Witness Name: Nathalie McPherson

Statement No: WITN0384001

Dated: 30 January 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF NATHALIE MCPHERSON

I, Nathalie Tamazine McPherson, will say as follows:

Introduction

1. I am a Crisis Care Practitioner (Band 6) at Nottingham Healthcare Foundation Trust (NHFT).

2. I make this statement in response to a request made under Rule 9 of the Inquiry Rules 2006, dated 17 December 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 at Birmingham City University in September 2012. I am registered with the Nursing & Midwifery Council (NMC), and I am currently a member of the Royal College of Nursing. I confirm I do not hold any professional appointments.

5. After qualifying, I worked as a Registered Mental Health Nurse at Pellon Care Centre (June 2013-March 2014), John Munroe Hospital (March 2014-September 2014), and then Mental Health Partnership Care's Annesley House (Low Secure Unit) (August 2014 – March 2017).

6. From March 2017 to November 2019, I worked as a Senior Nurse at St Andrew's Healthcare (Male Medium Secure Unit). In November 2019, I became a Clinical Team Leader at Cygnet Derby, and I stayed until July 2020.

7. I joined the NHFT Crisis Resolution and Home Treatment Team in July 2020 as a Crisis Care Practitioner. This is my current role, and the role I was in during my interactions with VC.

8. In addition to the above, I also worked as a Bank Registered Mental Health Nurse at various providers between March 2010 and 2025.

Training and system of work

9. When I joined NHFT, I completed all of the essential and mandatory training as part of the induction process. This included breakaway training, which is renewed yearly. I have exhibited my training records to this statement as WITN0384002, WITN0384003.

10. Information about the patients I was involved with was shared through a combination of Rio documentation and verbal communication within the team. I routinely reviewed progress notes, risk assessments, core documents and any existing care or crisis plans to ensure I had an accurate understanding of the patient's presentation, history and current risks. This was supported by regular multi-disciplinary team (MDT) meetings and structured handovers at the start of each shift, which ensured all clinicians were aware of any updates or changes.

11. During a typical handover, the team reviewed the caseload using the RAG-rating system, with particular focus on patients rated red due to higher levels of risk or complexity. The handover usually covered the reason for referral to CRHT, current and historical risks, mental state updates, information from carers or family, and any relevant social or environmental factors. We also discussed medication issues, planned follow-ups and any outstanding actions such as arranging Mental Health Act assessments, safeguarding contacts or escalation to senior clinicians. This structured approach ensured continuity of care and supported safe, informed decision-making for each patient.

12. I have access to Rio, and I am not aware of any restrictions to my access. I do not have access to SystmOne, however I do not consider this to be an issue. I have not needed to get information from SystmOne for the purposes of my role, and if I did, there are others in the team who do have access.

13. At the start of a shift, or before becoming involved with a patient, I review the key information within the electronic patient record to ensure I had an accurate and up-to-date understanding of their needs and risks. This included reading the core assessment, the risk assessment, recent progress notes, and checking any alerts or demographic details. Where relevant, I would also look at physical health information such as the Physical Health Profile and/or Audit C (which covers alcohol use) and review any recently uploaded documents (such as discharge summaries or correspondence) to identify any new information that might impact the patient's care, for example, if the patient is due to start a type of medication that will require regular physical health checks. .

14. I recorded information about the patients I was involved with by documenting all relevant details in their Rio progress notes and updating any required clinical documents, such as the core assessment, risk assessments, and other care-related records. I would also add the latest information provided by the patient (such as changes to consent, contact details, or significant updates) directly to RiO. In addition to written documentation, I routinely shared information verbally or in written form during handovers and MDT meetings to ensure the team had a consistent and up-to-date understanding of the presentation and risks for the patients I was involved with.

15. Where a patient has had multiple admissions under the MHA, I capture any patterns in a patient's repeated MHA admissions by documenting clearly on RiO, noting their presentation, triggers, and risks. I also discuss anything significant with senior staff in handover or supervision, and I will always speak with the consultant or on-call doctors if an MHA decision is involved. If needed, I contact other professionals like care coordinators or ward staff, in order to share information, or to request support for a particularly complex patient. All of this information feeds into the patient's ongoing care and crisis planning so we can respond more effectively in the future.

16. In terms of the relationship between inpatient care planning and the care planning undertaken by CRHT, the two teams work together to ensure continuity of care. The ward will start the care plan if the team have identified aspects of the plan that should be implemented on the ward in order to support discharge; for all patients, CRHT will take over the care plan after discharge through the 72-hour follow-up. If the patient is already open to a local mental health team (LMHT), the ward will usually hand over to the LMHT directly, but if this can't be arranged, especially near weekends, CRHT complete the follow-up instead. Afterwards, CRHT either hand the patient back to their LMHT or, if the patient not under a team, create a crisis plan and return their care to the GP. The ward also sends a discharge summary to the GP. Overall, communication between inpatient services and CRHT ensures a consistent, safe transition into the community.

17. From a CRHT perspective, the risk assessment is what really shapes a patient's care plan. When I assess a patient, the risks I identify (such as suicide risk,

self-neglect, deterioration, or environmental pressures) directly inform what level of support we put in place. The risk assessment guides how often we see the patient, what interventions we offer, and what actions we need to take if risks increase. Risk is not a one-off thing for CRHT; we review it at every contact. If risks go up, the care plan changes straight away, for example by increasing visits, involving seniors, considering informal hospital admissions, or options under the MHA. If risks reduce, we can start planning for alternatives, such as reducing medication. CRHT can use a wide range of options in order to respond flexibly to risk, provide appropriate levels of support, and ensure care is tailored to the patient's needs at any given time. So, in CRHT, the risk assessment drives the care plan, because it tells us how to keep the patient safe at home or whether hospital admission may be necessary, and what everyone needs to focus on to manage the patient's risks effectively.

18. If I had concerns about a patient posing risks to others, I would report these to the appropriate people, including the police, the Approved Mental Health Practitioner (AMHP), senior clinicians, and the wider MDT, depending on the nature and urgency of the risk. I would also update the patient's records and follow safeguarding procedures as required. I felt comfortable raising such concerns within MDT discussions and with senior clinical staff, as the team culture encouraged open communication, clear risk escalation, and shared decision-making to ensure safe and effective management of risk.

19. In my role within CRHT, I contribute to discharge planning for patients under our care. This involved assessing risk, reviewing the patient's progress, and

determining when they were safe to discharge from CRHT. I ensured appropriate follow-up arrangements were in place, either by handing the patient back to their community mental health team or, if they were not open to a team, by developing a crisis plan and returning their care to their GP. My role also included ensuring that relevant information was communicated clearly to the next responsible team to support safe and effective continuity of care.

20. 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

21. Before I discuss my interactions with VC, I wish to make clear that I do not have any independent recollection of these interactions, my understanding of VC's condition or history, or what information I received prior to my interactions with VC. My knowledge is therefore limited to the information that was formally recorded and shared within the team.

22. At the time of my interactions with VC, my understanding of the incidents which led to VC being under the care of CRHT was based solely on the information available to me at the time through clinical records and team communication. This included handover information, MDT documentation, and progress notes recorded within the RiO electronic patient record system. These records outlined the circumstances surrounding VC's referral, his presenting risks, and the rationale for CRHT involvement.

23. My understanding of VC's psychiatric presentation and history, his condition at the time, and whether he had ever been involved with the police was based entirely on the information available within the clinical documentation. This included progress notes, risk assessments, and MDT handover records held on the RiO electronic patient system, as well as historical Rio entries. These records outlined the VC's mental state, identified risks, and the reasons for the CRHT team's involvement.

24. My understanding of VC's treatment and care plan at the time was based solely on the documented records available to me, including the written care plan, nursing notes, and information recorded by the wider multidisciplinary team within the electronic patient record, including progress notes. My actions and clinical understanding were guided by what had been agreed and documented by the treating team.

25. Moreover, I do not have an independent recollection of receiving any specific verbal information in advance of my involvement with VC, nor do I recall any individual providing verbal information to me. However, in line with standard CRHT practice prior to visits or contacts, any information available to me would have been accessed via the RiO electronic patient record. This would typically include progress notes, core assessments, risk assessments, care plans, relevant correspondence, and demographic information as appropriate. I am unable to provide further detail beyond routine practice or what is recorded contemporaneously within the RiO record.

26. I do not have an independent recollection of having a specific role in formulating VC's care and treatment plan beyond what is documented in the RiO electronic patient record. Any involvement would have been in line with standard CRHT practice, contributing information as part of routine MDT working and documenting observations or contacts where appropriate. Decisions regarding the patient's care and treatment plan were made within the MDT and recorded accordingly.

27. I do not have an independent recollection of undertaking a specific risk assessment in respect of VC. Any assessment of risk would have been carried out in line with standard CRHT practice and recorded within the RiO electronic patient record, such as within progress notes or risk assessment documentation where appropriate. I am unable to comment on any conclusions beyond what is documented in the contemporaneous records.

28. I do not have an independent recollection of VC's presentation during my interactions with him, or the risks that VC posed to himself or others at this stage. Any observations regarding VC's presentation, behaviour, or any aggression or violence would be reflected in the contemporaneous documentation recorded within the RiO electronic patient record. I am unable to provide further details beyond what is documented.

29. I have been asked to consider my interactions with VC that are included in the Patient Record Summary ("PRS"). I do not have an independent recollection of these interactions beyond what is documented in the notes written at the time. Moreover, given the passage of time between these interactions and the

making of this statement, I am unable to comment on the completeness of record and do not wish to add or amend to the entries concerned.

(a) 20 January 2022, 11:00am

30. The PRS includes an entry on 20 January 2022 at 11:00am, which states as follows:

> "*Valdo arrange with my colleague FS to be seen at Subway off Unit 1, Off Ilkeston Road, Nottingham, EN, NG7 3AG for around 11 am.*
>
> *My self and CPN Fatima S was running a bit late. I attempted to call several times to say we were on our way and running late but Valdo did not answer.*
>
> *[o]n our arrival we rang Valdo as he request - attempted call several times - he eventual answered stating he already left and explained that he does not like answering private number. I asked if he was far away as we did not mind waiting for him to return as we also apologised for running late, however Valdo stated that he would prefer to meet tomorrow, [I] asked if we could book him an OPA appointment however he stated that this would not work for him as he attends uni and subway is nearer the uni than HH OPA, so agreed he would meet us again at 11 am on the 21/02/22 then head off to uni and requested that we did not call him from a private number.*
>
> *plan: appointment at 11 am - Unit 1, Off Ilkeston Road, Nottingham, EN, NG7 3AG.*"
>
> [NHFT0000168, pg.206]

31. Based on the contemporaneous record, the purpose of this visit was routine CRHT contact with VC as part of ongoing assessment and engagement. As documented, the visit did not proceed as planned due to difficulties making contact and VC having left the agreed location. The intended purpose was therefore not achieved on that occasion, and an alternative arrangement was agreed.

32. I do not recall why I asked if I could book in an Outpatient Appointment (OPA) appointment for VC, beyond what is recorded. However, in general CRHT practice, offering an OPA may be considered when a face-to-face review is required, and a home visit is not feasible or appropriate. OPAs provide a private and confidential clinical environment and may be suggested to support engagement, flexibility, and patient preference. Attendance at OPAs is not mandatory for all patients under the care of the Crisis Team and is determined on an individual basis, considering clinical need, risk considerations, and patient choice. Similarly, the frequency of OPAs will depend on the particular patient: for example, a patient on an Amber RAG rating would need to attend an OPA three times a week (which is the same frequency with which a home visit would be required), and a patient on a Green RAG rating might be seen once or twice a week.

33. Based on the record of my call with VC, the contact was limited to practical arrangements regarding attendance and rescheduling. A full mental state assessment would not ordinarily be possible or appropriate during a brief telephone exchange of this nature, and there is no indication in the record that a formal mental state assessment was undertaken at that time.

34. In standard CRHT practice, where medication concordance is a concern or a planned contact is missed, this would be addressed through discussion within the MDT, review of the patient's care plan, and adjustment of contact arrangements as required. Any actions taken would be documented and handed over appropriately. However, I am unable to comment further as to

whether this was done for VC beyond what is recorded in the contemporaneous documentation.

(b) 21 January 2022, 09:00am

35. The PRS includes an entry on 21 January 2022 at 09:00am, which states as follows:

> *"CRHT advise consultancy supervision and case formulation prior to plan visit - With supervisee Jo Baker. male 30 years of age risk: psychosis, previous detention under MHA after being detain on the 136 suite, held student hostage in accommodation -students has been moved elsewhere due to risk.*
>
> *hx of approaching neighbours due to persecutory ideas/auditory hallucinations.*
>
> *agree to work with CRHT - medication concordance mane - will only meet in public places cafe' etc.*
>
> *To continue with plan as per post MHA plan by Dr Mike Skelton*."
>
> [NHFT0000168, pg.206]

36. Based on the contemporaneous record, the entry reflects a routine CRHT supervision and case formulation discussion held prior to a planned visit, which is standard practice within the team. Such discussions are used to share relevant background information, consider engagement approaches, and ensure appropriate MDT awareness. This entry was not intended to constitute a standalone formal risk assessment. Within CRHT, assessment of risk is undertaken through multiple mechanisms, including review of documented risk assessments, supervision, MDT discussion, and ongoing clinical contact, with relevant information recorded on the RiO electronic record. Otherwise, however, I do not have an independent recollection of the specific reason for this entry.

37. I do not have an independent recollection of reviewing, updating, or contributing to a specific risk assessment following this interaction beyond what is documented in the RiO electronic patient record. I am unable to identify a specific risk assessment reference number and cannot comment further beyond the contemporaneous documentation.

(c) 21 January 2022, 11:00am

38. The PRS includes an entry on 21 January 2022 at 11:00am, which states as follows:

> "*CRHT: Valdo met CPN S. Wiecek and N. McPherson at Subway Unit 1, 1 Midland Way, Nottingham NG7 3AG which is opposite his student accommodation. On our arrival SW rang Valdo he answered and said he was sat inside subway and would meet us outside which he did.*
>
> *Valdo was dressed in dark clothing with his hood up over his head and trainers, he appeared guarded during conversation.*
>
> *Valdo said he was aware the reason we were here and that he agreed to work with CRHT and had consented to taking his medication. He took 2 x 10mg aripiprazole and observed him putting this into his mouth he declined taking any water or fluid. We tried to engage him in conversation so we could ensure med concordance, but he said he had to leave as he was headed to university.*
>
> *He agreed to meet CRHT again at 11 am same place and again declined OPA saying he had university and was not aware that today was Friday and tomorrow was Saturday even then he decline coming to OPA and said he would meet us at subway again tomorrow. As he walked away we watched him walking towards his accommodation and as he was passing a bin he put his hand to his mouth - then threw something in the bin which appeared to be the medication we had just given him.*"
>
> [NHFT0000168, pg.206]

39. Based on the record, observations were made regarding the patient's presentation and engagement, and these were documented accordingly. There is no indication in the record that a formal, structured mental state examination

or a formal capacity assessment was undertaken during this interaction. I am unable to provide further detail beyond what is documented.

40. I cannot specifically recall why I considered that it would be necessary to engage VC in conversation. However, in standard CRHT practice, engaging a patient in conversation during contact supports assessment of engagement, clarification of plans, and facilitation of medication concordance. Any engagement undertaken would have been consistent with routine clinical practice and recorded accordingly.

41. I do not have an independent recollection of the steps that were taken following this interaction with VC beyond what is documented in the contemporaneous records, including whether I shared my observations in respect of potential non-concordance with any other members of the CRHT team responsible for VC's care. The interaction was a two-person visit, and observations were documented within the RiO electronic patient record. In standard CRHT practice, such documentation forms part of the handover and is accessible to the wider MDT for ongoing review and action. I am unable to provide further detail beyond what is recorded.

42. I cannot recall what my impression was in respect of VC's willingness to take his prescribed medication. However, based on the record, VC appeared to engage with the plan during the interaction and was observed to place the medication into his mouth, although, subsequent observations gave rise uncertainty as to whether the medication was ingested. As such, my impression

of VC's willingness to take the prescribed medication was mixed and uncertain and based solely on the patient's actions and engagement as recorded.

43. I do not have an independent recollection of attending any MDTs at which these issues regarding VC's care were raised. I am unable to provide details regarding attendance, discussions, or decisions beyond what is documented in the records.

(d) 21 January 2022, 4:22pm

44. The PRS includes an entry on 21 January 2022 at 04:22pm, which states as follows:

> "*t/c returned to Ellie mental health team university, raised her concerns that we are 2 days into home treatment and feel that it is ambiguous to whether or not its working are not. and her views are that we should be considering a MHax over the weekend if there is another fail medication concordances. Ellie stated that she will liaise with CRHT and EIP CCO (Adele Pinder) - on Monday.*"
>
> [NHFT0000168, pg.207]

45. I do not have an independent recollection of taking steps to pass on concerns raised by Ellie Turner to other members of the team for VC's care while he was under CRHT during this period, beyond what is documented in the contemporaneous record. The concerns raised during the telephone contact were recorded within the RiO electronic patient record. In standard CRHT practice, such documentation forms part of the daily handover and MDT review process, particularly where a patient is subject to enhanced monitoring. I am unable to recall sharing this information with specific individuals beyond what is documented.

46. I cannot recall holding a specific discussion with a colleague regarding risk beyond what is documented in the records.

47. As part of routine CRHT practice, I felt comfortable raising any concerns regarding patient risk within MDT discussions and with senior members of the clinical team. This was consistent with the team's established culture of shared responsibility, supervision, and escalation where clinically indicated.

Reflections

48. Having reviewed the documentation, I recognized the seriousness of the incident and the impact such events can have on patients, families, and staff. Reviewing the documentation as part of writing this statement has reinforced to me the importance of clear record keeping, appropriate, appropriate escalation, and effective MDT communication when concerns arise.

49. I do not have an independent recollection of the events beyond what is contained in the documented records, and therefore I cannot identify any specific change in my practice linked to my personal recollection of this incident. However, as part of my ongoing professional development, my practice has continued to evolve in line with training, experience, and reflective practice. In practical terms, this includes maintaining clear and accurate documentation, ensuring effective communication with colleagues and other services, and adhering to appropriate escalation and safeguarding procedures.

50. I confirm that 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.

Recommendations

51. In terms of the recommendations I think the chair of this inquiry should make to ensure lessons are learned and to prevent similar attacks in the future, I think that from a general clinical practice perspective, and without reference to the circumstances of this matter, continued emphasis on clear MDT communication, robust documentation, timely escalation of concerns, and regular review of medication concordance and engagement within community crisis services may assist services in identifying and managing risk. Ongoing training, supervision, and staff support when working with high-risk presentations remain important.

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: 30 January 2026

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1	WITN0384002	Essential training records of Nathalie McPherson
2	WITN0384003	Personal Training history of Nathalie McPherson
3	NHFT0000168	Patient Record Summary of VC