Witness Name: Eleanor Turner
Statement No: WITN0054001
Dated: 19th September 2025

**THE NOTTINGHAM INQUIRY**

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**FIRST WITNESS STATEMENT OF ELEANOR TURNER**

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I, Eleanor Turner, of the University of Nottingham, University Park, Nottingham, NG7 2RD (the "**University**"), will say as follows: -

## INTRODUCTION

1. I am a Mental Health Social Worker, registered with Social Work England. I am employed by the University currently as the Head of Specialist Wellbeing Services (Counselling and Mental Health). I have been employed by the University since 2014.

2. This witness statement is made to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 Request dated 26 June 2025.

3. I qualified as a mental health social worker in 2004 and worked for about eight years as a community psychiatric social worker, managing a case load of mentally unwell patients in the community. I completed further training in working with personality disorders and worked closely with, but not for, the personality disorders service. I then worked as an Eating Disorders Specialist, before joining the University in 2014. Once at the University, my initial role was Senior Mental Health Advisor. I then became Head of the Mental Health Advisory Service ("**MHAS**"). Two years ago, I became Head of Specialist Wellbeing Services, which is the umbrella for the MHAS and the University Counselling Service. I remain a registered social worker.

4. My role between 2019 - July 2023 was Head of Mental Health Advisory Service. That role included the following: managing and developing MHAS's services, providing clinical supervision to members of the team and ongoing support to staff in key welfare roles and liaising with key health, social care and third sector organisations to establish effective referral pathways.

5. MHAS is a specialist, referral only service for students experiencing significant mental health difficulties. It is an advisory service as the name says: we do not provide mental health diagnosis, assessment or treatment. MHAS provides advice to help students manage their mental health and liaises with external services, where needed, to ensure support and risk are communicated effectively between the University and relevant statutory mental health services. The service has mental health advisors, and senior mental health advisors. In the last year we saw approximately 1,500 students, out of about 37,000. MHAS accepts referrals from University staff and external stakeholders (for example, NHS providers). MHAS will respond to students if students contact the service directly, but MHAS does not advertise that it accepts self-referrals from students. That is because the simple message for students is that they should contact the Support and Wellbeing team first, which then triages all issues. We encourage the stepped care approach with first contact with the Support and Wellbeing team. We are a very small team and need to ensure that we have the time to work with those who need the service.

6. The University's Support and Wellbeing team are based in schools and faculties to provide advice and support to students with regard to their wellbeing and to help them access more specialist services when needed. They also provide advice to staff within the schools and faculties. They are the first port of call for any student concerns and students will then be signposted to more specialist services if appropriate.

7. I am asked about the relationship between academic staff, the Support and Wellbeing team and MHAS and whether there were any guidelines or

procedures which set out or explained that relationship. MHAS had a strong and regular liaison with the Support and Wellbeing team which acts as a pastoral level interface between our service and the schools. MHAS has some direct contact with academics, where a student is on our caseload, where the nature of someone's issues is related to academia and we have the student's permission. For example, if we are supporting a student who is on a psychiatric ward and needs help to navigate extenuating circumstances, we might speak to their personal tutor with their permission. The only time I would liaise with academics without permission is if we feel there is a risk posed to people in the school which we need to liaise directly about. We have had some cases where students have posed a risk to staff and students within a school, by behaving in a way which causes alarm to students and staff as a result of mental illness, and that would warrant us liaising directly with the school to help them manage. There were no guidelines which set out that relationship as far as I know.

8. MHAS would rarely interact with the police directly: we would be more likely to go through the University's Security team to facilitate that liaison. We would interact directly with police for example if we were reporting students missing, or where we have information which might be relevant to pass on to police. Interactions with the police were variable; they were much better when liaising with the Nottinghamshire police force because of an agreement that information would be shared, and much harder when liaising out of area where we found it much harder to get information.

9. Liaison with external statutory services, including the NHS mental health services, is at the heart of what MHAS does. By statutory services I mean the NHS and social care teams, which have statutory duties for their patients and service users in a way that we don't in the University setting. When those services interact with a student they ultimately manage the risk relating to the person: I would refer to them as being the 'risk holder'. We also work with other services which are non-statutory, like charities which provide support for those who self-harm, and those charities would not act as the risk-holder. In almost all of our MHAS cases there is NHS involvement (students without

external involvement are very unlikely to need MHAS support), with an NHS risk holder who is ultimately responsible for taking decisions about the management and treatment of that student's condition, with MHAS providing all the support we can to try to ensure that the student can engage with their studies and the University experience.

10. We generally become involved with students if they are referred to us from another University service. Sometimes we are alerted to students in difficulty by NHS services; for example, if a student has presented at the local A&E with suicidal feelings, then the local NHS team based in A&E make a plan of care and let us know. We can become involved with students before they start at the University. For example, if a future student discloses as part of their application that they have an eating disorder and are in hospital, we try to liaise with them before they start at the University, sometimes together with the Disability Support Service. We then work to facilitate the handover between the individual's current NHS service and the relevant Nottingham NHS service. We would meet the student in the first week of term and assist with medication transfer and other issues - we act as a support service and the primary responsibility for their care would remain with the NHS.

11. When a student is first referred to MHAS, we assess whether they are suitable for our service. If so, then they are on our caseload and allocated to a Mental Health Advisor. If they do not meet the criteria for input from MHAS, they would be referred as appropriate to the University Counselling Service, to a University Support and Wellbeing practitioner, perhaps the NHS primary care mental health team or NHS talking therapies team - it would depend on need.

12. Any student eligible for support from MHAS is on the cusp of, or receiving, NHS support at a secondary care level (inpatient, community teams, eating disorder service, early intervention psychosis, etc). Those on the cusp of receiving NHS secondary care support are typically students regularly attending A&E with mental health crises, where there is effort being made to keep them out of secondary services. The majority of students who use self-

harm as a coping mechanism are supported at a primary care level and can access the counselling services and other NHS primary care services.
Where a student is on the cusp of secondary care, they will be held within NHS primary care. We provide information to that student's GP which as a statutory service, is the risk holder, so that the GP can manage the risk and escalate to secondary services if needs be.

13. We can also refer directly to some secondary care mental health services under informal local arrangements but would copy in the GP to that referral as they are technically the referring body. We would refer to community services where appropriate such as the Early Intervention Psychosis team ("**EIP team**") and specialist eating disorder service. We have built up relationships and negotiated with service leads to draw up referral pathway documents.

14. When students on the MHAS caseload are under the care of a secondary service, we communicate directly with that secondary care team and, depending on the case, may also liaise with the GP. For example, where a student has an eating disorder and is under the care of NHS specialist eating disorder services, we would communicate with both the NHS team and the GP as the GP holds responsibility for physical monitoring. When a student is in the psychiatric ward, we ideally want to join the ward review so that we have full information; usually that is permitted as the student wants us to be there. Sometimes we step out of the picture if a student under NHS care does not want to work with MHAS; that is their right and we would generally pull back but make clear that we can be contacted at any time and make clear to the NHS that we need to be alerted to any risks in our community. At times we work alongside NHS services. For example, if we are the driving force behind a Mental Health Act assessment and have a good relationship with the student, then we may be present at the assessment by the Approved Mental Health Professional ("**AMHP**"). We are not playing any formal role in the risk assessment in those situations, but are facilitating and supporting. We also sometimes work with the EIP team with students who are in an early phase of psychosis, and we provide a joint appointment with that student on our University premises. The NHS specialists would take the lead in relation to

assessment and management decisions, but we would seek to provide support and continuity to the student.

15. MHAS would try to instigate a Mental Health Act assessment if we felt someone is too unwell to be treated in a community setting. The NHS' Crisis Resolution & Home Treatment Team ("**Crisis team**") are the gatekeepers to the ward, so generally in this situation we would be referring to the Crisis team and say we do not think that this person can be safely kept in the community. We have direct route to the Crisis team, we just phone them up. We cannot demand a Mental Health Act assessment (only the NHS or a nearest relative can do that), but we might be in contact with a nearest relative and tell them that they have a right to ask for an assessment and we feel that is the course that should be taken.

16. We are reliant on good communications with community mental health teams, GP practices, social workers and hospitals. Broadly, we have good relationships with those teams. Where students agree to full sharing of information then we should be able to have access to full details. Most students agree to information-sharing: the stall is set out clearly for students accessing the service that we will generally share information with the NHS, and that is our model. However, students have the right to not have NHS information shared from the NHS to the University and in those cases we remind the NHS that they should still share relevant information about risk to our University community and are able to do that without permission. Sometimes that information sharing does not happen, particularly where there are agency staff who do not understand about interactions with the University and that problem has increased over the years. We have built up good relationships with some NHS services, particularly local services, but sometimes the relationship is harder with out of area services.

17. I am asked to exhibit any policies or procedures which regulated the relationship between the University and the police or external mental health services. I do not know about police procedures - that would be led by the Security team. MHAS works within University guidelines and policies. MHAS'

FAQs for referrers talk about communication and how we share information [UNIN0001811]. We use the Student Wellbeing confidentiality statement (this was brought in around 2023) [UNIN0001812]). University data protection policies and privacy notices also provide a framework [UNIN0001813, UNIN0001814, UNIN0001815, UNIN0001818]. There is no formal information sharing agreement between the University and the NHS and other statutory mental health teams. The rules are clear as far as I am concerned - that if people give permission that information can be shared, then it can all be shared. If students do not give permission, then medical information can only be shared where it is relevant to a risk to self or others within the University community.

18. We also work with the Disability Support Service in the University. Most of the students in MHAS are in receipt of a support plan through the Disability Support Service - this sets out agreed reasonable adjustments, e.g. they may receive a smaller exam room, extra time, extensions to coursework deadlines, etc.

19. We also work with the Safeguarding team. Any safeguarding situation would be managed via the Safeguarding team, but risk relating to mental illness would be managed primarily by MHAS.

20. I am asked to set out the training I received on student wellbeing, how to deal with mentally ill students, risk assessment, student safeguarding and risk to others. Within MHAS, everyone had to be a health or social care professional, i.e. to be registered in either mental health social work, mental health nursing, occupational therapy or psychology and have a significant amount of experience in statutory services. It follows that we have all had highly relevant core training and experience. The training and experience that I had as a mental health social worker is central to my role at the University. Before I joined the University, I had training in risk assessment, safeguarding and GDPR each year. Every professional in the team would have had training in risk assessment. Because of the professional nature of staff in the teams, we all have a mandatory requirement for a minimum amount of continued

professional development to maintain our registration. At the University we have mandatory safeguarding training. We run internal training events, where someone with an area of expertise delivers training for the team to manage that requirement, such as on the implications of the CASS report relating to transgender services published in 2025.

21. In relation to risk assessment, we do not have specific University training, but as I have said we are all skilled in risk knowledge and have experience in risk management. The team talk about risk all of the time. We have a clinical lead in the service who supervises all of the mental health advisors and senior advisors, who provides clinical supervision - she is a psychiatric nurse whose previous role was management of inpatient facilities and lead clinician for the mental health team that sits alongside A&E (Department of Psychological Medicine in Nottingham). Every member discusses case load with her at a monthly meeting - talking about cases, getting input into them, discussing risk assessment.

22. In order to access the service, students demonstrate risk, usually risk to self. Risk assessment forms part of the initial assessment; there is a form we use now (since around the summer of 2022) when a student first makes contact with MHAS [UNIN0001816, UNIN0001817] and, at the time, any initial risk assessment would have been recorded in the narrative notes. Risk assessment is a dynamic process, happening all the time. We do not use a risk matrix because we do not have training in using any specific risk matrix tool, and so risk information is held within journal entries, along with the plan. I think it's important to emphasise that we do not do the sort of clinical risk assessment which NHS specialists and AMHPs do. We gather risk information on behalf of the University to share with statutory services who can manage that risk. We risk assess to enable the right support to be put in place for the student by the NHS.

23. I am asked about the Fitness to Study process [UNIN0001824, UNIN0001825]. I was not very involved in that process. I used to see it as a process which was very linked to a student's academic performance and not

really linked to any effect of that student's behaviour on other people. I did not think of the Fitness to Study process as one that would help to assess or manage risks posed by a student. It was not seen in that way - I saw it really as a way to support a student who could not manage their studies. I have been more aware of how to use that policy in risk management since it changed to the Support to Study process in September 2023 and became more closely linked with the Wellbeing services [UNIN0001826, UNIN0001827]. I have triggered the use of the policy in the last year where the behaviour of a student with mental health issues was causing distress and worry to others and the student would not accept advice to stay off campus. I cannot think of another occasion before then when I had used the policy to keep someone off campus.

24. I am asked what actions I would or could take in my role if I had concerns about the risk a student posed to the safety of others. Most people who pose a risk are not mentally unwell so would not be in our service. It is very rare for us in MHAS to deal with a student who poses a risk to others. If that was the case, I would seek a Mental Health Act assessment as above if appropriate. I would refer to other NHS services as appropriate. I would consider initiating contact with the University Security team or police if it was an immediately concerning situation. Now, I would also consider the Support to Study policy, and whether to alert the student's designated emergency contact under the emergency contact protocol.

25. I have provided contemporaneous notes to the Inquiry and would like to explain that the quality of the notes is not as high as I would usually expect of myself and others in my team. In MHAS, I inherited a paper-based service. When we went into lockdown in the pandemic we had no electronic note-taking software, and so we had to create a new system under huge time pressure at a very difficult time to keep the service running, and without any IT support. Our administrator set up a SharePoint file and we put in any information we had into folders for each student. For each student there was a running note in a Word document which we all made entries onto whenever we dealt with that student's case. Additionally, there was a duty log, where the

duty worker would show what had been rolled over or completed on duty on any one day - where that related to someone on a case load, it should have been transferred to the relevant running note. We now have a system called UniHub which is a more bespoke system for recording case notes electronically.

**CHRONOLOGY**

26. I have been asked to set out a chronological account of my contact with Valdo Calocane, who I will refer to as Valdo throughout this statement.

27. I provided support to Valdo between 1 June 2020 and April 2022, through my role at that time as the Head of MHAS. Valdo was a registered student at the University. Valdo was one of the students on my caseload.

Events in 2020

28. I first became aware of Valdo on 1 June 2020. Claire Thompson, Associate Director (Student Wellbeing), forwarded an email trail to the MHAS shared inbox, which included an email that had been sent from Valdo's University email account from Valdo's mother, Celeste Calocane [UNIN0000140].

29. Ms Calocane's email of 1 June 2020 informed the University that Valdo had recently been admitted to Rowan 1 Ward at Highbury Hospital, Nottinghamshire due to a psychotic episode. Ms Calocane stated that Valdo would be unable to take his online exam on 2 June 2020 and that he would need an extension and she was seeking advice as to what she needed to do on Valdo's behalf. That was the first time that I was made aware that Valdo was suffering from mental illness.

30. I made a telephone call to Ms Calocane. She advised me that Valdo had been assessed via police contact and detained under section 2 of the Mental Health Act. Ms Calocane informed me that Valdo's family lived in Wales and were

very worried about him. I outlined the role of MHAS and reassured her that there was no need for her to complete anything in relation to Valdo's academic study [UNIN0000734].

31. I also called Paige Smith, Student Support and Wellbeing Officer (Engineering). The purpose was for Paige to be a conduit to the academics. I asked Paige to advise the academics in the department in which Valdo was studying that no action was currently needed in relation to Valdo's studies [UNIN0000734]. I cannot remember the precise conversation that I had with Paige, but I probably asked her to see if we could put a halt on chasing emails to Valdo (for example about failing to complete an assessment) and told her that Valdo's mother should not complete the extenuating circumstances claim form. Paige emailed to confirm she had done this [UNIN0000949]. I gave the advice I did because where a student is being held under section, this can indicate a lack of capacity and so it makes sense to pause the academic side of things until we have confirmation from mental health services that the student is well enough to make their own decisions. We can't act on the request of a parent without the student's consent because we do not know what the relationship is like between a parent and their child and whether a student would be happy for their parent to intervene on their behalf. Our usual plan of action in these circumstances is to communicate regularly with the ward, if possible, and wait for the student to get better to the point that discharge planning can take place. When a student has been sectioned as here, MHAS will talk to a parent or carer and it will often be useful to get information from them, and we let the parent or carer know contact details and that we will act on information they give us and they should share concerns. We will be clear that we cannot share information back with them until the student has capacity to give us permission to do that. There was also an issue about data sharing, and the potential for a data breach if we shared information about a student with a parent. I recommended that a data breach form should be completed [UNIN0000739] - we would not normally even be confirming that a student is a student - because for example a student may have interrupted or left studies and not want family to know, which is their right.

32. On 1 June 2020 I emailed Jamie Dickinson, Off-Campus Affairs Manager (who provided off-campus support) to find out whether he knew where Valdo was living [UNIN0000881] - the University is reliant on students inputting their addresses into the system, and not all students do that. Valdo had not, and his mother could not recall his address. Jamie Dickinson did not have his address and wrote '*without more info we can't work out if he has housemates that might be affected. We'd reach out to them and check in normal circumstances*'.

33. I made a call to Highbury Hospital to ask for the MHAS details to be placed on Valdo's medical file, so that there could be a channel of communication between MHAS and the NHS [UNIN0000734]. I noted that I had done this in an email to Paige on 2 June 2020 [UNIN0000919].

34. On 3 June 2020 I received an email from Dr Faizal Seedat, Consultant and Clinical Director at Highbury Hospital. I replied promptly, indicating that I thought that it would be helpful for us to liaise about Valdo. We arranged a telephone conversation for that afternoon [UNIN0001527].

35. I spoke to Dr Seedat on the afternoon of 3 June 2020. Dr Seedat told me Valdo's address (Brook Court) and gave me information about Valdo's behaviour before admission, which I had not known about. Dr Seedat informed me that Valdo had gained entry to a fellow resident's property on the first floor. The individual had been so concerned for their safety that she had jumped out of a window, sustaining a significant injury and requiring surgery. Dr Seedat also informed me that Valdo was requesting discharge to his Nottingham address [UNIN0000734].

36. I called Rowan 1 Ward, Highbury Hospital on 3 June 2020 and spoke to Valdo, who had lost his mobile phone. We discussed the need for Valdo to submit an Extenuating Circumstances claim in relation to a missed exam in order for him to have a first sit in the resit period (a first sit means that full marks would be

available to him). Valdo was aware that he needed to submit this once he had access to a computer. We also discussed Valdo's desire to remain in Nottingham following his discharge. I advised Valdo that I considered it would be better for him to return to Wales where he had support from his family. Valdo informed me that he had a further year to complete at the University but had not yet arranged accommodation for the 2020-21 academic year, though he didn't feel that this would be difficult [UNIN0000734].

37. Valdo was open to talking about the idea of moving out of his current accommodation and returning home to Wales for support from his parents and others. I recall discussing with him the pros and cons of staying in Nottingham versus going home. I told Valdo that I was looking into whether he could go home to Wales. We agreed that I would telephone him on 8 June 2020 – but I don't think I did.

38. From the information available to me at the time, I did not think that it was appropriate for Valdo to be discharged to his Nottingham address. I was advocating for Valdo to return home to Wales for support from family and engagement with mental health services there.

39. I relayed the above information to Jamie Dickinson by email [UNIN0000881]. I contacted Jamie as Dr Seedat had given me Valdo's address which was off-campus and Jamie deals with any incidents that happen off-campus. My belief was that Jamie would have known if there were any other University students in the accommodation in question and, if there were, he would be the person to liaise with them. Jamie was going to check whether anyone else lived with Valdo, and said in an email to me that '*if we find students close by, we can reach out and check in on them*' but that the accommodation '*looks predominantly residential*' (that is a term used to mean non-student accommodation) [UNIN0001803]. My understanding is that there were no other students in that accommodation at Brook Court which would have included the person who jumped out of the window. I summarised that in my case summary as '*Discussion with Off Campus who established no other*

*students at property, appears to be largely residential complex.'* [UNIN0001401].

40. On 9 June 2020 I called Rowan 1 Ward for an update [UNIN0000734]. I was informed that Valdo was showing ongoing improvement but was still isolating himself in his room and was reluctant to socialise. I spoke to a staff nurse. I was informed that Valdo was compliant with aripiprazole (his anti-psychotic medication) and that a referral had been made to the EIP team. The EIP team is part of the secondary mental health services provision and works with people who have experienced psychosis for the first time. It is a team we work very closely with when needed.

41. I was advised that Valdo's discharge was planned for the following week and that Valdo wanted to move initially back to accommodation in Nottingham and then move to Birmingham to an unknown address. I voiced concerns regarding risk assessment and the plan for Valdo to return to accommodation in Nottingham, where he would not have family support, and where other students may be present. Any discharge would come with a discharge plan including a current risk assessment. I requested that the risk assessment be emailed to me and that I be called back by the Consultant. I did not receive a copy of the discharge plan. I don't believe that I was called back by the Consultant - I don't have any notes of a further conversation with him and would normally make and keep notes of that sort of conversation. We always ask to see the discharge risk assessment, but we are rarely provided with it.

42. Following my call to the ward I was uncomfortable about the approach to risk. I had a discussion with Stuart Croy, the University's Head of Security, regarding liaising with the police. That was an unusual step, but I wanted to communicate widely that I had serious concerns about someone being discharged back to a property where there was (as far as I knew) a person who had been so scared that she had jumped out of a window. I wanted to know the police view about Valdo returning to that property in Nottingham and wanted the University's concerns about risks to be shared with the police.

Stuart advised me that it was unlikely that the police would give an opinion on the appropriateness of the discharge plan but agreed to voice concerns on behalf of the University. I provided Stuart with a case summary on 10 June 2020 by email [UNIN0001401], summarising the information which I had to date in this way:

*Case Summary*

*01.6.2020 - Email received fro Valdo's Mum to School reporting Valdo admitted to psychiatric ward on s.2 Mental Health Act. Suspected first onset psychosis. Liaison with Mum, off campus and ward re: role of MHAS. Ward report Valdo admitted via s.136 following attempting entry to neighbors flat resulting in unknown female exiting 1st floor window in fear resulting in serious injury requiring surgery.*

*03.06.2020 - Discussion with Consultant Psychiatrist Dr Faizal Seedat who confirms address is Apartment 7, Brook Court, Player Street, Nottingham. Feels trigger was isolation. Unclear drug screen. Reports Valdo improving and discharge to Nottingham address being planned. Discussed rationale for recommending Valdo return to Mum's property in Wales and concerns for both Valdo and unknown female if he were to be discharged to Nottingham address.*

*Telephone call with Valdo, gave information regarding support. Valdo appeared distracted during call and lacked insight into the fact he had been unwell and/or the impact of his planned return to Nottingham address. Advice given re studies. Declined ongoing support but understands need for MHAS to remain involved for time being.*

*Discussion with Off Campus who established no other students at property, appears to be largely residential complex.*

*09.06.2020 - Telephone call to ward for update as planned. Staff nurse reports Valdo to be improving and now compliant with medication. However, Valdo is isolating self on ward and not engaging in any meaningful way with ward staff or activities. Nurse reports Valdo's discharge is planned for next week and he continues to plan to return to Nottingham address before possibly moving to Birmingham despite having no known links with Birmingham. I again voiced my concern at risk assessment and discharge plan. Requested email copy of risk assessment and left message for Consultant to call me to discuss.*

43. The police response which was forwarded to me was that because he was being released by professionals there did not appear to be any risk [UNIN0000594] and I understood that the police would be contacting the woman who had jumped out of the window [UNIN0001747].

44. I made notes of what happened on 9 June 2020 in the running record and produce those [UNIN0000734]. I can see that I refer to seeking the name of the AMHP to ensure they feel discharge is safe and appropriate. I can't see emails to the AMHP at this time and don't have any recollection of contacting them.

45. I am asked whether in relation to events in June 2020 I think sufficient consideration was given to my concerns and appropriate action taken in light of them by (i) the University and (ii) NHS mental health services and/or (iii) the police.

46. In all of this I was acting on behalf of the University, and I believe that through me the University was taking appropriate action. When I liaised with other services in the University, I have no complaints about how they responded and I don't identify anything else that the University should have done - I did not ask anyone in the University to do anything that was not done.

47. In relation to the NHS, I do not think that they gave my concerns sufficient consideration. I did not try to persuade them not to discharge Valdo: that was not my role. I did not see the discharge risk assessment and I could not influence their discharge decision. As I did not see the discharge risk assessment, I had not seen evidence to be satisfied that Valdo had recovered enough to be discharged from the ward - the picture I was getting was of someone not meaningfully engaging with treatment and still isolating himself - but ultimately I did not have all the information that they were working from. I had to accept that the NHS experts had made the decision to discharge and my concern was where he was going to be discharged to. I was very frustrated that the NHS would not use their skills and communication and engagement

to try to get buy-in from Valdo for a plan to return to Wales and they could have done more to encourage him to do that. I appreciate that the end result may always have been that he exercised his right to go back to the Nottingham accommodation that he had paid for, and the NHS cannot insist that a person returns to their family which was my suggested plan. However, I did not feel that I was being listened to properly by the NHS.

48. In relation to police actions in June 2020, it would have been helpful to have had more police support in relation to the unknown woman who had jumped out of the window. I had no way of identifying her or contacting her and I was worried about whether she would feel safe if she was still in the Brook Court property and saw Valdo after he had been released. I did not feel that the police took that seriously, although I do not know what actions they took in relation to that woman.

49. On 10 June 2020 I sent an email to Valdo saying that he needed to engage with MHAS support [UNIN0000734]. I knew that Valdo had been discharged, although I cannot recall how I knew that and I understood that he returned to Brook Court. Valdo did not respond to this email. I could not make Valdo engage with our service. I did not feel that I could do anything else. I knew that he had been assessed as safe for discharge by NHS experts, that there was a discharge plan, that he would be supported by the Crisis team. The Crisis team supports people who are vulnerable to admission to psychiatric inpatient facilities. Their role is to prevent admissions because outcomes on ward can often be poor – home treatment is always the first line of support. As far as I was concerned, NHS services were responsible for Valdo's care and were engaged with him, and he had chosen not to have additional advice and support from MHAS.

50. After this, the next involvement of MHAS was on 23 July 2020 when MHAS received an email from Rowan 1 Ward informing us that Valdo had been readmitted [UNIN0000734]. Catherine (Cath) Gent, Mental Health Advisor in MHAS, had a telephone call with a Staff Nurse called Gordon and was advised

that Valdo had been admitted under section 3 of the Mental Health Act on 14 July 2020 [UNIN0001652, UNIN0000614]. I believe I was on annual leave at the time, which is why Cath dealt with the matter. Cath was advised that Valdo had experienced a relapse in his psychotic illness and that he had reportedly broken into a neighbour's flat and accused him of abusing his family. Gordon also reported that Valdo was now in agreement and concordant with his treatment plan and that Valdo was aware of the liaison between the ward and MHAS. Cath was informed that Valdo's discharge was planned for 30 July 2020.

51. I am aware that there is a file note on the MHAS duty log from 23 July 2020 [UNIN0000614] which reads:

"*Clerk from Rowan 1 contacted to advise a student was admitted to the ward- t/c made to the ward- no one available so contact number left.*
*Spoke with Gordon (ward staff) who reports Valdo was admitted under section 3 on 14th July 2020. It appears he was experiencing 'voices' which led him to break into a stranger's home whom he believed was abusing his family. Police involved. No physical harm to family.*
*Reportedly concordant with treatment and discharge planned for 30th July 2020 if progress continues.*
*Upcoming exams in August 2020.*
*Email sent to Engineering welfare/ EIP- t/c planned for 1.30pm to discuss.*
*Discussion taken with EIP- plan for discharge as above*
*Discussion taken with Ellie and email sent to CPN Claudia Birtles.*
***Plan***
*Ellie to liaise with team and ward next week*"

52. I was not aware of that entry at the time, but I see reference to a discussion with me and it would not be unusual for me to speak to another member of the team when on annual leave.

53. Cath had a telephone call with Abigail (Abi) Parsonage from the EIP team who

advised her that Valdo's named worker was Claudia Birtles (Community Psychiatric Nurse). Abi reported that Valdo had been non-concordant with his medication for a period of 2 weeks before the incident. Abi confirmed that it was planned for Valdo to be discharged back to his current accommodation on 30 July 2020 and that he intended to remain in his flat until he had completed his August re-sits. He would then move to Wales to his family address. Cath discussed concerns about the appropriateness of Valdo returning to his accommodation in Nottingham in light of ongoing risk to others [UNIN0000734]. I would have reviewed the notes on my return from leave.

54. I emailed Stuart Croy and Claire Thompson on 23 July 2020 [UNIN0000620] in order to inform them that Valdo had been readmitted to hospital. I wrote:

*"For info. Following the email below, Valdo has had a further admission under similar circumstances (see entry below)*

*Circumstances leading up to admission It appears he barged passed his neighbour gaining access to the flat and demanded the neighbour apologise for the crimes Valdo believed he has committed.*

*Other neigbours came to the man's aid and police arrived. He was detained on a sec 136 and subsequently detained on a section 3. He had reportedly been non- concordant with medications for 2 weeks preceding this. It seems he has had escorted leave to his flat during this admission.*

*We are advocating heavily for Valdo to return home but Valdo is keen to stay in Nottingham and the ward are supportive of this. I will speak with Valdo and the community team next week."*

55. On 29 July 2020 I tried to telephone the ward but nobody was available to take my call (I made a note of this [UNIN0000734]). I did not receive a call back.

56. I telephoned the ward again on 30 July 2020. It would have been a staff nurse that I spoke to although I have not noted that. I was informed that Valdo's discharge back to his Nottingham address was planned for 31 July 2020. I remained concerned about the appropriateness of Valdo being discharged back to his Nottingham accommodation. I was concerned that there had now been two incidents of aggression by Valdo against people in accommodation. I shared that concern. We discussed risk, however the ward felt that Valdo had improved and that he could manage the risks independently. I made notes of this conversation [UNIN0000734]. Again, I had to accept the assessment of NHS professionals that he was fit to be discharged. I was again particularly worried about him going back to Brook Court - I did not know whether the person who jumped out of the window was still there. I also still felt that it would be better for Valdo's recovery if he was at home as he seemed to have a very supportive and caring family.

57. I emailed Geoff Culpin, the assessing AMHP, on 30 July 2020 in order to flag my concerns about Valdo's discharge plan from the ward and seek his opinion [UNIN0000304]. I had been given his name by the hospital. It's very unusual for MHAS to contact an AMHP about discharge - I was so worried about Valdo, I did not think it was healthy for him to return to a place where people around him would be frightened of him and I was worried about the effect on residents. I contacted the AMHP because I thought he might give an opinion about risk. I wrote:

*"I hope you don't mind me contacting you but I have been informed that you were the assessing AMHP for student V.C DOB: 04.09.1991 this month and I wanted to flag up my concerns regarding his discharge plan from Rowan 1 and seek your opinion.*

*I haven't met Valdo yet as he is not keen to engage in our support but I became aware of his first admission in early June following the incident where he attempted entry to a neighbors flat on the first floor and she was so concerned that she jumped out of the window resulting in serious injury requiring surgery. At the point of discharge Valdo was requesting discharge*

*to his Nottingham address but I was concerned about the psychological risk to the female resident and potential vulnerability of Valdo and I therefore advocated he return to Wales for support from family and engagement with Mental Health Services there. I spoke with Valdo on the telephone and was concerned about his lack of insight into the events surrounding the incident or the seriousness of it. As you are aware, he chose to return to his Nottingham flat all the same and services did not feel they could intervene. I raised my concerns with both Adult MH Services and the local police force.Following the most recent incident, I was surprised to learn that Valdo is being discharged tomorrow to the same address. I remain concerned for the residents but I am also increasingly concerned for Valdo in terms of the other residents and their fears around his mental health. If this was University managed accommodation, we would be carrying out a detailed risk assessment and it is likely that we would be supporting him to return to Wales. Valdo is citing his academic work as a rationale for staying in Nottingham but all his work is now online and there is no need for him to be located near to the University. I am going to continue to try and engage him with our team.*
*I would be really grateful for any thoughts you have about this one".*

58. I'd like to explain what I meant by "*If this was University managed accommodation, we would be carrying out a detailed risk assessment and it is likely that we would be supporting him to return to Wales*". My understanding was that if Valdo had been living in University-owned accommodation then the University would have had more scope to put boundaries in – we could have stopped him from returning to that accommodation or put him into a flat on his own. We do not have similar powers in relation to privately rented accommodation. If he had been in University accommodation, then I would have done an unstructured narrative risk assessment, making a recommendation that he should not stay in the property, with a rationale. That would have been escalated via Claire Thompson as MHAS would not have the power to remove Valdo's rights to stay in his accommodation. It would have been for Claire to determine the process after that. Generally, I would expect the first stage to be an informal

communication in writing to the student saying we had assessed it as unsuitable for him to remain in accommodation. If the student did not agree to move out then I understand the health and safety policy [UNIN0001828] or other policies could have been used to make a student leave University-owned accommodation (I understand the Fitness to Study policy was not then in force).

59. At that time in July 2020, it was Covid, it was out of termtime, so Valdo would not have been going on campus. If it had been termtime with everything open then I think we would have gone through a process of considering whether Valdo should be excluded from campus. It is hard to judge looking back, but I do not think that I would have recommended that he should stay off campus or pause studies as he had been judged to be well by the NHS and was under the care of the Crisis team which we would expect to flag deterioration to us. I would also have been mindful that often a young person has one episode of psychosis and makes a full recovery.

60. Geoff responded to my email a few minutes after I had sent it, but only to thank me for raising my concerns and that he would forward them to the ward for consideration [UNIN0000304]. That was not helpful to me, as I had already communicated my concerns directly to the ward.

61. I also emailed Valdo, copying in Abi Parsonage, on 30 July 2020 [UNIN0001200]. I wrote:

*"I'm not sure if you remember me but we spoke around the time of your last discharge from the ward in June. I was sorry to hear you had been unwell again. I understand from the ward that you are being discharged tomorrow and that things have started to improve for you which sounds positive.*

*I am really keen that we form part of your support Valdo so I am copying in Abi Parsonage who I understand is going to be supporting you along with the Crisis Team. Can you let me know a convenient time that we can speak on*

*the telephone and a number that I can reach you on please? It will be important for us to think about your wellbeing alongside your studies in a way that supports your recovery and your academic goals.*

*I look forward to hearing from you".*

62. Valdo responded on 4 August 2020 via email and said he was happy to talk and he gave me his telephone number [UNIN0000734]. We had a telephone call [UNIN0000734]. This was the second time that I had spoken to Valdo and I still had never met him face-to-face. Valdo had been discharged back to his Nottingham address and informed me that he was engaging with the Crisis team, who were visiting daily. Valdo described feeling well since discharge, with no symptoms of psychosis, no thoughts of harm or threat from other people and no risk to self. He indicated that he was compliant with his medication and that he understood that non-compliance had led to his second admission. We discussed upcoming exams. Valdo had a query regarding his re-sit exams and I advised him to contact the Support and Wellbeing Team in the Faculty regarding this and provided their email address. Valdo indicated that he would be remaining in Nottingham for the majority of the summer and would commence year 4 of his studies in September. He had not yet decided where he would live after his tenancy ended in September. Valdo was aware of the risks around isolation but described a handful of good friends in Nottingham that would reduce this impact. We discussed a referral to Disability Support in order for a support plan to be put in place, which I advocated strongly for, but Valdo declined this. I made Valdo aware that he could contact me at any point if he changed his mind. He was reluctant to engage with MHAS but agreed that I could call him during the first week of term. I understood that he was engaging with the Crisis team which would be managing his risk.

63. Following my call with Valdo I updated the Support and Wellbeing Team (Engineering) via email [UNIN0000778]. I wrote:

*"Just to quickly update you that Valdo has now been discharged back to his Nottingham address following a further admission. He has a query regarding his resit exams and will be emailing you today or tomorrow. He has declined a referral to DS despite me advising this would be helpful. He is compliant with his medication and happy to engage with the Crisis team who are visiting daily. I will call him in the first week of term and let you know if anything has changed. Please get in touch if there are any concerns".*

64. I believe that I did call Valdo in the first week of term, but did not get through to him. I also believe that I tried him again a few times, but with no success.

65. On 4 November 2020 I was copied into an email from Valdo to Emma Barney (the Senior Tutor for the Mechanical, Materials and Manufacturing Engineering Department) [UNIN0000067]. He explained that he had decided to voluntarily interrupt his studies for the remainder of the academic year as he was unable to meet the current demands of the course. I replied to Valdo on 6 November 2020 [UNIN0001205]. I told him that I thought that he had made the right decision and that I hoped that he was getting support at home. I asked Valdo to let me know if there was anything that I could do to help.

Events in 2021

66. After 6 November 2020, my next contact in relation to Valdo happened on 18 January 2022.

67. I am asked by the Inquiry whether I was aware that in September 2021, Valdo assaulted police officers and was detained under the Mental Health Act 1983. I was not made aware of these incidents at the time. I think I should have been made aware of them. If they had happened in Nottingham, I would have expected the NHS and police to contact the University – I would have expected the NHS to contact MHAS and the police to contact the Security team. If they had happened outside Nottingham, I would still want to be made aware but would not have the same expectation of being made aware as we

did not have the same relationship with other police forces and other NHS bodies. I would have wanted to know because it related to significant mental illness of one of our students and particularly because there was an incident of aggression. We would have liaised with the ward, tried to engage with Valdo and tried to become part of the support on discharge planning.

Events in 2022

68. Claire Thompson, Associate Director (Student Wellbeing), forwarded me details about an incident by email on 18 January 2022 at 8.51am [UNIN0000938]. The incident involved Valdo. I believe that Claire and I spoke about the incident the day before, on 17 January 2022 - although I do not recollect the details of our conversation, I note an email from Claire in which she describes me saying that if there were concerns that night it would be best to ring for police support [UNIN0000260] and I note that Claire made a record of our call on a report she made through the Report and Support system [UNIN0000362] and a critical incident report [UNIN0000157] which I would not have seen at the time. The incident report informed me that one of Valdo's flatmates had reported being assaulted and trapped in their accommodation by Valdo. The police had been contacted and had visited the accommodation to deal with the situation, but Valdo had not been arrested, apparently because the student who had reported the assault had not sustained injuries. The incident report said that the student felt unsafe.

69. Following receipt of the incident report I telephoned Abi Parsonage from the NHS EIP team and left a message for her to call me back [UNIN0000734].

70. There is an entry on our duty report from 18 January 2022 which reads: '*HO contact with MHAS. Incident report indicating may be relapsing with sig. risk to others. See notes*' [UNIN0000033]. HO means 'history of'. The notes I was referring to were the running notes, i.e. a Word document into which we made notes about telephone calls and cut and pasted relevant emails [UNIN0000734].

71. Later the same day I telephoned the EIP team a second time and spoke to Adele Pinder, Community Psychiatric Nurse. I was advised that Claudia Birtles was the worker assigned to Valdo. I was informed that Valdo had failed to attend an appointment with them the previous day, which was the 5th time he had not attended. I was informed that Valdo's engagement was poor and that he had run out of medication. I had not known any of that and was concerned that I had not been told. I asked why the EIP team had not made contact with MHAS, and Adele was unable to explain why that had not happened. These are risk flags and even if the NHS did not have Valdo's permission to liaise with us, in my view these are risks which they are entitled to communicate to us. Any significant deterioration markers indicate a risk to self and others - this is now poor compliance with medication, apparent lack of self insight, repeated lack of engagement - that is a really worrying picture for us in the University. It was particularly worrying because Valdo was in accommodation in Raleigh Park with lots of other students around, and there had been a third incident of aggression in accommodation (that we were aware of, the other two being those that happened in Brook Court). I was informed that Adele would liaise with the police to get further information and find out where Valdo was, and that the EIP team would then attend with the police to assess Valdo. I was also told that Valdo had had a further admission to a psychiatric ward a short time before this incident, following a police incident where he was tasered due to non-compliance and that Valdo had a history of assaulting police. This was the first I had heard of this additional admission and police incident and I don't believe I received any further information about them. I made notes of that call and others on that day [UNIN0000734].

72. On the same day, 18 January 2022, I forwarded the incident report to Adele Pinder of the EIP team via email [UNIN0001476]. Adele asked for Valdo's flat number and said that she had tried to ring the police, but they were not disclosing any information at that time. She said that the EIP team was considering carrying out a Mental Health Act Assessment [UNIN0001476].

73. I had a telephone call with Stuart Croy in order to alert him to the incident and check when Valdo's University student card had last been used, which would help us locate where he was so that I could tell the NHS/AMHP. I provided risk information to Stuart and he agreed to check Valdo's card access and to let me know if and when Valdo was located [UNIN0000734].

74. I contacted Christopher (Chris) Hoskins in the University's Residential Experience (ResX) team by email [UNIN0001033] and then by telephone [UNIN0000734]. We discussed the four students who shared a flat with Valdo. We agreed that Chris would explore alternative accommodation for those students. I said I did not think it was safe for them to be in the same flat as Valdo. I expected Chris to take the lead in providing support - I was ensuring that the right people knew so that those students were supported. I informed Chris that 999 should be called if any agitation or aggression from Valdo was noted by either staff or students. He gave me Valdo's address [UNIN0000183].

75. I subsequently had a telephone conversation with Mark Davis, University Crime Prevention/Reduction Manager in the Security team, who informed me that Valdo's card usage indicated that he had left Jubilee Library at 6am [UNIN0000734].

76. At 11:10 I emailed Valdo's address to Adele and Claudia of the EIP team and told them that Valdo's phone was currently turned off (I had tried his phone) [UNIN0001476]. I passed on the information that Valdo had left the library at Jubilee Campus at 6am and said that he was probably at his flat sleeping, which was my best guess. I asked to be kept informed as to when they would be attending with the police so that I could liaise with the accommodation provider. I was trying to use our intelligence in the University to help the NHS/AMHP work out where he was to assess him.

77. I received a telephone call from Clarice Bagtas, an AMHP, who informed me

that she was applying for a warrant and would be attending Valdo's address that day with the police to carry out a Mental Health Act Assessment [UNIN0000734].

78. I was working part time and 3pm was when I usually finished for the day. At 14:19 I provided Chris Hoskins with Clarice Bagtas' contact details in case the Mental Health Act Assessment was convened after 3pm [UNIN0001202, UNIN0000734]. Chris informed me that all of Valdo's flatmates had been moved from the flat and that staff were aware of the need to call 999 if there were any concerns about Valdo [UNIN0000734].

79. On 19 January 2022 I was informed, through a telephone call with the AMHP team, that Valdo's Mental Health Act Assessment had not gone ahead the previous day as there had been no place of safety available in Nottingham and the risks were felt to have been mitigated by moving Valdo's flatmates out of their accommodation and into alternative accommodation.

80. I updated colleagues (Mark Davis of the Security team, Claire Thompson and Chris Hoskins) via email [UNIN0001311]. I spoke to the assessing AMHP who was on the rota that day, Rosie (I didn't get her surname and do not know it), who informed me that once the bed manager had confirmed space on the 136 suite, she would convene the Mental Health Act Assessment. I refer to this phone call with Rosie in an email [UNIN0001476] and in my running note [UNIN0000734]. A 136 suite is a facility where individuals detained by police under Section 136 of the Mental Health Act can be taken for assessment and initial care. These suites provide a safe environment for individuals experiencing mental health crises while awaiting assessment under the Mental Health Act. Previously, people were held in police cells if the power was used, but there are now suites in hospitals for this. At 12:20 I informed Chris Hoskins, Claire Thompson and Mark Davis that the Approved Mental Health Professional and the police would be attending Valdo's accommodation at 1pm that day to execute the warrant and take Valdo to the Cassidy Suite, the Section 136 suite at Highbury Hospital, for assessment

[UNIN0001485].

81. At 14:18 I received an email from Chris Hoskins confirming that Valdo had been in his room when the police executed the warrant and had been taken for assessment, and that the Mental Health Act assessment would be taking place at around 15:00 that day [UNIN0001528].

82. Following Valdo's assessment, I had a discussion with the AMHP, Rosie and the consultant psychiatrist who had been involved in the assessment (I made notes of this [UNIN0000734]). I cannot remember the male consultant's name. I was informed that Valdo had not been detained following the assessment and that he would be returning to his accommodation. We had a discussion about the risk that Valdo posed to other students – the consultant advised me that he couldn't comment on that but he asked me whether Valdo could be moved to another flat and said that he was pleased the other students had been moved. I explained my concerns that releasing Valdo to that accommodation where there were other students would be putting other students at risk. I asked the consultant if he could confirm whether he felt it was "*safe enough*" for Valdo to reside in student accommodation and was told that he was unable to answer that question but that he "*was suitable for home treatment*". I was so agitated in this conversation that I remember raising my voice - and my husband came into the room to tell me that he and the children could hear my voice, which was obviously unprofessional. I was so incredulous that a psychiatrist would not answer my reasonable questions about risk to our student community. I felt so agitated at the end of that conversation. There was such a lack of engagement. The consultant confirmed that Valdo was felt to be suffering from a mental disorder and that Valdo was guarded during the assessment. I talked about the previous incidents - and the consultant must have had Valdo's mental health history. The consultant felt that as the police had not taken any action in relation to the altercation, it was not of any particular consequence (I think he used that phrase), though later in the conversation he said that he felt that Valdo's mental health contributed to the altercation. It did not make sense to me that

the consultant would use the police's lack of action as any indicator of the level of risk. I was concerned that the police were dealing with the recent event in isolation as an incident between housemates, but had not considered risk in the context of past events, and the consultant agreed this was probably the case. I said all this. I felt that the conversation was cyclical with no satisfactory explanation of how the consultant and the AMHP had reached the view that Valdo should not be detained under section.

83. I called Chris Hoskins to advise him of the plan for Valdo to return to his accommodation and I recommended that the other students remain in alternative accommodation [UNIN0000734].

84. The following day, 20 January 2022, I had a discussion with Chris Hoskins [UNIN0000734]. Chris advised me that the accommodation provider did not want Valdo to remain in their accommodation as he had breached the code of conduct and that the students who had been moved were asking for refunds. Chris informed me that there was no self-contained accommodation available in the block where Valdo was currently living and that he had been told by Claire Thompson that she would not support a move to University-owned accommodation. Chris told me that Valdo had spoken about being released from his tenancy a few weeks previously. I recommended that Security attend if the affected students needed to return to their flats (for example to collect belongings) and agreed that I would gather information about risk by obtaining an update from the NHS Crisis team and speaking to Valdo, and see if an informal plan could be formulated in relation to his living arrangements and feed back to Chris later that day.

85. I telephoned the Crisis team who informed me that they had made attempts to contact Valdo that morning. Contact had eventually been made and Valdo had arranged to meet them at Subway. I was informed that they attended late and that Valdo had already left and refused to meet them again that day. As such the Crisis team was on high alert and there was a plan to discuss Valdo at the multi-disciplinary meeting the day after. It was my view at this point that

the home treatment plan had fallen down and that it was not a sustainable plan for Valdo to remain in his current accommodation. I asked for a senior member of the Crisis team (a "Band 7") to call back as I did not think that Valdo's current management plan was safe enough (I made notes of this [UNIN0000734]).

86. I also made multiple calls to Valdo; however, I received no answer and there wasn't a facility to leave a voicemail. I also emailed him requesting contact and noted those actions [UNIN0000734].

87. Also on 20 January 2022 I was copied into emails showing that Valdo was doing better from an academic perspective at that time [UNIN0000600]. Claire Thompson emailed me to say "*I think we need to ask the secondary care team to help us consider what info, if any , should be shared with the team. He is likely to be in labs as part of his course so this does need to be considered once the immediate situation is resolved.*" [UNIN0000591]. I can't recall that email. The Secondary care team would be the Crisis team or the EIP team. I am unsure whether I spoke to the NHS teams about Valdo's risk on campus - but the NHS teams' approach generally where people are deemed suitable for home treatment is that they are suitable to live in the community and attend university. It is generally a protective factor to attend university. The action I took in the days that followed included trying to understand the Crisis team's assessment of risk, trying to escalate the issue, trying to speak with Valdo and sharing information with Valdo's personal tutor, Stewart McWilliam.

88. On 21 January 2022 I sent Valdo an email advising him that I had tried to call him a number of times that week due to concerns about his mental health. I asked him whether he was able to talk to me that morning [UNIN0000053]. He did not call me back.

89. As I had not received a call back from the Crisis team the previous day, I called the Crisis team to discuss risk management [UNIN0000734]. I fed back that I was uncomfortable with the plan that was in place because Valdo had

disengaged from home treatment on day 1 of the plan. I asked for a plan about what would happen if Valdo did not engage again that day and was told that there would need to be evidence of further deterioration or increased risks before calling a Mental Health Act assessment. I was not happy with that position. I expressed the issues being caused in the community and in particular that five students were already in temporary accommodation as a result of an incident involving Valdo. I communicated the accommodation provider's view that Valdo should not remain living there. The Crisis team indicated that they were unable to assist with accommodation and suggested that if the accommodation provider could release Valdo from his tenancy, he could get a flat in the community. I reminded the worker who I was talking to that risks were not confined to other students, but that there had been a previous incident involving injury to a member of the public (this was the incident I had found out about on 3 June 2020, when an individual had thrown herself out of a window). I suggested that if Valdo did not engage that day, there should be a further Mental Health Act assessment. Ultimately, I cannot require the NHS to do an assessment, I can only strongly push for it, which I was doing. They agreed to update me following a visit scheduled for 11am that day (Friday 21 January 2022) [UNIN0000734].

90. I received an email from Claudia Birtles, Community Psychiatric Nurse, EIP team, asking whether there had been any developments with Valdo's accommodation. Claudia said that the EIP team were also concerned that home treatment was potentially quite risky and, in her opinion, unlikely to be successful [UNIN0000734].

91. I made a further telephone call that day to the Crisis team and spoke with Staff Nurse Natalie (I made notes of this [UNIN0000734]). I was informed that the Crisis team had made contact with Valdo, that he had been observed taking his medication but that he had taken it without water and walked away. I was informed that the Community Psychiatric Nurse was unsure whether Valdo ingested the medication or not and that the entire engagement took no longer than 20 minutes. I was advised that the Crisis team's position was that if

Valdo's presentation the next day was similar, a Mental Health Act Assessment would be considered.

92. That contact was on Friday 21 January 2022. After the weekend, on Monday 24 January 2022, I received an update from the Crisis team. I was advised that Valdo had been concordant with his medication over the weekend and that he continued to present as guarded. A further visit was planned for later that day (I made notes of this [UNIN0000734]).

93. I telephoned Claudia Birtles, Community Psychiatric Nurse, EIP team. She explained that she had had no ongoing relationship with Valdo since his last admission and that she was awaiting improvement under the Crisis team before attempting to re-engage. She indicated that Valdo was highly suspicious of services [UNIN0000734].

94. I also telephoned Valdo a number of times. I initially received no answer and there was no ability to leave a voicemail [UNIN0000734]. Claudia had provided me with an alternative phone number and I was able to reach him on that new number [UNIN0000734]. Valdo was guarded and suspicious on the phone and gave monosyllabic answers. He said that he was in the process of securing alternative accommodation but wouldn't confirm where. He said that his accommodation would be available within the next week or two but agreed to contact the landlord to ask for the date to be brought forward. Valdo was aware of the position when it came to the academic side of things. I advised him to submit an Extenuating Circumstances claim but he said he did not believe that this was necessary and that he would be speaking with Stewart McWilliam, his personal tutor, later that week. Valdo said he did not want to engage with MHAS at that point in time though he agreed to speak to me again the following day.

95. I had a Teams call with Stewart McWilliam, Valdo's personal tutor, to give him some background information [UNIN0000734]. That was because Valdo had said that he would be speaking to Stewart, and I wanted Stewart to be aware

in general terms of concerns that we had. I may have told him to meet Valdo on Teams, not in person and to call Security if there were concerns (Security were aware of Valdo's illness). Stewart indicated that he had some awareness that Valdo had some struggles with his mental health. I provided Stewart with some risk information in the context of Valdo's current and historic presentation - I remember telling him about the woman who had jumped out of the window and the more recent incident involving the students. Stewart planned to inform Valdo that I had been in touch and to offer support around the Extenuating Circumstances process and I agreed that I was happy to provide evidence for an Extenuating Circumstances claim if required (I made notes of this [UNIN0000734]).

96. I did not consider using policies to exclude Valdo from University premises. I think if we were to do it now, we would consider using policies to do that. I think at the time we were being led by the NHS teams responsible for his care and it would have felt difficult to justify placing restrictions on his movements as the NHS were continuing to home treat and therefore were assessing that he was safe to be in the wider community.

97. On 25 January 2022 I tried to call Valdo a number of times, as agreed the previous day, but he did not answer [UNIN0000734].

98. I received a telephone call from the Crisis team and was told that Valdo had not attended his planned appointment that day. I offered to support the Crisis team in gaining access to Valdo's accommodation and asked them to consider a further Mental Health Act assessment. I again communicated my view that the home treatment plan was not working (I made notes of this [UNIN0000734]).

99. On 26 January 2022 I made a telephone call to the Crisis team. I was informed that if Valdo did not engage with the team that day, they would request a further Mental Health Act assessment [UNIN0000734].

100. On 27 January 2022, I had a telephone call with the Crisis team and I

was informed that a Mental Health Assessment had been called for that day [UNIN0000734]. I provided Chris Hoskins' details to coordinate access to Valdo's accommodation and updated Chris and Claire Thompson by email [UNIN0000145].

101. On 28 January 2022, I was told that the Crisis team was still awaiting a warrant but that a Mental Health Act assessment was planned for that day [UNIN0000734].

102. I received a telephone call from Valdo, who was distracted and guarded. He wanted to know about a conversation that he thought I had had with his mum [UNIN0000734]. I had not spoken to Valdo's mum since June 2020 and I told Valdo that.

103. On 31 January 2022 I called the Crisis team and was informed that Valdo had been admitted to Redwood 1 Ward under section 2 of the Mental Health Act on 28 January 2022 [UNIN0000734]. I had not known about that for a three day period - and only found out because I was continuing to make enquiries. I informed the Support & Wellbeing Team about Valdo's admission and asked that staff in Valdo's department be made aware of this [UNIN0001745]. I also informed Chris Hoskins. We agreed that it was best to leave Valdo's belongings in the flat for the time being but that the other housemates could now return [UNIN0000734].

104. I called Redwood 1 Ward at Highbury Hospital on 2 February 2022. I provided information about my role and asked to attend the ward review [UNIN0000734]. Case workers from MHAS try to go to these review meetings when they are able – they usually happen once a week – so that we can feed in, get information about students that might help us and seek to set realistic expectations for discharge. I was advised that Valdo remained acutely unwell and that he was guarded, suspicious and keeping himself to himself. I ensured that the ward had my details and were aware of Valdo's accommodation situation (I made notes of this [UNIN0000734]).

105. I had a conversation with Claudia Birtles, Community Psychiatric Nurse, EIP team on 3 February 2022. Claudia informed me that Valdo was presenting as well on the ward and that she was concerned that he may be discharged. We discussed the incident where Valdo had assaulted a fellow student and agreed that speaking to the affected flatmates would be helpful (I made a note of this, [UNIN0000734]).

106. I contacted Chris Hoskins who agreed to contact Valdo's flatmates, Ryan and Christopher, to ask their permission for us to share their telephone numbers with the NHS [UNIN0000734].

107. Stewart McWilliam contacted me on Teams in the middle of the afternoon on 3 February 2022 for an update and I said that Valdo remained in hospital and that I would update him (Stewart) when things changed. I asked Stewart if there was anything that needed addressing in order for Valdo to be able to complete his course. Stewart replied that they would have a better picture of this once the exam board had taken place in a couple of weeks. He said that Valdo would have a strong case for extenuating circumstances, but that the longer he was away from his studies, the worse the situation became. Stewart said that he would keep me posted [UNIN0001610].

108. At 17:30 I received a phone call from Chris Hoskins advising me that, to his surprise, Valdo had turned up in his accommodation [UNIN0000734]. I understood from Chris that other students had been unnerved by Valdo's visit – he had gone into the shared kitchen and stood around – but that Valdo had not done anything inappropriate.

109. I made a call to Redwood 1 Ward and was informed that Valdo had s.17 leave that day which allowed him to temporarily leave the ward, and he had now returned to the ward. I had not been told about that leave in advance. I discussed my concerns about risks in accommodation and asked the ward for

support in ensuring that Valdo understood the importance of not attending the flat unaccompanied. I suggested that if Valdo needed access to his belongings that we would arrange for security to provide support. I provided my contact details again and asked that I was called the following day once my concerns had been discussed with the nursing team [UNIN0000734].

110. I was not called back, but I called the ward again the following day, 4 February 2022. I spoke to Dr Gibson, who was unaware that Valdo had gone to his accommodation and said that this had broken the conditions of his section 17 leave (under section 17, the responsible medical officer can grant leave for patients from the ward, but they remain under section). I was advised that Valdo was presenting as well on the ward. I passed on contact details for only one of Valdo's flatmates, Chris GRO-B (I believe I got these from Chris Hoskins and that we had consent to pass them on), Dr Gibson agreed that he would call him to understand the context of the alleged assault. I have been asked to expand insofar as I am able on my recollection as to how Chris GRO-B's contact details were passed on to Dr Gibson, but I do not have any information on this other than as I have set out above. I have also been asked whether I can expand further as to the process taken to obtain Chris GRO-B's and Valdo's other flatmates' consent for the provision of their contact details to the external mental health service and any discussion between them and the University about this. I cannot as I did not have the conversation with Chris GRO-B (or any other of Valdo's flatmates) about passing on their contact details; I believe it was Chis Hoskins who spoke to Chris GRO-B and I am not aware whether he (Chris Hoskins) spoke to any of the other flatmates. Dr Gibson and I agreed that Valdo would be encouraged not to attend his accommodation and that the ward would liaise with MHAS if Valdo needed to collect belongings. I was advised that the ward would support Valdo with securing alternative accommodation. Dr Gibson informed me that Valdo was not keen on information being shared between the NHS and the University, but that he agreed that risk communication on a need-to-know basis was advisable. I was told that Valdo did not want me to attend the ward review [UNIN0000734].

111. Chris Hoskins contacted me on 9 February 2022 and told me that Valdo had returned his keys for his accommodation at Raleigh Park the day before and had ended his tenancy [UNIN0001323].

112. On 10 February 2022, I telephoned the ward and provided an update regarding Valdo's accommodation situation. The ward was not aware that Valdo had returned his keys. I was advised that Valdo remained guarded and that a ward review would take place later that day. As Valdo did not consent to information sharing, I was unable to attend this review and agreed to telephone the ward for an update the following day [UNIN0000734].

113. I telephoned the ward on 11 February 2022. I was told that Valdo's presentation remained unchanged and that he had reiterated that he did not want contact between the NHS and the University. I was informed that the professionals involved were aware of this and comfortable to continue communicating anything relating to risk. I was informed that Valdo was being provisionally considered for discharge on 24 February 2022 and that he hadn't said what his plan was about where he would live. I asked about whether a community treatment order was going to be made. As I know from my social work training, an order of this nature can be made to ensure that people who are deemed to be mentally unwell and dangerous are legally obliged to be compliant with medication, and that they can be returned to hospital if they do not comply. I thought that Valdo had likely met the threshold for that, given the cyclical nature of his risk, but the ward team disagreed (I made notes of this [UNIN0000734]).

114. On 13 February 2022, Stewart McWilliam messaged me on Teams asking for an update on Valdo. I replied letting Stewart know that Valdo remained in hospital and I asked for academic recommendations in light of how much Valdo had missed in terms of his studies. I told Stewart that I planned on speaking to the ward and Valdo when I was back from leave [UNIN0001610].

115. On 22 February 2022 I emailed Stewart McWilliam again to ask him what the academic plan was for Valdo [UNIN0000926]. Stewart informed me by email [UNIN0000796] that Valdo would struggle to catch up if he missed too many weeks of academic study and suggested that an interruption to studies would be advisable. Stewart said that if Valdo was reluctant to interrupt, the department could consider supporting him through the remainder of his studies through the use of a disability support plan and extenuating circumstances claims. On 24 February 2022 I emailed Stewart McWilliam back and informed him that Valdo was reluctant to engage with MHAS but that I would continue to liaise with external mental health services. I asked Stewart to communicate his academic recommendation to Valdo at their next meeting [UNIN0000404].

116. On 22 February 2022 I telephoned Valdo. He was preoccupied with the events of 3 February (when he had been on s17 leave and returned to his accommodation). He said he had not returned to his accommodation and that, as a result of my communication with the ward, his section 17 leave had been revoked. Valdo said that he was being discharged within the next few days and did not want any ongoing contact with MHAS, though he agreed to a telephone call that Friday. His intention around reengaging with Claudia Birtles from the EIP team on discharge was unclear. Valdo told me that he was in the process of sorting out new accommodation but was non-committal about where that was. Valdo said that he didn't need any help communicating with his academic department and that everything was in hand. He was keen to end our conversation. I made notes [UNIN0000734].

117. On 28 February 2022 I called Valdo. He informed me that he had now been discharged. I had not been informed about that by the NHS. This was really concerning in the circumstances - I would have wanted to have had conversations about risk and to know about the discharge plan. Valdo again declined any input from MHAS but said that he was engaging with Claudia Birtles from the EIP team. He said he was taking his medication. Valdo

acknowledged the need for University and NHS services to communicate, particularly in regard to any concerns or risks in the future and was aware that I would be emailing Claudia Birtles (I made notes of this [UNIN0000734]).

118. I emailed Claudia in order to update her as follows:

"*Hi Claudia, I hope you are well? I've just spoken to V.C who informed me he is now discharged from the ward and engaging with you. He reports currently being compliant with his medication. He has declined input from this team but is aware I am contacting you. I do not have a current address for him if you could update me for our records? I have explained to V that I can sit in the background as long as we (you and I ) have communication should there be any concerns in the future in regards to engagement, relapse or other risk. He understood and agreed to this. Does that sound OK with you? Happy to chat on the phone if its easier?*" [UNIN0000734]

119. Claudia responded, confirming that Valdo had been discharged that Thursday (24 February 2022) and that she had seen him on Friday morning. Claudia described Valdo's engagement with her as remaining on a very superficial level, but she thought that he appreciated the need to engage to try to avoid any further admissions. Claudia was happy with the plan that I had outlined in my earlier email and said that as long as Valdo remained compliant, she didn't expect that we would have too many concerns. Claudia told me Valdo's new address [UNIN0000734]. I understood from this agreement that I would be alerted if the NHS thought there were risks to the student community and I could then take appropriate action.

120. On 11 March 2022 I received a message from Stewart McWilliam via Teams advising me that Valdo had decided to graduate with a BEng degree based on his second and third year marks [UNIN0001610] (I made notes of this [UNIN0000734]). I responded on 17 March 2022 to thank him for the update and told him to let me know if he needed anything [UNIN00001610].

121. On 26 April 2022 I received an email from Chris Hoskins informing me that Valdo had returned to his old flat on 21 April 2022 [UNIN0001354]. One of the Raleigh Park security officers had approached him and Valdo had said he was visiting a friend, but gave a false name when asked who he was visiting. Chris said that Raleigh Park security had escorted Valdo off the site. Chris said that Valdo had not been aggressive or confrontational and that the ex-flat mate he had spoken to had said that he felt safe, but thought that the incident was strange. Chris said that the ex-flat mates and the accommodation provider had been asked to contact the police if Valdo returned and they felt in danger in any way or if Valdo acted in a way that they found concerning. Chris asked me whether I could check that Valdo was OK and to reiterate boundaries to him. I responded to Chris and advised him that Valdo had completed his studies but would remain a student until graduation (I said this because Stewart McWilliam had told me on Teams on 11 March 2022 that Valdo had decided to graduate with a BEng degree), and that I had informed Valdo's NHS team about the incident [UNIN0001437].

122. On the same day, 26 April 2022, I forwarded details of the 21 April 2022 incident to the NHS: I sent it to Claudia Birtles [UNIN0000633], who said she would try to discuss the incident with Valdo when he met the EIP team for his medication that Friday. Claudia described Valdo's engagement with services as being "*very superficial*" and said that Valdo was attending for medication every 2 weeks. Claudia suggested that Valdo had probably returned to the accommodation to look for post as he had recently said he was trying to find out some information. Claudia described Valdo as remaining very guarded and being quite disillusioned with mental health services, she said he shared very little. Claudia also said that it was difficult to assess Valdo and that full disengagement with services was likely to be the only indication that things had deteriorated further [UNIN0000633].

123. On 29 April 2022 Claudia Birtles emailed me to inform me that she had seen Valdo that day [UNIN0000633]. She said there was no change in Valdo's presentation and that he was still guarded. Claudia said Valdo had told her

that he was not aware that he was not allowed to return to his previous accommodation and that he had spoken to reception and there had been no difficulty in obtaining his mail. Claudia was being replaced by a new Care Co-ordinator, Gary, who was copied into her correspondence.

124. As Valdo was not living in University accommodation, had completed his studies as far as I was aware and did not want to engage with University support, there would therefore not be any ongoing support from us. I told Claudia all this and that she should contact the University if needs be. At this point, my understanding was that Valdo's care was led and managed entirely by the NHS and the University did not have a part to play in this.

125. I had no further correspondence with or about Valdo after that date. I have set out all of the incidents and detentions and complaints that I am aware of.

126. I am asked whether the University commenced any disciplinary / misconduct investigation into any complaints made about Valdo. As far as I know, there were no misconduct investigations. In MHAS we would not have been pressing this as a conduct issue as it was clear from the start that Valdo was so unwell. We saw it as a health issue, not a conduct issue. It would have been Claire Thompson's decision about whether to bring in the University's Conduct and Investigation team, and I do not know for sure whether she did - but I did not have any contact from the Conduct and Investigation team.

127. As far as I am aware we did not press for Valdo to be considered under the Fitness to Study process, although again that would have been Claire's decision. My approach would have been that as Valdo did not have capacity at times when he was very ill, we would not start the process then. When Valdo was well he could manage just about with his studies and so we would not start the process then.

**OBSERVATIONS**

128. I am asked whether I think I should have been told more about Valdo's behaviour while at the University, his mental illness and/or his interactions with the police. Yes, I think I should have been told more about the police incident, the non-engagement with services, the dates of admission, discharge and the discharge plans. More information should have been shared with me by Notts Healthcare trust, and more information should have been shared from the police to our Security team (about his other interactions with the police). I would have wanted more information for a number of reasons. More information would assist MHAS to provide the best support to Valdo. It would help us to support our NHS colleagues best (for example, when they couldn't find him, I could've checked his University card to find out where he had been). Knowing about his level of violence would also help me to know whether I was safe when meeting him and would assist with assessing other risks.

129. I am asked how responsive the NHS and police were. They were not very responsive as I have set out above.

130. I do not identify, looking back, additional actions that I or others in the University could have taken in respect of Valdo. I found the case very worrying at the time and would like there to have been shared ownership of such a concerning case within the University - which is the case now under the Cases of Concern framework which I describe below. I don't think that would have changed anything but would have been more supportive of me.

131. I am asked whether I consider there are any structural issues (such as guidelines/policies, training, organisational structure, communication with others in or outside the University) which contributed to any issues I have identified. I was not aware at the time of how to use the Fitness to Study process to manage risk. A better understanding of the Fitness to Study process may have helped me, although ultimately it would have been for Claire Thompson to engage that process so I don't think that my lack of familiarity with that process made a difference.

132. I am asked what recommendations I think the Chair of this Inquiry should make to ensure lessons are learned and to prevent similar attacks in the future and what improvements I think could be made in the sector or in the University to deal with acutely mentally ill students and/or students who pose a risk to the safety of others. I don't have suggestions for preventing similar attacks, but I have some wider suggestions for areas to consider:

- **Training.** It would be really helpful if we could access the statutory training available to NHS clinicians, particularly around risks associated with mental health which are largely risks of suicide. The NHS teams that MHAS liaise heavily with have mandatory risk training each year and it would be good to have the same training so that we are working in a consistent way and using the same terminology etc.
- **Information sharing policy with the NHS**. The rules are clear as far as I am concerned that if students give permission then all information can be shared. If students do not give permission then the NHS have a responsibility to share information that relates to the student's risk to self or others within the University community. Although that is clear to MHAS, and to many people in the NHS, we sometimes face difficulties in obtaining information. Sometimes that is because individuals (often agency staff) do not understand the rules or are not prepared to apply them. Sometimes it is a practical issue that nobody thinks of updating the MHAS team. Being able to refer to a joint policy would make the process a lot easier. It we had a clear policy, with a clear route and clear process for information sharing, then I think it would be more likely that information would be shared consistently and without delay. The most helpful policy would be a national policy between all universities and all NHS services, so that there is consistency.
- **Information sharing with the police.** It would also be helpful to have more information from the police about the risks our students pose. We have lots of information now from our local police force, but very little from other police forces. It would be helpful for there to be a national policy which we could point to, and to have police proactively

share information with us which is relevant to risks in our student community.

- **Internal risk flags.** It would be helpful to have clarity about what information should be shared by university mental health and wellbeing services with academic staff. For example, it might be helpful to have a way to flag a student's notes if they have been violent: we do that within MHAS but it is not possible to do that on our internal systems with the wider university, and I would be concerned that it might stigmatise the student, or create data protection issues, or breach of privacy issues, so I would welcome the Chair's consideration of that.
- **Cases of Concern process**. We now have a multi-disciplinary cases of concern process at the University, which I think is very effective [UNIN0001831]. I feed into risk assessments in that process when students are known to MHAS. If a student with mental health issues was violent now then they would be picked up by the cases of concern process. In weekly meetings we discuss students of concern and make joint assessments of what risks are posed to our University community and that student. We operate across the disciplines - bringing together conduct, wellbeing, mental health, safeguarding, academic services and others where relevant. It is not a separate team or a fixed route, but a process operating under terms of reference to hold cases, share information and formulate plans. We make joint plans of action - which could be conduct action taken by the Investigation and Resolution team (previously the Conduct and Investigation team). The action could be the Support to Study process being followed. It could be the case that MHAS takes the lead and liaises with the NHS. I do not know whether other universities have a similar process, but I have found it very positive that there are lots of different people within the University feeding their views into the management of complex cases.

**Statement of Truth**

I believe the content of this statement to be true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: GRO-B

Dated: 19th September 2025

**Index to First Witness Statement of Eleanor Turner**

| No. | Inquiry URN | Document Description |
|---|---|---|
| 1. | UNIN0001811 | Guidance, re: Mental Health Advisory Service - Information for Referrers - Frequently Asked Questions, by University of Nottingham & Mental Health Advisory Service, Cripps Health Centre |
| 2. | UNIN0001812 | Policy guidance, re: Student wellbeing confidentiality statement, University of Nottingham |
| 3. | UNIN0001813 | Policy document, re: Data Protection Act Policy, by University of Nottingham |
| 4. | UNIN0001814 | Policy guidance, re: Data Protection Policy, University of Nottingham |
| 5. | UNIN0001815 | Policy document, re: Data Protection Policy, University of Nottingham |
| 6. | UNIN0001818 | Notes, by UoN re: Privacy notices |
| 7. | UNIN0001816 | BLANK Referral to Mental Health Advisory Service Form, University of Nottingham |
| 8. | UNIN0001817 | Screenshots of Student Wellbeing Referral (24-25) Form of Valdo Calocane |
| 9. | UNIN0001824 | Policy document, re: Fitness to Study Policy, by Quality and Standards Committee/Campus Life Division |
| 10. | UNIN0001825 | Policy document, re: Fitness to Study Policy, by Quality and Standards Committee/Campus Life Division |
| 11. | UNIN0001826 | Policy document, re: Support to Study Policy (Formerly Fitness to Study), by University of Nottingham |

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| 12. | UNIN0001827 | Policy document, re: Support to Study Procedure (UNUK), by University of Nottingham |
| 13. | UNIN0000140 | Email from Claire Thompson (UON) to SS Welfare Engineering (UON) and MH Support (UON), re: Valdo's Illness |
| 14. | UNIN0000734 | Letter from Celeste Calocane to Sir/Madam, re: Valdo Mendes Calocane |
| 15. | UNIN0000949 | Email from SS Welfare Engineering to Eleanor Turner, re: RE: Valdo's illness |
| 16. | UNIN0000739 | Email from Eleanor Turner (UON) to SS Welfare Engineering (UON), Kishen Rengaraj (UON) and Donald Giddings (UON), re: Valdo – caution because of GDPR |
| 17. | UNIN0000881 | Email from Eleanor Turner to Jamie Dickinson, re: Re: Student V.C ID: 10351712 |
| 18. | UNIN0000919 | Email from Eleanor Turner to SS Welfare Engineering, Kishen Rengaraj and Donald Giddings, re: Re: Valdo - caution because of GDPR |
| 19. | UNIN0001527 | Email from Seedat Faizal to Eleanor Turner, re: RE: this is about Valdo |
| 20. | UNIN0001803 | Email from Jamie Dickinson [UoN] to Eleanor Turner [UoN], re: RE: Student V.C ID: 10351712 |
| 21. | UNIN0001401 | Email from Stuart Croy (UON) to Andrew Hallsworth (Nottinghamshire Police), re: Concern |
| 22. | UNIN0000594 | Email from Stuart Croy to Eleanor Turner, re: FW: Concern |
| 23. | UNIN0001747 | Email from Stuart Croy [UNIN] to Eleanor Turner [UNIN], re: FW: Concerns |

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| 24. | UNIN0001652 | Report dated 18/01/2022, compiled by Ellie, Re: Summary of MHAS Duty Contact with Valdo Calocane 2020 – 2022 |
| 25. | UNIN0000614 | Report dated 27/03/20 compiled by [unknown], re: Duty Report from 27.03.20 |
| 26. | UNIN0000620 | Email from Eleanor Turner (UoN) to Stuart Croy (UoN), Claire Thompson (UoN) and Catherine Gent (UoN), Re: Concern |
| 27. | UNIN0000304 | Email from Eleanor Turner [UNIN] to Catherine Gent [UNIN] and Claire Thompson [UNIN] Re: Fw: Query |
| 28. | UNIN0001828 | Policy document, re: Quality Manual - Students required to withdraw on grounds of health and safety, by University of Nottingham |
| 29. | UNIN0001200 | Email from Eleanor Turner to Valdo Mendes Calocane and Abigail Parsonage, re: Following your Discharge |
| 30. | UNIN0000778 | Email from Eleanor Turner (UON) to SS Welfare Engineering (UON), re: Student V.C 10351712 |
| 31. | UNIN0000067 | Email from Valdo Mendes Calocane to Emma Barney and Eleanor Turner re: Voluntary Interruption of Study |
| 32. | UNIN0001205 | Email from Eleanor Turner [UoN] to Emma Barney [UoN] and VC, re: Re: Voluntary Interruption of Study |
| 33. | UNIN0000938 | Email from Claire Thompson to Eleanor Turner, re: re referral |
| 34. | UNIN0000260 | Email from Claire Thompson [UNIN] to ResX [UNIN] Re: Raleigh Park |

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| 35. | UNIN0000362 | Report dated 17/01/2022, compiled by University of Nottingham, Re: Report 313 Assault |
| 36. | UNIN0000157 | Report dated 17/01/2022, compiled by Claire Thompson University of Nottingham, Re: Critical Incident Record of Valdo Calocane |
| 37. | UNIN0000033 | Report, dated 30/09/2021, compiled by [Unknown], Re: Student medical details |
| 38. | UNIN0001476 | Email from Eleanor Turner to Abigail Parsonage, re: Re: re referral |
| 39. | UNIN0001033 | Email from Christopher Hoskin to Eleanor Turner, re: RE: Incident |
| 40. | UNIN0000183 | Email from Christopher Hoskins to Eleanor Turner Re: Incident |
| 41. | UNIN0001202 | Email from Eleanor Turner [UoN] to Christopher Hoskins [UoN] re: Re: Incident |
| 42. | UNIN0001311 | Email from Eleanor Turner (UON) to Mark Davis (UON), Claire Thompson (UON) and Christopher Hoskins (UON), re: University of Nottingham Security |
| 43. | UNIN0001485 | Email from Eleanor Turner to Mark Davis, Claire Thompson and Christopher Hoskins, re: Re: University of Nottingham Security |
| 44. | UNIN0001528 | Email from Christopher Hoskins to Eleanor Turner, Mark Davis and Claire Thompson, re: Re: University of Nottingham Security |
| 45. | UNIN0000600 | Email from Claire Thompson to SSSup-Engineering and Eleanor Turner, re: RE: Student Progress Check |
| 46. | UNIN0000591 | Email from Claire Thompson to Eleanor Turner, re: Fw: Student progress check |
| 47. | UNIN0000053 | Email from Eleanor Turner to Valdo Mendes Calocane, re: Support |

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| 48. | UNIN0000145 | Email from Christopher Hoskins (UON) to Eleanor Turner (UON) and Claire Thompson (UON), re: V.C |
| 49. | UNIN0001745 | Email from SS-Sup-Engineering (UON) to Emma Barney (UON), James Rouse (UON), Antonio La Rocco (UON) and another, re: FW: Student V.C ID 14308023 |
| 50. | UNIN0001610 | Messages between Eleanor Turner and Stewart McWilliam |
| 51. | UNIN0001323 | Email from Christopher Hoskins (UNIN) to Eleanor Turner (UNIN), Re: VC end of tenancy |
| 52. | UNIN0000926 | Email from Eleanor Turner to Stewart McWilliam, re: Update |
| 53. | UNIN0000796 | Email to Stewart McWilliam (UON) to Eleanor Turner (UON), re: Update |
| 54. | UNIN0000404 | Email from Eleanor Turner (UoN) to Stewart McWilliam (UoN) Re: Update |
| 55. | UNIN0001354 | Email from Christopher Hoskins (UON) to Eleanor Turner (UON), re: V.C |
| 56. | UNIN0001437 | Email from Eleanor Turner to Christopher Hoskins, re: Re: V.C. |
| 57. | UNIN0000633 | Email from Eleanor Turner (UNIN) to Claudia Birtles (NUHT) and Gary Carter (NUHT), re: V.M.C |
| 58. | UNIN0001831 | Policy document, re: Student Cases of Concern Meeting - Terms of Reference, by University of Nottingham |