Witness Name: Agnes Matikiti
Statement No: WITN0395001
Dated: 05 February 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF AGNES MATIKITI

I, Agnes Matikiti, will say as follows: -

INTRODUCTION

1. I am a band 6 section 117 Commissioning Nurse working at NHS Midlands & Lancashire Commissioning Support Unit. Between 2020 and 2022 I was employed by Nottinghamshire Healthcare NHS Foundation Trust ("**NHFT**").

2. This witness statement is made to assist the Nottingham Inquiry (the "**Inquiry**") with matters set out in the Rule 9 Request dated 27 October 2025 (the "**Request**"). The Request asks me to provide a witness statement including information on my career and role; the training and system of work at NHFT; my interactions with VC; and any reflections and recommendations I have in light of VC's attacks.

3. This witness statement was drafted on my behalf by external solicitors and counsel 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 qualified as a nurse in 2019. I undertook my training at the University of Nottingham, where I was awarded an MSc in Mental Health Nursing.

5. In my first role I worked as a band 5 staff nurse at St Andrew's Healthcare Nottinghamshire. I worked in this role until 2020.

6. Between September 2020 and October 2022, I worked as a band 6 Crisis Care Practitioner for NHFT. I worked within the Crisis Resolution and Home Treatment Team ("**CRHT**"). This was my role at the time of my interactions with VC. During my time at NHFT I contributed to discharge planning for patients under my care.

7. After leaving NHFT in 2022, I worked on an ad-hoc basis as an agency worker for Thornbury Nursing Services. Between February 2023 and January 2026, I worked as a locum staff member for the Child and Adolescent Mental Health Services ("**CAMHS**") in Chesterfield. I also worked as an ad-hoc bank nurse for the Derbyshire Healthcare NHS Foundation Trust.

8. I have been in my current role as a band 6 s.117 commissioning nurse since July 2024. I previously worked in the role part time alongside my locum work, but from February 2026 I will be working full time.

TRAINING AND SYSTEM OF WORK

Training

9. I received training from NHFT on the assessment of risk for mental health patients of violence towards others. The training that I received was

Prevention and Management of Violence and Aggression ("**PMVA**") training, crisis resolution training, and breakaway training.

Information sharing

10. When I was working in my role as a Crisis Care Practitioner for NHFT, the types of information would be shared with me about patients I was involved with included risk assessments for the patient and care plans. I had access to RIO, and this is how I accessed all patient records. I would also receive written and verbal handovers at the beginning of every shift.

11. In practice, at the beginning of any shift I would generally read any updated risks for a patient, previous visit notes for the patient, handover records, and current plans for the patient.

12. I recorded and shared information about patients with whom I was involved on RIO. I would also share information about patients with the shift lead on the team, so that information could be handed over to the incoming team at the end of the shift. The shift lead was a member of the nursing team, and the lead changed every shift.

13. Where I had concerns about any patient, and the risk that they posed to others, I would have discussions within wider Multidisciplinary Team ("**MDT**") meetings. I felt comfortable sharing my concerns with the whole team. I knew that any information that I shared with other members of the team would be treated confidentially.

14. I also felt that I had to share certain information with other members of the team. For example, it was important that clinicians starting a shift were aware of any concerns that had arisen during the previous shift. Sharing information about a patient would also help other staff members to form relationships with the patient.

15. If I had concerns about the risks posed by patients under my care, I felt comfortable raising these concerns with senior members of the CRHT. I felt comfortable approaching anyone on the team, including senior clinicians and consultants. When I was working at the CRHT, I felt like consultants' doors were always open to discuss patients and engage.

Care Planning

16. I have been asked how clinicians in my position ensure that patterns in respect of a patient's presentation and condition are captured within ongoing care planning, for patients who have had multiple admissions under the MHA.

17. It may be helpful to explain what my role was in care planning as a nurse on the CRHT. My role would have been to draft a care plan during the initial assessment of a patient who would be under the care of the CRHT, if I carried out that assessment. Sometimes, a patient would also have other care plans, such as those produced by inpatient wards.

18. When producing a patient's care plan, I would be aware of the patient's history because I would look at their records on Rio. I would look at the reasons for any previous admissions to inpatient care. I would gather information from Rio and my assessment of the patient so that I could understand their triggers, risks, and any possible signs of relapse. I would then put this information into the patient's care plan. Information about a patient's patterns, and a history of multiple admissions under the Mental Health Act 1983 ("**MHA**"), would therefore be captured in the care plan.

19. I have also been asked about the relationship between inpatient care planning and care planning undertaken by the CRHT. Normally, a patient would be discharged from inpatient care into their Local Mental Health Team

("**LMHT**"). However, the CRHT might become involved in the patient's care (and care planning) in certain circumstances. This could be because of a patient being discharged on (or shortly before) a weekend or bank holiday, as the LMHT does not work on weekends or public holidays. In those circumstances, the CRHT would do the patient's 72-hour follow up post-discharge. The CRHT may also be involved in a patient's care in the community if the LMHT does not have the capacity to carry out frequent visits to the patient, but a higher number of visits is required. In those circumstances, the CRHT would provide support in visiting the patient. The CRHT may also be involved with a patient in the community following discharge if they are high risk.

20. When a patient is discharged from inpatient care into the community, their care plan will change because their context has also significantly changed. In inpatient care, a patient will be observed and monitored continuously throughout the day. There is 24/7 supervision of the patient. In the community, a patient will be seen at most twice a day, usually for a minimum of 30 minutes per visit.

21. Usually, during the transition between inpatient care and the community, a patient's care co-ordinator ("**CCO**") at the LMHT would attend their ward rounds and discharge planning meetings before discharge. I do not remember whether nurses from the CRHT attended these meetings, but they may have done for patients who were going to be discharged into the CRHT.

22. Once a patient is discharged into the community, nurses from the LMHT or the CRHT will need to assess the patient's risk and mental state in the course of much shorter visits to the patient. This has an impact on care planning for the patient. For example, if we had concerns about a patient's medication concordance we would make sure that during the visits we looked for signs such as responding to unseen stimuli, staring, or displaying unusual eye

contact. We would observe the patient taking their medication and stay with them to make sure they did not spit the medication out.

23. In care planning we would also think about whether the patient has family to support them at home. We would see if the patient had next of kin who we could contact if, for example, a patient did not answer their door for a visit.

24. During a patient's treatment, clinical nurses working in the CHRT were able to put in place plans for contact with a patient following a visit. These plans were recorded at the end of the visit records entered on RIO after contact took place. In this way we would have an ongoing role in the patient's treatment planning. If we had concerns about a patient after a visit, we would record this in the meeting notes so that our concerns could be monitored in future visits, and where appropriate escalate our concerns to senior clinicians.

25. I have also been asked how risk assessments are used in the formulation and development of a patient's care plan. As I have explained above, during the writing of a patient's care plan I would assess the patient's risks and also look at their history on their medical records. This information would inform the care plan for the patient. When assessing a patient the CRHT would always produce an updated risk assessment for the patient if they had previously been in the care of the team. This was to ensure that any changes in the patient's risk, at the time of their presentation and assessment by the CRHT, were captured.

INTERACTIONS WITH VC

26. I have reviewed VC's records [NHFT0000168], and I can see that I had two interactions with him while he was being cared for in the community. Due to the passage of time and the number of patients that I have seen since 2022, I no longer remember these interactions. When I saw the news about VC's

attacks in June 2023, I probably did remember his name and the fact that he had previously been under the care of the CRHT. However, I do not remember meeting him.

27. Normally, before meeting any patient for the first time, I would look at their records on RIO to get an understanding of the reasons why they were under the care of the CRHT. In particular, I would look at the notes from the patient's most recent visits. These notes would include information on the purpose of the visits, the medication that the patient was taking, and the patient's presentation in the last few days or weeks. At the end of visit notes there was also a plan for the patient, which I would review.

28. In the CRHT we would also have morning meetings to discuss patients. Any patients who were 'Red RAG' patients (i.e. high-risk patients) would be discussed daily during these meetings.

29. I do not remember what information I read about VC before I met him. Nor do I recall what my understanding was of his history, psychiatric presentation, condition, treatment and/or care plan, or past involvement with the police. However, I think it is likely that I read VC's most recent records on RIO before meeting him for the first time.

30. I have reviewed VC's RIO notes for the days before I met him. I can see that the records refer to VC having a history of aggression and forced entry into other people's property [NHFT0000168, p.205]; a history of forcing entry into other people's property and holding people hostage [NHFT0000168, pp.205 and 206]; and problems with medication compliance [NHFT0000168, p.206]. His records state that he had previously been detained under s.136 MHA, which would have involved the police [NHFT0000168, p.206]. As I have said, I likely would have read this information before meeting VC.

31. In terms of VC's care and/or treatment plan, I can see from his records that the purpose of visits to VC was to ensure medication compliance, and that contact was to be carried out in pairs [NHFT0000168, pp.205-206]. This would have been because of the risk of lone working with VC, due to his history of aggression.

32. I was not involved in the formulation of VC's care and treatment plan while he was under the care of the CRHT. VC's care and treatment plan would have already been in place by the time I saw him. It would have been written on his first assessment.

33. I have reviewed VC's patient records and I can see that I had two recorded interactions with VC on 22 and 23 January 2022. My role as a community psychiatric nurse ("**CPN**") within the CRHT during this interactions would have been to ensure VC's medication concordance.

34. My first interaction with VC was on 22 January 2022. I can see from VC's records that I saw him for a visit in public, to monitor his presentation and medication concordance [NHFT0000168, p.208]:

> "***Summary of contact***
> *Valdo met CPN AM and CSW BN outside Subway Unit 1, 1 Midland Way, Nottingham NG7 3AG which is opposite his student accommodation. On our arrival BN rang Valdo and he walked to wards ourselves and introduced himself.*
>
> *Valdo was dressed in black jeans and black coat with his hood up over his head and trainers, he appeared guarded during conversation. Lips appeared dry and cracked.*
>
> *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.*
>
> *Accepted his medication, took 2 x 10mg aripiprazole and observed him putting this into his mouth he declined taking any water. Engaged*

well in conversation so we could ensure med concordance. He agreed to meet CRHT again at 11 am same place…"

35. As I have said above, I no longer remember this meeting. However, from reviewing the records I can see that the purpose of this visit was to administer medication to VC. Looking at my notes from the meeting, it appears that this purpose was achieved. The notes state that VC accepted his medication. In the notes, I wrote that VC did not accept water with his medication. In my experience, this is not unusual. Some types of medication dissolve in the mouth, so they do not need to be taken with water. Other patients simply do not want to have water with their medication. In those circumstances, I would usually stay with the patient and speak to them to make sure that they are not holding the medication in their mouth. I can see from my record of the meeting on 22 January 2022 that I said that VC did "*[e]ngage well in conversation so we could ensure med concordance*" [NHFT0000168, p.208]. This suggests that we spoke to VC to ensure that he had swallowed the medication, and were satisfied that he was not holding it in his mouth.

36. Due to the passage of time, I cannot remember what assessment I carried out of VC's mental state or capacity during my interaction with him. However, in general during a visit I would assess a patient's mental state by looking at their appearance, cleanliness, and eye contact. I would look for signs that the patient is anxious or fidgety.

37. I can see from VC's notes that his visits took place in public on the street. The visit also appears to have been very quick. This can make assessing a patient's mental state more challenging. There are lots of distractions in public, such as people walking around. It is also more difficult to discuss information about the patient's care in public, due to concerns about confidentiality. When assessing a patient in public, I might look for signs such

as how they are reacting to other people on the street. I do not however remember whether it was busy outside during my visit with VC.

38. I can see from the record that I noted that VC had his hood up and appeared guarded. I also said that his lips appeared dry and cracked. I do not remember whether this gave rise to any concerns about VC's mental state. It is possible that VC may have been guarded because he was meeting different staff members on a daily basis at the visits. I can see that the plan recorded in the meeting notes was for the CRHT to meet VC again the following day.

39. I cannot remember whether I assessed VC's capacity during this interaction. On short visits such as these, I would not have carried out a formal capacity assessment for VC. However, in general if I had any concerns about a patient's capacity, for example because they did not appear to understand the purpose of visits or the reason why they were taking medication, I would escalate this and consider asking for a capacity assessment or MHA assessment.

40. My second visit with VC was on the following day, 23 January 2022. An entry in VC's records, drafted by Patrick Crolla, says the following [NHFT0000168, p.209]

> "***Summary of Contact:***
> *Valdo seen at Subway (Unit 1, 1 Midland Way, Nottingham NG? 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.

[…]

***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.

Difficult to obtain views re: medication Valdo shrugging when asked about his views in requirements for medication."

41. Again, the purpose of this visit was to ensure that VC was taking his medication. Reviewing the record, it appears that this purpose was achieved. The record states that VC said he was happy to accept his medication.

42. I cannot remember what my assessment was of VC's mental state during this meeting. However, I can see from Mr Crolla's notes that VC's presentation was similar to the previous day. He appeared to be dehydrated, had his hood up, and was guarded. Mr Crolla's notes also say that VC was monosyllabic in his speech. I can see that the plan following this visit was for VC's daily visits to continue for the purposes of medication concordance [NHFT0000168, p.209].

43. As with the 22 January visit, I cannot remember whether I assessed VC's capacity during this interaction.

44. I do not remember what further steps I took following these interactions with VC. I cannot remember whether I undertook, reviewed, updated, or contributed to any risk assessments in respect of VC while he was under the care of the CRHT.

45. I cannot remember attending any MDTs at which issues around VC's care were raised. However, the CRHT used to do morning meetings with the shift lead nurse, consultants, and band 7 staff. During these meetings we would discuss red RAG patients, which would have included VC. MDT meetings took place twice weekly, and I may have attended VC's MDT meetings if I was the duty shift lead for the day or if I had any concerns about him. It is therefore possible that I was present during discussions about VC in meetings.

46. I do not remember having any conversations with colleagues about risks posed by VC to others.

REFLECTIONS AND RECOMMENDATIONS

47. It is difficult for me to offer reflections on VC's attacks or recommendations to the Chair of the Inquiry, because I cannot remember my interactions with VC.

48. In general, learning about VC's attacks has been difficult. It has made me question whether my interactions with patients such as VC are effective. It is difficult to understand what led to VC's attacks.

49. The attacks have not changed the way that I work. This is because every patient's case is individualised, and every patient is different. It is therefore difficult for me to decide whether to change my practice based on a single case.

50. 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.

51. To my knowledge, I have never been involved in the care of any other mental health patient who, following discharge or when in the community, killed or seriously injured a member of the public.

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: 05/02/2026

Index to First Witness Statement of Agnes Matikiti

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