Name: Nigel Blackwood

Statement No: WITN0308001

Dated: 30 November 2025

**THE NOTTINGHAM INQUIRY**

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**FIRST WITNESS STATEMENT OF NIGEL BLACKWOOD**

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I, Nigel Blackwood, will say as follows: -

**INTRODUCTION**

1. I am the Professor of Forensic Psychiatry at King's College London and a consultant forensic psychiatrist with the South London and Maudsley NHS Trust. I have been a qualified medical practitioner since 1991 and a consultant forensic psychiatrist since 2004. I am approved under Section 12(2) of the Mental Health Act 1983.
2. I devote one day of my working week to medicolegal work, and am regularly instructed by the Crown, the Defence and the Court to provide psychiatric reports in criminal matters. Such reports typically consider the nature of any identified mental disorder, the potential impact of mental disorder on offending behaviours, the availability of psychiatric defences, and subsequent

approaches to sentencing in the event of conviction. My primary duty in written reports and giving evidence is to give objective, unbiased opinion on matters within my expertise in order to help the court to achieve its overriding objective. I understand that this duty overrides any obligation to the person from whom I have received instructions or by whom I am paid.

3. This witness statement is made to assist the Nottingham Inquiry (the "Inquiry") with the matters set out in the Rule 9 Request dated 4 September 2025 (the "Request").

**BACKGROUND**

4. I have been asked to set out a detailed chronological account of my involvement in the case of R v Calocane together with an accurate record of all the information I was provided with in respect of Mr. Calocane.
5. I have been further asked to consider a number of additional matters: family concerns with respect to the psychiatric reports; Mr. Calocane's history of substance misuse; reports of potential stalking behaviours in 2022; Dr. Latham's involvement in the case; the investigation undertaken by the police and prosecution by the CPS; the content of the His Majesty's Crown Prosecution Service Inspectorate (hereafter, HMCPSI) report (particularly Section 6). Finally, I have been asked to reflect on any identified issues arising from the above, and any lessons which could be learned from the case to help to prevent similar attacks in the future. I will deal with each of these matters in turn.

## MY INSTRUCTION

6. I was first contacted by telephone by Mr. Alan Murphy, Specialist Prosecutor at the CPS East Midlands Complex Casework Unit, in the afternoon of 14 June 2023 (CPSE0000789). He outlined the recent events in Nottingham and requested that I accept instructions to provide a psychiatric report for the Crown if required. I agreed. He subsequently contacted me by email to confirm our conversation.

## CHRONOLOGY OF INVOLVEMENT

7. I was further contacted by email on 26 June 2023 by Mr. Murphy. He informed me that the case has been timetabled through to a trial in January 2024, albeit the Plea and Trial Preparation Hearing (PTPH) date had been moved back to 31 October 2023. He noted that the defence were due to serve their psychiatric report by 15 September 2023, but that he did not expect to be given anything by them (eg the defendant's medical records) until they had obtained their report and had decided what to do with it (i.e. whether to serve it or not). He asked if there was anything I would like to be provided with before that time. I requested the usual materials which a psychiatric expert considers: GP records; psychiatric records; the inmate medical records (from the period of remand); exhibits and witness statements; BWV footage at the scene; custody records; police interviews; toxicology.
8. I received further emails from Mr Murphy in July and August 2023 alerting me to case materials added to my Egress file for review (5th July: custody record;

18th August: materials including details of his previous his previous hospital admissions; general unused material that had been disclosed, some of which contained references to extreme violence videos discovered on his phone) (CPSE0002936, CPSE0004085).

9. I received an email from Ms. Kessie Pochin, a Paralegal Officer at the East Midlands Complex Casework Unit on 23 August 2023 alerting me to the placement of further served evidence and unused material on my Egress folder for my review (CPSE0002681).

10. On 19 September 2023, Mr. Murphy contacted me by email to tell me that the defence psychiatric report had not been served as expected on 15 September 2023 (CPSE0001545). The defence solicitors had informed the CPS that they were in receipt of the report, but that they wished to discuss its contents with Mr. Calocane and his barrister before serving the same. The solicitors had noted that the instructed psychiatrist had recommended that Mr. Calocane be transferred to hospital under ss48/49 of the Mental Health Act 1983 for assessment and treatment of his mental illness; and that Mr. Calocane had a diminished responsibility partial defence available to him. Mr. Murphy had advised the solicitors to put this in writing to the court and to the CPS; he also noted that the CPS would request that the case be listed for mention as soon as possible so that the defence team could go through the report with Mr. Calocane in the court cells if required to expedite matters.

11. On 21 September 2023, Mr. Murphy contacted me to ask whether, if Dr McSweeney's report was received on 29 September and forwarded to me, I would be able to prepare a report on fitness to plead / diminished

responsibility / disposal before the scheduled PTPH on 31 October 2023 (CPSE0002360). I did not reply immediately.

12. On 2 October 2023, Mr. Murphy contacted me by email, attaching the defence psychiatric report prepared by Dr. McSweeney dated 25 August 2023 (but only received by the CPS on 2 October 2023) (CPSE0000848). He noted the report's conclusions that Mr. Calocane was fit to plead, did not have the complete defence of insanity available to him, but did have the partial defence of diminished responsibility available for the murders. He noted that he had requested the source material which Dr. McSweeney had viewed but which at that point was unavailable to the prosecution (a General Practitioner healthcare summary for Mr Calocane dated 22nd June 2023; multiple documents and letters from Mr Calocane's past psychiatric records; an email dated 21st June 2023 from Mr Calocane's mother, Celeste Mendez, providing a summary of Mr Calocane's mental health history; and some text messages sent from Mr Calocane to his family members in 2020). He noted that the defence had confirmed that the defendant would cooperate with me. He enquired how long I would need to prepare my own report, noting that if the report was likely to be just after the PTPH (31 October 2023) then he would attempt to get that hearing adjourned. Finally, he noted that he was about to disclose more material to the defence including the full phone download: I already had earlier police reports which indicated that there was phone material supportive of previous issues with paranoia.
13. We spoke by telephone later on the afternoon of October 2 2023. I outlined my preferred timings for the provision of my report given other competing demands on my time. I planned to see the defendant in the week

commencing 6 November 2023 with report completion by 17 November 2023. The PTPH could be delayed to accommodate this timing. Mr. Murphy noted CPS concerns at how some of the evidence in the case could be consistent with Dr McSweeney's findings, and told me that he would include such concerns in the formal letter of instruction.

14. After the conversation, I emailed Mr. Murphy to seek the most up to date compilation of CCTV footage to help to understand Mr. Calocane's behaviours on the day/night in question (CPSE0001325). Mr. Murphy replied later that afternoon, alerting me to the placement of this material in my Egress folder. He noted that he had included three other CCTV compilations for the three separate incidents, and that further detail on Ilkeston road would be added to the main compilation in due course. He further asked that I note new information concerning materials sent by the defendant to his brother on the morning of the attacks and family medical notes from 2020 which were held to be relevant to the mental health issues in the matter. At the end of the afternoon, he sent through a review of Mr. Calocane's usage of his phone in the hours before the murder, the sequence of events (SoE) chart and handset analysis as email attachments.

15. Mr. Murphy sent a formal letter of instructions on 4th October 2023 as an email attachment (CPSE0000790). He noted the Crown's concerns relating to Mr. Calocane's text message to his brother (the 'I already have done' comment showing an apparent awareness of the killings) and apparent ability to exercise self-control at the time of the attempted break-in at Seeley-Hirst House (stopping when a motorist drove past) and asked me to specifically address such concerns in my report. He noted that the defendant had not yet

provided the Crown with consent to access his full medical records and so these could not be given to me at this stage; I was asked as to inform those instructing me as a matter of urgency if the absence of such records would impede or prevent me from completing a proper report. He noted that I planned to see the defendant w/c 6 November 2023 with report completion by 17 November 2023. The court was aware of those dates and he expected that the PTPH would be listed early in the week of 27 November to accommodate this.

16. Mr. Murphy sent me an amended letter of instructions (see uploaded documents, CPSE0000153) on 5 October 2023. These included 5 specific questions which I was to address in my report:
    i. Does the defendant have any diagnosable medical condition? If so, what is the prognosis? Is it treatable and if so how?
    ii. Is the defendant fit to plead and/or stand trial?
    iii. Was the defendant capable of forming the requisite intent for the offences at the time of the separate incidents?
    iv. In your opinion is a possible defence of loss of control/diminished responsibility available to the defendant in respect of the three counts of murder? (as opined in defence report)?
    v. If a finding is made by the court (of guilt, or that the defendant did the acts in question), what would your recommendation be as to disposal?

17. On 10 October 2023, Mr. Murphy forwarded me further information from Mr. Calocane's mother, in the form of an email which she had shared with the defence, entitled 'Context for Valdo's mental health history' (CPSE0000023). I

understood that Dr. McSweeney had considered the same in formulating his report.

18. At the time of Dr. McSweeney's assessment, Mr. Calocane was remanded at His Majesty's Prison (HMP) Manchester. I therefore initially sought to review Mr. Calocane at HMP Manchester. I attempted to contact legal visits by telephone in the w/c 30th October 2023, but was unable to establish any contact with staff. I sent an email to legal visits on 2 November 2023, requesting visits on 8 and 13 November 2023. Sarah Constable at Legal Visits apologised for the lack of telephone contact in an email later on 2 November 2023, noting that the prison had been very busy. She informed me that Mr. Calocane was no longer at the prison. When I asked whether he had been transferred to Rampton high secure hospital, she noted that she was only able to tell me that he had been transferred out.

19. I sought further information from the CPS on 2nd November 2023 concerning the hospital transfer details (Mr. Murphy was on annual leave at the time) (CPSE0004088). I wrote an email to the medical director at Rampton high secure hospital, Dr. John Wallace, to enquire whether he was at Rampton, and to arrange reviews if so. Later on that day, Ms. Pochin wrote to me to tell me that Mr. Calocane had in fact been transferred to Ashworth high secure hospital (in fact, on 1 November 2023), and provided me with his responsible clinician's details. I told her that I would review Mr. Calocane at Ashworth, and asked for a revised report submission date of 24 November 2023.

20. I wrote to Dr. Mirvis on 6 November 2023 asking to review Mr. Calocane on 14 November 2023. Mr. Murphy wrote to me to tell me that Mr. Calocane had consented for me to review the medical records. He also asked that I keep to

the previously agreed direction to serve my report on the court by Monday 20 November 2023.

21. Dr. Mirvis kindly arranged for my review at Ashworth. I reviewed all the provided materials before assessing Mr. Calocane. These materials are summarised in my first report (paragraph 16, CPSE0000011), and in more detail in the appended 'Materials' document (WITN0308002).

22. I interviewed Valdo Calocane at Ashworth high secure hospital for five hours on 14 November 2023 in morning and afternoon sessions. I reviewed relevant Ashworth notes during the lunchtime break on that day. I discussed his care with his consultant psychiatrist at Ashworth (Dr Mirvis) by telephone on 17 November 2023. My contemporaneous handwritten notes taken from the review are provided elsewhere (WITN0308003). These notes, together with relevant background materials, informed my subsequent 26 page report dated 20 November 2023 (CPSE0000011).

23. I did not meet with or interview the survivors of the attacks, the bereaved families or the family of Valdo Calocane to inform the report. Such meetings would be unusual for an instructed psychiatric expert to conduct. Experts rely on the extensive case materials as documented above, together with clinical review and discussion with other involved clinicians to formulate their reports. On occasion, further collateral information may be sought from family members of the defendant in a clinical interview where there is diagnostic uncertainty or where a new diagnosis has been suggested by defence experts. This is particularly common in cases where, for example, new diagnoses of neurodevelopmental disorders such as autism spectrum disorder have been made, and the same requires further detailed exploration.

In this case, Mr. Calocane had an established diagnosis of paranoid schizophrenia, and his family had already contributed significantly to an understanding of his background, clinical presentation and the communications received at the time of the index offences as detailed in my report. I did not consider that further interview was required to help to formulate my understanding of the case or the diagnostic formulation employed.

24. I was reminded by Mr. Murphy by email on 14 November 2023 that my report was due to be served on the court and defence by Monday 20 November 2023 (CPSE0008346). He noted that the families of the victims wanted to speak to the CPS and prosecution counsel ahead of the PTPH regarding the psychiatric position and that a Teams meeting was being set up for later in the w/c 20 November 2023. Mr. Murphy noted that the CPS would need to have had my report before then with sufficient time to consider it with the police before we speak to the families. I replied that I had seen him at Ashworth on that day, and that my view was that the partial defence of diminished responsibility was available to him, and that the best disposal would be via a Section 37/41 to conditions of high security. Mr. Murphy noted the same, and enjoined me to answer all the specific questions raised in the letter of instruction within my report.

25. On 15 November 2023, Mr. Murphy further wrote to me to ask that when I gave my opinion on disposal, I specifically address the possibility of a hybrid order (s45A) in my considerations (CPSE0008347). He noted that this was an obvious consideration for the court in this case, particularly as diminished did not arise in respect of the three counts of attempted murder. He

understood that that the supervision and powers of recall in the community if released are actually almost identical (to a S37/41) despite the apparent differences in the regimes, but that it would be helpful to have my views on this. I assured him that I routinely considered this matter in disposal recommendations.

26. On 20th November 2023, I received further medical and university materials disclosed by the police in an email from Mr. Murphy: these included statements by his University Professors and housemates (including a statement by Sebastian GRO-B) (CPSE0007845). The behaviours documented in these new materials were again consistent with his psychotic illness. They were rather 'distal' to the offences themselves, and I did not include their detail in my psychiatric report.

27. I completed and submitted my report in the early hours of 21 November 2023. Mr. Murphy wrote to tell me that the trial was listed from 16 January onwards and that I may have to give evidence depending on the position the CPS eventually adopted particularly as regards sentence (CPSE0008288). I provided details of my availability to attend at Nottingham CC in person as requested.

28. Mr. Murphy told me in a telephone conversation later in November that the CPS were going to further instruct the consultant forensic psychiatrist, Dr. Richard Latham, to review the evidence in the case, the three psychiatric reports prepared in the case to date (McSweeney, Shaffiula, Blackwood) and to consider whether the conclusions reached by the psychiatrists on the issue of diminished responsibility had been properly reached by them. I understood the rationale for the further review.

29. Mr. Murphy wrote to me on 8 December 2023 (CPSE0000166). He noted that a question had arisen in CPS consultation with the families of the deceased around the fact that the psychiatrists, including myself, did not interview the defendant's brother or the security guard at Seely Hirst House as part of our investigations. Both of these people had interacted with the defendant on the morning of the killings. Mr. Murphy asked me to provide a written response to the following question:

"Elias Calocane spoke to the defendant on the telephone at 4.52am on the day of the attacks (in between the killings of Barnaby & Grace and Ian Coates). A witness statement referring to this phone call has been taken, served and provided to you. Ivan GRO-B saw the defendant and spoke to him at 5.06am on the day of the attacks (in between the killings of Barnaby & Grace and Ian Coates). A video-recorded interview referring to this interaction has been obtained, served and provided to you. Both of these witnesses therefore interacted with the defendant during the period within which he was carrying out these attacks. In determining the defendant's mental state at the time of the attacks, and whether or not he may have available to him the defence of diminished responsibility, would there be any benefit to a forensic psychiatrist in personally interviewing either or both of these witnesses? Alternatively, would there be any reasons why it would be unnecessary or inappropriate to carry out such interviews, either on the facts of this case or in general. Please provide explanations for the answers"

30. In reply (by email) on 12th December 2023 (CPSE0000166), I wrote:

'I noted the key interactions you mention in preparing my report.

It is very unusual for experts to seek to further interview those involved as witnesses in any case (I have never done this in more than 20 years of report writing). We rely on the materials gathered by the police. If there were significant questions or doubts in my mind which were not addressed by the case materials/ police interviews/ witness statements, I would seek CPS authority for focused police re-interviews.

I do occasionally interview family members if further clarity is sought re. a potential psychiatric diagnosis (as collateral information). However, the state of mind underpinning the fatal assaults is clearly indicated by the written materials shared with his family shortly before the assaults; case materials (including family accounts) clearly demonstrate the nature of his illness; this is consistent with his earlier and later clinical presentations and the psychotic diagnosis. While respecting and understanding the family's search for meaning and for certainty, I do not think that further interviews with either of the two identified individuals are warranted in this case'.

31. I understand the CPS were subsequently in receipt of Dr Latham's report dated 12 December 2023 (CPSE0000017).

32. Mr. Murphy wrote to me on 19 December 2023 to inform me that the CPS had informed the defence and the court that they would accept the guilty pleas to manslaughter on the grounds of diminished responsibility (CPSE0000564). The court would now list the case for sentence, probably around 16 January 2024 onwards.

33. Mr. Murphy wrote to me on 22 December 2023 to inform me that he had received further medical records from the prison which I may wish to be aware of prior to my giving evidence in the case (CPSE0000563). An updated

version of the package of material that the defendant sent to his brother the night before the attacks was also uploaded to my Egress file for my information. An addendum addressing these materials and the police review of prison records was not sought.

34. Mr. Murphy wrote to me on 8 January 2024 to inform me that sentence had been listed for 23-24 January 2024(CPSE0000776). The prosecution wished to call me on 23 January (in person) and have me available for 24 January (when one of the defence psychiatrists was likely to give evidence) in case my recall was required. In reply, I noted that I could speak to the extra evidence sent to me pre-Christmas in oral evidence if required.

35. I was provided with Dr Mirvis' report dated 14 January 2024 (CPSE0000484) and Dr McSweeney's addendum report dated 12 January 2024 (HMCP0000459) by Mr. Murphy by email on 17 January 2024. I asked to review Dr. Latham's report; this was provided to me later on 17 January 2024 (CPSE0000581).

36. I was asked by Mr. Murphy on 17 January 2024 to provide a further addendum report 'on the question of sentence generally' (CPSE0004149). He noted that, in reality, the choice for the court was between a ss37/41 hospital order with restriction, or a term of life imprisonment with a specified minimum term coupled with a s45A hospital and limitation direction (a hybrid order). I was therefore asked to address the following:

    i. Outline the differences in theory and also in practice between the two options and to comment as to whether the differences are in fact more in the realms of theoretical than practical;

ii. Consider the position if D is transferred from hospital to prison: our understanding from previous cases is that D can be transferred back into the hospital setting if that is considered necessary;

iii. Consider the likely length of time he considers it will be before D could be considered for transfers from High security to Medium security to Low security hospital settings, together with the requirements in each event. Is there any difference in any of these matters between the s37/41 route and the s45A route?

iv. Consider the likely period before any consideration of release into the community or a prison setting would be considered together with the requirements before such a release would be approved. Again, is there any difference in any of these matters between the s37/41 route and the s45A route?

v. If you feel unable to give any indication of time periods, could you explain why and give such assistance as you can so that the court can assess the competing arguments for the different disposals.

Mr. Murphy noted that sentence was listed for Tuesday 23 January 2024 and that a report was required before then.

37. I provided the further 5 page addendum report addressing these matters dated 22 January 2024 (CPSE0000152).

38. I attended the Crown Court in Nottingham for the sentencing hearing. On Tuesday 23 January 2024, I met with the prosecution instructed barrister, Mr Karim Khalil KC, to discuss the psychiatric reports in the case. I listened to the prosecution opening of the case and to the statements made by family

members of the victims. On Wednesday 24 January 2024, there was a brief meeting with defence counsel and the three psychiatric experts who were to give evidence to explore whether there were any points of difference between us. There were none. I gave my own evidence in chief and under cross-examination. I listened to the evidence provided by the defence instructed expert, Dr. McSweeney, and Mr. Calocane's responsible clinician, Dr. Mirvis. The prosecution submitted that the most appropriate sentence would be imprisonment, together with a hospital and limitation direction under Section 45A of the MHA 1983. The defence argued for a hospital order with restrictions (Section 37/41, the psychiatric equivalent of a 'life sentence'). On my return to London, I listened to the sentencing remarks made by Mr. Justice Turner on Thursday 25 January 2024. The High Court judge agreed with the defence submission and made Mr. Calocane subject to a Section 37/41 order. Mr. Calocane returned to his psychiatric bed at Ashworth Hospital under the care of Dr. Mirvis. Mr. Murphy subsequently sent me the sentencing comments by email (CPSE0000576; CPSE0007218).

## ISSUES ARISING

### Concerns raised with the CPS concerning the psychiatric assessments

39. *Witnesses were not spoken to as part of the psychiatric assessments*

I was aware of, and had replied to, these concerns, as documented in paragraphs 29 and 30 above. My view on this matter has not changed on further reflection. Even if further interviews had been conducted (eg with the security guard at Seeley house) and he had resolutely told me that the

interaction with Mr. Calocane had been entirely normal in his view, and that he had seen no signs of a psychotic illness at the material time, this would not have fundamentally changed my approach to the partial defence. The behaviour at that time was highly unusual (attempting to break into a hostel to assault others unknown to him) and strongly suggestive of a disturbed mental state. Individuals in the grips of a psychotic episode may have intermittent periods of lucidity and appear 'normal' to others (particularly those who are not clinically trained) in brief interactions. The whole picture must be taken into consideration. His wider behaviours and accounts of the reasons for such behaviours clearly demonstrate his psychotic experiences and beliefs at the material time. One set of countermanding observations (if such had been obtained in a further interview) would not have argued against the clinical conclusions made by all instructed psychiatrists.

40. *The assessments focused on Valdo Calocane's mental state at the time of the assessment and not at the time of the offence*

I was not aware of these concerns. All instructed psychiatrists considered Mr. Calocane's mental state at the time of their assessments (see for example, my paragraphs 86-88 in the 20 November 2023 report) and at the time of the index offence (see for example, my paragraphs 44-45, and further materials germane to his mental state in the description of the lead up to/ aftermath of the index offences from case materials and his own account in the 20 November 2023 report) (CPSE0000011). The psychiatrists must consider in detail the components of a partial defence of diminished responsibility, and to do so they must reflect on the mental state at the time of the offence, as

derived/ best estimated from case materials and interviews with the defendant. The instructed experts did so.

I can understand familial frustrations that the experts instructed in the case could not draw on a detailed psychiatric assessment of Mr. Calocane's metal state at, for example, the time of arrest. This is one element of forensic practice that has perhaps deteriorated in the last 30 years: historically, a police surgeon would call out an on-call consultant or higher trainee to assess a suspect soon after arrest and reception into police custody. Today, police surgeons have been largely replaced by custody nurses and liaison and diversion practitioners (typically psychiatric nurses). Detailed mental state examinations by psychiatrists will typically only be available if there has been an assessment for admission under the Mental Health Act. Although he did not engage with liaison and diversion staff, it was nevertheless recognised that he was unwell; diversion to a mental health hospital at that stage would not occur because of the gravity of the offending (that is, the lack of diversion at that point does not mean that he was mentally well at the material time). Psychotic individuals charged with serious offences are retained within the criminal justice system pending further assessment in the early period of imprisonment which will inform their later transfer to psychiatric hospital.

41. *There was a delay in carrying out psychiatric assessments after the incident which impacted on the accuracy of the assessments*

I was aware of these concerns as a result of family statements made to the press in the wake of the sentencing hearing. Psychiatric experts instructed by the prosecution work to a timeline agreed with the CPS as detailed above.

Psychiatric reports as instructed by the defence are provided first; prosecution instructed experts respond to any potential psychiatric defences raised in such reports. In some cases, my services are retained when a defence report is considered likely, but then dispensed with when no psychiatric defence is forthcoming. The time which inevitably accrues between the offence(s) and the time of the prosecution instructed psychiatric assessment enables the collection of further important information: further case materials as detailed above; details of the presentation in prison (note the important further evidence of psychosis, paragraphs 67-75); details of the early presentation in hospital (my paragraph 77) (CPSE0000011). The consistency of his psychotic presentation in different settings at different timepoints is important information. In this particular case, there was a further small delay to my assessment consequent upon the uncertainties surrounding the site of his hospital transfer placement as detailed above. The accuracy of the assessment is in my view no less for occurring some 5 months after the index offences: the intervening months provided important information which helped to further clarify the clinical picture. The descriptions of his mental state closer in time to the index offences (whether in communication with his brother before the offences, or in assessments in the early part of imprisonment) are entirely consistent with the diagnosis of paranoid schizophrenia and the fact that he was actively psychotic at the time of the assaults. The possibility that an individual is fabricating or exaggerating his clinical presentation for legal gain is an active consideration for all instructed psychiatric experts, and one to which I was alive. None of the instructed experts considered that fabrication or exaggeration played a role in the case.

**Substance misuse recorded by Dr. Mirvis**

42. Mr. Calocane had told me that he had experimented with cannabis (weed) on one occasion when a student at Nottingham University, but did not like the effects of the same. He did not tell me of its specific effects (paragraph 20 of my November 2023 report) (CPSE0000011). The age at which he misused cannabis is consistent with the account later given to Dr. Mirvis.
43. The potential impact of any substance misuse on an individual's mental state and actions is an important consideration in any forensic psychiatric examination. Cannabis or other misuse did not feature in case materials including past psychiatric records. Mr. Calocane denied any substance misuse on the day/night/morning of the assaults (paragraph 80 of my November 2023 report) (CPSE0000011). My understanding is that toxicology was not available from his time in police custody and that urinary drug screening was not conducted on remand into prison. Such information would have been helpful in considering any potential impact of substance misuse on his mental state at the time of the killings. However, his mental state abnormalities continued to obtain many months after any such substances would have left his system: that is, even if substance misuse had obtained in the weeks before or on the day in question, his illness was not/ is not reducible to a drug-induced psychosis. The clinical picture is of a major mental illness (paranoid schizophrenia) with an onset and course unrelated to substance misuse.

**Reports of 'stalking' behaviours**

44. I received the witness statement of Sebastian GRO-B on 20th November 2023, shortly before the submission of my first report (CPSE0007848). I was thus aware of Mr. Calocane's behaviours towards that individual. I had not seen the police reports now shared with me. I note that the behaviours were ultimately considered not to represent stalking, and no further action was taken. The witness statement of Mr. GRO-B provided further evidence of Mr. Calocane's disturbed behaviours a time when his psychosis was under-treated (in July 2021). However, these behaviours were rather 'distal' to the offences themselves, and I did not include them in my report.

**The appointment of Dr. Latham**

45. This additional layer of review is unusual in my experience of providing psychiatric reports for the prosecution. Nevertheless, I understood the need for this further 'check and balance' given the gravity of the index offences and familial concerns that the three psychiatric reports already obtained be subject to further independent scrutiny, in particular to inform the core CPS decision as to whether to accept guilty pleas to the three counts of manslaughter. I was not involved in the appointment of Dr. Latham, but welcomed the additional scrutiny by a highly experienced clinical colleague. In the event, Dr. Latham concurred with the instructed psychiatrists' approach to the matter, but this did not appear to assuage familial concerns about the availability of the partial defence.

## The police investigation

46. The investigation conducted by the police provided me with the materials required to complete a detailed psychiatric report. I have no relevant concerns.

## The prosecution by the CPS

47. I received detailed instruction and timely assistance by the CPS in Nottingham. I have no relevant concerns.

## HMCPSI REVIEW

48. I was contacted by Mr. Anthony Rogers, the Deputy Chief Inspector of the HMCPSI on 21 February 2024 by email (HMCP0000583). He told me that the HMCPSI had been commissioned by the Attorney General to undertake an inspection of the CPS actions in the case. He asked for a meeting to discuss my involvement in the case to help to inform the report. I met with James Jenkins and Jo Milner, legal inspectors, on Microsoft Teams on 29 February 2024. A note had been provided to me by Mr. Jenkins before the meeting to guide our conversation, as follows:

    'In short, we wish to speak to you as part of our independent evidence gathering on whether the CPS decision to accept pleas to manslaughter on the grounds of diminished responsibility was compliant with the Code for Crown Prosecutors. We do not seek to speak to you about the quality of CPS engagement with the families, the sentencing exercise, or the final sentence.

    In relation to the decision to accept the pleas to manslaughter, the bereaved families have posed several questions. These include: why the defendant

killed their child or father, rather than anyone else that he came across? how can the defence of diminished responsibility have been available to him when there was evidence he decided to kill some people but not others? How does his ability to form some rational judgments and not to attack some people fit with the conclusions that his abilities were substantially impaired?

In particular, and with these questions in mind, we wish to speak to you to ensure we correctly understand certain aspects of your report, which concluded that the defendant's ability to form a rational judgment and exercise self-control was substantially impaired.

The broad topics and questions on which we would appreciate your assistance are:

i. The approach taken to assessing the mental state of a defendant at the time of the offending.

Q. As an expert, how do you go about 'back-calculating'? i.e., what is the recognised approach taken in forensic psychiatry to establish the state of mind of a person at the time of a killing?

ii. The relationship between the ability to form a rational judgment and the ability to exert self-control.

Q. Are these two aspects assessed separately or are they seen as inextricably linked?

Q. What is the relationship between the assessment of 'lucid periods' and the assessment of self-control?

Q. Can you confirm that your conclusion was that D's ability to do both things (i.e., form a rational judgment and exert self-control) was substantially impaired?

iii. Your assessment of the evidence that suggested D may have formed rational judgments and/or exercised some degree of self-control in the hours before and during the period of his attacks.

Q. In reaching your conclusion, what weight did you place on such evidence, for example: his pre-planning; his admission to you that he resisted voices telling him to harm others, until he reached Ilkeston Road; the images showing D standing near several young people on a tram a few hours before he killed the students; and the image showing him face to face with a security guard outside Seeley House at a time when he said he felt compelled to kill by voices?'(HMCP0000597).

49. We spoke for approximately half an hour. A draft copy of the conversation was subsequently provided to me, and I submitted minor edits to the same.
50. The subsequent summary of the content of our meeting is accurate (section 6.26).
51. I considered that the HMCPSI review was thorough while recognising that I am a forensic psychiatrist, not a lawyer.

## LESSONS LEARNED

### The approach taken to the management of Mr. Calocane's illness and his risks to others

52. Mr. Calocane had a four-year history of a major mental disorder, paranoid schizophrenia, by the time of the index offences. His illness had been principally characterised by reality distortion symptoms (auditory hallucinations, persecutory delusions, delusions of control, thought insertion, withdrawal and broadcast) together with disturbances of his affect (irritability, fear, hostility, aggressivity) when psychotic. He lacked insight into the morbid nature of his experiences, the pathological nature of the disorder or his need for maintenance medication treatment. He was tormented by his experiences, the full extent of which he sought to conceal from his treating clinicians.
53. Schizophrenia is associated with a significantly increased risk of violence to others: the best recent meta-analysis of more than 30 years of good epidemiological studies (Whiting et al, JAMA Psychiatry 2022) (NHSE0002731) examining this issue concluded that there was an approximately four fold increased risk of violence perpetration in men with schizophrenia and a seventeen fold increased risk of homicide. However, absolute risks of violence perpetration in register-based studies were less than 1 in 4 in men with schizophrenia spectrum disorders over a 35-year period. Psychotic symptoms such as persecutory delusions, in association with disturbances of affect (particularly anger), are one of the potential drivers of violence. Treatment with anti-psychotic medication significantly reduces such risk of violence.

54. Mr. Calocane was thus at increased risk of violence to others when psychotic. The circumstances in which psychiatric care is currently delivered merits careful scrutiny before focusing on individual decision making in a case where, while an increased risk of violence to others could be predicted, the extent and ferocity of violence visited on multiple entirely blameless individuals unknown to him could not. Some of the systemic issues which exerted important influences on his care included: a lack of inpatient psychiatric beds; a reluctance to enforce treatment when signs of risk are clear; a reluctance to utilise existing restrictive frameworks which promote treatment adherence in those who are psychotic and lack insight into their psychosis; lack of confidence with respect to violence risk assessment; fragmentation of clinical care (multiple teams, private sector admissions); premature discharge of the non-engaging psychotic patient to a primary care service which lacks the skills, time and resource to re-engage a patient in treatment. None of these issues were specific to the treating Trust or individual clinicians therein. Blaming individuals for decisions made in an under-funded system overwhelmed by demand is misplaced in my view.

55. To consider some of these issues in turn:

i. Psychiatric services have been chronically under-funded for many years, with a significant reduction in, and lack of, inpatient beds. Pressures on the use of inpatient beds are intense. Significant service pressures are exerted on inpatient clinicians to minimise inpatient stays; they are an expensive resource, and inpatient admissions are considered erroneously as ‘failures’ of community care. Clinicians internalise a lack of resource (here, inpatient bed availability) such that short admissions (if admission can be

secured at all) become the norm. This is typically justified under the guise of using 'least restrictive practice' or employing 'positive risk taking'. Mental health teams are vulnerable to ascribing a greater degree of autonomy to the acutely unwell psychotic patient than is reasonably merited: finding the balance between autonomy and restriction in mental health treatment is challenging, but should be informed by improved risk assessment practice and the better utilisation of extant treatment frameworks.

ii. Short inpatient stays and prompt return to community care may be merited in those at low risk to themselves or others. For those such as Mr. Calocane who lack insight into the pathological nature of their symptoms; do not consider that they have a mental illness that requires treatment; have clearly demonstrated their lack of compliance with oral medication in the community; and whose psychotic symptoms underpin their manifest risk to others, establishing and monitoring compliance with depot anti-psychotic medication becomes essential. Short admissions to inpatient care *were* secured in his case at times of heightened risk to others (prior to his disengagement). However, longer periods of inpatient care were required to establish medication compliance (using depot anti-psychotic medication) and (after Section 3 detention) the use of the Community Treatment Order (CTO) framework. Such monitored treatment is typically associated with symptomatic and risk reduction. However, clinical professionals (the psychiatrists and Approved Mental Health Professionals [AMHPs] involved in CTO decision making) may erroneously regard the use of such legal powers as hostile to a patient, despite the fact that the

treatment which is ensured within the framework may be the only route to symptomatic improvement and risk reduction. Clinical trials are required to increase clinicians' confidence that treatment under the CTO framework usefully impacts on symptom and risk reduction.

iii. Scalable violence risk prediction tools (including sociodemographic, familial, and treatment risk factors) have been developed (the OxRisk tools), and their use in early intervention services explored. Such tools show promise for assessing clinical needs around violence risk, but again require funded trials to explore their impact on risk management practices and violence reduction in patients with schizophrenia. Improved risk assessment alone is of little use; such assessments must inform improved risk management including the use psychotropic medication and wider aspects of multi-disciplinary care.

iv. Care for individuals with severe mental illness is also fragmented, with multiple different teams managing inpatient admissions (as here, in different NHS and private settings) and community care (Home Treatment Teams, Early Intervention Teams, Community Mental Health Teams etc). Such fragmentation shields clinicians from seeing the consequences of their decisions as the patient moves from one team to another. Continuity of care from the same psychiatrist and mental health team – both in hospital and in their local community – is typically associated with better engagement with services, and better outcomes including a reduced risk of relapse. Continuity of care can also help reduce risk when patients become unwell. Mr. Calocane *did* receive an important measure of stability in his treatment in the community in an early intervention in psychosis

team, with consistent relationships with a consultant psychiatrist and (until their departure) one care co-ordinator whose therapeutic relationship with Mr. Calocane was sufficiently good to recognise periods of increased risk which underpinned inpatient admission and treatment.

v. Retaining the insightless individual with psychosis in clinical services can be difficult in the absence of compulsion. Premature discharge to primary care services was a widely utilised approach for the non-engaging mental health patient, with the assumption that the patient would return to care via their GP or through emergency departments when their treatment needs overwhelmed their ability to maintain their lives in the community. NHS England have already issued guidance to trusts reminding them not to discharge patients with serious mental health issues if they do not engage with appointments.

**The approach taken by the CPS and psychiatric experts to the partial defence of Diminished Responsibility**

56. I note the families' continued concerns about the CPS's decision to accept the pleas of diminished responsibility for the murders. I simply note Lord Hughes statement in the Supreme Court case of R v Golds [2016] UKSC 61 (CPSE0000181):

"It is an important part of the Crown's function, where the charge is murder and a case of diminished responsibility is advanced, to assess the expert evidence … and its relationship to any dispute of fact. If it is clear that the defendant was indeed suffering from a recognised medical condition which substantially impaired him in one of the material respects, and that this

condition was a significant cause of the killing, the Crown is entitled to, and conventionally frequently does, accept that the correct verdict is guilty of manslaughter on the grounds of diminished responsibility and no trial need ensue … Acceptance of a plea to manslaughter may properly be given either before trial, thus making it unnecessary, or after testing the evidence if that is required."

The weight to be given to the medical evidence is a matter for legal investigation and argument and judicial direction, considered alongside other evidence.

57. The families also appeared to struggle with the fact that Mr. Calocane had no defence to the charges of attempted murder but did have a defence to the charges of murder. If his abnormality of mental functioning substantially impaired his ability to form a rational judgment or to exercise self-control when killing three of his victims, why did it not substantially impair his ability when at the same time he attempted to kill the other three victims? If he could be convicted of the attempted murder of the three people he intended to kill but who survived, why could he not be convicted of the murder of the three who did not survive? However, in England and Wales, diminished responsibility is not a defence to a charge of attempted murder.

**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: 30th November 2025

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1. CPSE0000789 Email from Nigel Blackwood [Kings College London] to Alan Murphy [CPSE] re: External Email - Re: Op Hendrix (Nottingham murders)

2. CPSE0002936 Email from Alan Murphy to Nigel Blackwood and Alan Murphy, Re: Op Hendrix - custody record

3. CPSE0004085 Email from Alan Murphy to Nigel Blackwood and Alan Murphy, re: External Email - Calocane MH records

4. CPSE0002681 Email form Kessie Pochin [CPS] to Nigel Blackwood [CPS], Karim Khalil KC, Peter Ratliff [6KBW] and others, re: Op Hendrix - Case material

5. CPSE0001545 Email from Alan Murphy to Nigel Blackwood and Alan Murphy, re: Hendrix - Defence Psychiatric Report

6. CPSE0002360 Email from Alan Murphy to Nigel Blackwood and Alan Murphy, re: [CJSM] Re: HENDRIX - Defence psychiatric report and future timetable

7. CPSE0000848 Email from Nigel Blackwood to Alan Murphy, re: External Email - Re: Valdo Calocane / Adam Mendes

8. CPSE0001325 Email from Alan Murphy to Nigel Blackwood and Alan Murphy, re: External email - CCTV

9. CPSE0000790 Email from Nigel Blackwood to Alan Murphy, re: External Email - Re: Op Hendrix - Instruction Letter

10. CPSE0000153 Letter from A. Murphy to Dr Nigel Blackwood re: DEFENDANT(S): Valdo CALOCANE aka Adam MENDES, URN: 31CF0944023,

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1. CPSE0000023 Email from Alan Murphy [CPS] to Nigel Blackwood [KCL], Alan Murphy [CPS] and Kessie Pochin [CPS], re: FW: External Email - RE: [CJSM] RE: R v Valdo Calocane / Adam Mendes U20231322 / 31CF0944023 - email chain between prosecution and defence lawyers to agree directions and to obtain VC's medical records

12. CPSE0004088 Email from Alan Murphy to Nigel Blackwood and Alan Murphy Re: External Email - Psychiatric assessment Mr Calocane

13. CPSE0000011 Medical Report of Professor of Forensic Psychiatry, Nigel Blackwood, King's College London, re: Psychiatric Report on Valdo Calocane

14. CPSE0008346 Email from Nigel Blackwood to Alan Murphy, re: Re: External Email - Re: Your report - Calocane / Mendes

15. CPSE0008347 Email from Nigel Blackwood to Alan Murphy RE: Your report - Calocane / Mendes

16. CPSE0007845 Email from Alan Murphy to Nigel Blackwood RE: Valdo Calocane / Adam Mendes

17. CPSE0008288 Email from Nigel Blackwood to Alan Murphy, re: Re: External Email - Calioocane psychiatric report USE THIS ONE

18. CPSE0000166 Email from Nigel Blackwood to Alan Murphy and Kessie Pochin, re: External Email - Re: R v Calocane / Mendes

19. CPSE0000017 Expert Report from Dr Richard Latham, Consultant Forensic Psychiatrist, Re: Psychiatric Report of Valdo Calocane aka Adam Mendes

20. CPSE0000564 Email from Alan Murphy to Nigel Blackwood and Alan Murphy, re: Calocane / Mendes

21. CPSE0000563 Email from Alan Murphy to Nigel Blackwood, re: Calocane / Mendes

22. CPSE0000776 Email from Nigel Blackwood to Alan Murphy Re: External Email - Re: Calocane / Mendes sentencing - 23&24 January

23. CPSE0000484 Expert Report by Dr Ross Mirvis, Consultant Forensic Psychiatrist, Ashworth Hospital re: Psychiatric Report on Valdo Calocane (aka Adam Mendes)

24. HMCP0000459 Expert Report from Dr Leo McSweeney re: Psychiatric Addendum Report prepared for Bhatia Best Solicitors on Valdo Calocane (aka Adam Mendes)

25. CPSE0000581 Expert Report of Dr Richard Latham, re: Psychiatric Report of Valdo Calocane aka Adam Mendes

26. CPSE0004149 Email from Alan Murphy to Nigel Blackwood and Alan Murphy, re: RE: External Email - Re: Op Hendrix - instructions to prepare an addendum report

27. CPSE0000152 Expert Report from Nigel Blackwood MA MD FRCPsych, Re: Addendum psychiatric report on Valdo Calocane aka Adam Mendes

28. CPSE0000576 Email from Alan Murphy to Nigel Blackwood, re: Calocane sentencing remarks

29. CPSE0007218 Sentencing Remarks, Rex v Valdo Calocane, Nottingham Crown Court

30. CPSE0007848 Witness Statement of Sebastian dated 22/09/2023

31. HMCP0000583 Email from Anthony Rogers (HMCPSI) to Nigel Blackwood, James Jenkins, re: HMCPSI inspection of the handling of the Calocane case by the Crown Prosecution Service

32. HMCP0000597 Letter from James Jenkins to Nigel Blackwood, Re: Inspection of the actions of the Crown Prosecution Service in the Valdo Calone case

33. NHSE0002731 Report dated 22/12/2021, Compiled by Daniel Whiting, BM, BCh; Gautam Gulati, MD; John R. Geddes, MD and others, Re: Association of Schizophrenia Spectrum Disorders and Violence Perpetration in Adults and Adolescents From 15 Countries A Systematic Review and Meta-analysis

34. CPSE0000181 Judgment of the Supreme Court, R v Golds

35. WITN0308002 Index of case materials available to Professor Blackwood at the time of writing his psychiatric reports

36. WITN0308003 Hand written notes from psychiatric assessment at Ashworth Hospital