**Witness Name**: Dr Peter Carter OBE

**Statement No**: WITN0341001

**Dated**: 9 December 2025

# THE NOTTINGHAM INQUIRY

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# FIRST WITNESS STATEMENT OF DR PETER CARTER OBE

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I, DR PETER CARTER OBE will say as follows: -

## Introduction

1. I am an Independent Healthcare Consultant.

2. This witness statement is made to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 Request dated 16 October 2025 (the "**Request**").

## Career and role

3. I commenced my NHS career by training as a psychiatric nurse. After working for several years as a clinician I embarked on a managerial career culminating in being appointed CEO of the Central & North West London NHS Mental Health Trust from 1995 to 2007.

4. In addition to my nursing qualifications, I have a master's degree and PhD from the University of Birmingham. I am a Hon Fellow of the Royal College of General Practitioners and an Ad Eundem of the Royal College

of Surgeons (Ireland). In 2010 I was awarded the inaugural medal from the Royal College of Psychiatrist's for my contribution to mental health.

5. From 2007 to 2015 I was the CEO of the Royal College of Nursing. Since leaving the RCN I have been asked on three occasions to be the interim Chair of NHS Trust's that have had significant challenges.

6. I have given expert witness evidence in over 200 cases of health related litigation and I have also investigated serious untoward incidents.

7. In 2006 I was awarded the OBE for my services to the NHS

**Care Programme Approach and the Supervision Register.**

8. The Care Programme Approach (CPA) was introduced in 1990 and was a framework for mental health services to assess, plan, coordinate and review the care of individuals with complex needs.

9. In 2021 NHS England said that the CPA would be replaced by a new Community Mental Health Framework to provide a more equitable and universal standard of care.

10. The Supervision Register was introduced in 1994 by the then Secretary of State for Health. It was a UK based system to identify individuals with severe mental illness who were at significant risk of serious violence or suicide. The objective was to ensure these individuals received coordinated care and a care plan to reduce risk, with a key worker and regular reviews.

11. Essential to the effective use of these two concepts was that of teamwork

and communication. The inquiry led by Jean Richie QC in 1994 revealed a catalogue of missed opportunities to prevent the killing of Jonathan Zito by Christopher Clunis due to poor teamwork and a lack of communication between the agencies that were charged with caring and supervising Christopher Clunis **[WITN0341002]**.

12. The Supervision register was a controversial initiative with some professionals feeling it was politically motivated and had little impact on clinical practice, while others saw it as a way to highlight the need for better resources. This has not prevented serious incidents in the field of mental health care. For example, between April 2022 and March 2023 mental health staff in England reported over 17,000 serious incidents.

13. I have been asked to comment on how it might be possible to identify if a patient is not taking their antipsychotic medication. With some antipsychotic medications such as Clozapine and Lithium there are regular drug tests as these drugs can have serious side effects. These tests would also reveal non-compliance. With other drugs, the state of a person's mental health would be the most common and effective way of assessing compliance. With depot injections this is not an issue as the injection is usually administered by a nurse.

14. If a patient is not taking their medication, then this is identified by a deterioration in the patient's mental state. This will usually be discussed with the patient and their relatives if the consent to do so has been given by the patient. The barriers to this approach is that the patient may lack insight and may not give permission for their condition to be discussed with the

appropriate relative.

15. When a patient is non-concordant with medication an option open to clinicians is to place the patient on a detention order and the medication can be legally administered without consent and if necessary, the patient may have to be physically restrained in those circumstances. This approach is the final option as in the first instance a range of psycho-social approaches should be used. This involves discussing with the patient why there is a need to take the medication and working with the patient to devise a care plan. If the patient is in the community and becomes non-compliant then a Community Treatment Order (CTO) can be invoked.

16. A CTO is a legal instrument that compels patients who are living in the community to take their medication and if they do not, they can be readmitted to hospital. A common feature of people with psychotic illnesses such as schizophrenia and paranoid schizophrenia is the lack of insight. It is not uncommon that these people are resistant to taking medication. In these circumstances the decision may be taken away from the patient and the medication is administered without consent. The very fact that they are suffering from a psychotic illness may result in them lacking the capacity to make a rational decision about their care.

**Clinical practice, treatment and risk management**

17. In respect of risk assessments, this should be the cornerstone of caring for people with mental illness. Of particular importance is to assess the risk of violence to others, self-harm and neglect. In carrying out risk assessments

the need to look at past and present behaviour is paramount. This should involve others such as family, employers and other associates all of which is dependent on the patient giving permission to the clinicians involved to speak with these people.

18. Nurses have a key role in assessing risk. Nursing is the discipline that has the most contact with patients and nurses follow the patient throughout the clinical pathway. The most effective care is that which involves multidisciplinary teamwork.

19. There are a range of different approaches to assessing risk. For example, there is the DICES scale and the Suicide Probability Scale. These tools are useful but have low predictive value and are not a substitute for a clinician's assessment. I believe there is a place for these tools, but their effectiveness should not be overestimated or over relied upon.

20. Nurses have access to guidance on risk from the Royal College of Nursing, the Care Quality Commission and the Health and Safety Executive. The training and guidance for nurses is covered in their undergraduate course and once qualified it is the responsibility of the individual nurse to keep their clinical practice up to date and for their employers to provide update training. From my experience training and guidance is variable and there should be a greater emphasis on the uniformity of risk assessment and the need to ensure that all employers place a high emphasis on risk assessment.

21. As previously stated, risk assessment should be the cornerstone of caring for people with severe mental illness. Sadly, there are occasions when this has not been the case and can lead to serious incidents of violence and self-harm. The disparity in risk assessment can be with both in-patients and those in the community.

22. The key to successfully treating people with severe mental illness is the need to ensure compliance with medication. If this does not happen then people will relapse, and the consequences can be tragic.

23. Lack of insight is the common denominator in psychotic illness and this lack of insight should be at the forefront of the clinicians thinking. Whilst it is good practice to involve patients in decisions about their care plan, this does not mean the patient's wishes should be paramount as they may lack the capacity to make rational decisions. Ideally the least restrictive practice should be engaged but there are occasions when this is simply not possible and is indeed not in the best interests of the patient let alone the public.

24. Consideration should always be given to the patient's immediate presentation, but so should consideration be given to their history. This is why it is important to have comprehensive case notes with the input of the whole of the multidisciplinary team to ensure there is an overview of the patient. This is particularly important for people with a history of violence or self-harm.

25. Patients may express wishes about their care and treatment and it is not uncommon that there is a differing view between that of the patient and the

clinicians and/or their families. This requires careful navigation, and, in many cases, an appropriate outcome is reached. However, there are occasions when the wish of the patient conflicts with their clinician and/or their family. Depending on the nature of the conflict there will be occasions when the wishes of the patient must be overridden. This is usually when the patient lacks insight or there is a view that the patient is a danger to themselves or others.

26. In respect of diagnostic labels, I understand the reticence on the part of some to attach labels for fear of impacting on the long-term prospects of patients. The reality is that when people have conditions such as paranoid schizophrenia these fears must be set aside. This is ultimately in the interests of the patient and those who might be affected by the behaviour of the patient.

27. Although mental health services have suffered years of under investment this must not be used as an excuse for poor decision making. Each serious incident must be judged on a case-by-case basis. There will be examples of over stretched under resourced teams but there will also be examples of poorly thought through care plans that cannot be excused by a lack of resources.

28. In respect of sharing information with a patient's family. The primary responsibility is that psychiatrists have a duty to maintain confidentiality. This can be set aside if it is deemed the patient lacks mental capacity and it is in the best interests of the patient to inform their family or if there is a

risk of harm to an individual. This is an area of clinical practice that is often a matter of contention between psychiatrists and patients or with the families of people who have a relative with a severe mental illness. It is not uncommon that families can feel excluded from decision making and care planning.

**Recommendations**

29. The fragmentation of services if often an area of criticism, particularly when there has been a serious incident. Multidisciplinary and multi-agency work is complex and the lack, at times, of sharing critical information can lead to a lack of continuity of care and patients falling out of the system.

30. I believe clinicians should be empowered to feel more confident in setting aside the wishes of the individual patient when it is in the interest of safety and indeed the care of the patient themselves.

31. It is difficult for me to suggest the recommendations the Chair of the inquiry should make as I do not have the level of detail that the inquiry will establish. Therefore, from distance several things occur to me:

    i. Was there a computerised system where there was a comprehensive overview of Valdo Calocane? If not, there should have been. If there was such a system, why did the professionals involved discharge him to a GP when all the information available to them should have made it clear that he was a danger to others.

    ii. When patients such as Mr Calocane who had a history of extreme violence drop out of the system there should be a concerted effort

in tracing them. Simply discharging him was clinically negligent. The Chair should recommend that in these circumstances a multi-agency review should be convened with the police being informed that there is an imminent possibility of people being in danger. Also, in this circumstance the family should be involved.

iii. I understand Mr Calocane said he had an aversion to needles which meant he would not accept a depot injection. In my opinion he should not have been allowed to make that decision. His history was such that it was self-evident that he would relapse with the high likelihood that he would become highly disturbed and violent which proved to be the case. The clinical team should also have been cognisant that a psychiatrist in July 2020 wrote in Mr Calocanes case notes "*there seems to be no insight or remorse, and the danger is that this will happen again and perhaps Valdo will end up killing someone*".

iv. Psychiatry is not a precise science. Psychiatrists often have to work on the balance of probability. With Valdo Calocane because of his history, it was self-evident he would relapse if he was not taking antipsychotic medication. The decision to discharge him appears to be indefensible.

32. It is unclear to me who made the decision to discharge him. The Chair should recommend that a decision of the magnitude to discharge a patient of Mr Calocane's disposition should only be taken by a Consultant

Psychiatrist.

33. Depending on the findings of the inquiry a recommendation should be made that psychiatrists must not be risk averse in speaking with the families of patients who they believe are a danger to them or 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: 9.12.25

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