Witness Name: David Waldron

Statement No: WITN0389001

Dated: 02 February 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DAVID WALDRON

I, David Waldron, will say as follows:

Introduction

1. I am the Out of Area and Subcontracted Clinical Lead for Bed Management at Nottinghamshire Healthcare NHS Foundation Trust ("the Trust"). This is a Band 7 role and I have been in post since September 2021.

2. I make this statement in response to a request made under Rule 9 of the Inquiry Rules 2006, dated 10 December 2025. In this statement, I discuss my career and role, system of work, and 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 am a Registered Mental Health Nurse. I qualified in 2003 with a diploma in Mental Health from the University of Nottingham.

5. I worked on acute mental health wards at Queens Medical Centre (part of Nottingham University Hospitals NHS Trust) and Highbury Hospital (part of the Trust) from 2003-2010. In 2018, I sustained an injury and could no longer work on acute wards. I subsequently took up a role in the bed management team, as a Band 6 Bed Manager. My role helps to coordinate bed flow in the Trust, for both Out of Area and subcontracted beds, alongside the Out of Area Bed Manager. Any referrals into the service are submitted by the Crisis Resolution Home Treatment Teams (CRHTs) in accordance with their gatekeeping processes [**NHFT0017677, p.13-14**]. At this time there were a number of bed managers in post to provide 24-hour support of bed flow management. These comprised of both Band 6s and Band 4s.

6. In September 2021, I took up the role of Out of Area and Subcontracted Clinical Lead following this alongside my Bed Manager colleagues as a Band 7 and I have been in this role ever since.

7. The role of the Out of Area and Subcontracted Clinical Lead for Inpatient care aims to provide active and effective case management for in patients with acute mental health difficulties who have been placed in either out of area beds or one of the Trust's subcontracted beds. We are also expected to progress ongoing plans for transfer/discharge to community teams, or to facilitate repatriation to local inpatient units.

8. As a Bed Manager I worked closely with the then Out of Area Bed Manager before taking up this role. The role title changed to Out of Area and Subcontracted Clinical Lead, when I took up post in September 2021. The role requires me to work with a range of health and social care professionals across the Trust and external organisations, to ensure that treatment pathways are put into place that are appropriate and delivered in a timely manner. In addition, the Clinical Lead should ensure that there is a clear pathway of transition for each patient through both internal and external service, include acute, psychiatric intensive care and rehabilitation services.

9. In general, the expectation of an Out of Area Clinical Lead for Subcontracted and Out of Area Beds is to manage the independent sector beds that the Trust is using and to aim for a reduction in this number.

10. It is important to understand that out of area admissions are a specific type of admission to independent health care providers commissioned by the Trust – this refers to patients who are admitted to a provider outside of the geographical footprint of Nottinghamshire.

Consideration of out of area treatment

11. A patient will be considered for out of area treatment if there is not a local adult mental health bed for them to be admitted into, or if the available bed is not suitable (for example, if the patient requires a psychiatric intensive care unit ("**PICU**") bed, and only a lower-level bed is available). Admission out of area or to an independent provider is a last resort.

12. Patients can be placed out of area for a variety of reasons – including if a patient is a staff member, or if there are safeguarding concerns if the patient is placed locally. At the time, I would work with colleagues within the bed management team to work out where patients needed to be admitted, and if an Out of Area bed was the most appropriate option, those arrangements would be made.

13. There is a practice of 'stepping up' temporary beds, if it takes significant time to find an appropriate bed. This means patients, once formally detained under the Mental Health Act, were treated in those temporary beds before being moved. For example, in the case of VC, his section 136 bed on the Cassidy Suite was 'stepped up', and he received treatment under formal detention under the Mental Health Act in that bed, prior to being moved to a PICU bed at Cygnet Victoria House.

14. At the time, once it had been determined that a patient required out of area treatment, the referrer ensured that the patient's electronic healthcare record (on Rio) was completed. This included the Core Assessment, Risk and Safety Assessment, Summary and Care Plan, Safeguarding Alerts and Progress Notes. It also contained the up to date records of where the patient was (such as on a section 136 suite). All of these records were sent to the patient's Care Coordinator ("CCO") as well as the Bed Management Team.

15. The Bed Management Team considered what inpatient unit and placement would be most suitable for the patient. The appropriateness was impacted by the patient's presentation, healthcare needs and bed type requirements (such as a PICU or an acute bed). Further to this, gender segregated wards needed

to be considered – such as whether the patient needed to be placed in an all-male or all-female ward.

16. This information, including the documents set out at paragraph 13, as well as risk assessments, care plans and physical care requirements were put onto the relevant spot purchase provider forms. These forms are then sent to the providers as part of the request for a bed.

Continuity of Care Principles

17. The Continuity of Care Principles Standard Operating Procedure in place at the time applied only to subcontracted beds and not spot purchase beds. Therefore, the relevant Trust policy in relation to spot purchased beds was "Admitting Patients to Spot Purchased Beds", which is exhibited here at **WITN0389002**. This sets out the expectations for the Bed Management team to share the relevant information with the provider of the spot purchased bed to support safe and best transitions upon admission and discharge, as well as effective information sharing.

18. Subcontracted bed providers had read only access to the Rio patient records. The CCO and/or Bed Manager would receive updates from the provider at ward rounds and would update Rio and upload any relevant paperwork. Providers who provided spot purchased beds could also be offered read only access to the Rio record, and the same principles of sending updates to the CCO and/or Bed Manager to keep the notes updated would apply. The usual practice was for staff at the external provider to coordinate with the Trust's Bed Management

team to obtain any additional information required from Rio that had not been sent with the referral documentation.

19. Any individual coming into a local or out of area bed would still have the same input from the local mental health team, as if they were treated in a Trust bed.

Measures in place to reduce the use of out of area beds

20. At the time that VC was placed at an out of area provider, there would be a daily Meeting, known as the Daily Demand Meeting ("**DDM**"), Monday to Friday. I would attend this DDM. The other regular attendees would be the General Manager, the Operational Manager, the Bed Management Team Leader and the Band 6 Bed Manager of the day. This meeting functioned as a review of the bed acuity and needs at the time. If a patient's acuity or need changed, and they could be stepped down from an inpatient and discharged back into the community, we would take actions to do so. If a bed within the Trust became available, we would take steps to repatriate that patient to that bed.

21. The Trust's present Continuity of Care Standard Operating Procedures **[NHFT0000425]** have been re-written since VC's admission to reflect the growth in the bed management and out of area teams and introduce more leadership roles within those teams to ensure less out of area beds are being used where possible, and where possible, patients are repatriated to local beds. These Standard Operating Procedures also now cover spot purchased beds.

22. At the time, and today, there would be a check of available beds on a daily basis, so that any patient that could be repatriated would be.

Trust oversight during an out of area placement

23. At the time, for sub-contracted beds, quality oversight was maintained in line with the Trust's Continuity of Care Principles Standard Operating Procedure. For spot purchased beds, in a similar way for subcontracted beds, any community involvement the patient had would continue – and therefore the patient's CCO would be in charge of making regular contact with the placement provider and patient during their admission. The CCO would attend ward rounds and be charged with making the appropriate community referrals for the patient for both health and social care needs.

24. If the patient was not under the care of a community team at the time, a member of the bed management team would perform these duties.

25. If any issue arose from the Daily Demand Meeting ("**DDM**"), including any issue of bed flow or admissions or discharges, these would be escalated to the Quality Assurance team within the Trust who oversees the out of area beds. At the time (and currently), the Clinical Quality Lead with oversight of all these beds was Jennifer Thompson.

26. The Bed Management team would expect the CCO to lead all communications and if they had any issues, they would be expected to feed that back to the team.

27. In terms of sharing and receiving relevant information during a placement, this would take place via ward rounds, care notes and regular updates of relevant documents. When a patient was placed out of area, an update would be put onto Rio every working day (Monday – Friday). The CCO would also be expected to attend the ward and get direct feedback from the patient, and the patient would be asked to feedback on their admission once they were discharged back into the community.

28. At the time, I do not recall any barriers or issues to sharing information with out of area providers generally, and I do not recall any specific issues relating to the sharing of information in regard to VC's out of area referral.

Interaction with VC and chronology of events

29. I did not have any interactions with VC personally. The Inquiry has directed me to the following entries in VC's progress notes on Rio:

'4 September 2021

1155:

BMT Entry
PICU Referral sent to Huntercombe Central and Roehampton for [VC]

1507:

BMT ENTRY
Referral is now in for Cygnet Blackheath or Victoria House' [**NHFT0000168, p.172-173**]

30. I can confirm that at the time of making these entries, I would have understood from the referral and previous Rio notes that VC required an out of area bed. I understood that he was a patient suffering from psychosis and

had known risks to others. The reference to "BMT" in the notes refers to Bed Management Team – I used this identifier to show that my team was making the entry. The PICU referral is a reference to the form filled out by Dr Ben Lomas on 3 September 2021 [**CQCM0001240**]. I would have also seen the original gatekeeping document compiled by the Crisis Home Resolution Team, explaining the rationale for VC's original detention and admission to the Cassidy Suite [**NHFT0017964**], and the Bed Management Daily update sheet from 4 September 2021, which showed bed occupancy on local beds, as well as male PICU beds and spot purchased beds [**WITN0389003**].

31. The Huntercombe Group referral is exhibited at [**NHFT0017813 and NHFT0018131**].

32. I cannot recall why Huntercombe Central and Roehampton were my initial choice for out of area placement, but I believe this would have most likely be down to bed availability at the time. These providers had no available beds at the time but if either of those providers had a bed then the other referrals would have been closed.

33. I cannot recall but believe that the referral was changed to Cygnet Blackheath or Victoria House due to bed availability at the time.

34. I updated the Rio record at 7:38pm on 4 September 2021 to state:

'BMT ENtry (sic)

Referral chased at Victoria House and Blackheath, Bed gone at Blackheath and Valdo has been declined by Victoria House re their acuity and his current requirement for Seclusion, which continues on the Cassidy suite' [**NHFT0000168, p.173**].

35. I updated the record to show that VC had been declined a bed by various providers, as availability had changed at some providers, and other providers did not feel that they could meet his acuity and requirements. Referrals were re-sent by my colleagues to Cygnet Maidstone, Stevenage and Victoria House on 6 September 2021 [**NHFT0000168, p.177**], and Cygnet Victoria House and Stevenage declined the referral on the same day [**NHFT0000168, p.178**]. Victoria House responded on 9 September 2021 and asked for the referral to be resent the next day [**NHFT0000168, p.187**]. My colleague re-sent the referral on 10 September 2021 [**NHFT0000168, p.187**], and VC was accepted at Cygnet Victoria House that same day and transferred on 11 September 2021. This was confirmed later to the admin support team in the Adult Mental Health Team [**WITN0389004**], although I note from the Rio record that VC's CCO was aware and updated VC's mother [**NHFT0000168, p.190**]

36. Whilst VC was at Cygnet Victoria House, his admission was monitored primarily by his CCO. However, in my role as Out of Area Bed Co-ordinator, I monitored which patients were in Out of Area beds and kept records up to date. We had a rolling record of current inpatients, which was a working document which would be kept updated as and when there were changes to

the beds we were managing. I exhibit copies of the record of showing VC in a Out of Area (spot purchased) bed, when he was an inpatient at Cygnet Victoria House at **WITN0389005**. I have also exhibited the records showing VC as an inpatient at the Bestwood Ward once he was stepped down from a PICU bed [**WITN0389006**]

37. I was sent a Patient Review document on 21 September 2021 from Cygnet Victoria House [**NHFT0018341**] which provided an update on VC's condition, as well as an updated risk assessment carried out by Cygnet Victoria House on 21 September 2021 [**CQCM0001414**].

38. I was asked by Julie Attfield to provide an update on the number of patients in Out of Area beds on 15 September 2021. I responded the same day [**WITN0389007**]. This included confirmation that VC was a patient at the PICU at Cygnet Victoria House.

39. On 23 September 2021, at 14:50, I made the following entry into the Rio notes:

'OOA Coordinator Entry

Clinical Update from Cygnet Victoria House... Tracey reports that [VC] is now stepdown ready. Update is that [VC] has displayed nil of violence and aggression, has had no incidents in the past week, is fully concordant with prescribed medication and is self supporting of ADLs and taking appropriate food and fluid.

Tracey has been updated as to the current bed state and will send updated information to the beds team. BMT have been updated' [**NHFT0000168, p.191**].

40. This clinical update was sent to me Tracey Reed, who worked as a Mental Health Nurse at Cygnet Victoria House. I responded to her email stating that we still had limited male beds available [**WITN0389008**]. As was usual practice, I entered this update onto the Rio notes, and this was available for the wider Multi-Disciplinary Team to review.

41. On 28 September 2021, at 17:09, I made the following entry into the Rio notes:

    '*OOA Coordinator Entry*

    Call made back to Cygnet to discuss their request to step down [VC] to a local OOA acute ward. Team not available but message left for them to be notified that having discussed this with flow manager Hill a return to local acute bed is preferable and an OOA move is not sanctioned at this time. To be further discussed in tomorrows DDM.' [**NHFT0000168, p.192**].

42. The reference to Cygnet's request to "step down" VC refers to the clinical update received on 23 September 2021, notably that VC could be moved off the PICU and onto a regular acute ward. Flow manager Hill is Joanna Hill. I had emailed Cygnet Victoria House on 28 September 2021, stating it was the Trust's intention to repatriate VC, but it was delayed due to the lack of male beds available. I had updated my senior colleagues, including my service manager as part of the DDM, and confirmed to Cygnet Victoria House that repatriation to an acute bed for VC remained a priority [**WITN0389009**]. We were aiming to ensure repatriation could happen as soon as possible if bed availability allowed. Cygnet Victoria House sent me a follow up email on 29

September 2021, and I confirmed that I would discuss VC's case with my team [**WITN0389010**].

43. My reference to a "local acute bed" being the preferred choice refers to the Trust policy that a patient should always be in a local bed (within Nottinghamshire) to support continuity of care principles wherever possible. This further enables their CCO to maintain better contact with them, and for any local family to visit more frequently. It also enables the Trust to have better oversight of the quality of care provided.

44. An out of area move was not sanctioned at this point, due to bed availability within the Trust, and maintaining the principles set out above. I cannot remember if VC's move was discussed at the DDM on 29 September 2021, as I cannot recall that meeting as another Bed Manager would have been involved.

45. I can see from email correspondence that I emailed Aliya Large, a Bed Co-ordinator, on 29 September 2021 to see if it would be possible to get VC admitted to Bestwood Ward at Priory Arnold Nottingham the acute ward in Nottingham that VC was moved to after Cygnet Victoria House) [**WITN0389011**]. Aliya Large referred VC to Priory Arnold Nottingham that same day [**WITN0389012**]. On the same day, I emailed Cygnet Victoria House to confirm VC had been referred to the Bestwood Ward [**WITN0389013**], and this was further confirmed on 30 September 2021 [**WITN0389014**].

46. VC was transferred to the Bestwood Ward at Priory Arnold on 1 October 2021 [**WITN0389015, WITN0389016**].

47. I can see from the records that VC was discussed at the Weekly Bed Management meeting with the Priory Group on a number of occasions [**WITN0389017, WITN0389018, WITN0389019**] and a Notification of Assessment from Social Care referral took place on 5 October 2021 [**WITN0389020, WITN0389021**]. I cannot remember these meetings in detail but confirm that I have reviewed the minutes and they are accurate to the best of my knowledge.

48. VC was also discussed at the Priory Group Bed Huddle on the 20 October 2021 [**WITN0389022**]. This was a regular meeting where the Priory Team would discuss the current and future needs for all patients and feedback to the CCO and Bed Management Team. I can see from these minutes that VC had no recorded issues on the ward at the time and his preference was to go to private rented accommodation. I can confirm that that is my recollection of that meeting. I also note that VC's name is mis-recorded as "Victor". This is a typo and although I cannot remember why this was written, I believe it was a mistake.

49. On 3 November 2021, at 15:43, I entered a discharge summary into the Rio notes in respect of VC's time at the Priory Arnold. This information was provided by the Priory Arnold [**CHCA0000014**]. I do not recall this specifically, but in line with usual practice, I would have immediately uploaded this to Rio for other colleagues to see, and so that it could be discussed at MDT if necessary.

Reflections and change in practice

50. I have not given any interviews or made any public comments about the actions of VC. I do not feel that I can offer any useful reflections to the Inquiry. I was not aware of concerns about the disproportionate overuse of Mental Health Act restrictive measures with black African and black Caribbean patients publicised in the context of Mental Health Act reform.

51. I consider that there have been positive changes in the bed management structure since the events took place, and I am aware of improvements in MDT discussions in relation to information sharing. MDTs now discuss care plans in more detail, and there is a greater engagement with social care colleagues. Since VC's admission, there has been a significant reduction in the Trust's use of out of area beds.

52. The Bed Management Team now has better oversight of bed management, and we have developed a better relationship with the providers who we use, for example, we now meet weekly with each hospital we have placements with. There is a better structure of reporting – we have a bigger team, with more senior clinical leaders and meetings (including DDMs) are more focussed in looking at the length of stays and trying to reduce this. This is reported up to senior colleagues and there is a push for each patient to be out of area for as little time as possible. The BMT have better clinical oversight now – but this does not affect the Continuity of Care Principles that a CCO should lead patient care. But if someone arrives in crisis and needs admission with no previous interaction with mental health services, we will assist with making the relevant referrals to the local mental health teams.

53. I do not have any suggestions for recommendations for the Chair of this Inquiry, or for improvements to multi agency working.

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

David Jonathon Waldron

Dated: 2nd February 2026

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5	CQCM0001240	PICU Gatekeeping referral form, 3 September 2021
6	NHFT0017964	Gatekeeping document compiled by the CHRT team
7	WITN0389003	Bed Management Daily update sheet, 4 September 2021
8	NHFT0017813	Huntercombe Group referral (1)
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11	WITN0389005	Record of VC's admission in spot purchased bed at Cygnet Victoria House
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