Witness Name: Merima Jordon
Statement No: WITN0092001

Dated: 05/11/2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF MERIMA JORDON

I, Merima Jordon, will say as follows:

1. This statement responds to the Rule 9 request dated 18 September 2025. It provides details of my career and role in the Nottinghamshire Healthcare NHS Foundation Trust ("**NHFT**"), and my interactions with Valdo Calocane ("**VC**") in May and July 2020.

2. 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.

3. I note that the Rule 9 request was addressed to "Jordan", with an "a" which is incorrect. My surname is Jordon.

Career and role

4. I qualified in 2004 as a Registered Mental Health Nurse having completed a diploma in nursing at Nottingham University. I am registered with the Nursing and Midwifery Council (Pin 01/0949E).

5. From 2004-2005, I worked as a staff nurse (Grade D), on an acute inpatient ward with NHFT. This was at A44 Queens Medical Centre. I moved to Grade E in 2005 and continued to work there until 2007.

6. From 2007-2009, I worked as Clinical Lead in Neurological Care and Rehabilitation Centre at The Oakleaf (a private care home). I also worked as a staff nurse from 2010-2013 for an addiction inpatient service at Priory Nottingham (a private hospital).

7. I returned to work in the NHS in 2013-2014 as a Community Psychiatric Nurse and Care Coordinator (NHFT). I worked in Stonebridge for the recovery team.

8. In 2014-2019, I worked as a Crisis Care Practitioner with the City Crisis Resolution and Home Treatment Team (NHFT) in Highbury. I was Band 6.

9. At the time of my interactions with VC, I was working as a Clinical Nurse Lead (Band 7) also at the City Crisis Resolution and Home Treatment Team (NHFT) in Highbury. I have been in that role from 2019 to the present.

Training and system of work

10. As part of my qualifications, I did lots of work on the ward (clinical placements) . As part of that we had management of violence and aggression training (both physical and theoretical). Assessing risk was part of the placements.

11. Whilst working at NHFT as well as in other private sectors, I have had to undertake mandatory training. This includes clinical risk and safety, clinical risk assessment and management and management of violence of aggression. I did risk management training in Rampton in 2004/2005. I also did NHFT's mandatory annual training in clinical risk and safety management.

Patient information

12. Information about patients is typically available on RiO and shared via the daily handover. The usual process in handover is to discuss any changes in patient

risk, presentation, as well as any concerns. Discussions would be had about any changes to medication and any liaisons with other services. We would also look at what was needed by way of follow-up (for example, making referrals, or any outstanding jobs).

13. At the time of my interaction with VC, I had access to RiO with no known restrictions. I had no reason to access SystmOne or other medical record systems. SystmOne is mostly about physical health so RiO is the one we would use. At the time, if GP notes were needed, we would ask the GP.

14. At the beginning of a shift and prior to dealing with a patient, I would access RiO and read core assessments, risk assessments and progress notes for information. If there was a new patient or a transfer of care I would look to see if there were any uploaded documents about the new patient such as letters or risk assessments.

15. For any new patient / referral, the usual process for the Crisis Resolution and Home Treatment Team ("CRHT") is to update the core assessments, including risk assessment and care plans as well as to update the progress notes on RiO following an initial assessment. The core assessment forms should be updated, unless it was already completed by another team at the point of referral.

16. I would also send an email to the patient's team, if applicable, and ask them to review notes if, for example, a patient was assessed by me out of hours or left a note in the jobs diary for the person on duty to liaise with the team.

17. If the patient is not opened to NHFT, I would send an email to referrer or call them (if we have contact details) to request that they liaise with myself / the crisis team.

18. I would also update a patient's family/next of kin if the patient was agreeable to this. I would do this either in person or via the phone. I would also assess the need to breach confidentiality if this was required (for example if there was an

immediate risk to a person) and share concerns with the relevant services (including East Midland Ambulance Service ("EMAS") via 101 or 999).

19. Whenever I assess/review a patient myself, I document their presentation on RiO progress notes with a clear plan. If risk or any other information in the core assessment changes, I update the core assessment and risk assessment forms accordingly.

20. Alerts on RiO are also a good way of communication. For example, if a patient was known to carry a weapon or had known incidents of aggression, the alerts system could be used in order to communicate quickly with others in the team.

21. In some situations, for example, where I only attended a patient's ward review, I would document the plan agreed at the ward review and CRHT's role in RIO progress notes.

22. Any further information obtained via phone, for example any discussion within the team or other health care professionals involved in their care or even the patient's family, would be documented in RIO progress notes for anyone involved in patients care to see and access.

Reporting concerns

23. CRHT medics are available every day from Monday to Friday. The duty medic (consultant psychiatrist) is available from 9am-8pm on these days. Each morning, we discuss patients on Red RAG.

24. Where concerns are raised about patients by staff following a visit (for example an escalation of risk to self or others), then we add that patient to our "urgent discussion" in the afternoon MDT. This happens daily. We also discuss Amber RAG patients during the MDT.

25. We also have a Clinical Nurse Lead (my role), available daily (including Saturday and Sunday). We are available to support staff with any queries and discuss risk.

26. If risk is imminent or too high for us to manage (violence, aggression, weapon carrying), then I would call 999 and ask for the police and/or the EMAS as required.

27. I am comfortable escalating any concerns I have to the MDT and senior members of the clinical teams. We have very good medic cover with accessible staff (both medical and nursing).

28. I contributed to discharge planning for patients under my care. I never did this for VC. However, in general, we use the RAG system. I would assess /review patient's risk and mental health and collaboratively decide on the best support and care post discharge, such as the care pathway plan, which would also involve crisis plan and liaison with the other health care providers, including GP and family (as applicable). Once all in place, patient then can be discharged from CRHT care.

29. I am not aware of having been involved in the care of any other mental patient (other than VC) who, following discharge or when in the community has killed or seriously injured a member of the public.

Gatekeeping overview

30. CRHT provide intensive support at home for individuals experiencing an acute mental health crisis as an alternative to hospital admission. Home treatment is an appropriate alternative to hospital admission for working age and older adults with severe mental illness (e.g. schizophrenia, manic depressive disorders, severe depressive disorder) and with an acute psychiatric crisis of such severity that, without the involvement of a CRHT, hospitalization would be necessary. For those who might need to go to hospital, referral is made to CRHT to assess further if we might be able to put support in place in the community. Such patients should be willing to receive home treatment which can be safely provided in their home environment.

31. Gatekeeping is the term used in mental health services to explain the role and function of a process where we assess a patient's needs to ensure they receive appropriate level of care and if we could offer an alternative community based support to hospital.

32. It is the responsibility of CRHT to gatekeep every patient that may require admission to an inpatient bed in the Trust.

33. The CRHT gatekeeping process considers all other, least restrictive options before admission, to ensure that limited resources are used effectively.

34. CRHT (usually a senior nurse from CRHT/ B7), is also expected to attend Mental Health Act Assessments ("MHAA") as detention in hospital is not the only outcome of the MHAA.

35. If a patient was not admitted to hospital or detained under a section of the Mental Health Act 1983 following an MHAA, then community support would be discussed. The CRHT gatekeeper would then make follow-up arrangements with the patient. This can include anything from signposting to other services in primary care, discharging the patient back to the care of the LMHT, offering home treatment, further assessment with the CRHT, or referral to a more specialized service for the patient's needs (for example, Neurodevelopmental Specialist Services, LMHT, social care, and intensive home treatment team for age 65 and over).

Gatekeeping on 24th May 2020

36. On 24 May 2020, gatekeeping in respect of VC was requested by Dominic Lloyd, a mental health nurse from the Liaison and Diversion Service who contacted us. According to RiO, Mr Lloyd had already contacted City Emergency Duty Team and requested an MHAA. The role of CRHT was to attend the MHAA once it had been confirmed. No other assessment or contact was required by CRHT at the time.

37. I cannot recall my conversation with Mr Lloyd.

38. I did not undertake a face-to-face gatekeeping assessment. Mr Lloyd and I only had a telephone discussion. I delegated the task to my colleague Annette Palmer (Clinical Nurse Lead). She then attended a face-to-face gatekeeping assessment on behalf of City CRHT. Given the duty system, we delegate based on availability. So, I delegated the task to Ms Palmer as she was the available clinician at the time.

39. I did not carry out any risk assessment as part of the gatekeeping process. I took information from Mr Lloyd and reviewed the RiO notes. I did not attend a face-to-face gatekeeping assessment with VC and nor did I speak with VC on the phone or in person. Therefore, I was unable to carry out a risk assessment, and the only information I recorded is my discussion with Mr Lloyd.

40. I informed the Bed Management Team ("BMT") that there was a pending MHAA in Bridwell Custody Suite. BMT's role is to coordinate patient admissions, ensuring timely and appropriate patient placement and liaison with the assessing team following the MHAA. I had no further role at this time apart from ensuring that they were aware of the MHAA and had accurate details so that they could find the right setting for the patient as required.

Gatekeeping on 25 May 2020

41. I also cannot recall any discussion that took place on 25 May 2020. All the information I have is as set out in the RIO notes written at the time.

42. I did not speak to the police or anyone else. As set out in the RIO notes, Sally Evans had the initial phone call and discussed it with us (CNL Rachael Masterson and I) . I would have then further reviewed the RIO notes to understand and collect the relevant information required for us to make a decision. The decision was that CRHT would not be able to support someone with that level of risk safely in the community and therefore that home treatment was not a feasible option.

43. As I did not see VC face-to-face or carry out a gatekeeping assessment, I was unable to carry out a risk assessment. However, I had enough information from VC's recent contact and assessment from other services and healthcare professionals to advise that home treatment, even on Red RAG with twice daily visits, was not a feasible option.

44. Also, because I did not attend the gatekeeping assessment in person, I did not record the outcome. The RIO entry recorded on 25 May 2020 at 16.08 was just a brief RIO entry to document the rationale for not attending the MHHA (p.4, NHFT0000168).

45. I did not speak to VC via phone, video link or face to face.

RAG system

46. The RAG system uses a traffic light system. In CRHT we use it to categorise and communicate the complexity of the situation including assessment, risk management and medication concordance.

47. Red indicates intensive treatment (people who we need to see daily), amber indicates someone coming out of the crisis stage (may be seen 2-3 times per week), and green indicates that the patient is moving towards discharge.

48. Due to being new to the service, a recent act of aggression, and requiring further assessment of his pathology and risk as well as medication concordance, the assessing team recommended for VC to be placed on Red RAG. This meant that twice daily visits were needed, with a visit agreed for the same evening (24 May 2020).

Understanding of VC following his first and second arrest

49. I did not see or assess VC myself. I had to review the RIO notes to find his information.

50. There is limited psychiatric history on RIO as he was not known to mental health services at the time. There were no previous admissions to a psychiatric hospital or referrals to mental health services. According to the notes, VC's mother had also denied any family history of mental illness or that VC had any mental health issues or risk to self or others in the past (as recorded by Dr Gandhi during MHAA on 24 May 2020).

51. As to diagnosis and condition, I note the impression recorded by Dr Gandhi on 24 May 2020 and Dr Rosa Sadrael on 25 May 2020 at 18:05 that VC had first episode psychosis due to sleep deprivation and stress.

52. As to capacity, I had no contact with VC or any discussions regarding his capacity during his first or second arrest. However, the RIO notes indicate that he did not have capacity to consent to admission during his second arrest.

Involvement with VC during first admission to Highbury between 25 May 2020 and 17 June 2020

53. I did not have any involvement at that time.

VC's Second Admission (13 July 2020 - 31 July 2020)

54. VC's medical records show that I attended a pre-discharge meeting/ward review on 28 July 2020 led by VC's Responsible Clinician (NHFT0000168 at p.105). There is also an entry on 1 August 2020 which notes that VC's discharge plan was at the end of his Second Admission (NHFT0000168 at p.118).

55. I don't recall attending the ward review or discussions at the time beyond what is recorded in RIO.

56. However, from reading the notes, my understanding is that Dr Seedat requested that CRHT support VC in the community on a daily basis for medication concordance. The understanding was for CRHT to do a 3 day follow-up and then to offer daily contacts to monitor medication concordance, mental health and risk. The plan was for CRHT to liaise with the care coordinator within the LMHT in order to undertake a joint visit within the community to review the care, risk and needs.

Risks associated with VC's presentation and condition at end of second admission.

57. At the end of VC's second admission, the risk was noted that if VC was to stop medication that he would relapse. However, at the time of his discharge, there were no concerns noted, and the clinicians were happy for him to be discharged as per the plan. VC's mother was also in attendance during this review and had no objections.

58. Prior to the ward review, I would have reviewed the risk assessment, core assessment and progress notes. I did not have any subsequent contact with VC personally after this.

59. The purpose of hospital admission was for assessment and treatment, which would include risk assessment. I did not carry out any risk assessment myself.

60. I cannot recall any discussion we may have had during the ward review on 28 July 2020. Having referred to the RIO notes, the reasons for admission included historical and current risk, progress on the ward and discharge plan.

VC's second period under community care

61. VC's medical records show that on 3 August 2020, I entered a note titled "senior case load review" (NHFT0000168). This noted that VC was "posing an increasing risk to both himself and others".

62. Case load review is the review of patients' RIO notes, not the patient themselves. Therefore, VC was not seen face-to-face. The case load review is an opportunity for us to review the patient's notes, their contact with services

prior to their CRHT referral, why they were referred to CRHT, CRHT's involvement, risk management, pathway and plan of care.

63. The usual process is to review RIO entries, recent MHAAs, previous admissions, notes on risk assessments, engagement possible triggers, doctor's views, and observations of the professionals involved in that patient's care.

64. In this case I reviewed VC's contact with the mental health services and police (as recorded in RIO). My conclusion in the RIO entry is therefore from the notes. It is not my personal view. It is what was documented by doctors who reviewed VC at the time.

65. As to whether I considered that VC posed a risk of aggression and violence during his second period in community care, I cannot remember what I thought at the time.

66. According to RIO notes, there were no recorded incident of violence whilst under the care of CRHT during his Second Period in Community Care.

67. My only contact with VC was during ward review on 28 July 2020. I also don't remember this.

68. Further, I did not make any assessments or observe VC myself in respect of his willingness to comply with medication.

69. I did not have personal involvement in VC's care or prescribe medication.

70. As to my understanding of VC's diagnosis and condition during his Second Period in Community Care, the impression from the ward at the time of discharge was: "Acute relapse due to non-concordance with medication, Likely schizophrenia. He had 2 psychotic episodes". (NHFT0000168 p106) . VC's long-term prognosis was that he needed treatment for psychosis and would need to continue taking medication for at least 2 years.

71. VC was also referred to the appropriate team (EIP) Early Intervention in Psychosis to continue with the assessment, risk management and treatment in the community.

6 August 2020 MDT

72. VC's medical records show that on 6 August 2020 I attended an MDT with Dr Skelton (NHFT0000168 at p.164). I do not remember this.

73. During the MDT, VC's discharge was not discussed or considered. Prior to the MDT, we would have reviewed all relevant information on RIO.

74. The recommendation at the MDT was to review VC's RAG rating. This would include risk assessment, mental health needs, compliance with treatment and engagement. The RAG rating could be increased or decreased depending on risk, engaging, and mental state. During RAG review, we would also review whether home treatment is feasible/required.

75. My understanding of VC's condition would have been informed by reviewing all of the relevant notes. This would have included the notes by CRHT Nurse Clive Chimbi on 1 August 2020 (NHFT0000168 at p.119) and the note on 3 August 2020 (NHFT0000168 at p.122). We would review VC's progress and engagement with CRHT, his mental state and risk.

76. The notes show that CRHT considered and reviewed all of the relevant information, the patient's wishes, mental state, capacity, and continued to assess the best appropriate support in order to maintain engagement and safety of the patient and others.

Medication, capacity, discharge and risk

77. I did not observe VC take or refuse medication at any point.

78. I did not personally review VC's mental state and/or capacity at any point during his Second Period Under Community Care.

79. I also was not personally involved in the discharge and transfer of VC's care to EIP.

80. As for any risk that VC posed, discussion on risk happened within MDTs, with other professionals on the ward.

Reflections & recommendations

81. I did not know a lot about VC, especially towards the end nor I had any reason to access his RIO notes. Therefore, I can't recall what was happening in 2020. I followed the plans and kept an eye on things as per my involvement. I don't think there was anything to do differently.

82. As for recommendations, I think it would be helpful to have a system for everybody to help work together as services, including sharing information.

83. I confirm that I have not given any interviews or otherwise made public comments about the actions of VC or the matters under investigation by the inquiry.

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:5/11/2025

Index to First Witness Statement of Merima Jordon

No.	Inquiry 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