

Witness Name: Dr Timothy Baker

Statement No: WITN0084001

Dated: 01 DECEMBER 2025

THE NOTTINGHAM INQUIRY

SECOND WITNESS STATEMENT OF DR TIMOTHY BAKER

I, Dr Timothy Baker, will say as follows: -

Introduction

1. I am Dr Timothy Martyn Baker, General Practitioner, Senior Partner and Mental Health Lead at the University of Nottingham Health Service (UNHS). My qualifications are: BMedSci (Hons), BMBS, FRCGP, DRCOG, DCSRH, DipSEM and MFSEM. I have worked as a General Practitioner at UNHS since 2001 and as Senior partner since 2023. I am also a volunteer for East Midlands Immediate Care Scheme (EMICS) and in this capacity I attended the scene of the incident in Alfreton Road as part of the medical response and performed emergency resuscitation to two of the victims. I am providing this statement purely in relation to my General Practice role.
2. This witness statement is made to assist the Nottingham Inquiry (the "Inquiry") with the matters set out in the Rule 9 Request dated 4th September 2025 (the "Request").

Background

3. I have been asked to answer further questions with regards to the medical records of Valdo Calocane and interactions between primary and secondary services.

Policies and relationship with secondary services generally

4. There are no **local** policies, guidance or protocols in existence in relation to the treatment of mental health patients in primary care that we are aware of.

5. NICE has produced guidance which is summarised below:

a/c/d.Psychosis and schizophrenia in adults: prevention and management [NHSE0000539]

- Clinical guideline | Reference number:CG178 | Published: 12 February 2014
- *1.3.1.3: Early intervention in psychosis services should aim to provide a full range of pharmacological, psychological, social, occupational and educational interventions for people with psychosis, consistent with this guideline. [2014]*
- *1.3.1.4: Consider extending the availability of early intervention in psychosis services beyond 3 years if the person has not made a stable recovery from psychosis or schizophrenia. [2014]*
- **1.3.3 Assessment and care planning**
- *1.3.3.1: Carry out a comprehensive multidisciplinary assessment of people with psychotic symptoms in secondary care. This should include assessment by a psychiatrist, a psychologist or a professional with expertise in the psychological treatment of people with psychosis or schizophrenia. The assessment should address the following domains:*
 - **psychiatric** (mental health problems, risk of harm to self or others, alcohol consumption and prescribed and non-prescribed drug history)

- **medical**, including medical history and full physical examination to identify physical illness (including organic brain disorders) and prescribed drug treatments that may result in psychosis
 - **physical health** and wellbeing (including weight, smoking, nutrition, physical activity and sexual health)
 - **psychological and psychosocial**, including social networks, relationships and history of trauma
 - **developmental** (social, cognitive and motor development and skills, including coexisting neurodevelopmental conditions)
 - **social** (accommodation, culture and ethnicity, leisure activities and recreation, and responsibilities for children or as a carer)
 - **occupational and educational** (attendance at college, educational attainment, employment and activities of daily living)
- **1.5.2 Return to primary care**
 - 1.5.2.1: Offer people with psychosis or schizophrenia whose symptoms have responded effectively to treatment and remain stable the option to return to primary care for further management. If a service user wishes to do this, record this in their notes and coordinate transfer of responsibilities through the care programme approach. [2009]
 - **Relapse and re-referral to secondary care**
 - 1.5.3.6: When a person with an established diagnosis of psychosis or schizophrenia presents with a suspected relapse (for example, with increased psychotic symptoms or a significant increase in the use of alcohol or other substances), primary healthcare professionals should refer to the crisis section of the care plan. Consider referral to the key clinician or care coordinator identified in the crisis plan. [2009]
 - 1.5.3.7: For a person with psychosis or schizophrenia being cared for in primary care, consider referral to secondary care again if there is:
 - poor response to treatment

- *non-adherence to medication*
- *intolerable side effects from medication*
- *comorbid substance misuse*
- *risk to self or others. [2009]*

b.Mental health of adults in contact with the criminal justice system

- NICE guideline | Reference number:NG66 | Published: 21 March 2017 [NICE000036]

b.Violence and aggression: short-term management in mental health, health and community settings [NICE0000023]

- NICE guideline | Reference number:NG10 | Published: 28 May 2015

b.Violent and aggressive behaviours in people with mental health problems

- Quality standard | Reference number:QS154 | Published: 29 June 2017 [DHSC0000067]

6. The University of Nottingham Health Service is a Primary Care NHS General Practice with 44,000 patients situated on the University Park campus. Nottinghamshire Healthcare NHS Foundation Trust is the County's local Secondary Care and Specialist provider of Mental Health Care and we share care of patients under the specialist responsibility of Secondary care according to mental health care plans. We expect to receive information when patients have been reviewed in the form of correspondence from clinic letters. The amount of information varies, but as a minimum could be expected to detail diagnosis, information about risk to self or others, ongoing treatment plan, any changes, and any actions for the GP. Secondary Care is responsible for mental health and the GP is responsible for physical health.

7. In Primary Care we would expect a patient to be discharged from secondary mental health care only when and if it was considered safe and appropriate to do so. In most cases this can work well, good examples being patients with anxiety and depression. For conditions such as psychosis which are by nature

relapsing and remitting serious lifelong conditions, with variable levels of insight then, as is common with serious conditions in different specialities, it is desirable for them to stay under secondary care follow-up on an ongoing basis. When patients are no longer considered to be so unwell they require hospital admission, it would be Primary Care's expectation that these patients with serious mental illness are then followed up by a community mental health team until their condition is stable.

8. In VC's primary care record [CHCA0000030] there are two entries related to Covid Vaccinations which he received in 2021. These were not given at the practice. The two entries include the site codes RX1 and R6E0V. RX1 is the national code overseen by Nottingham University Hospitals Trust and R6E0V we believe refers to a temporary covid vaccination centre which was operated from the Forest Recreation Ground in Nottingham.
9. As far as we are aware, VC did not have any objection or resistance to needles or vaccinations.

Physical health of patients with psychosis or schizophrenia

10. The NICE guidance on *Psychosis and schizophrenia in Adults* addresses at 1.5.3.1-5 monitoring the **physical health** of patients with these conditions in Primary Care. This is important for two main reasons; firstly so that physical health is not forgotten when the subject often being discussed in consultations is mental health, secondly because patients with these conditions are at higher risk than the general population of having physical health problems. Their risk of coronary heart disease is doubled, chronic lung disease quadrupled, diabetes mellitus increased by a factor of six and lung cancer by a factor of two-and-a-half.
11. The responsibility of monitoring the physical health of patients with psychosis or schizophrenia is usually with Primary Care. We maintain a register of patients with severe mental illness (SMI) based on information from the Trust and prescribing data and invite these patients in for additional annual health checks

in-line with best-practice. This is an opt-in offer as with all other NHS screening for physical health conditions. The LMHT also have a healthcare assistant (SB) who completes these checks for patients on this register. Results from these checks are entered into our system and the patient record, and the results acted upon in the same way as our own results.

12. Each registered patient on our list also on our SMI register is invited for a health check with our healthcare assistant. This is done by text-message for patients who have agreed to this form of messaging. At this visit they have their height, weight, pulse and blood pressure checked, and blood tests taken to check cholesterol and for diabetes. A smoking and alcohol history is taken and appropriate advice given. Results of this then go to the GP for review, and the patient is invited in to discuss the results. Between 2020 and 2023 this process was affected by Covid-19 restrictions for a period of time when only 'essential' visits to healthcare settings were advised.
13. The practice was responsible for monitoring VC's physical health *apart* from during his times of admission to hospital. In practice this is the offer of annual physical health checks by invitation. These are opt-in and not mandatory physical health checks.
14. The Practice contacted VC in-line with SMI monitoring guidance and after periods of admission with the Trust. It should be borne in-mind that this was during Covid-19 restrictions (all that could be completed remotely was done-so, and only 'essential' in-person consultations took place): [CHCA0000030]
 - a. 17 Aug 2020 Tel call from Dr Murphy followed by SMS invite to make an appointment with the practice nurse team.
 - b. 10 Sep 2020 Telephone consultation: Ear problem
 - c. 22 Apr 2021 SMS Invite to make an appointment (after receiving letter from Trust dated 15 March 20 21, received 21 April 2021)
 - d. 22 Apr 2021, appointment made for VC 23 April 202
 - e. 23 Apr 2021, appointment reminder message sent
 - f. 23 Apr 2021 SMS DNA message after appointment missed

- g. 24 May 2021 SMS reminder invite to make appointment
 - h. 2 July 2021 SMS further reminder inviting VC to make an appointment
 - i. 28 Oct 2021 SMS Offer of GP appointment (after receiving letter from Priory dated 22 Oct 2021, received 27 Oct 2021)
 - j. 29 Oct 2021 SMS Offer of healthcare assistant appointment
 - k. 4 Nov 2021 SMS reminder invite to make healthcare assistant appointment
 - l. 29 Sep 2022 SMS from Stuart Keeling (Specialist Mental Health nurse, Uni Health Service GP) offering help following discharge to practice from LMHT
 - m. 30 Sep 2022 SMS invite (annual physical health check)
 - n. 11 Nov SMS invite reminder
 - o. 21 Nov 2022 SMS sent by Sam Bailey LMHT Healthcare Assistant
 - p. 1 March 2023 VC spoke with Sam Bailey and declined physical health check
15. VC's record [CHCA0000030] shows that he was contacted by Dr Murphy for a telephone review and then further text messages regarding making physical health checks and offering further GP reviews although he did not proactively make an appointment or attend on the date (23rd April 21) when a specific appointment time was made for him. His only engagement was a telephone call to the NHCT health improvement worker (Sam Bailey) who contacted him by telephone on the 1st March 2023 and stated: 'P/C to Pt to book him in for a SMI physical health check as Pt is on anti psychotic medication on the smi register. I spoke to Pt and offered him an appointment but Pt declined, saying that he was alright and did not need any health checks. I advised Valdo that the checks where connected to his medication, but still Pt declined.'
16. VC opted not to attend any appointments for physical monitoring.
17. The commonest reasons for non-engagement with the offer of physical health checks at the practice are that a patient has left their university course and

moved away, they have had health checks back elsewhere (undocumented - either in the UK or abroad), or they make the informed choice not to engage. Since patients are presumed to have mental capacity unless proven otherwise this is accepted.

- a. In order to facilitate the offer of physical health checks we attempt to contact the patient to check if their contact details are correct and send reminder messages when they have elected to receive text messages from us.
 - b. Other than the above, we do not have a policy for raising, reporting, referring or escalating the fact of non-engagement with physical health monitoring with others, such as secondary health services. Physical health is considered as being separate from mental health in this regard. Adults with capacity can choose whether or not to engage with this offer and we were not prescribing for VC.
18. None of VC's non-engagement with attempts to monitor his physical health gave rise to concerns about his engagement with health services, his mental health, treatment compliance or his stability. Discharges from secondary care are considered to be specialist decisions based on careful review of diagnosis, risk and safety. Adults are presumed to have capacity (to engage or not with physical health monitoring) unless proven otherwise.

Communication and co-operation with secondary mental health services

- 19 Clinic letters, AMHP assessments and admission/discharge notifications are sent to GP Practices to record specialist interventions and keep the Primary Care record up to date of important diagnoses, treatment and plans.
20. Documents received by the Practice are first scanned on to the patient record and then screened by a workflow team to identify diagnoses for coding, results to record and action-points needing attention by a GP or other team member such as a clinical pharmacist, nurse/mental health nurse or administrator.

21. Document CYGN0000106 is a letter addressed to the Practice dated 9 September 2021. This was never received until brought to our attention by this Inquiry and forwarded to us.
- a. This appears to be a document generated by Nottinghamshire Healthcare NHS Foundation Trust detailing an assessment on 4 Sep 2021, updated on 8 Sep 2021 by Miss Busayo Ajewole RMN. It describes an episode when he was arrested on 14 July 2020, VC responding to auditory hallucinations prior to a previous admission resulting in him entering a resident's flat and her sustaining serious injury trying to escape by jumping out of a window, and signs of relapse after stopping treatment abruptly on 31 August 2021, characterised by persecutory delusions, auditory hallucinations and lack of insight. It concludes with VC being in seclusion under observation.
 - b. This document was not provided to The Inquiry as it was not received and therefore not in the patient record.
 - c. If this letter had been received by the Practice, we would consider him to have been admitted, to be in a safe and appropriate place and receiving care. There are no action points for Primary Care in this letter.

Discharge from secondary mental health services to the Practice

22. When a patient under the care of secondary mental health services is discharged to the care of their GP, we invite them in to see or speak with the GP and signpost them to support in the community.
23. The Practice was informed through a letter from Sharon Heath of Nottinghamshire Healthcare NHS Foundation trust's Early Intervention in Psychosis ("EIP") team dated 23 September 2022 [CHCA0000013] that VC had been discharged from their EIP service back into Primary Care. The Practice received this letter, it was scanned and went through our workflow process, reviewed by Stuart Keeling (our specialist mental health nurse) who sent an

SMS message on 29 September inviting VC in for review and signposting him to support. On 30 September VC was contacted again by SMS to invite him to make an appointment with the healthcare assistant for his annual physical monitoring checks. A reminder SMS invite was sent on 11 November.

24. This letter gave the following information: *"No contact has been made with Valdo for period of time despite attempts to make contact and having carried out cold calls. A letter was sent to Valdo dated 17 August 2022 inviting him to contact the team if he still wanted support with his mental health. However, there was no response to this invitation. Therefore at this time, we are closing his referral and transferring his care back to yourselves. If Valdo chooses to engage with services, or his mental health deteriorates, please re-refer back to our team in the future."* No additional specific consideration was given to the fact that Valdo was being discharged due to non-engagement rather than because he no longer required the treatment or support of the EIP team. Reasonable attempts had been made to contact him by SMS, letter and visit. Adult mental capacity is assumed unless proven otherwise. From the GP perspective he is an adult with full mental capacity making an informed choice whether or not to engage with specialist care, AND his specialist team has judged this decision to be safe and appropriate without any ongoing support from their team. There is no discharge plan or action plan for the GP other than to re-refer if concerns are raised. Additionally, it should be borne in mind that there was a likelihood that Valdo could be back home in Wales with his family (and in Wales he may have separate Primary Care notes if registered with a GP there, not visible to us.)
25. In my experience as a General Practitioner non-engagement is a recognised and accepted reason for discharging a patient from secondary mental health services. Patients may move away, our students are often on their 'year-out' of their university course, they may be unable to keep appointments for a variety of reasons or feel that they do not need or want what secondary care is able to offer them.
26. The circumstances in which a Practice would challenge a decision to discharge a patient to its care would be if it were known that there was a clear and present

danger to the patient or others if that specialist care were to be withdrawn, outside the ability of primary care to manage.

27. The Practice did not consider challenging the decision to discharge VC to our care on 23 September 2022. The Primary Care record held no concerns about VC. We entrust the Trust to make safe clinical decisions.
28. The record shows multiple communications were made to VC by a variety of methods in a timely manner from both Primary Care and secondary care following his discharge from the LMHT in September 2022.
29. If the Practice had been involved or engaged in the decision to discharge VC in September 2022:
 - a. The Practice's position would have been to clarify who was responsible for ongoing prescribing (if appropriate) and record a clear plan for the future, including re-referral.
 - b. We would contact the patient to discuss ongoing care with the GP and annual physical health checks.
30. VC's ongoing non-engagement after September 2022 was not identified by the Practice as a concern as he was assumed to have mental capacity to make his own decisions and because secondary care had made the clinical decision that it was safe and appropriate to discharge him from their care.
31. Actions that could have been taken in respect of VC's ongoing non-engagement after September 2022 in addition to SMS messaging could have been to telephone or write him a letter. It is our experience (and VC's expressed preference) that SMS messaging is the main way young people prefer to receive communication. Cold calls are intrusive and frequently unanswered and letters often appear to go astray or unread. All these methods are used by us when concerns are raised.

Recommendations

32. The practice undertook a full review of our care and contact with VC alongside the report of the CQC national Clinical Advisor for General Practice as part the S48 request. We worked closely with the CQC to review our care and contacts with VC and the physical monitoring of SMI patients. [CQCM0016517, page 62]
33. The conclusion to the in house review was: 'Following the events of June 23, the practice undertook a significant analysis of our records, processes and procedures which were also reviewed by the CQC National Clinical Advisor for General Practice as part of the S48 report who found no issues, reported nationally that our processes and systems met national best practice guidance and verbally commented on the high quality nature of our care. We have subsequently reviewed our processes around engagement of SMI patients and changed the policies around the use of text messages to encourage other forms of communication alongside their use. We continue to work with the national team involved in the independent review.'
34. The January 2025 *Independent Investigation into the care and treatment provided to VC*, produced by Theemis [NHSE0000298], included the following comments:

"Transfer of VC's risk and management does not appear to have been actively managed in transfer between the community mental health team and the GP. The Royal College of psychiatry's guidance on Good Psychiatric Practice... states: 'when discharging from care, the psychiatrist should inform the patient, the referrer and the primary care team about the possible indications for future treatment and how to access help in future.'

Interviews with staff within the primary care setting considered that primary care should be involved in discharge and long-term management planning of more complex individuals or those with a history of poor concordance or violence. Interviewees told the independent investigation that it has been common

practice for patients to be discharged from community mental health teams without their involvement.”

In our previous witness statement (paragraph 12) we explained that “*discharge from Secondary Care is wholly a Secondary Care decision*”.

In my opinion the Practice would like to be involved in discharge decisions and long-term management planning of more complex individuals or those with a history of poor concordance or violence. These are the patients most likely to run into problems requiring specialist intervention and beyond the scope of modern-day Primary Care. When a patient is at risk of being discharged due to non-engagement or without an assessment it would be helpful if secondary care discussed any concerns with the referrer before making their decision.

35. I am familiar with the Royal College of General Practitioners’ paper *Mental health in primary care*, dated September 2017. [WITN0227002]
36. That paper [WITN0227002] comments as follows: “*Primary Care also has a duty to provide physical health care including offering screening, to those people with SMI such as schizophrenia. However, there is no clear direction as to who should manage people with stable SMI who no longer require the expertise of specialist secondary care services. Many of these people are being discharged into primary care with no planning or support.*”

As to this comment:

- a. Yes. I agree that there is no clear direction as to who should manage people with stable severe mental illness (SMI) who no longer require the expertise of specialist secondary care services. In practice, for the majority, the GP offers annual physical health monitoring and takes over responsibility for prescribing when there is a clear discharge plan given by secondary care.
- b. Patients discharged from secondary care into primary care are contacted by us to offer early GP support and review, and to signpost them to multiple other sources of support, including NHS-funded Talking Therapies. They are also contacted by us annually for their physical health checks

c. Our views on recommendations that could address these issues would be to ensure:

- Discharges for SMI patients are both safe and appropriate for their condition and accompanied with a clear management plan and directions in case of relapse.
- Discussion with Primary Care should be involved in complex cases, especially those with a history of poor concordance or violence.
- Where it is known that a patient is, or has been, violent when unwell, that this is communicated to Primary Care. In this way notes can be made in their record for Primary Care and other organisations by way of their Summary Care Record (for example Emergency Departments and out-of-hours healthcare providers) so that appropriate precautions for safety be made when they are seeking healthcare.
- For patients with diagnoses such as schizophrenia characterised by symptoms such as delusions (false beliefs), paranoia, lack of insight and consequent relapse and remission, that they remain under secondary care. In pre-Covid days of assertive CPN outreach teams' non-engagement would have been a red flag.

37. I have reviewed the transcript of the Theemis interview provided [TCLT0000350] which appears to be an accurate transcript of the conversation. I have no further comments in relation to this interview.

38. I hope this additional statement is of assistance to those undertaking the inquiry and I am happy to provide any further clarifications if needed.

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: 1st December 2025

Index to Second Witness Statement of Dr Timothy Baker

Exhibit No.	Inquiry URN	Document Description
1	NHSE0000539	NICE Guidelines on Psychosis and Schizophrenia in adults: prevention and management, updated 12 February 2014
2	NICE0000036	NICE Guidelines, mental health of adults in contact with the criminal justice system, Dated 21 March 2017
3	NICE0000023	NICE Guidelines, violence and aggression: short-term management in mental health, health and community settings
4	DHSC0000067	Quality Standard, violent and aggressive behaviours in people with mental health problems, dated 29 June 2017
5	CHCA0000030	Medical Records of Valdo Calocane from 19/11/2014 to 28/01/2022, UNHS Cripps Health Centre
6	CYGN0000106	NHFT risk and safety assessment of VC dated 9 September 2021
7	CHCA0000013	Letter from Sharon Heath, Clinical Team Lead re discharge due to non-engagement, dated 23 September 2022
8	CQCM0016517	CQC S.48 Report
9	NHSE0000298	THEEMIS report re: Independent investigation into the care and treatment provided to VC, dated 1 January 2025
10	WITN0227002	Royal College of General Practitioners paper titled Mental Health in Primary Care dated September 2017
11	TCLT0000350	Transcript of interview of Tim Baker and Stuart Keeling by Theemis Consultancy, dated 10 June 2024