Witness Name: Patrick Crolla
Statement No: WITN0149001
Dated: 04 November 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF PATRICK CROLLA

I, Patrick Victor Crolla, will say as follows:

Introduction

1. I am Clinical Lead (Band 7) in the Nottingham City Crisis Team within Nottinghamshire Healthcare Foundation NHS Trust ("**NHFT**").

2. I make this statement in response to a request sent under Rule 9 of the Inquiry Rules 2006, dated 22 September 2025. In this statement, I discuss my career and role, my training and qualifications, and my involvement 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. In July 2005, I graduated with a Diploma in Professional Nursing Studies from the University of Manchester. In May 2024, I also completed a degree module in prescribing at Sheffield Hallam University, which means I am now qualified as a non-medical prescriber, and therefore can prescribe medication in the mental health remit.

5. I am a member of the Nursing and Midwifery Council. I confirm that I do not hold any other professional appointments.

6. Upon qualifying, I worked as a Registered Mental Health Nurse (Band 5) on one of the Acute Admissions Wards at Queen's Medical Centre. Queen's Medical Centre is part of NHFT.

7. In May 2008, I became a Clinical Team Leader (Band 6) on a different Acute Admissions Ward at Queen's Medical Centre.

8. From May 2009 to March 2013, I was a Clinical Team Leader (Band 6) on the Cassidy 136 Suite at Highbury Hospital. From March 2013 to February 2019, I was a Team Manager (Band 6) on the Cassidy 136 Suite.

9. From February 2019 to April 2023, I was a Crisis Care Practitioner (Band 6) at Highbury Hospital. This is the role I was in at the time of my interactions with VC. My role was a devolved management, leadership and development role in ensuring and supporting the effective delivery of clinical practice by the Crisis

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Resolution Service to clients aged 18 and over with severe mental health problems and/or an acute psychiatric crisis in accordance with quality practice and procedures. As part of this role, I would undertake mental health assessments and provide support to clients within a variety of settings including the client's home, and other health and non-statutory settings.

10. Since April 2023, I have been a Clinical Lead (Band 7) in the Nottingham City Crisis Team.

Training and system of work

11. I cannot remember the specific training in the assessment of risk for mental health patients of violence towards others that I received while obtaining my qualification. However, each term, there would have been time allocated to various mental health placements, and lectures and theory-based education including risk assessments.

12. Since joining NHFT, I have completed the annual essential training programme each year; this includes packages tailored to my role. One of these packages is clinical risk assessment training in relation to mental health.

13. I also receive annual practical training in therapeutic management of violence and aggression. When I was working on the acute wards, this training would include the practical resolution of management of violence and aggression (such as physical techniques and restraint), and theoretical management of violence and aggression, such as de-escalation training. Now that I work in a

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community role, this training includes breakaway training and training in verbal de-escalation of risk, as well as the theoretical approach to managing violence progression.

14. In terms of the information that was shared with me about the patients I was involved with, patients would be referred to the Crisis Team by doctors, the emergency department, carers, or by themselves. Upon receiving that referral, the duty nurse would ask questions about the patient in accordance with the triage referral form. This would include general information about presenting problems, mental health history, physical health concerns, medications, family involvement, substance use, situational risks, historical risks, demographic risks, mitigating or protective factors and forensic history. This information would be recorded on the form accordingly.

15. We would also gather information from the core assessment, risk assessment, the care plan formulated following assessment, the risk alerts on RIO, the historical information on the RIO progress notes, and the situational assessment. We would also look at historical information in correspondence such as GP letters. We also have access to the Nottinghamshire Health and Social Care Portal which is helpful to see medication that the patient might be on. We would then make a decision about whether to conduct an initial assessment of the individual, or whether we would signpost for more appropriate provision of care.

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16. At the start of each shift, a verbal handover would be provided by the Shift Lead or Duty Nurse.

17. I have access to the RIO Records, and more recently, I have also had access to the Nottinghamshire Health and Social Care Portal. I am not aware of any restrictions on my access to those systems. The Nottinghamshire Health and Social Care Portal provides access to information from primary care, regarding previous GP appointments, Emergency Department presentations, physical health investigations, allergies, and previous/current prescribed medications.

18. Prior to dealing with a patient, I would read the RIO record, including progress notes and the alerts, the core assessment, risk assessment, care plan, family details, medication, social circumstances, and patient preferences.

19. In terms of sharing information about the patients I was involved with, this would be done by updating their core documents and RIO Progress Notes, and by speaking with other clinicians in the Multi Disciplinary Team ("MDT") meetings. I would use also communicate with colleagues via email where required, such as regarding a specific clinical intervention.

20. I would escalate any concerns that I had about the risks posed to others by patients I was involved with through the Shift Lead, the Team Lead and/or MDT. The target for the Crisis Team to respond to a risk is four hours. However, if a situation was escalating and I required urgent support, I would also use 999 or 101 to escalate the matter to the police. Sometimes the Police would be willing

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to attend, if, for example, one of our patients had a weapon; other times, however, the Police might say that a mental health crisis is not something that they respond to.

21. I always felt comfortable in raising concerns about risk within wider MDT discussions and with senior members of clinical teams. For example, if one of the team had interacted with a patient and felt that they demonstrated an increased risk, this would be discussed with the consultant at the MDT.

22. I confirm that I have not 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.

Interactions with VC

23. I cannot recall exactly what information I received in advance of my involvement with VC. However, from the RIO records, I can see that the Crisis Team were supporting VC on his discharge from hospital. I cannot remember the verbal information that I was given, or who provided this to me.

24. I cannot recall what my understanding of VC's psychiatric history, his diagnosis and/or condition, capacity, treatment and/or care plan, and whether he had ever had involvement with the police would have been at the time of my interaction with him, but this would have been based on what was in the RIO notes.

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25. In terms of VC's presentation, my first contact with VC was a pleasant visit and it was good to see that VC had some insight into his mental health. When I first arrived at the home address, VC was not present. I rang him and he said that he was studying at the University and was '10 minutes' away. I waited and VC came back to the flat. VC was engaging and amenable to discussion about his mental health. He did not have full insight into his illness but had begun to accept different perspectives to the thought processes that he was experiencing prior to admission. I saw no verbal or non-verbal physical cues for aggression or violence. Patient Record Summary ("**PRS**") [NHFT0000168 p 127-128].

26. On my second contact with VC, we met at the Subway car park which is an unusual place to conduct a visit. I was aware that he was difficult to engage and therefore this location was selected as a compromise, as this was the only way to facilitate any engagement with him at that time. VC was guarded, and his body language suggested he was suspicious: he had his hood over his eyes, he was monosyllabic in his speech, was clearly wary of speaking with me, and displayed some underlying agitation which suggested to me that he wanted the appointment to end as soon as possible. He was not verbally or physically aggressive, but his body language made me feel uncomfortable (PRS) [NHFT0000168 p 209].

27. I cannot recall why I did not include these observations in my RIO progress note at the time, or why I am able to now recall this information retrospectively. I would speculate that I have come to these conclusions by reflecting on my meeting with VC, which has potentially been influenced by the events following VC's discharge from the Crisis Home Treatment Team. The only other avenue

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for this information to be handed over would have been via peer discussion and/or MDT discussion; I do recall similar information to this being discussed with my peers, but I am unclear whether this would have been handed over via the MDT.

28. VC made me uncomfortable because his guarded demeanour was consistent with behaviour typically shown by patients who are experiencing psychosis, and who potentially have associated unpredictable behaviours.

29. The PRS include an entry on 01 August 2020 at 04:49pm [NHFT0000168 p 119], which states:

> *OOH Contact*
> *Telephone call received from Valdo to inform the team that he has now located his medication, with no further requirements for orders by the team.*

30. I confirm that this record is complete and accurate; there is nothing that I wish to add or amend.

31. The PRS include an entry on 08 August 2020 at 12:12pm [NHFT0000168 p 127-128], which states:

> *Summary of Contact:*
> *Valdo seen at home address by myself.*
>
> *Appeared well presented and amenable, returning home after an initial call by myself.*

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Valdo reports that he has been engaging in reading and attending to his own needs via shopping, whilst also going to his local gym following recent opening after COVID.

Viewpoints obtained re: recent experiences i.e. admission and an increase in psychotic ideation, with Valdo feeling that he was currently attempting to makes sense of this in that he had found the experiences confusing and asked himself very reasonable questions about why this may have happened to him.

Education offered re: stress-vulnerability with Valdo appearing to acknowledge this in that he had been experiencing increased distress due to his exams at this time, which may have been a contributing factor to his deterioration in mental state.

Previous psychotic phenomena referenced, with Valdo stating that he is not currently experiencing auditory hallucinations in the form of a running commentary, accepting that this had been the case and was also not experiencing any persecutory thoughts in relation to his neighbours or other people.

Education also offered form a CBTp(sic) perspective when taking time to analyses any paranoid thoughts specifically and review perspectives in relation to this.

Risk:
Young male, with a significant mental health diagnosis, some degree of social isolation due to moving to University.
Dynamic stressors re: University exams and increase in workload Pre morbidly prefers own company
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 during todays visit (although as previously noted, responses to questions were very slightly delayed).
Confirmed ha(sic) the number for CRHT and reminded to call anytime for support.
Valdo reported that University are aware of MH service involvement and feels the university is being supportive regarding studies.
Protective:

- *Supportive family*
- *University Support*

- *Flat mates*
- *CR/HT on a 24/7 basis*
- *EIP Involvement*
- *Nil illicit substances/alcohol*
- *Developing insight*

Medication:
- *Cholecalciferol: 800 Units, OD*
- *Aripiprazole: 10mg, OD*

Valdo was able to repeat his medication to me to include medication names, uses and dosage/frequency.
No issues reported with concordance, with Valdo happy to continue with medication in the medium to long term, subject to review.
Nil side effects reported
Valdo aware that EIP will be open to any discussion to any changes re: medication, should Valdo experience any issues with the medication or feel that he wishes to discontinue.
Contact with EIP emphasised prior to any decisions re: medication. Provision of medication unclear form previous documentation, with nil medication card available under CRHT.

Pathway:
LMHT- EIP City South: Claudia Birtles

Carer/family input:
Advised that he is getting on well with his flat mates and sees them regularly. No concerns reported.
Contact with family in Wales, stating that he is taking on advice and chatting regularly.
Happy for information re: care to be shared with family.
RAG:
Green- Further to stabilisation of mental state and decrease in psychotic symptoms
Discharge scheduled at next CRHT appointment (medication required)

Plan:
- *Home visit scheduled for 1508/20, between 9 and 12pm (CC)*
- *Establish further clarity re: medication provisions (Patrick Crolla)*

32. I confirm that this record is complete and accurate; there is nothing that I wish to add or amend.

33. Prior to my contact with VC, the Care Co-ordinator had done some excellent work on gaining collateral information from VC's mother, which led to me interpreting that VC's family were involved, and that they wanted to be supportive and to help him. I cannot recall whether VC said that he wanted his care relayed to his family.

34. I cannot recall what support I believed that VC was receiving from his university, or his flatmates. When the entry states "Nil illicit substances/alcohol", I cannot recall if this is what VC told me. I also cannot recall what developing insight I believed VC to have had, or what advice VC said that he was taking from his family. This is due to the passage of time since that interaction and the present day.

35. Where I record "no issues reported with concordance, with Valdo happy to continue with medication in the medium to long term, subject to review", I did rely on what VC said, and that he was developing insight into his illness.

36. The PRS show an entry for 12 August 2020 at 11:20am (Page 128, NHFT0000168 p 128], which states:

> *T/C with Valdo, who states that LMHT have previously been providing medication.*
> *Email forwarded to CCO, Claudia Birtles to confirm.*
> *Valdo informs me that he has 3/7 of medication remaining.*
> *CRHT can provide additional medication to compensate (in preparation of Saturday's appt. if LMHT are unable to co-ordinate.*
> *Plan:*

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- Appointment for 15/08/20, between 9am and 12pm confirmed (CC)

- LMHT to provide further meds (if previously agreed) (Claudia Birtles

37. I confirm that this record is complete and accurate; there is nothing that I wish to add or amend.

38. The PRS show an entry for 23 January 2022 at 11:22am [NHFT0000168 p 209], which states:

> *Summary of Contact:*
> *Valdo seen at Subway (Unit 1, 1 Midland Way, Nottingham NG7 3AG) by myself and CPN, Agnes Matikiti, choosing to conduct the appointment outside.*
> *Queries made as to whether Valdo would prefer to meet at alternative locations, to maintain his privacy, with Valdo maintaining that he would prefer this arrangements.*
> *Valdo presented as previous, wearing a black coat with hood up and black jeans.*
> *Lips continue to appear cracked with potential dehydration in evidence.*
> *Nil overt signs of responding to psychotic phenomena, with speech content remaining normal in rhythm and tone, although rate was very much monosyllabic with Valdo appearing as guarded in his responses.*
> *Risk:*
> *Male, psychosis, previous detention under MHA, approaching neighbours due to persecutory ideas/auditory hallucinations (neighbour needing to jump form window to leave on one occasion), verbal hostility*
> *Currently felt to be non concordant/sporadic use of medication, leading to verbal hostility and threats towards a fellow student.*
> *Protective: engaging in support from services, engaging with student services, nil thoughts of self harm, nil use of alcohol/illicit substances*
> *Medication:*
> *- Aripiprazole: 20 mg, OD*
> *Medication provided by CRHT, for return to CRHT clinic following use*
> *Valdo reports he is happy to accept his medication, although concordance appears sporadic based on*
> *historical references and reports since the start of the year.*

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Difficult to obtain views re: medication Valdo shrugging when asked about his views in requirements for
medication.
Pathway:
- CCO (Adele Pinder) under the EIP Pathway

RAG:
Red- Daily visits for the purpose of med concordance and monitoring of mental state/risks

Plan:
- Home (Subway) visit for the purpose of medication concordance (CRHT)

39. I felt that VC was guarded due to his body language and his agitation of wanting to leave the appointment. In terms of the significance that I attached to VC appearing guarded, after VC took his medication, I remember thinking that I did not want to ask any more questions or put him under any pressure due to his agitation and suspicion, in case this put us at risk. The situation was difficult, because patients have to deteriorate to a certain extent in order for us to use the Mental Health Act proportionately, but this means we cannot always treat patients as proactively as we would like.

40. Had more options been available to us, the most likely option that we would have pursued for VC would have been hospital admission, together with use of anti-psychotic medications with interventions made in an attempt to maximize VC's adherence, Hospital admission would have allowed More proactive treatment of the psychosis symptoms seen from VC here would require changes to mental health legislation, to enable mental health professionals to treat people against their will, while still acting in accordance with the patient's human rights.

41. We visited VC as a two because we could see that his approach had been guarded, and it was likely that he was suffering from symptoms of paranoia; we also knew about VC having had verbal and physical alterations in the past, so the decision had been taken for him to be visited in pairs.

42. My knowledge as to whether VC was taking his medication was informed by a verbal handover from staff, and the documentation in the progress notes. I cannot recall whether I asked if VC understood what medication he should be taking, or what other specific questions I asked on this occasion, due to VC's presentation at the time.

43. The purpose of the 'daily visits' mentioned in this entry is to monitor whether people are taking their medication or not, to perform a mental state evaluation, and to evaluate the associated risk. We took VC's medication with us and watched him take it during this visit..

44. Following this contact with VC, my colleagues and I discussed that VC appeared to be unwell, and he seemed to be wary, so visits should continue to be done in pairs. We also discussed that VC appeared to be suspicious and guarded, and that there were concerns about non-concordance with his medication. These risks were also discussed at a daily RED Rag meeting, which included oversight from the CRHT Responsible Clinician and/or duty consultant. I cannot remember these discussions specifically, however.

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Reflections

45. In light of VC's attacks, I primarily feel very sad for the victims and families, and for VC and his family. However, having reviewed the documentation, I am happy with the standard of care provided by the Crisis Team during those times.

46. These events have not led to me changing the way I practice. I am happy with the decision that I made at the time, and the level of detail and documentation provided.

47. I confirm that I have not given any interview or otherwise made any public comments about the actions of VC or the matters under investigation by the Inquiry.

Recommendations

48. From a systemic perspective, I believe that cuts to public services over the last ten years have contributed to high profile incidents of this nature. This includes cuts to services such as the Assertive Outreach Team, which was proven to reduce risk in people with severe and enduring mental health problems that find it difficult to engage with mental health services. In my opinion, the Chair of the Inquiry should recommend that the Assertive Outreach Team is brought back.

49. The lack of funding has also impacted on the Crisis service in general. For example, recently the government set up the Clinical Access Line, which fields calls to mental health services. This is a good initiative, but the staffing needs

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were met by taking six full-time staff from the Crisis Team. When you account for 'human factors' such as annual leave, sickness, and so on, we have worked out that this leaves the team unable to complete around eighty fewer visits per week than before. This means the team cannot provide the level of responsive care that is required. A further recommendation that I think the Chair of the Inquiry should make is therefore that the Crisis Team should have more resources.

50. I also think that the Chair of the Inquiry should recommend a more robust process for the ways in which mental health services work together with the police. In relation to this case in particular, the Early Intervention Psychosis (EIP) service reported to the police that VC was missing, and no steps seem to have been taken in either direction. Obviously, the police have many different things to prioritise, but I think there should be more importance attached to the police trying to contact a missing person who has severe mental health difficulties.

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: 04/11/25

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Index to First Witness Statement of Patrick Crolla

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

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