Witness Name: Louise Symcox (nee Chapman)

Statement No: WITN0305001

Dated: 20 November 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF LOUISE SYMCOX

I, Louise Symcox (nee Chapman), will say as follows:

Introduction

1. I am a Bank Nurse (Band 6) for the Street Triage team at Nottinghamshire Healthcare NHS Foundation Trust (NHFT). I am also a Mental Health Specialist Nurse (Band 7) at Sherwood Forest NHS Trust.

2. I make this statement in response to a request made under Rule 9 of the Inquiry Rules 2006, dated 20 October 2025. In this statement, I discuss my career and role, my training and system of work, and my interactions with Valdo Calocane (VC).

3. This witness statement was drafted on my behalf by the external solicitors acting for the Trust in respect of the Inquiry, with my oversight and input, following discussions in writing by email and by video conference.

Career and Role

4. I graduated from the University of Central Lancashire in 2015 with a degree in Mental Health Nursing. This qualification was awarded by the Nursing and Midwifery Council ("NMC"). I am not a member of any Royal College or other professional organisation, and I do not hold any professional appointments.

5. After graduating in 2015, I began working as a Mental Health Nurse (Band 5) in prison assessment and medium secure male forensic services. In this role, I was dealing with individuals who have committed crimes, but who are also mentally unwell.

6. After around 18 months, I then moved to step-down low secure services in the same forensic hospital. In 2017, I then took up a role as a Community Forensic Nurse (Band 6) with the same forensic unit. In this role, I was still supporting the same patients that I had worked with in the medium secure unit, except that I was managing them in the community.

7. I joined the NHFT Community Forensic Team in 2019 and worked there for around nine months. I found that this team worked differently to the Community Forensic Team in Lancashire, and it was not such a good fit for me, so I moved to the Street Triage Team. It was in this role where I interacted with VC.

8. I stayed in the Street Triage team until around 2021. I then moved to Sherwood Forest NHS Trust as a duty manager (Band 7). This was not a mental health

specialist role, but rather a role which involved managing the hospital from an acute side.

9. In 2023, I completed my Mary Seacole senior leadership programme with the NHS Leadership Academy.

10. In 2024, I then took up my current role at Sherwood Forest, which is also a Band 7 role. I am currently completing my master's degree in Senior Healthcare Leadership with the NHS through Arden University. I will complete this in 2027.

11. I continue to work for NHFT as a Bank Nurse (Band 6) for the Street Triage Team.

Street Triage Service

12. The Street Triage is a joint service between NHFT and Nottinghamshire Police: NHFT is responsible for the nurses who work for the service, and the Nottinghamshire Police are responsible for the Police Officers that are provided.

13. The decisions made by the Street Triage team are made jointly by the Police Officers and Nursers. The Police Officers offer a perspective on the criminal side of things, such as whether the individual can be charged, and the Nurses consider the mental health aspect. Together, the Nurses and Police Officers would have a professional discussion and decide jointly which route to go down for each patient.

14. The Nurses in the Street Triage team are based in the Police Headquarters, and they have access to the Police System. So, I could see all the 999 calls that were coming in; any calls that had a mental health tag would be reviewed, to see if it was appropriate for involvement from the Street Triage team. For example, if we are contacted regarding an overdose, although that might relate to mental health issues, this is a matter for the ambulance service, not for the Police or Street Triage Service.

15. If we considered that it was appropriate for the Street Triage Team to respond, then I would check RIO for the patient's records, and look for any warning signals for previous serious violence or aggression, if they are open to any teams, or what the last contact was with teams. If there were any such concerns, we would provide a summary of those concerns in a set format for the police officer, who would then put them on the police system.

16. Street Triage are not an initial response team, so we would only respond once initial officers had attended and made an assessment to see if we are needed. If the response officers feel that the Street Triage team are required, they will call us, and we will attend.

17. Because there is only one Street Triage team that runs during the day, and two Street Triage teams at night, we do not have the capacity to attend every incident where we might be needed, but if we cannot attend, then we will try and provide signposting, advice, or support instead. Alternatively, if the patient

is already open to a team, we can let that team know about the incident, so that team can get in touch with them.

18. Once we have completed a Mental Health Act (MHA) Assessment of the patient, there are a variety of options that are open to us, depending on the needs of the patient at that time. For example, we can detain the patient under section 136 MHA (which the Nurse would coordinate from the health side); we can contact the crisis team and ask for gatekeeping; or we can contact the patient's GP, drug and alcohol services, and/or homeless service.

19. I would usually become involved with patients through the route set out at paragraphs 14-16 above. However, occasionally, a Police Officer may contact the Street Triage service to say that they have just encountered a particular individual and ask if we know anything about them. More recently, the team has also started to use a clinician's team chat between different crisis teams, as this is more efficient than going through the help lines, but this was not in place at the time of my interactions with VC.

20. In addition to the RIO records and the Police records, I also had access to System One, which is the system used by the General Healthcare Authority. This is because there would be occasions where we assess somebody who has not had previous contact with the service. In those circumstances, we can use System One to check what GP the individual is registered with, and if there has been any GP entries on the system with any concerns.

21. In addition to accessing the various records held in relation to that patient, and the detail given in the 999 calls, information would also sometimes be shared by the Accredited Mental Health Professional (AMHP) team, which is the social services team who are responsible for co-ordinating MHA Assessments.

22. If the AMHP team is completing a MHA Assessment in the community, they will firstly attempt to complete this on their own, but if that is not successful, they will then apply for a section 135 MHA warrant through the court, which gives them the power to either attend the patient's property and complete the assessment there, or to remove the patient to a place of safety in order to complete the assessment. The Police will support the execution of that warrant if required, so often the AMHP team will call through to the Police using 101, either to make us aware of the plan in case there is a 999 call, or to ask us to attend alongside them. If the patient is significantly riskier, the AMHP team would usually provide additional information by way of a follow-up email, but this is not essential.

23. I can remember learning the basics of how to assess risk of mental health patients of violence towards others whilst at university; only the basics were covered because risk assessments do vary a lot across mental health settings. I also learned a lot about risk assessments whilst undertaking placements at the forensic unit and on Psychiatric Intensive Care Units (PICUs). I have not retained any materials on the training of risk that I received whilst obtaining my qualification.

24. When I worked in the Prison Assessment Service in Lancashire, we did a twelve-week intensive course on risk and risk management, because we were dealing with much higher risk levels.

25. Whilst I was working at NHFT, I do remember completing in-house training sessions on risk management and risk assessments (although I cannot remember specifically what these were called). When I was at the Street Triage team, we would also have an annual team day, where we would look at different cases, risk assessments, risk-managing patients, and our communications with the police. I have not retained any training materials for this course, as everything was done online.

26. To the best of my knowledge, I have never been involved in the care of another mental health patient (other than VC) who, following discharge or when in the community, has killed or seriously injured someone.

Involvement with VC

27. Prior to 03 September 2021, I recognised VC's name as a name that had popped up on 999 calls before. However, I did not have any further knowledge of VC beyond this.

(a) 03 September 2021

28. The Patient Record Summary includes an entry on 03 September 202, which states:

> *"Street Triage Entry:*
> *We were in the vicinity of Valdo's home address when an emergency shout for support went out from Officers on scene executing the S135 warrant, dictating that they were being assaulted and needed extra support.*
> *When we arrived, Officers had deployed the Taser twice and also Pava Gas to subdue Valdo due to him punching an Officer with significant force 3 times in the face and attempting to assault other Officers on numerous occasions. Valdo was not complying with any instructions or de-escalation techniques. Officers had to use leg restraints to remove Valdo from the address due to further attempted assault.*
> *As per policy for tasered patients he was transferred to QMC for a physical health check.*
> *Officers wanted to know if Valdo could be charged due to the serious nature of the assault with the Officer likely needing Hospital treatment. I advised the place of safety (cassidy suite) was more appropriate as he clearly needs an MHA ax and immediate MH intervention. Officers have agreed to transport to the Cassidy Suite.*
> *I have added an alert to RIO for the assault."*
>
> [NHFT0000168, pg.169]

29. I came to be involved in this incident because, at the time it happened, I was in the local vicinity of VC's home address when an incident came through the radio of my Police Officer Colleague. This incident came through as the result of another Officer pressing their emergency response button; when that happens, the emergency response button transmits audio from the scene to all Officers on that radio frequency button, and any Officers in the local vicinity are expected to respond and support.

30. We were able to establish that Officers needed support with the incident and could see that the AMHP team had pre-called 999 to alert us that they were conducting a Section 135 warrant at VC's address that evening.

31. Upon arrival at the scene the AMHP team were stood outside VC's address and informed us they have attempted to complete a Mental Health Act Assessment (MHAA). However, VC had refused entry to his property, and so the AMHP had called Police to support executing the warrant, as the Police have powers under section 135 to gain entry to an individual's property.

32. When the Police arrived, VC reportedly became aggressive, punched Officers in the face up to 3 times with force and was not responding to verbal de-escalation or commands. Officers had deployed Pava Gas and a taser twice to try and bring the situation under control. I can confirm that I did see Police Officers restrain VC. The incident was significant and required prolonged restraint by Officers to get it safely under control and remove VC from the property. Initial Officers on the scene and responding Officers to the emergency button restrained VC. Officers had to utilise leg restraints and continue to restraint and support VC out of the property.

33. VC was then put into transport to be taken to Queen's Medical Centre for a physical health assessment because he had been tasered. I advised that this was the policy for patients who have been tasered, as this can cause cardiac concerns. The Police therefore agreed to take him for these checks.

34. In terms of my perception of VC's demeanour and presentation throughout my attendance, VC was shouting and attempting to assault Officers and appeared to be manic and paranoid. However, as I did not assess his mental state, I am unable to ascertain if this presentation was due to his mental state, or a

response to the police presence or the violence / aggression that had happened during the execution of the section 135 warrant.

35. I did not talk to VC directly. I also did not assess his mental state, as he was subject to a section 135 warrant, which allowed the Police to take him VC to a designated place of safety for the AMHPs and doctors to complete a MHAA (which includes a capacity assessment).

36. I am unable to state what VC's capacity was at the time of the incident, as I did not speak to him directly. Capacity is issue and time specific and cannot be used as a blanket rule. The guidance on assessing capacity, which is governed by the Mental Capacity Act (MCA) 2005, requires that you must attempt to give patients information in various formats, including verbally and in writing. If capacity cannot be determined, you must come back and attempt again. You must be able to accurately demonstrate that a patient cannot understand, retain, reiterate or weigh up the decision in relation to which you are assessing their capacity in order to determine that they do not have capacity.

37. Due to the significant violence and Police presence at the incident, the MHAA not able to take place at VC's home address as planned. I did not assess VC's capacity at the incident; I also cannot speak for the AMHP or the two doctors that were present for the MHAA.

38. In terms of whether there were any alternatives to sending VC to the Cassidy Suite, this must be considered in the context of the section 135 warrant that was in place at the time.

39. A section 135 warrant allows the Police to remove a person to a designated place of safety for a full MHAA to take place. A section 135 warrant is only applied for and issued by the courts if the mental health team can evidence significant concerns for an individual's mental state and all efforts to assess and support the patient in the least restrictive way within the community have failed. Once a section 135 warrant has been executed, a full MHAA must take place as soon as reasonably practical (either at the time within a patient's home address or as soon as a patient is removed to a designated place of safety).

40. Within Nottinghamshire there are two designated places of safety under NHFT: the Cassidy Suite at Highbury Hospital, and the Acorn Suite at Sherwood Oaks (however, at the time of the incident, the Acorn Suite was at Millbrook Hospital). If a section 135 warrant cannot be completed safely within the community, then Police have powers to remove a patient from their home address to a designated place of safety when the warrant is executed. Under the MHA this can be a section 136 suite, or alternatively, if the section 136 suites are full, an Emergency Department within an acute Hospital. However, taking a patient to an acute Hospital under section 135 or section 136 can pose significant safety risks, as acute Hospitals are not secure environments and there are no mental health trained staff on site to support and care for the patient. It also means Police must stay with the patient for the duration of the section 135 or section 136, taking valuable Police resources from the community until the issue is resolved.

41. Within NHFT, the policy / procedure is to go to one of the designated section 136 suites if a bed is available. The suites provide a secure environment with a Registered Mental Health Nurse, a Healthcare Assistant, and Psychiatric Doctor on-site to provide mental health care and support to a patient deemed to be suffering from a mental health condition of a nature or to a degree which requires further assessment under the MHA.

42. The MHA 1983 Places of Safety Regulations 2017 severely restricts the use of Police Stations as a place of safety. The regulations state that a Police Station should only be used as a place of safety under exceptional circumstances; to avoid criminalising mental health patients and to ensure they have access to 24/7 mental health care (which cannot be provided in a Police Station). Taking a mental health patient to a Police Station can also exacerbate their condition and does not provide a therapeutic environment for care or accurate assessment. A Police Officer of Inspector level or above would have to authorise a mental health patient being taken to a Police Station as a place of safety if a patient poses an imminent risk of serious injury or death to themselves or others, that risk cannot be safely managed within a health-based place of safety, and no other suitable health-based places of safety are available.

43. At the time of the incident there was a suitable health-based place of safety available at the Cassidy Suite, and this was also the nearest health-based place of safety to VC's address and incident. Due to being tasered, VC was taken to the local Emergency Department for physical health checks, as per policy; once

VC had been medically cleared, he was then transported to the designated health-based place of safety. The Cassidy Suite received a full handover of the incident and VC's risks and were happy to accept him onto the suite. The Police can provide support in a health-based place of safety if the patient is violent or aggressive, however the health-based place of safety have their own restraint team and can also administer PRN medication including rapid tranquilisation under the guidance of a Psychiatric Doctor to bring violent incidents associated with a decline in mental state under safe control. They can also provide the necessary physical health observations and management (immediately after and every 15 minutes for the first hour) following rapid tranquilisation.

44. I believe that, at the time of the incident, due to VC being subject to a section 135 warrant and a designated place of safety being available and able to support VC's presentation, it was the correct decision to take VC to the Cassidy Suite for a full MHAA to be completed following physical health clearance.

45. An Officer did ask me on scene if VC could be taken to a Police Station and charged with assault on the Officers, however I quoted the guidance explained above and that we were unable to assess VC's mental state or capacity, and a MHAA should take place at the Cassidy Suite. If VC was found not to be detainable, he could be arrested on release from the Cassidy Suite. Although VC was not arrested at the time, the offences can still be logged as crimes, with further review by the Police for potential charges following the MHAA and recommendations at the time in relation to his capacity during the incident.

46. I discussed this incident with the Cassidy Suite staff when I called to see if there was a bed available and handed over the incident. I did not discuss this incident with staff at the Emergency Department as Police transported VC there and we did not attend as there was no clinical need for our attendance. To the best of my recollection at the time (given the incident was four years ago) I cannot remember discussing the incident with anyone else.

47. I was involved making the decision to take VC to the Cassidy Suite following his physical health review; this was also discussed with the AMHP and the two doctors on scene who were also in agreement this was the best course of action to allow the MHAA to be completed, as the section 135 warrant had been executed. I also discussed this decision with my Police Officer colleague from Street Triage and Officers on scene. It was agreed Officers would transport to the nearest Emergency Department for physical health review then onto the Cassidy Suite for mental health act assessment.

48. I then completed my entry on RIO and added an alert for assault of emergency workers following this incident. The alert that I added read:

"Alert Type	*Violence and Aggression*
Alert Date	*03 Sep 2021*
Entered By	*Chapman, Louise (CPN)*
Comment	*Valdo has assaulted a Police Officer by punching him in the face with significant force 3 times when executing a S135 warrant. He has also attempted to assault numerous other Officers and was Tasered twice and Pava Gas deployed. The Officer is likely to require Hospital treatment for injuries.*
Next Review Date	*03 Sep 2022"*

[NHFT0003401]

49. Warning signals can be added to the front page of RiO when there is a serious event. When the Street Triage team would do RiO checks for the police, the first thing we would check is the warning box, as that is where clinicians put any significant events, so that any clinician is immediately aware of the risks posed, without having to go through the patient's entire notes. This also means that you cannot miss the risks associated with that patient.

50. I cannot recall what time I added this alert to the system. I would have added it as soon as I was able to, however, this might not have been immediately after each incident. This is because my first priority after attending one call was often to go and attend the next call, which could be on the other side of the county. However, anything that needed doing immediately would have been communicated to the relevant teams and made known at that time.

51. My reasons for adding this alert to the system were to ensure that anybody who dealt with VC in the future would know that the last time a section 135 warrant was executed at his property, officers sustained injuries. If I had not put this information in the warning note, there is a chance it could have been missed later on.

52. This alert would have been seen by anybody who accessed VC's notes on RiO.

53. I did not review this alert on 03 September 2022. When we put an alert on RiO, the system always asks for a review date; our standard practice is to put the review date as one year from the date of the incident. However, in reality, once

a risk has developed, it will remain an ongoing risk, and so once an alert is added to RiO, it will not be removed (unless it transpires that the basis of the alert was not true).

54. My attendance at the incident involving VC on 03 September 2021 was recorded in records held by the police [NGPF0000033], which reads as follows:

> *"Valdo Calocane dob 04/09/1991 - Assisted at a S.135 warrant following emergency button being activated. Male assaulted officers punching to face numerous times and headbutting."*

55. I did not make this entry; I do not know for certain, but I believe that it would have been made by my Police Officer colleague Dan. As a Nurse, I could not make entries on the police system, so any entries that needed to be made (for example, the results of a RiO search) in that system would be made by the Police officer, and I would also copy the same into RiO. When I put an entry in RiO following an assessment, however, that is my entry, and this will include details that the police do not need, such as the mental health side of things.

56. My Police Officer colleague who I believe made his entry was aware of the incident because he was at the scene with me. He would therefore have received the same information as me.

Recommendations

57. I do not feel as though I am able to ask the Chair of the Inquiry to make any recommendations, because I only attended this incident by chance. It was not

a Street Triage call; we only attended because it was an emergency, and we were on the next street over.

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: 20/11/2025

Index to First Witness Statement of Louise Symcox

No.	URN	Document Description
1.	NHFT0000168	Medical Records of VC from 24/05/2020 to 14/06/2023, Various NHFT Staff/Teams, re: Patient Record Summary
2.	NHFT0003401	Medical Records of VC from 24/05/2020 to 13/06/2023, Nottinghamshire Healthcare NHS Foundation Trust Re: Alerts, Assessments, MHA/MCA Details, All HoNOS, Core Documents and CPA
3.	NGPF0000033	Police records re: Assessment outcomes in relation to whether patients should be referred to GP/CAMHS or not