depot/assertive outreach, etc) is appropriate, the two considerations are what level of risk, and what level of harm? As to the level of risk, this should to be defined as 'significant' or, even, 'more than minimal'. The meaning of 'significant' was considered by the Court of Appeal in *R v Stephens and Mujuru* [2007] 2 Cr. App. R. 26 ([RLIT0000081]) in the context of its use in section 5 of the Domestic Violence, Crime and Disorder Act 2004,[7] i.e. the offence of causing or allowing the death of a child.[8] This was of course the test for determining criminal liability for the death of a child

[7] '5 The offence (1) A person ("D") is guilty of an offence if— (a) a child or vulnerable adult ("V") dies or suffers serious physical harm] as a result of the unlawful act of a person who— (i) was a member of the same household as V, and (ii) had frequent contact with him, (b) D was such a person at the time of that act, (c) at that time there was a significant risk of serious physical harm being caused to V by the unlawful act of such a person, and (d) either D was the person whose act caused the death or serious physical harm] or— (i) D was, or ought to have been, aware of the risk mentioned in paragraph (c), (ii)D failed to take such steps as he could reasonably have been expected to take to protect V from the risk, and (iii) the act occurred in circumstances of the kind that D foresaw or ought to have foreseen.' Section 5(6) defines 'serious' to mean 'harm that amounts to grievous bodily harm for the purposes of the Offences against the Person Act 1861 (c. 100)'.

[8] Section 5(1)(c) and (d) defined to prove that the defendant, was or ought to have been aware of, a "significant risk of serious physical harm". The CA held that '… the word "significant" was an ordinary English word in general use and there was no reason to think that Parliament intended it to bear anything other than its normal meaning within s.5 of the 2004 Act. The decision as to whether the risk was significant, and, if it was, whether a defendant was or ought to have been aware of the fact, was one of fact for the jury applying their collective understanding of the word "significant". Therefore the judge was wrong to tell the jury that the word meant "more than minimal" and he should not have sought to define the word when directing the jury; and, if asked, he should have told the jury to give the word its ordinary meaning.'

where the maximum sentence on conviction is 14 years' imprisonment. A different – and lower – threshold is contended to appropriate in the immediate context, where the outcome is mandated medical treatment and supervision to mitigate the objective risks of harm that are a consequence of a mental health condition. The objective is appropriate treatment to address risk – in the interests of the individual and the public – not punishment;

4. The evidence in the immediate case, from the Arvato incident alone, supports an approach that the test for qualifying harm should not be a requirement that it is 'serious' or 'grievous bodily harm'. Any physical harm should qualify, as should significant psychological harm (e.g. the psychological harm caused by sustained disordered conduct by a neighbour with an untreated mental health condition). It is observed that different provisions of the Mental Health Act 2025, including grounds for detention under section 5, and section 6 grounds for community treatment orders, presently require 'serious harm'. The Inquiry is invited to recommend that this definition of harm is amended to remove the requirement that it is 'serious' harm. Firstly, why is it acceptable that members of the public, and/or emergency workers, will be exposed to a clinically objective qualifying risk of harm amounting to actual bodily harm rather than serious harm? Even applying the CPS charging guidance set out above, it is obvious that less than serious harm should qualify. Secondly, there is no evidence that clinicians can calibrate what level of harm – between 'actual' and 'serious' – an individual with qualifying mental health conditions will cause if in an acute state of paranoid psychosis;

5. Public safety must be entrenched culturally in both charging and clinical decision-making (police; CPS; clinicians). This is recognised to be likely to require and involve greater use of CTOs and/or mandated depot medication and/or a variant of assertive outreach. It is observed that those with paranoid schizophrenia, and other mental health conditions, often lack insight into their own condition, and the necessity of treatment, as a symptom of their mental health condition. This intrinsically dangerous quality of such illnesses promotes mandated supervision and treatment;

6. Consideration should be given to a national risk-ownership protocol for qualifying individuals (recognising that not everyone with a diagnosis of paranoid schizophrenia will necessarily qualify, still less those with other mental health conditions), equivalent to that presently under review by the Southport Inquiry. Given the risk requires ongoing clinical/forensic assessment, the obvious party to 'own' the risk is those responsible for clinical management, but they must be assisted in that by having access to relevant police data (see [99](2), above);

7. As to police powers, the right under PACE 1984 to take samples from those in custody should be reviewed generally, and specifically where there is or may be any question of a relevant mental health condition (e.g. as to any future determination of diminished responsibility following a homicide) and/or the use of drugs (lawful or otherwise, and with the same potential relevance). Such testing is time-critical and a reasonable component of any such criminal investigation. It should not depend on the consent of the suspect. The level of interference with the rights of the suspect is, objectively, minimal, and in any event proportionate to the competing benefits;

8. The Inquiry may wish to consider recommending that any police or CPS decision not to prosecute an individual in consequence of their mental health condition should be superintended by a senior officer or CPS lawyer. This would mitigate the risk of established policies not being applied (as they clearly were not in relation to VC), and promote the pro-active sharing of information in that context with those responsible for clinical management;

9. Whatever recommendations are made, the Inquiry is invited to review for itself the effectiveness of their practical implementation at a suitable date in the future. This will promote public accountability from affected parties and – importantly – an iterative process whereby the final outcome is informed and improved by subsequent operational experience;

10. This approach would reproduce that taken by the Bichard Inquiry, where the initial 22 June 2004 Inquiry Report was followed by a 17 March 2005 final report that considered progress with implementing the original recommendations;

11. Without such a direct review by the Inquiry itself, there is a real and substantial risk that the necessary and practical reforms recommended and intended will not achieve their objectives. This has been the documented experience following other public inquiries.

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14 August 2026 HUGH DAVIES KC