

Witness Name: Annette Palmer

Statement No: WITN0299001

Dated: 21 November 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF ANNETTE PALMER

I, Annette Palmer, will say as follows:

Introduction

1. I am a Clinical Lead Nurse (Band 7) at Nottingham Healthcare NHS Foundation Trust (NHFT).
2. I make this statement in response to a request made under Rule 9 of the Inquiry Rules 2006, dated 21 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 NHFT 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 qualified as a Registered Mental Health Nurse in April 2006 at Nottingham University. Since then, I have been registered with the Nursing and Midwifery Council (NMC), and I have experience working in acute ward settings and working within community settings.
5. In 2019, I began working as a Clinical Lead Nurse (Band 7) in the City Crisis Team. It was whilst working in this role that I interacted with VC, as I attended his Mental Health Act (MHA) Assessment on 24 May 2020.
6. I currently work as a Clinical Lead Nurse (Band 7) with the Clinical Access Line, NHS 111 Option 2, which is part of NHFT.

Training and system of work

7. I cannot specifically recall what training in assessment of risk for mental health patients of violence towards others I received while at university, as it would have been part of the discussions that we had about how we treat and manage risk and health and safety. It is also something that I would have covered whilst on placements, as I would have received inductions on the policies and procedures for managing each different environment and interacting with different people.
8. Since working at NHFT, I have undertaken annual training in the Prevention and Management of Violence and Aggression (PMVA). I have also completed training on Suicide Awareness and Response, Domestic Abuse Stalking and Harassment / Multi Agency Risk Assessment Conference (DASH/MARAC),

Clinical Risk and Safety, and Leadership in Safeguarding. I have completed regular refresher training for Suicide Awareness, Clinical Risk and Safety, and Safeguarding.

9. Information would be verbally shared with me about the patients I was involved with either face-to-face, or by telephone. I would also update RiO, send updates via email, and place letters in the post. The method of communication we chose would depend on the situation, for example, if somebody had received treatment outside NHFT, we might request information about that treatment via email.

10. I had access to RiO local, but not RiO Forensic or SystemOne. However, I do not consider that only having access to RiO Local affected my ability to fulfil my role.

11. When I was in the Crisis Team, if another member of the team wanted to discuss a patient with me, then I would read the information about that patient on RiO, including their risk assessments, care plans, and progress notes. I would also check for any documents that had been uploaded to RiO, and also the alerts. Alerts can be added to RiO in order to flag risks which are considered to be significant in relation to that patient; for example, if a patient has been violent and aggressive, and perhaps caused damage to property or assaulted someone, we might put an alert on RiO so that the risk is immediately clear when you access the patient records.

12. If I was part of an MDT, I might also access the notes of the patients who were being discussed, in order to be able to contribute to the discussion. Alternatively, I might make the notes on behalf of the MDT, so I would also access patient notes accordingly. Additionally, if I received a phone call from a patient's family member or from another service expressing concerns about that patient, I would also access the notes so I could record those concerns.

13. If I had any concerns about the risks posed to others by the patients I was involved with, I could report these to the wider multi-disciplinary team (MDT), and any other services or teams involved with the patient. I have always felt comfortable in raising any concerns that I had.

Assessments under MHA 1983

14. Since qualifying as a nurse, I have attended numerous Mental Health Act Assessments (MHAA), both prior to, and since, May 2020. I have undertaken these assessments as an inpatient nurse and whilst working in the community. In my role working for the City Crisis Team as a Band 7 nurse, I carried out the role of "gatekeeper", which involves supporting discussions in relation to deciding whether a person requires hospital admission, or whether they can be supported at home by the crisis team. I also advocate for the least restrictive practice that is suitable for each patient.

15. I am required to complete mandatory training on both the Mental Health Act 1983 (MHA) and the Mental Capacity Act 2005 (MCA) every three years by NHFT. I also complete mandatory training on the Care Programmed Approach

every three years. This is mandatory training provided by NHFT, which covers: working with care coordinators to update care plans during or after a crisis; initiating or revise risk assessments and safety plans; and promoting continuity of care between crisis intervention and ongoing community support. I understand that the training materials associated with these courses have been provided as part of the Trust's disclosure to the Inquiry (see [NHFT0015487]) so I have not exhibited the same to this statement.

16. Under the MHA, part of my role is to promote least restrictive practice, act in a compassionate, way and enable person-centred care; assess safeguarding risks, mental capacity, and manage risks including intoxication; work collaboratively with families, carers, and community services; and support voluntary admission where possible.

17. I follow the NMC Code of Conduct in crisis mental health settings, which encourages us to enable rapid, ethical decision-making under pressure and to collaboratively work with police, social care, and emergency services. It also states that as professionals we are to complete safeguarding and risk management for individuals in acute distress whilst maintaining professionalism in emotionally charged environments. I have exhibited a copy of the NMC Code of Conduct to this witness statement as WITN0299002.

18. There is also the Mental Health Crisis Concordat. This is a national policy, covering responding in a timely way for persons experiencing a mental health crisis, which involves enabling: access to support before crisis point; early

intervention and prevention to avoid escalation; clear pathways for individuals and carers to seek help 24/7; urgent and emergency access to crisis care; rapid response from health, social care, and emergency services; safe and appropriate places of safety (not police cells unless necessary); respectful, dignified, and person-centred care; multi-agency collaboration (e.g., NHS, police, social services); support for ongoing recovery and relapse prevention; and involvement of voluntary sector and community resources. I have exhibited a copy of the Mental Health Crisis Concordat to this witness statement as WITN0299003.

19. In terms of my understanding of my role as a nurse in the MHA process, working alongside Approved Mental Health Practitioners, and registered medical practitioners, my role involves "gatekeeping", which refers to the critical role that crisis teams play in assessing and managing access to inpatient mental health services. The goal is to ensure that hospital admissions are appropriate, necessary, and the least restrictive option available.

20. I confirm that I have not been involved in the care of any mental health patient other than VC who, following discharge or when in the community, has killed or seriously injured a member of the public.

Involvement with VC

21. I believe that the MHA assessment on 24 May 2020 was my first interaction with VC prior to 24 May 2020. I had no knowledge of VC prior to his arrest.

22. I came to be involved in the MHAA on 24 May 2020 after I was requested to attend as the Band 7 gatekeeper within the City Crisis team. I had a brief conversation with Benjamin Williams (AMHP) prior to arriving for the assessment. I cannot recall exactly what was said in that conversation, however when I speak to an AMHP before a request for gatekeeping, usually the AMHP will confirm the name of the person that the MHA Assessment had been called for, a brief overview of why the assessment has been called, and confirm the time that the assessment is planned for. I would also have had the opportunity to ask questions too, such as who else is attending the assessment, or why the assessment is being called (if I did not already know this).

23. I was informed of the circumstances around VC's arrest prior to my arrival on 24 May 2020 by the AMHP. I was also given a brief outline of the circumstances from the assessing team after arriving at the police station. My main understanding was that VC had attempted to get into the room of a female, and was arrested for burglary, as documented on RiO [NHFT0000168, pg1]. VC had no previous mental health history, but he was felt to be mentally unwell, as his RiO notes indicate.

24. In relation to my understanding of whether VC had been aggressive and/or violent, my understanding was that VC had broken into his neighbours room and caused damage to the door.

25. The detail of what VC told me about these events is included in the MHAA [NHFT0000168, pg2].

26. I accessed VC's RiO notes for the purposes of conducting the MHAA. I also received the information set out above at paragraph 23. I was also informed that VC was studying at Nottingham University, and that he did not have any family in Nottingham. I cannot think of any other information that I could have accessed but did not.

27. The AMHP Report records that there was a delay in the assessment: "*Waited for CRHT gatekeeping until 12:12*" [NOCC0000044, pg1].

28. Gatekeeping refers to the critical role crisis teams play in assessing and managing access to inpatient mental health services. The goal is to ensure that hospital admissions are appropriate, necessary, and the least restrictive option available. I recall that I arrived late to the mental health act assessment but cannot remember the reason for this.

29. It is recorded in the AMHP Report that Benjamin Williams spoke to VC's mum by telephone for the purpose of the MHAA [NOCC0000044, pg3], and afterwards, informed her of the outcome [NOCC0000044, pg4]. I did not speak to VC's mum before the MHA Assessment was carried out. The standard practice when carrying out a MHA Assessment is for the AMHP to call the individual's family member, to make sure they are informed of the process; I would not call the family member, unless the circumstances were unusual. Here, even though VC had been arrested and had already had an informal

assessment by a mental health team, so the MHA Assessment was requested through that route, I did not speak with VC's mum.

30. The AMHP report records that VC did have capacity to make the decision to consent to his care plan, but the following was also observed: "*Valdo found it difficult to understand and retain information. It is felt that he lacked capacity to consent to treatment, however, he was agreeable to taking medication and accepting of CRHT input stating that he did want help*" [NOCC0000044, pg5]. I agree with that statement.

31. The AMHP report also states that VC was thought to be experiencing a "psychotic episode" [NOCC0000044, pg4]. I believed that he was.

32. In addition, the AMHP report states that the risks were deemed "low enough for Home Treatment to be explored" [NOCC0000044, pg4]. They were low enough, at the time of the assessment.

33. In terms of the statement that it was in VC's "best interest to pursue home treatment at this time" [NOCC0000044, pg7], I believe that it was right for home treatment to be explored given VC had no prior mental health history and was willing to receive support from the crisis team. VC had agreed that he would accept medication as part of his treatment, and that he would engage with the crisis team.

34. The document titled "RG contact with VC was on 24.05.20 for a MHA assessment" states:

"RG states that the team of professionals considered the research evidence that shows over representation of young black males in detention and recalls that Anna palmer was able to persuade us that CRT could provide a safe and reasonable alternative of supervised medication and 2 visits / day. With the option to admit if the community treatment plan failed."

[NHFT0004927, pg2]

35. I do not recall who made this note. However, while I can voice my opinion as to whether somebody should receive treatment at home, it is not my job to persuade them of my view. The decision as to whether to admit someone to hospital is the decision of the AMHP and the medical doctors. From what I can recall, I simply agreed that it was right for us to consider home treatment for VC, and I advised what home treatment could look like for him. I also advised that VC could be visited twice daily, and that if home treatment failed, VC should be admitted to hospital.

36. I felt that if VC was agreeable to having home treatment, and medication was started following his assessment, then this would go some way to mitigate the risks pertaining to VC (such as further deterioration of his mental state and assessing his willingness to engage with home treatment). Following the MHA assessment, I returned to the crisis team office, collected VC's medication, and then attempted to visit VC at home to oversee his medication concordance.

37. At this point, we had not formulated a formal care plan. Rather, after the assessment had been completed, we agreed an initial plan regarding what should happen next. That initial plan was that VC would be started on some medication, which would be delivered to him. The normal practice is then for the Crisis Team to take over, while we continued to provide and monitor medication, then a formal care plan would be formulated in collaboration with the patient.

38. I cannot recall whether twice daily visits were suggested by Dr Gandhi or Dr Malik, or whether this was something suggested by the AMHP or myself. This is a discussion that all of us would have taken part in, and within that discussion, I would have articulated what the crisis team could deliver in terms of visits. However, I did agree that the crisis team could and should visit VC twice a day.

39. Shortly after the MHA Assessment concluded, I did complete the "Mental Health Clustering Tool" at around 15:00 on 24 May 2020 [NHFT0002579], and the "Risk and Safety Assessment", at around 16:00 on 24 May 2020 [NHFT0003815].

40. The Mental Health Clustering Tool is a clinical assessment tool used in NHS Mental Health Services to group patients into care clusters based on their needs and symptoms, rather than their diagnosis alone. It can support care planning, resource allocation, and the Payment by Results system.

41. The purpose of the clustering tool is to ensure patients with similar needs receive similar levels of care. It can also help services plan and deliver care more effectively along with supporting funding decisions based on the complexity and intensity of care required.

42. The purpose of completing a risk assessment is to: identify potential risks such as self-harm, suicide, aggression, neglect, or vulnerability; evaluate the severity and likelihood of these risks occurring; inform clinical decision-making to ensure appropriate care planning and interventions; promote patient safety by proactively managing risks; support legal and ethical responsibilities by documenting concerns and actions taken; and facilitate communication among multidisciplinary teams to ensure consistent and coordinated care.

43. Whilst the first use of the Mental Health Clustering Tool can indicate the level of symptoms an individual is experiencing, the idea is that the clustering tool is repeated and updated to help us monitor symptoms and be able to see if symptoms are worsening or improving during the patients care and treatment journey.

44. The risk assessment are also designed to be repeated and updated, when new assessments are completed or when new risks are identified or when risks reduce.

45. The Mental Health Clustering Tool and Risk Assessment documents may be shared with other services when care is being transferred, or the patient is

referred to other services. For example, VC was admitted to hospital following his second arrest, so the documents would be available to the ward team because they are saved on RiO and the ward staff had access to RiO.

46. For "*Overactive, aggressive, disruptive or agitated behaviour (current)*" in the Mental Health Clustering Tool, I graded VC as "*2 = Mild problem but definitely present*". This was based on the information available at the time; breaking into a neighbour's room could be viewed as disruptive behaviour.

47. For "*Other mental and behavioural problems*" in the Mental Health Clustering Tool, I graded VC as "*3 = moderately severe problem*". This is because VC appeared to be having a psychotic episode, but his possible triggers were unclear. During his mental health assessment his behavior was discussed. My impression was that, as result of him responding to unknown stimuli, he believed that his mum was being raped in the room that he broke in to. VC admitted that he was having some unusual experiences and not feeling himself, and he admitted hearing voices.

48. Looking back, the matters recorded in the documents were accurate based on what I knew at the time.

49. I recorded that VC had "no past history of illicit substance use or forensic history". This was information obtained during the MHA Assessment.

50. I visited VC's address during the evening of 24 May 2020, at around 21:50:

"I went to Valdo's address to deliver medication and observe him taking it. I was unable to access the building. Attempted to call Valdo on his mobile. There was no answer. I was aware that his mum was visiting him this evening so I rang her. She was just arriving and I met her outside. We both tried to call Valdo's mobile number VC phone number 4 again but there was no answer and the call went to answering machine. Checked on Rio and saw that David - Street Triage Nurse was making an entry. Telephone call to David. He advised that Valdo had been arrested again and taken to the Bridewell Police station after breaking the door of a neighbour's and gaining entry. I explained this to Valdo's mum and family and informed them about likely outcomes regarding mental health treatment. Explained informal and section status's and rights of appeal. Valdo's mum voiced that she would prefer that her son goes in to hospital for treatment as he is a risk to others in his current mental state. Given contact number for the Bridewell. Advised me that she was going there to see if she could see him. Advised that they may not let her see him. Medication returned to Highbury Hospital and placed in the medication cabinet."

[NHFT0000168, pg3]

51. I attended VC's home in accordance with the agreed plan following the MHA Assessment for the crisis team to oversee VC starting medication.

52. I can recall that I briefed VC's mum on the situation over the phone. I explained why I was at VC's home address, and what I was intending to do, which was to oversee him take some medication. Due to VC not being seen, and receiving information about his second arrest, I discussed possible options of what could happen now, such as admission of VC into hospital. VC's mum expressed that she would like VC to be admitted to hospital.

53. I documented VC's mum's comments that VC is a risk to others in his current mental state for other colleagues to see, however, I was not involved with him after this contact, and so I do not know what impact this had on VC's care plan

or treatment. I believe that because VC's mum was aware of his initial arrest, and he was then arrested again, she was becoming concerned for VC and for other people. I believe this is why she said she would like him to be admitted to hospital.

54. I asked David from the Street Triage team what had happened in order for VC to be arrested again. I voice that VC should have an admission in to hospital due to his second arrest.

55. I was surprised when I found out that VC had been arrested for a second time, as I was expecting to see him to give him his medication.

56. I cannot recall if I saw VC following his second arrest. I also cannot recall whether I had any further involvement with VC over 24 and 25 May 2020.

57. I created an "Alert" within VC's medical records on 24 May 2020:

*Alert Type Violence and Aggression
Alert Date 24 May 2020
Entered By Palmer, Annette
Comment Arrested for damage to a neighbouring flat door after he believed that he heard his mother screaming from inside the flat.
Next Review Date 30 Dec 2020"*

[NHFT0003401]

58. I do not recall what time I recorded this alert; I will have added it to the system as soon as it was practical for me to do so. I added this alert to make other colleagues who may have provided care to VC of the risks that he posed. The

alert was recorded on the RiO system, so anyone with access to RiO would see it.

59. I did not review the alert on 30 December 2020, as to the best of my knowledge, I was not involved in VC's care and treatment around this date. Alerts can be reviewed and amended by anyone involved in a person's care and treatment.

60. I took part in a "caseload review" on 14 August 2020:

"Caseload Review

Green Rag

Two recent admissions under MHA – one in June 2020 (discharged on 16/6) and most recent one in July 2020 . Valdo was admitted on 15th July , under similar circumstances as his previous admission, posing an increasing risk to both himself and others

Valdo had decided to stop taking his medication 2 weeks after his discharge from his last admission. He believed that he was well and that he did not have mental health problems . He also believed the medication was slowing him down when he was studying for an upcoming university exam. Over the following 2 weeks, and after stopping his medication, he had started to hear voices. The voices were in the 3rd person and for the most part were derogatory in nature.

Significant improvement noted. Denied experiencing any visual or auditory hallucinations and could not recall the last time he had experienced this. No signs of responding to any unseen/unheard stimuli. Valdo reports that the university has been supportive.

Action and plan

Home visit scheduled for 1508/20, between 9 am and 12pm Establish if medications are required."

[NHFT0000168, pg129]

61. In terms of the information I received / accessed to inform this entry, I reviewed the RiO notes and made a summary of VC's progress in relation to the care being provided by the crisis team. I did not speak with VC directly.

62. At this point, it was unclear if VC was taking his medication or not. However, his symptoms appeared to be reducing, and VC denied hearing voices. The instruction to check if VC needed medication was aimed at whoever visited VC next.

63. My basis for recording that there had been a "significant improvement noted" was that it had been documented in previous entries on RiO that there had been an improvement in relation to VC's symptoms. From reviewing RiO, it appeared to me that there had been significant improvement in VC's mental state during the period of time that the crisis team had been involved in VC's care. VC denied experiencing auditory hallucinations, he was meeting with the crisis teams for planned appointments, and practitioners had documented on RiO that they had observed improvements in his mental state.

64. The home visit scheduled for 15 August 2020, appears to have been conducted by Clive Chimbi:

"City crisis team summary of contact

arrived at his flat at 12:10 he was not in at that time. I Rang him and he said he was due to return in 30mins as he had been out shopping.

On his return we met in his flat. He was pleasant polite and welcoming. he mentioned that he had been keeping himself busy preparing for his exams. He is also being going out for walks when he can. he reports sleep is quite good infuse is getting enough of it not tired on waking and not taking any next during the day. Diet is also reportedly good, he said that he's trying to eat healthy and be healthy. he feels that his mental health is much more improved. He denied experiencing any unusual ideas, he denied having fears that hewas not safe in his flat or that

people were out to get him. He denied auditory and visual hallucinations. He feels his mood is stable in states that is neither up nor down. Objectively I found him to have a masked expression and euthymic in mood.

His speech was free of unusual ideas and no more in rate flow and fluency. There is no evidence of disorder.

There is no evidence of altered perceptions. There was no evidence of poor cognition. we discussed this discharge from the crisis team he feels that is ready for this. He was made aware that he can contact the crisis team out of no more working hours. He was made aware that you can contact his normal local mental health team Monday to Friday between the hours of nine in the morning and five in the evening. He feels support from CPN and is enough at the present time. He knows that you can self refer back to the crisis team if this is warranted . He also knows that he can talk to his GP and his local mental health team for support.

Risk

at the current time risks appear low in all areas. He's not a risk to himself and is not a risk to people.

It is worth noting the crisis team got involved as it was feared that he may not be compliant with his medications. while at the present time he expresses that he is happy to continue with medications there is a possibility that he could become non compliant. This will possibly leads to another relapse.

Carer/Family input

Valdo states speaks his mother nearly everyday. he reports that she does not have any concerns with regards to his mental health. I'm note from RIO mother feels that there is an improvement in his mental state. Mother also aware that she can contact the crisis team or the local mental health team if she has any concerns.

Medications

Aripiprazole 10mg
Colecalciferol

Pathway LMHT

Plan

Discharged from crisis team today. The office will ring the local mental health team on Monday to inform of this discharge."

[NHFT0000168, pg130]

65. I was not involved in the home visit of 15 August 2020. I cannot recall that I was informed of the outcome, or any information arising from the home visit, by Mr Chimbi. This is because when a patient has been assigned to the Crisis Team, they will be visited by members of that team, and I would not necessarily be made aware of those visits, unless I am actually involved with that patient at the time, or the staff member who has conducted the visit wanted to discuss something about that patient with me.

66. I do not recall being aware of the decision to discharge VC from the Crisis Team following this home visit. As above, if I am not involved in the patient's treatment for that day, then I will not know about their plans for discharge.

67. I am unable to comment on what Clive Chimbi meant by his finding that VC had *"to have a masked expression and euthymic in mood"*.

68. In the context of VC having been discharged, the ongoing risk of non-compliance meant that the risk that VC could stop taking his medication in the future was likely to be an ongoing risk.

69. VC did receive further home visits over the following weeks [NHFT0000168, pg130 onwards]. This is because when VC was discharged from the Crisis Team, his care and treatment was transferred to the Local Mental Health Team Early intervention in Psychosis Service. They continued to visit VC and would continue to assess and monitor his mental health.

70. On 21 January 2022, I spoke to "Ellie", a student support worker:

"Telephone call received from Ellie - Student support worker. Expressed concern about Valdo's missed appointment with the crisis team. Accommodation complex that he resides in want him to leave their accommodation. Ellie would like to be updated as to whether Valdo has been seen today and has requested a call back on [REDACTED]."

[NHFT0000168, pg206]

71. I was present in the MDT following this conversation, and I raised and discussed my concerns with Dr Skelton.

72. I cannot recall having any further involvement with, or input into VC's care, other than that touched upon in the above questions.

Recommendations

73. In terms of recommendations which this Inquiry should make to help prevent similar attacks in the future, I think the process of applying for Community Treatment Orders needs to be reviewed. I think it should be made easier to apply for one of these orders where there is evidence of non-concordance that increases the risk posed to self and others.

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

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Dated: 21/11/2025

Index to First Witness Statement of Annette Palmer

No.	URN	Document Description
1.	NHFT0015487	Training materials submitted on behalf of the Trust
2.	WITN0299002	The Nursing and Midwifery Council Code of Conduct published 2015, updated 2018.
3.	WITN0299003	HMG's Mental Health Crisis Concordat, February 2014
4.	NHFT0000168	Medical Records of VC from 24/05/2020 to 14/06/2023, Various NHFT Staff/Teams, re: Patient Record Summary
5.	NOCC0000044	Report dated 24/05/2020, compiled by Dominic Lloyd, RE: AMHP Report Referral and Assessment of Valdo Calocane
6.	NHFT0004927	Medical Records of VC from 24/05/2020, Dr Rahul Gandhi, re: MHA Assessment
7.	NHFT0002579	Medical Records of VC from 24/05/2020 to 27/05/2020, NHFT, re: Mental Health Clustering Tool (was HoNOS PbR)
8.	NHFT0003815	Medical Records of VC from 24/05/2020 to 31/08/2020, medical establishment unknown, re: Risk and Safety Assessment
9.	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