Witness Name: Stephen Quartey

Statement No: WITN0275001

Dated: 19 November 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF STEPHEN QUARTEY

I, Stephen Quartey, 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. In this statement, I will first explain my career and role, and then my training and the system of work for the role I was in when I interacted with VC. I will then give details on my interaction with VC.

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

Career and Role

4. I am a Registered Mental Health Nurse; I qualified in May 2006. I was awarded a Diploma in Mental Health Nursing from the University of Brighton in May 2006.

5. I am a member of the Royal College of Nursing ("RCN") and the Nursing and Midwifery Council ("NMC").

6. I have worked across many services in the UK as a Registered Mental Health Nurse. I started working at Nottinghamshire Healthcare Foundation Trust ("NHFT") as an Agency Nurse in 2015. I worked across all departments, including the Cassidy Suite, the Psychiatric Intensive Care Unit ("PICU") and Highbury Hospital.

7. I have been a Band 6 nurse since I qualified in 2006.

8. At the time of my interactions with VC, I was the nurse allocated to the Cassidy Suite for that night shift.

9. I left NHFT in around 2022, I am still a nurse although I am currently on a career break.

Training and system of work

10. As part of obtaining my qualifications, all training was based on the curriculum of the mental health course. We were trained on the basic principles of nursing, assessments, planning and evaluations.

11. At NHFT, I would not say there was any formal training in terms of a course, however, we get educated about things that have been updated on the system; there is some training that relates to core assessments, risks to self, risks to others, risks to property, neglect and other elements of risk. Also, if there was something which I did not understand, I could ask colleagues.

12. When coming onto a shift, the nurse handing over would provide information about patients who are already in situ in the Cassidy Suite as well as any potential admissions that may be coming in. The police may also call in and tell us who they have and any information they have about the person, and they may request information from us.

13. We are also able to access information on RIO and if time allows, I could scroll through and find out information about their health, their circumstances and any risks.

14. As an agency member of staff, I did not have direct access to the RIO system. In order to access RIO, I would need another member of staff, i.e. bank staff to log on, and then I could sit next to them and read the information.

15. Prior to dealing with a patient, I would read clinical notes recorded by the clinician and notes in relation to the MDT which gives a broader view about the

patient, including their background information, any developments and also the risk assessment.

16. I would record and share information by recording it on RIO and in the nursing notes or if there was the need to cascade information to a professional on the phone then I would do so. Because I do not have access to RIO it would be difficult to email a professional but with the permission of the individual who has signed me in, I could do so.

17. The aim and purpose of a "Summary & Care Plan" [for example, **NHFT0000199]** is that it highlights the things that need to be implemented or done with regards to an individual and helps with the assessments.

18. To formulate a plan or treatment, you will need to be aware of the risk factors that relate to an individual. You also need to have an idea about their social circumstances, not just treatment alone. It is also important to engage with an individual to formulate a plan for treatment and if they are not able to engage, then engage with their nearest relative.

19. When a patient has multiple admissions under the Mental Health Act 1983 ("MHA 1983"), the ultimate responsibility lies with the responsible clinician. From the point of view of a nurse working in the Cassidy Suite, we may receive information from the police, we can review the RIO notes and when we make contact with the Approved Mental Health Practitioner ("AMHP") they can liaise with the consultant. Before the patient arrives and a decision is made to detain, they would have read through the notes and would have met with the individual

in the Cassidy Suite to make a decision on detention; that decision does not involve us nurses.

20. In relation to ensuring any patterns are captured, I would go back through the previous notes as far as I can to look at those previous admissions but would also look at the information currently received and then look at how the individual is presenting prior to the MHA 1983 assessment.

21. If a patient in involved with the community mental health teams and those teams feel that there are issues which merits an admission, they will relay that to the inpatient services.

22. The Mental Health Clustering Tool, for example, **NHFT0000185**, is a tool for risk assessment and classification of risk.

23. Risk assessments give a good idea of the care that can be safely implemented to ensure patient safety. For example, if a risk assessment indicated that a patient is at risk of suicide, it would be apt to have a care plan that said that if they go on section 17 leave wearing trainers, they may need to hand over their trainers on return so that they cannot pose a risk to themselves. Risk assessments give a good idea about how to formulate a care plan to maintain the safety of that individual and of others.

24. If I had concerns, I could raise these to the band 6 nurse on shift who supports the whole unit, including the PICU and the acute services; I call them the shift coordinator, but I think they have a different name in Highbury Hospital.

Although I was agency staff, the decorum was fairly good and so I felt comfortable to raise concerns if there was an imminent risk.

25. In the Cassidy Suite, I would contribute to discharge planning for patients under my care, if an assessment takes place and the decision is made not to detain. That is not a discharge from the services, but just a discharge from the Cassidy Suite. In those circumstances, we would make sure that the person has a place to go and if not, where they should contact, if they need transport, if that transport needs to be secure transport, or if staff need to accompany them. If they need to be discharged to another service, we would contact that service and pass on the information that they need to know.

26. 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.

Interaction(s) with VC

I. VC's Fourth Admission at Redwood in Highbury Hospital, NHFT (under s.135 and then s.2 of MHA 1983)("Fourth Admission") 28 January 2022 – 24 February 2022 (27 days)

27. My involvement within VC's inpatient MDT during his fourth admission was with regards to detention under section 136 and making a decision whether to detain or not.

28. VC's medical records show that on 19 January 2022, I completed a "S.136 MHA Comms & Monitoring Form" in respect of VC **[NHFT0000260].** This is the document which the police will complete prior to brining an individual into the suite or when bringing them in. I do not recall what information I was given in respect of the incident which led to a s.135 warrant being issued in respect of VC and a subsequent MHA Assessment.

29. I cannot recall whether I sought any further information about the incident with VC's flat mates. On his arrival, VC was highly on edge so we were trying to keep him calm and not to ask questions of him that would instigate violence. We were trying to keep VC calm prior to the MHA assessment. We took what the police cascaded about hostage taking.

30. If a patient is cooperative, we may confirm with the patient if what the police told us was true, however, VC was not amenable to any nursing intervention and did not believe that he should be there, he just wanted to the assessment to be over.

31. I did personally review VC on this occasion as part of my nursing role and attempted to engage with him, but he was not amenable. From experience, when individuals are brought into Cassidy Suite and not amenable to engage, further pressure on them may lead to an escalation of violence and so I try to keep them calm until they are assessed by two doctors and the AMHP which is the main purpose of them coming to the Cassidy Suite.

32. I cannot recall whether I was present when the relevant MHA practitioners undertook the MHA 1983 assessments on 19 January 2022. My recollection in relation to this matter comes from the RIO documentation.

33. In terms of the risks that VC posed, if someone has been held hostage then the risk will be moderate to high as this poses a threat to life. In that respect, I did not want to make things worse by engaging further when he did not want to.

34. The purpose of the S.136 Comms & Monitoring Form is to give us an idea of why the individual has been detained, where they were detained, whether they have been seen by triage and if so, any information relating to that. If we have received information from the Police, we will put that onto the RIO system.

35. The following is recorded on VC's medical records on 28 January 2022 at 9:58pm [**NHFT0000168, at pp.213-214**]:

"...Valdo arrived on Cassidy accompanied by one paramedic and one soldier. He was dressed for the weather but appeared unhappy for being here. Staff introduced self to him and offered him a drink but he declined. Staff tried to engage him to cooperate with admission formalities but he stood by the door and stated that he is only here for a MHAAx and does not require to do his physical observations etc. Valdo declined all other interventions normally done at admission. He appears guarded with underlying anger and unpredictable of violence should he get detained after the assessment."

36. Additionally, there is a further record where I note the following observations in respect of VC on 29 January 2022 at 7:22am **[NHFT0000168 at p.216]:**

> VC "...declined to accept his 132 Rights patient information leaflets and sat on the floor in the corridor area [...] Duty doctor attended to clerk-in Valdo but he refused to engage...'

37. This was a night shift, and I recall that I received information from the AMHP that they had engaged with VC and had made a decision to detain him under s.2 MHA.

38. As VC was not engaging, I recall that I would have looked on RIO at the information, this would be the nursing notes which captures information leading to the admission. In general, I would review the most recent notes, including up to at least a week prior, because patients are reviewed weekly by their respective MDT and this provides a reliable source of information. If time allows, I will read further. I cannot recall if I reviewed notes from the Crisis Resolution and Home Treatment Team ("CRHT") or from the Early Intervention in Psychosis Local Mental Health Team ("EIP-LMHT").

39. In relation to my impression of VC on 28 January 2022, it was difficult to engage him to determine whether he could understand or retain information. It was therefore difficult to determine capacity, but two doctors and an AMPH

placed him under s.2 which gives the indication that he needed to be in hospital for assessment.

40. VC's medical records show that on 28 January 2022 I then completed Form H3 "Sections 2, 3 and 4 - Record of detention in hospital" in respect of VC **[NHFT0000070].** As part of completing this form, I did review the Form A4 "Section 2 – medical recommendation for admission for assessment" [**NHFT0000070, pp 7-10**]. The A4 is the medical recommendation that came across from the assessment with regards to his detention and highlights the presentation and risk. We cascade that information to the admitting unit.

41. In the case of VC, from that I read from the notes, there was a step-up admission. The Cassidy Suite is meant for detention under s.135 and s.136 only, however, there was a policy which enabled someone to be detained not under those sections temporarily until a bed becomes available on the main ward; I think this was the case here.

42. I cannot recall whether I reviewed the "AMHP Report Referral and Assessment" carried out by an approved mental health professional **[NHFT0000071].**

43. I believe that VC's diagnosis was of schizophrenia although I am not certain. I cannot recall what my understanding of VC's forensic history was at that time.

Initial observations, assessments and care plan

44. The records indicate that on 28 January 2022, I updated a "Risk and Safety Assessment" in respect of VC **[NHFT0000191]** which includes the following information:

a. *Under the heading "Details" (p.1):*

"Valdo is a 30-year-old student of African descent with a history of recurrent psychosis and poor engagement/concordance. He expresses and acts on hallucination experiences but lacks insight into his mental health condition. Valdo has not expressed thoughts to harm himself. He is detained under S2 of the MHA (1983, amended) and stepped-up to Cassidy Suite, awaiting a bed on the main ward.
Poor engagement with services.
Suspected non-concordance with medication, increasing risk of relapse.
No insight into MH condition."

b. *Under the hearing of risk "To Others" (p.2)*

"January 2022 - Valdo was reported to the Police and University staff alerted due to an incident in his flat. Two flatmates claim that Valdo physically assaulted them in the flat and refused to allow them to leave. They were only able to escape after one of them grabbed Valdo and held him back. According to the student report, the Police did not arrest Valdo as he hadn't inflicted any harm. Details of this assault are unclear at this point as Police have so far refused to share details [..]

During the MHA in September 2021 although Valdo was initially amenable, he refused entry to his flat and Police attended. At this point Valdo became increasingly agitated and aggressive towards the Police officers, causing physical harm to 3 officers. He was tasered twice but to no avail, officers then

had to use Pava Gas to subdue Valdo due to him punching an Officer with significant force 3 times in the face and attempting to assault other Officers on numerous occasions. Valdo was not complying with any instructions or de-escalation techniques. Officers had to use leg restraints to remove Valdo from the address due to further attempted assaults."

c. Under the heading "Risk Formulation" (p.4):

"Valdo is a 30-year-old gentleman known to services with a diagnosis of psychosis. Historically when unwell he has force entry into his neighbours' houses under the influence of his psychotic experiences, though no violence has resulted. He has had two admissions last year.

He continued to experience auditory hallucinations and fixated on persecutory ideas relating to the government. He was previously admitted on Rowan 1 ward and was discharged back to his flat. He has had input from his CPN and community doctors post discharge, He was detained on section 136 following making attempts to get into neighbours' apartments, he appears to be responding to Auditory hallucination. Valdo seemed to be responding to unseen stimuli. Acted suspicious of all activities [..] VC has no past history of mental health difficulties. He has no past history of illicit substance use or forensic history."

45. In completing these entries, I relied on the nursing notes on RIO, historical information given by other clinicians and the information that the police gave on the Form 1 document **[NHFT0000260]**, noting that VC did not want to engage and that I did not have the opportunity to contact his relatives. I cannot recall the names of the clinicians.

46. Within VC's clinical MDT, because he moved from the community to the inpatient unit, it would be the responsible clinicians responsibility to provide updates from both inpatient and the community because they will be reviewing them. Also, the nurses who come into contact with him, if they notice any risks, for example, if he was to have vandalised property, they would have an obligation to document that for the other team to be aware, so it is a joint responsibility.

47. When VC has a review with MDT, they will also update the joint risk assessment from their perspective, that will involve the consultant psychiatrist and the psychologist.

48. In relation to how the Risk and Safety Assessment would be used in VC's care and treatment, as clinicians we rely on information that has been documented by our colleagues to be fact, as although we may not have been present, we rely on that information to provide care. For example, I was not there when he held his flatmates hostage, but when he came into the Cassidy Suite, because I knew that had happened, I knew that if I pushed his limit in terms of his engagement, there was a risk that he could try and repeat the same behaviour and so the Risk and Safety Assessment helps to mitigate risk.

49. On 28 January 2022 a "Summary & Care Plan" was produced in respect of VC **[NHFT0000199].** When a Care Plan is formulated, for example, by the team in the community or by the inpatient unit, that Care Plan is not discarded. When

an individual comes to our attention, we normally add in further information to what is already there.

50. The whole document would not have been completed by me as I only engaged with him on 28 January; the update on 28 January would have been documented by me.

51. I believe that the information under the heading "Summary/Formulation" is accurate; I relied on clinical notes.

52. The diagnosis which states VC had "First Episode Psychosis" I think is correct. He was presenting with some elements of being guarded, but the fact that they placed him under s.2 suggests that there is some presentation that the team wanted to investigate or assess. If it had been very clear what they were dealing with, they would have placed him under s.3.

53. In completing these entries, I relied on historical information given by other clinicians. If time allows, then clinicians will review a patient's full history of admission as far as possible. Within the Cassidy Suite, individuals are mainly brought there for assessment, and it tends to be the shortest period of detention under the MHA 1983.

54. Similar to ensuring that the Risk and Safety Assessment was accurate and up to date, it would be the responsible clinicians' responsibility to ensure that the Risk Formulation section was accurate and up to date.

55. I believe that the section "Care Plan Details" is an accurate reflection of the care plan in place in respect of VC's treatment at Highbury Hospital during his Fourth Admission.

56. As I explained above in relation to the Risk Assessment, the Summary & Care Plan would also be used to try and mitigate risks.

57. I do not recall whether I had any further involvement in VC's care and treatment throughout his Fourth Admission.

58. I would have discussed VC with the team I was working with on the 28 January and the team that came to assess him as although they had some prior knowledge, they wanted to know how he was presenting when he was brought in by the police. I would have told the assessment team about the circumstances leading to the detention of VC, as documented by the police, and VC's presentation on Cassidy Suite while he awaited the MHA assessment.

Reflections and Recommendations

59. I will continue to ask myself whether there was anything that I could have done to prevent this, however, to my knowledge, there was nothing to suggest he would have done this, my involvement was limited.

60. I have not changed the way I practice as a consequence of these events.

61. 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.

62. I think the Inquiry should look at the support for the nursing teams in terms of staffing levels. It should also look at the availability of beds so that patients who need to be in hospital are given the opportunity to be, rather than being discharged when it is a 50/50 of whether they should be admitted.

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: 19/11/2025

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No.	URN	Document Description
1	NHFT0000199	Summary & Care Plan, 28/01/2022. Updated 02/02/2022
2	NHFT0000185	Mental Heath Clustering Tool, 24/05/2020
3	NHFT0000260	S.136 MHA Comms & Monitoring Information Form, 19/01/2022
4	NHFT0000168	Medical Records of VC from 24/05/2020 to 14/06/2023, Various NHFT Staff/Teams, re: Patient Record Summary ("PRS")
5	NHFT0000070	Form H3 Sections 2, 3 and 4 – Record of Detention in Hospital, 28/01/2022
6	NHFT0000071	AMHP Report Referral and Assessment, 28/01/2022
7	NHFT0000191	Risk and Safety Assessment, 28/01/2022, updated 02/02/2022