Witness Name: Sabelle Danson

Statement No: WITN0294001

Dated: 20 November 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF SABELLE DANSON, FORMERLY AISHA YUSUF

I, Sabelle Danson, also known as Aisha Yusuf, will say as follows:

Introduction

1. I make this statement in response to a request under Rule 9 of the Inquiry Rules 2006. It concerns my professional interactions with Valdo Calocane (VC) between his first presentation with mental health issues in 2019 and the attacks on 13th June 2023.

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.

Career and Role

3. I am a Registered Mental Health Nurse, and I qualified on 4 February 2016 when I obtained a Bachelor of Science degree in nursing from the University of West London

4. I am a member of the Nursing and Midwifery Council ("NMC").

5. I previously worked at East London Mental Health Trust before moving to Nottinghamshire Healthcare Foundation Trust ("NHFT") in July 2019 where I worked on Rowan 1 and then Redwood 1 on a contract basis. I am a Band 5 nurse and was a Band 5 nurse during my interactions with VC.

6. I no longer work at NHFT, I now work for an agency.

Training and system of work

7. When I attained my qualification the issue of risk would be very prominent when doing placements on wards and so we would go through this. While working for NHFT I did care planning and risk assessment training. This included mandatory training at the Trust which covered managing aggression when patients become irritable or violent.

8. At the start of a shift there would be a verbal handover from the nurse from the previous shift which would give information on the reason for admission of a patient, historical and current risk and current presentation. This was also accessible on the patient records on the RIO system.

9. I had access to patient records for inpatient care and a core assessment done by the community teams. Care plans and risk assessments were also accessible. I do not recall any restrictions on systems, but we would not have full access to community notes unless they were on RIO.

10. At the beginning of a shift, I would typically read the risk assessment and details of how the patient had presented in the previous shift. I also read the aspects of care that were discussed on the progression of the patient treatment plan.

11. If I had information to share, I would record the information on the RIO system and on medication cards and the handover booklet.

12. If I had concerns about the patients I was involved with, the response team could be summoned on an electronic system which was an alarm that each staff member had and once triggered, the system would beep out loud. Walkie talkie radios were also available to send alerts to all units. I could also inform the site senior nurse cover, the ward manager, ward doctors and the on-call doctor out of hours if required. I felt very comfortable raising any concerns about patients care and staff safety.

13. I have not, to my knowledge, been involved in the care of any other mental health patient (other than VC) who, following discharge or when in the community, has killed or seriously injured a member of the public.

Interaction(s) with VC

14. My knowledge of VC was during his admission in hospital and information was given on the reason for admission both written and verbal.

15. We would be given information on his diagnosis, whether he was detained under the Mental Health Act 1983 ("MHA 1983") or the Mental Capacity Act 2005 ("MCA 2005"). We would also be told of any historical and current risks, presenting mental state, whether the patient was accepting dietary intake and accepting personal care. If they were detained, we would be told whether they were given section 17 leave and whether they were being visited on the ward by others.

16. Written information was in the form of documents such as risk assessment forms, care plans and core assessments, ward round outcomes, section papers and MDT discussions, which included occupational therapies, psychologist, activity coordinators, doctors and other professionals involved in the patient's care.

17. I understood that VC was a university student at Nottingham University and that he had experienced a psychiatric breakdown. He was picked up by the police and later released. Police were called to a burglary in progress where VC had kicked a door causing damage and then found a woman in a bath who jumped out of a first floor window causing injury to herself. VC was detained under Section 2 of the MHA 1983 for assessment and treatment. VC was reported to be hearing voices; we were informed that he had not slept for a week and that he appeared lost while being spoken to. VC was admitted on Rowan 1 Ward.

18. VC was diagnosed with paranoid schizophrenia.

19. VC lacked capacity around his illness and believed that he was well enough to leave the ward while he did not have any leave.

20. VC was assessed and prescribed medication as he reported that he was hearing the voice of a woman screaming. The care plan was to engage VC and give him time to express his concerns, assess his mood and his mental state and to administer prescribed medication and monitor side effects. We were to offer him therapeutic engagement, assess his personal care, dietary intake, interactions with others and to support him toward recovery.

21. VC was involved with the police prior to his admission when the police were called due to his presenting risk.

22. On admission, he was isolating in his room, VC appeared to be experiencing thought block and he isolated in his room and refused dietary intake. His presentation improved when he started accepting treatment, he would come out of his room and engage with staff. VC would ask to leave the ward and return to university; he would be encouraged to engage in activities though he would be hesitant. VC would say that he wanted to be a better person.

23. The medical records indicate that I spoke to VC's mother on 26 May 2020 at around 10:39am:

26 May 2020, 10.39am

T/C from Valdo's mother, her name is Seleste Calcane, contact number GRO-B . Valdo's mother was concerned about securing Valdo's accommodation. Valdo's mother wanted to know how he was getting on, consent was sought from Valdo to speak to his mother, this was given. Staff are to support Valdo to speak to his mother as he does not have a mobile phone. Mother said she would be bringing clothes and a mobile phone for Valdo

(Page 7, NHFT0000168)

24. I can confirm that this is an accurate entry.

25. I was copied into an email sent at 15:44 on 26 May 2020 by Callie Dunn (Mental Health Legislation Caseworker) which was addressed to the "*Nurse in Charge*" (NHFT0000390). The email requested the nurse in charge to do the following regarding VC: "*Would you kindly arrange for the attached leaflet for Section 2 to be completed for the above named patient and if practicable ensure that the patient understands it by going through it with patient. It is also necessary to record when the patient had their rights read to them on Rio under the MHA section on the navigation page: - Could you please ensure that further attempts are made and recorded when appropriate.*". I was copied into this email because I was working on the ward. I cannot recall whether I was the nurse in charge of this shift. I do not recall responding to the email.

26. Although I do not recall the email, section 2 rights were read to VC as this is a statutory right. As VC was not accepting this, further attempts were made to express the rights to promote his understanding.

27. I later reviewed and interacted with VC and made the following entry:

26 May 2020, 5.35pm

Long day entry

Valdo was observed walking around the ward. He walked to the end to the corridor and started to kick a glass door. Staff asked him to stop, he would not. Verbal de-escalation was used to no avail. The alarm was triggered at 12:15, the response team arrived and restrained Valdo in prone position. He was administered 2mg Lorazepam on the right gluteal muscle. Staff established dialogue with him, said he wanted to leave the ward. Valdo appeared to have no insight of being detained under Sec 2 of MHA. Part of the restraint team disengaged, and he was escorted to his bed are in passive hold. IR1 334434

Vlado then ran from his room heading for the door, he was restrained and sat on a chair on passive holds.

Valdo went to the main door and started budging it. He was retrained on the flow and escorted to his bed area once he was settled.

Valdo was offered food at lunchtime while in his bed area, he refused to eat. He accepted drinks. Valdo offered supper, observed eating. He accepted oral 5mg olanzapine.

Observations

12:20 – 32 respirations per min

12:30 – 28 respirations per min

12:45 – 25 respiration per min

13:00 – 16 respiration per min.

Valdo's mother visited and brought him clothes, sketch pad and a pencil pouch. Pencil pouch was kept as contraband as staff continue to monitor his behavior.

Observations: Valdo was placed on enhanced eyesight observations to monitor his behavior and address issues of concern. Valdo settled and slept in the afternoon.

Therapeutic activity: Valdo utilised the garden with staff watching him as he made attempts to climb the perimeter fence.

Physical health: Valdo refused physical observations, he was suspicious of the measuring equipment. Breaths were observed.

Risk: Aggression, ascension, entering other service user rooms

(**page 8, NHFT0000168**).

28. The word 'ascension' should be 'absconding'; other than this, it is an accurate entry.

29. I was involved with VC at this point as I was the nurse on the ward and our role was to maintain a safe ward.

30. 'Long day entry' means that the shift is between 7am and 9pm in the evening.

31. I recall the incident in which VC kicked a glass door. VC was looking for a way to leave the ward as he said he did not understand why he was admitted. I considered the way in which VC was kicking the door to be aggressive. I asked VC calmly to move away from the door but he did not respond and so the response team had to be called for support.

32. It was around five minutes before VC stopped kicking the wall then he was stopped and damage was prevented by staff.

33. The aggression was directed towards the door, although when asked to leave, he turned toward staff in an aggressive demeanour, charging towards staff. This was prevented by restraining him.

34. There were approximately 10 people attending the incident, including staff on the ward and those attending to support.

35. A full restraint was needed which requires seven staff to support VC and he was supported to lay on the floor. It took around four minutes to restrain VC, and he was restrained on the floor in prone position with head management. VC was not talking during this but appeared to be in distress; he did not respond when he was informed that he would be given a lorazepam injection to support him.

36. When the injection was administered, VC was supported to stand up and he was escorted to his bed area on passive holds, which is two members of staff supporting him.

37. VC did not appear to understand when he was informed that he was being detained on the ward.

38. The restraint team disengaged, meaning that they released the holds when assessing whether he appeared settled. In practice, VC needed to settle to reduce the risk to others and causing personal injury by kicking a glass door. He was also looking for a means to abscond from the ward as he was asking to leave.

39. When presented with 5mg oral olanzapine at 4pm, VC accepted the medical without prompts; he did not say anything at this time.

40. During 12:20 – 13:00 observations were taken whilst VC was sleeping. When VC went to his bed area he slept and covered his head, and staff had to ask him to uncover his head.

41. VC's pencil pouch which was delivered by his mother was considered to be contraband as staff felt it was unsafe to give him sharp objects due to his presentation at the time. VC was informed that his pouch would be kept in the safe and he did not react for this.

42. VC utilised the court area for fresh air, however, was observed trying to climb the fence so he was asked to step down at return to the ward. This was considered significant as he could hurt himself when climbing the fence. He presented the risk of absconding from the ward.

43. VC was taken to the clinical room to have a full set of observations. He was suspicious when asked to put on a blood pressure cuff, looking at it suspiciously

and saying he did not want it. An oxygen probe was also presented but VC folded his hands and did not accept full observations. He then left the clinical room. This was significant as we were not able to monitor his full physical health.

44. In relation to the risks 'aggression, ascension *[which should read absconding]*, entering service user rooms', I considered this a risk as staff did not know why he wanted to enter other patients' rooms or whether he had forgotten his own door. VC was directed to his own bed area and staff were vigilant that he would not enter other patient's rooms.

45. I discussed these risks during handover for other staff to observe his movements around the ward.

46. By absconding, I meant the risk of him leaving the ward without authorised leave. By aggression, I meant that the risk of aggression was ongoing; as I was nursing him, I was aware that he could be aggressive.

47. The risk of 'entering other service user rooms' was recorded hand over was given on the morning on 27 May that VC was kicking other patient door and that staff needed to be vigilant and observant that he does not enter other patient rooms.

48. The incident in which VC kicked the glass door was reported formally by me. **NHFT0007520** relates to this incident and is an accurate reflection of what happened and what I saw on the day.

49. The records indicate that I reviewed VC on the morning of 4 June 2020.

4 June 2020, 6.37am

Mental state: Valdo was in hisspace laying on the bed. He did not respond to prompts for supper. Valdo is not on night medication. He came out of his bed

area when there was fire alarm. He then returned to his bed area after being offered assurance. There were no behavioral concerns.
Observation level: Valdo was nursed on general observations. Note appearance: He appeared well kempt.
Individual time: Valdo engaged with staff during fire alarm, said he was fine. Therapeutic activity: There was none during the night.
Other needs: Valdo did not express any needs. Risk: Low risk during the night.
(Page 21, NHFT0000168)

50. The above entry is correct, other than 'hisspace' should read 'bedspace'.

51. I attended an MDT meeting at 1.16pm on 8 June 2020 at which VC was discussed as per the notes at **page 26, NHFT0000168**

52. I was part of the MDT discussion as a nurse. I gave the nursing hand over about how VC was presenting on the ward. I gave handover to the MDT which is normal practice. Recording was done by the junior doctor through typing. I would have not made notes as the plans discussed were being recorded on RIO.

53. VC was considered as increasingly withdrawn as he was spending the time in his bed area and he was not responding to staff prompts. He was also not engaging with others and on approach, he was mute. I thought that VC was experiencing depressive mood.

54. Several attempts were made to engage with VC, but he was not responding to this. As VC continued to take his treatment, his symptoms improved.

55. It was considered necessary to try and dig deeper when VC declined an activity as we needed to understand why he was not engaging. For example, VC was not engaging in the patient therapies and the 1 to 1 session with staff, so we were not able to understand his thoughts. VC said he was hearing the voice of a woman screaming and that this was causing him distress. In terms of digging

deeper, I considered that the psychologists were more trained to explore thought processes as we, as nurses, would only be able to take what VC told us, we would try and ask further questions but if he did not want to talk, we could not push him.

56. Time away from his bedspace was considered important to observe VC's engagement with others, to monitor his mental state, his dietary intake and his personal care for his own wellbeing.

57. VC was given section 17 leave at the time when he was accepting treatment and when his mental health had improved.

58. VC's treatment was reviewed weekly to promote his recovery after treatment. He was accepting his medication and psychotic systems had improved; he was accepting ward activities and playing chess with staff. The MDT review were thereafter discussing his return to the community when he was well.

59. I believe that he was given good care by his responsible clinician and that this was evident by his recovery.

60. I reviewed VC in the morning of 17 June 2020 and made the following record:

17 June 2020, 6.37am

Mental state: Valdo was in his bed area laying on the bed. He did not respond to prompts for supper. Valdo is not on night medication. He has been observed sleeping through the night. There were no behavioral concerns.

Observation level: Valdo was nursed on general observations as there were no behavioral concerns.

Note appearance: He was in bed, room appeared tidy.

Individual time: There was none during the night.

Therapeutic activity: None

Other needs: Valdo did not approach staff for his needs.

Risk: Low risk during the night. (**Page 49, NHFT0000168)**

61. This record is accurate, as at the time he was being prepared for discharge he was engaging well on the ward, and no concerns were reported during handover.

62. I attended three board reviews at which VC was discussed on 22, 24 and 28 July 2020 [**pages 85, 91, 103 NHFT0000168**].

63. The purpose of a board review is to have an overall discussion of the patients on the ward. All patients on the ward at the time and their care is thoroughly discussed and the MDT will discuss the direction of care . This is carried out by the MDT, and I was involved in this as I was working on the ward.

64. It is recorded that VC was compliant with medication so that people involved in his care are aware that VC was accepting his treatment.

65. VC was encouraged to take section 17 to see whether he would return to the ward after unescorted leave. VC responded when asked and he returned to the ward.

66. I agreed with all of the plans and observations recorded.

67. I also participated in a ward review on 28 July 2020 at 4.57pm as per **pages 105-108 NHFT0000168.**

68. I was involved in the meeting on 28 July 2020 because as a Registered Mental Health Nurse as I was part of the MDT.

69. This was a meeting which took place weekly when patients were reviewed by their responsible clinician.

70. As far as I recall, **pages 105-108 NHFT0000168** is an accurate note of the meeting on 28 July 2020.

71. At this point, VC was being compliant with treatment, and he had recovered from the crisis episode, and he was being prepared for discharge into the community. He was engaging well with staff and other patients; he was polite on engagement, and he was not suspicious or guarded.

72. It was noted that VC had good self-care, this is important as poor self-care is a sign of self-neglect. If there were concerns, this would have been explored, such as finding whether he had clothes to change into or whether he was having a wash.

73. During the meeting I noted that VC needed to be referred to the crisis team and Local Mental Health Team, and that the community teams would continue to monitor his mental state. It was considered that VC may need more support from the crisis team on discharge and that this was to monitor his mental state and if he was taking his medication among others.

74. The discussions of the meeting were being typed by a doctor, I am not aware why the 'patient diagnosis' section is omitted.

75. I cannot answer how I understood the comment '*Dr Seedat explained he had enquired with the police who told him that 80-90% the incidents wont go on his record'.*

76. I do not recall whether I considered VC was 'saying the right things'. I believed that VC would continue taking him medication. At the time, VC seemed to recognise that he needed the treatment.

77. I do not recall VC reacting when he was told he would need to take the medication for 2 years.

78. VC was asked questions by staff, but he was not a talkative person. He would be asked whether he was struggling and in what way, whether he was finding medication helpful, what he wanted the team to do for him and his future plans.

79. It is noted that VC found the medication to be drowsy and that this was discussed with him [**page 106, NHFT0000168**]. Medication causing drowsiness was discussed with his doctor who had authority to review and make changes to the medication regime as required. I did consider this risky as drowsiness would restrain VC from staying awake during the day. He would not engage with staff while drowsy and there was a need to monitor his presentation and mental state and risk while alert. When noted, I would let the doctor know and to make changes on treatment.

80. I considered that the risks concerning VC's mental breakdown would have been mitigated by VC taking his medication and his mental state needed monitoring to prevent mental breakdown.

81. It was said that there needed to be more clarity around VC's risk and insight prior to discharge. The steps taken were as outlined by the doctor during his discharge planning such as follow up by the crisis team daily upon discharge and further follow up by the local mental health team ("LMHT") for continued monitoring of his mental health and risk.

82. It is said that VC did not have capacity to make decisions about treatment. I agree with this, VC was assessed as not having capacity around his mental health and was not accepting that he has a mental illness on admission. He would take his medication whilst on the ward, however, he would stop taking it whilst in the community, leading to a mental health relapse.

83. The records indicate that I completed an internal referral to the City Crisis Resolution Home Treatment Team on 29 July 2020 (**NHFT0000030)** shortly before VC's discharge from hospital (**NHFT0000168**). In making this referral, information was provided which was also available on RIO such as the reason

for admission, current treatment and the plan to monitor is mental state and risk, compliance with treatment and his well being. There was also a member of staff from the crisis team in the meeting who was aware of the discharge plan. This referral needed approval before the discharge to ensure there was follow up discharge care.

84. I attended a board review on 29 July 2020:

BOARD REVIEW

Date: 29/07/2020

Attended: VC

Aisha Yusuf - staff nurse,

Amanda Smillie – ward manager

Jordan- Clinical Team Leader

John- clinic team leader

Carly kane- ward clerk

Summary of last 24 hours Settled on the ward

Review of observation levels

General observations remain appropriate.

Physical healthcare needs None at present **Activities/OT input**

Recovery work done by Kajsa see Rio note.

Plan and jobs to be completed

Discharge Friday

Covid swab to be done today

Crisis referral to be done today

(Page 110, NHFT0000168)

85. This is an accurate note; I do not wish to add any amendments.

86. Once VC left the ward, I would confirm the discharge letter that was formulated by the doctor. This was copied to his GP and community team. A copy was also sent to VCs mother. Also ensured that the crisis team had a copy of VC's medication card which would be changed to a community card. The crisis team had access to Rio system where they would see the care plans and risk assessments formulated on the ward. VC was also given a list on contacts on who to contact when in need. My involvement with VC ended with the discharge planning.

87. Other than the incident when VC kicked the glass door, I did not witness any other aggressive behaviour or violence.

Reflections and recommendations

88. I believe that if VC was taking his treatment and he had followed up, then the outcome would have been different.

89. In my own practice, I have a continued awareness of risk posed towards myself and others and approaches to mitigating those risks.

90. I have not given any interviews or otherwise made any public comments about the actions of VC or the matters under investigation by the Inquiry.

91. I think the Chair of the Inquiry should recommend that mental health patients receive close monitoring for treatment to be accepted to prevent acute episodes and timely recall to acute settings or places of safety when there are management concerns in the community.

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: 20/11/25

Index to First Witness Statement of Sabelle Danson

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
2	NHFT0000390	Email by Callie Dunn (Mental Health Legislation Caseworker) to Nurse in Charge, 26/05/2020
3	NHFT0007520	Incident Details – Extended Inc Notifications, Formal Report.
4	NHFT0000030	City Crisis Resolution Home Treatment Team Internal Referral, 29/07/2020