Witness Name: Josephine Baker

Statement No: WITN0147001

Dated: 2 December 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF JOSEPHINE BAKER

I, Josephine Baker, will say as follows:

Introduction

1. I am a Team Leader (Band 7) in the Crisis Team at Nottinghamshire Healthcare NHS Foundation Trust ("**NHFT**").

2. I make this statement in response to a request under Rule 9 of the Inquiry Rules 2006, dated 22 September 2006. In this statement, I will explain my career and role, my training and the system of work for my role, and my interactions with Valdo Calocane ("**VC**").

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

Career and Role

4. I qualified as a Registered Mental Health Nurse in 2014 with the University of Nottingham. I am registered with the Nursing and Midwifery Council. I confirm that I do not hold any professional appointments.

5. On qualifying, I worked in a private medium secure mental health unit for approximately six months.

6. Following this, I completed my preceptorship within the community recovery team as a Community Psychiatric Nurse (Band 5) at NHFT, before gaining a substantive position within the Crisis Team as a Community Psychiatric Nurse (Band 6) in approximately 2015. This is the role I was working in during my interactions with VC.

7. In February 2022, I became a Team Leader (Band 7) in the Crisis Team. This remains my role to date.

Training and system of work

8. I cannot recall what specific training on risk I received while completing my qualifications, but I know that this training included lectures and E-Learning packages.

9. When I joined NHFT in 2014, I had an induction, during which I undertook the Managing Violence and Aggression course. I do an annual refresher course for

this training. Additionally, this year I completed a one-off course in Clinical Risk and Assessment training, which was run by NHFT's suicide prevention team. I understand that these training materials have been provided as part of the Trust's disclosure to the Inquiry so I have not exhibited the same to this statement.

10. I would access the RiO notes for each patient that I would be interacting with, or that I needed information about. Patients would also be discussed in the daily Multi-Disciplinary Team ("**MDT**") meeting. Around two years ago, we also introduced a virtual board, which lists all the patients on the caseload and any risks associated with them.

11. I have access to RiO, and do not have any restrictions on this access that I am aware of. In practice, prior to dealing with a patient, I would read the RiO notes, risk assessment and care plan. I would also record information about the patients I was involved with on RiO.

12. If I had any concerns about the risks posed to others by patients I was involved with, I would report this to someone more senior or the medic on duty. I felt comfortable raising any concerns that I had.

13. So far as I am aware, 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

14. In advance of my involvement with VC, I read the information that was held about him on RiO, and his MDT plan. Prior to my first interaction with VC, the plan was that the Crisis Team would look after VC's care until the Early Intervention Psychosis (EIP) team were able to take over.

15. At the time of my interaction with VC, my understanding of his psychiatric history, his diagnosis and/or condition, capacity, and treatment and/or care plan would have been in line with what was documented on his core assessment records. I was aware that VC had had involvement with the police, and I believe that this was the reason he had been referred to the Crisis Team at the time.

16. During my first interaction with VC, on 23 June 2020, I had no concerns about his presentation, he was engaged in our conversation and had good eye contact. During my second interaction, VC was much quieter. However, I did not witness VC display any aggression or violence on either occasion.

17. The Patient Summary Record ("**PSR**") includes an entry on 23 June 2020 at 12:03pm [NHFT0000168, pp.51-52] which states:

> *Summary: Home visit to Valdo this morning with CPN Daisy Coleman as per plan. Valdo appeared well kempt, good rapport established and he engaged in conversation well. Although he did not initially speak about hearing voices he appeared distracted at times and was staring for long periods of time. He said that his mental state had improved since being admitted to hospital, he described hearing voices that he was unable to manage prior to the admission, however that the intensity of his voices have lessened and he feels able to manage them currently. His voices are mainly about 'general conversation and him', Valdo did not give us examples but said that they can be negative towards him. He described a good sleep pattern and is eating and drinking well. Has had contact*

with his family/ friends and is now attending the online lectures for University. Valdo has extended his tenancy for at least another month and then is unsure whether he will find a job in Nottingham or in Birmingham. Reported to be taking his medication as prescribed, no side effects reported. We explained about the referral to FEP, which he was in agreement with. No further concerns.

Risk: Valdo has the ability to mask his psychotic symptoms. History of violence and aggression when mental health deteriorates. Further risk of deterioration in mental state if non concordant with medication.

Medication: Aripiprazole 5 mg OD Vitamin D

Pathway: FEP remains appropriate for a period of assessment. Valdo plans to remain in Nottingham until at least the end of July (he has extended his tenancy)and then will potentially staying in Nottingham or going to reside in Birmingham.

RAG: Green - Awaiting FEP. Plan:

1. *Telephone call to Valdo Friday 26/6/20 to monitor mood and mental state and to update him on FEP referral.*
2. *Joint visit to be arranged to hand over care (is open to EIP LMHT South on referrals?).*
3. *Valdo is aware he can contact CRHT for further support in the interim if necessary, which he said he would. Contact details given.*

18. We conduct home visits to provide intensive community-based treatment, support, information, education and medicine management for up to six weeks. We also provide support, information and education to relatives, carers and referrers where appropriate. As a team we aim to minimize the length of stay in hospital by actively contributing to discharge plans and providing intensive home treatment.

19. The purpose of this home visit was to monitor VC's mood and mental state and escalate any concerns that were raised. I believe that the visit achieved its purpose, because we were able to assess VC's mental state, we saw that VC

was settled, back to his daily routines, did not raise any concerns and confirmed that VC was happy with his current plan in regards to being referred to the early intervention team and ongoing treatment.

20. I documented the risks that I believed Valdo to have as: his ability to mask his psychotic symptoms; his history of violence and aggression when mental health deteriorates the further risk of deterioration in mental state if non-concordant with medication. I believe these were VC's risks based on other clinicians' notes and information that I knew about Valdo. When documenting the term 'masking' his symptoms, I refer to it meaning that it is when a person conceals, minimizes, or hides their true thoughts, feelings, symptoms, or behaviours. This can in turn make it harder for mental health professionals to accurately understand patients' level of risk. Masking is a common feature of mental illnesses which I work with on a daily basis; although not having had any formal training in 'masking', it is a fundamental skill of nursing and is a unique presentation to each patient and the MDT is mindful to this which is a common conversation.

21. In terms of what is meant by 'RAG: Green', the Crisis Team utilizes a RAG (Red, Amber, Green) clinical risk rating system and clinical decision tool related to care planning. Patients on 'Green' rating are considered to be towards the end of their treatment with the service and should have a discharge plan/date in place. These patients are typically seen once a week.

22. On this occasion, we relied on VC giving his own account of him taking his medication. Where there is no reason to question the patient's compliance with

medication, it is our usual practice to rely to their account. We relied on his account due to there being no reason for us to believe that he was not compliant with his medication, and VC not mentioning any side effects in relation to the same. If we suspected that he wasn't taking his medication, we would have explored this further. We gave VC the details of Crisis Home Treatment (CRHT) Team, as we do to all our patients. This includes giving information for how patients can contact us if they feel their mood or mental state has deteriorated. We explained that the CRHT team are a 24-hour service, and that we would be able to provide support if he felt he needed it. However, I did not think at this juncture that VC would need to access CRHT for any further support, due to his current presentation.

23. The PRS includes an entry on 27 January 2022 at 12:08pm [NHFT0000168 p212] which states:

> *City CRHT*
> *Saw Valdo this morning outside Subway with CSW Shawn Wilford. I had to ring Valdo 8 times between 10.30 am - 11.05 am before he answered. We arrived at Subway (where he wanted to meet), Valdo said that he would need to leave as soon as possible. I attempted to ask him to sit down, he refused this and also refused to sit and speak with me on the seating area outside. He asked for his medication, which I gave him (Aripiprazole 20 mg). I asked if he would need a drink, which he refused. I am unsure whether he took the medication as he walked off despite me attempting to watch his concordance. I tried to speak with Valdo regarding his University course, he told me that it was fine and there are no concerns with his course. I also asked him about his accommodation and his flat mates, he denied that they had moved out and said that they are all still living with him. We attempted to have a frank conversation about housing situation, however he would not accept that it was a concern currently. On return to the office I have had a discussion with Dr Skelton.*
> *Plan:*

1. *MHA to be called.*
2. *Telephone call to Ellie Turner (university) to discuss.*

24. I cannot remember the full extent of this conversation with VC in order to expand upon this note, or to provide the nature and content of the conversation that I had with VC outside Subway. However, my concerns were that VC was not engaging well, and that I was unsure whether he had taken his prescribed medication.

25. Following this meeting, I discussed the risks around VC potentially not being compliant with his medication regime with Dr Skelton. Due to these concerns and the risks that had been escalated in the past when VC had not been compliant with medication, Dr Skelton and I decided that we would call a Mental Health Act assessment as it was deemed no longer appropriate for VC to be treated in the community. At the time, we would 'call' a Mental Health Act assessment by telephoning the social care team and requesting that they complete that assessment.

26. When I called Ellie Turner from the University, I updated her on VC's current presentation, and that we had planned to call for Mental Health Act assessment.

27. I cannot remember whether I discussed any risk posed by VC with any colleagues other than Dr Skelton and Shawn Wilford, who was with me on this visit.

Reflections

28. In light of VC's attacks, I know VC was treated at different hospitals, on different wards, under different consultants. In hindsight, if this had not have been the case, I think VC would have stood out as an individual who needed to be on depot medication.

29. However, as a Crisis Team, I think we went above and beyond to engage VC in his treatment, and that is why I have not changed anything about the way that I practice as a result of these events.

30. I was interviewed by Theemis in my capacity as Team Leader of the City Crisis Resolution Home Treatment Team. I believe that the transcript accurately reflects what I said during this interview and there is nothing further that I would like to add.

31. During the interview, I stated:

> *"He was one of the patients that I personally didn't want to push forward, as in, you know, to aggravate him, just with the, sort of, demeanor, and closedness and the stare. Like, he had quite a fixed stare at the time and I thought, "Yeah, I don't want to push this any further. We'll have to go back and call a Mental Health Act assessment, because it's not a safe plan."*
>
> [TCLT0000756, pg.11]

32. I also stated:

> *"He was one of them… you know the patients that you go to and you think, "Yeah, I'm not pushing this any further." He was quite… [...] Intimidating in that way. [...] There are a lot of patients that I do press*

forward with and I would challenge quite heavily. I remember him being one of them that I wouldn't."

33. I had this impression during the appointment I had with VC, and I formed this impression due to his presentation at the time. This did not impact on the future treatment provided to VC as the outcome was the same in that on returning to the team, I called for a mental health act assessment as this was the safest way to be able to treat VC, being in a ward environment where he could be closely monitored, rather than in the community.

34. Within my remits of knowledge and skill, VC was staring at myself, not engaging in conversation, had his hands in his pockets and I couldn't be sure about his current mental state. There are occasions where it wouldn't have been appropriate to further press the patient that is potentially distressed by their mental health symptoms. However, I acted on my intuition and called a mental health act assessment where he was later detained. This is a further presentation whereby I used by own senses to inform my judgement.

35. I confirm that I have not otherwise given any interviews or otherwise made any public comments about the actions of VC or the matters under investigation by the Inquiry.

Recommendations

36. To ensure lessons are learned and to prevent similar attacks in the future, I think that the Chair of the Inquiry should make recommendations which include reintroducing the Assertive Outreach Team (AOT) as a pathway option for

patients. Around ten years ago, all the pathway options were merged into one local mental health team, so no one had a speciality role as such. NHFT is now reintroducing some of the pathways, such as the rehabilitation team and the EIP team, but I do not think there are any plans at present to reintroduce the AOT. In my view, the AOT was good because they would actively try and engage people that did not want contact with mental health services, who are also often the people who are most unwell.

37. Additionally, the number of Band 6 staff that we have in the Crisis Team has been reduced significantly over the past two years, with the result that the CRHT team now have capacity for 80 fewer visits per week than we did previously. If our capacity was increased, we would be able to respond more quickly to referrals, so this is another recommendation that I would like the Chair of the Inquiry to make.

38. I would also like the Chair of the Inquiry to recommend that information sharing between mental health services and the police is made easier, because currently it can be difficult to get information from the police about the individuals that we are dealing with.

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: 2 December 2025

No.	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
2	TCLT0000756	Record of interview of JB (Crisis team manager at NHFT) by Theemis dated 06/06/2024