Witness Name: Dr Frank Farnham

Statement No: WITN0415001

Dated: 20 February 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DR FRANK FARNHAM

I, Frank Farnham will say as follows: -

INTRODUCTION

1. I am a Consultant Forensic Psychiatrist at North London NHS Foundation Trust.

2. This witness statement is made to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 Request dated 30th January 2026 (the **Request**").

3. This witness statement was drafted on my behalf by external solicitors, with my assistance, oversight and input, following discussions in writing by email and by video conference.

CAREER AND ROLE

4. My name is Dr Frank Read Farnham. My professional qualifications are Bachelor of Science Honours Degree in Clinical Science and Bachelor of Medicine and Bachelor of Surgery, both awarded by Imperial College in 1989 and 1990 respectively. I was admitted as a Member of the Royal College of Psychiatrists in 1996 and elected as a Fellow in 2013. I am on the Specialist Register of the General Medical Council with specialist training in Forensic Psychiatry and am approved by the Secretary of State as having special experience in the diagnosis or treatment of mental disorder under Section 12(2) of the Mental Health Act 1983/2007.

5. I have been employed as a Consultant in Forensic Psychiatry for the North London Forensic Service, part of the North London NHS Foundation Trust, since 2000. I have a clinical and research interest in stalking and harassment which dates back to 1996. I am a member of the Fixated Research Group (FRG). The FRG won a competitive tender to research a database of concerning individuals collected by Royalty Protection Police over a period of approximately twenty years where there was concern about fixation on the Royal Family or on iconic Royal sites. This research was conducted between 2003 and 2006 and led to the fixated threat assessment centre (FTAC) becoming operational in 2006.

6. As regards my current roles, I have been a Consultant Forensic Psychiatrist at FTAC for twenty years. I am Consultant Psychiatrist to the Stalking Threat

Assessment Centre (STAC), a specialist service developed with the Metropolitan Police, North London NHS Foundation Trust, Probation and the Suzy Lamplugh Trust to assist in assessing and managing stalking behaviour. I also act as a Consulting Psychiatrist to the Clinical Consultancy Service – (CCS), a joint unit developed with Counter Terrorism Policing, the North London NHS Foundation Trust and Greater Manchester Mental Health NHS Foundation Trust. CCS assesses cases where there are concerns regarding radicalisation, fixation and mental disorder, usually arising from a referral to Prevent. I am also an Honorary Associate Professor of Security and Crime Science at the Jill Dando Institute, University College London.

THE FIXATED THREAT ASSESSMENT CENTRE

7. At FTAC I am one of five consultant psychiatrists and psychologists. I have worked there since its inception and am currently employed there one day per week. I share a "pod" with another Consultant colleague and work with two Detective Constables and a band 7 nurse.

8. The primary purpose of FTAC is the assessment and management of threats posed to prominent individuals and their working environments by "isolated loners" who pursue idiosyncratic quests or grievances. These individuals often engage in behaviours such as stalking, harassment, unwanted intrusion, and persistent complaining.

9. FTAC is generally involved in threat management rather than risk assessment. Threat assessment is typically an operational time critical process conducted by police or other law enforcement professionals that lacks a scheduled timeline and focuses on immediate victim protection through the evaluation of situational and dynamic factors, and a plan is agreed between healthcare professionals and the police. Threat management uses a flexible individual-focused structure, and is designed to be very specific to each case, as to take into account what is happening with the individual at that specific time Conversely, violence risk assessment is a process usually conducted by health care professionals. In forensic services, risk assessment generally involves a multi-disciplinary approach and the use of structured assessments such as the HCR-20, and I return to this in more detail later on in my statement.

10. Referrals into FTAC can come from a variety of sources. Most referrals come from or are to do with, Members of the Royal Family and Members of Parliament, FTAC also receives referrals regarding risks to specific sites, such as Royal Palaces, the Palace of Westminster, Government Ministries, and buildings within the government security zone. Correspondence officers will refer in concerning correspondence and police officers will generally refer in approachers. Referrers, such as protection personnel or correspondence staff, perform a preliminary risk screening using a checklist of criteria provided by FTAC to determine if a case is suitable for referral.

11. The core aspect of FTACs work is the evaluation of threat using a multi-agency approach that combines professional judgement with policing intelligence via

police databases and the use, if proportionate, of the NHS Spine Portal to access the contact details of an individual's GP and/or community mental health team. The threats assessed include potential violence, distress to the prominent individual, disruption of events, and waste of police or public resources. Additionally, a core responsibility is the safety of the individual themselves, who may be vulnerable due to mental illness or their presence in armed environments.

12. The role of the consultants at FTAC is to broker relationships between agencies, foster appropriate information sharing and advise about clinical aspects of a case where necessary. The relationship between the police and the health colleagues at FTAC has been built over time. Issues of trust and confidentiality have been worked through and the consultants' nurses and social workers at FTAC work well with the police.

13. FTAC does not have a statutory function and is not responsible for the management of individuals in the community. FTAC operates essentially as a virtual liaison and diversion scheme – a specialist assessment and management unit that attempts to facilitate entry into appropriate care by "catalysing" interventions from local health and social care. Most subjects referred to FTAC suffer from serious mental illnesses but FTAC cannot take on every possibly mental ill person who writes or attends. There has to be evidence of mental disorder, fixation and threat. FTACs role is to identify these individuals and refer on if appropriate.

14. When an individual is referred to FTAC, the team will receive details of the concerning behaviour, such as scans of letters, emails, or reports of approaches to prominent people or sites. The referral should also indicate which criteria from the referrer checklist the case satisfies. This information is analysed using a structured triage process. The initial assessment involves a joint review by a Forensic Nurse Specialist and a Detective Constable to determine the likely meaning of the behaviour, the subject's motivation, and their mental state. The police will then carry out a series of checks on police indices. FTAC will create a nominal. A nominal is a registration that a case has been acknowledged. The decision to make a case a "nominal" is an administrative step that occurs for every referral processed by the FTAC. If the assessment concludes that FTAC will take no further action, generally because the person does not meet FTAC referral criteria, a nominal record is created to log the subject, and the rationale for not progressing the case is recorded on the nominal page. Conversely, if the team decides to conduct further work of any kind, such as further investigation or active management, they create both a nominal record and a linked episode. Thus, while every subject becomes a "nominal" for record-keeping purposes, a case that remains solely a nominal represents a decision that the referral does not require FTACs active intervention.

15. If the case meets FTAC criteria, then a concern level will be allocated and a decision will be made to contact the individuals GP or community mental health team to make further enquiries. Allocating a concern level is a matter of professional judgement, and whilst tools such as the Communicated Threat

Assessment Protocol (CTAP)[1] can provide some guidance, this will have to be taken on a case-by-case basis and be led by considering all the evidence together. If a case falls within FTACs remit and is assessed as moderate or high concern, the management plan typically involves identifying relevant agencies to take responsibility for long-term management. FTAC psychiatrists do not intervene to detain people under the Mental Health Act or carry out any treatment directly. Clinical decisions need to be made locally but FTAC can help by sharing information and occasionally attending professionals' meetings to discuss the best plan for the person. FTACs role in general is to impart information about the concerning communication or behaviour in order to facilitate an individual receiving further, fully informed, assessment and treatment as necessary.

16. The role of consultants, both psychiatrists and psychologists within FTAC is to provide clinical support to the Forensic Nurse Specialists and police officers who manage day-to-day casework. The consultant will review the "concern level" allocated to new referrals. The amount of material it is considered proportionate to attempt to access will depend on the concern level allocated. As a team we will review the initial management plans to ensure they are defensible and appropriate. We use the CTAP to evaluate concern. Factors such as delusions, substance abuse, and personality disorder and overt threats or escalation are also considered.

[WITN0415007]

[1] https://ctap25.com/

17. For more complex cases, FTAC might use other structured professional judgment tools, such as the Stalking Risk Profile or HCR-20. In a more complex case, the individual may be known by several services, and we might suggest a 'professionals meeting' is held with those services who have knowledge of the person (such as the police and local mental health services) but do not have the full picture. Alternatively, the request may come from one of the other services. We may use structured professional tools to present some further information on the person to aid in multi-agency working and address concerns.

[WITN0415008]

18. FTAC holds weekly "POD reviews" (team meetings) where ongoing cases are discussed with the Forensic Nurse Specialist and the Detective Constable. During these reviews, the consultant would oversee the progress of cases, approve decisions to designate cases as "inactive" (closed), and ensure that the rationale for closure, including a final concern level, is formally recorded. The consultant would also be responsible for ensuring that the episode case summary is completed upon closure, providing a clear history for any future re-referral.

19. Information sharing is strictly governed. All NHS staff are responsible for ensuring that confidential clinical information obtained from NHS sources is stored on NHS systems and not on police databases. However, we would also ensure that necessary risk information is communicated to partners; for example, the management plan often involves catalysing multi-agency interventions and sharing relevant intelligence with local police or health partners to mitigate risk. This needs to be done sensitively and proportionately.

REFERRAL OF VC IN MAY/JUNE 2021

20. I have no direct memory of the case as it was over four years ago. All referrals are sent to the FTAC mailbox, and then a nominal is created by the duty team. I would not have reviewed the email **[WITN0012003]**, as it was not sent to me, but rather the generic FTAC mailbox (which I would not routinely review), but the information in the email was transferred into the nominal record, in line with normal protocol. Therefore, I would have reviewed the FTAC nominal record **[WITN0012004]**, but I do not have any specific recollection of doing so. I did not review the body-worn footage, which was in line with normal protocol. I would have only looked at body-worn footage if I was requested to, and I was not in this case. I would not have sought or obtained any further information in respect of VC.

21. Nominals would be discussed as part of the weekly pod supervision. As stated in the previous paragraph, I would have seen the TOM entry that created the nominal record. There were no email communications between me and other individuals within FTAC. I have no recollection of this specific case, but my normal practice would have been to approve the decision made by **Officer X** and **GRO-B** **[WITN0012004]** to keep VC as a nominal at this time.

22. I would not have formed any particular view about VCs mental state other than that he had travelled a long way and evidence of displacement is a potential risk factor. His request to be arrested also seemed odd. Together these factors

suggested that he may have been mentally ill. However, he presented with no overt symptoms of mental illness. He did not appear fixated and the officers did not have any concerns about his presentation / mental state. In any case, mental illness alone is not a reason for FTAC to take on a case for further management. The reference to a domestic ABH on 24 May 2020 where VC was not prosecuted, was taken into account, but did not impact the specific FTAC assessment that was carried out or the threat level VC was assessed at.

23. FTAC would not routinely share information about a nominal to other agencies. To put this into perspective, in **2021** FTAC received about **one thousand five hundred** referrals, of which about a third were approachers and a third were rejected and stayed as nominals. If an individual is taken on as an episode, then FTAC would refer on to other agencies as appropriate on a case-by-case basis. From a health perspective this would likely be the individual GP and/or local mental health services. The purpose is to ensure that the person is receiving appropriate mental health care.

[WITN0415007] **[WITN0415008]**

24. FTAC uses the CTAP^ and sometimes the stalking risk profile (SRP)^. I have exhibited both documents to this statement. As stated, FTAC is primarily concerned with threat rather than risk. FTAC uses a structured professional judgement (SPJ) approach to considering threat whilst acknowledging that it is impossible to accurately predict risk of serious violence at the individual level because of the large number of false positives inherent in any attempt at prediction. Key factors that are taken into account by FTAC are the presence

of active mental illness, in practice psychosis, accompanied by evidence of fixation on, and threat to, the prominent individuals that FTAC covers.

GENERAL QUESTIONS

25. It seems necessary to state at the outset that mentally ill people are much more likely to be the victim of violence than the perpetrator. However, as I have understood in the course of my practice over the last 30 years, it has become apparent that schizophrenia is a risk factor for violence, particularly in combination with substance abuse. There are some key references to these facts, two of which I have exhibited to this statement [**WITN0415002, WITN0378003**].

26. As regards my practice, over the last few years my clinical NHS work has involved various multi-agency initiatives, as set out above, and I no longer have inpatients. However, in forensic practice generally, risk assessment is routinely and regularly undertaken, both in inpatient wards and in community settings. The HCR-20 is routinely used for this purpose. In fact, the use of the HCR-20 V3 is essentially mandated in secure mental health services in the United Kingdom (and is part of the NHS England service specification for Adult High Secure Services, **NHSE0000020**), regardless of whether a person has a history of violence.

27. Under those circumstances risk assessment itself risks becoming a job that needs to be done to satisfy various contractual requirements rather than a fundamentally meaningful exercise. It is of note that at the Annual Royal College of Psychiatrists Forensic Faculty Conference in March 2022, there was a debate on 2 March 2022, of the motion "*This house believes that it is time to stop doing long risk assessments like the HCR-20 because they have not improved patient outcomes*". [**WITN0415005**] More people voted for the motion – ie, more of those in attendance thought it was time to stop doing long risk assessments. Dr Caroline Logan, subsequently wrote about this in the introductory chapter of her book – 'Managing Clinical Risk – Guide to Effective Practice'.[2]

28. The task is 'doing the HCR-20' rather than understanding the nature of this person's risk of harmful behaviour in order that what the team discovers informs what the team then does about it. In my view risk assessment can become a bureaucratic exercise alongside many others in forensic services rather than an informative, guiding and consequential process. It then risks becoming detached from the risk management cycle.

29. I am less clear about how risk is assessed in adult general services. There is often a section on "risk" contained within letters and reports from adult psychiatric services but these are not usually structured. Better training

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[2] Managing Clinical Risk - Guide to Effective Practice, Second Edition edited by Caroline Logan and Lorraine Johnstone, DOI: 10.4324/9781003186564-1

regarding violence risk assessment is probably necessary but I would reiterate that I am a forensic psychiatrist and do not work in general psychiatry.

30. Another problem in violence risk assessment is understanding what is meant by violence. The most recent iterations of the HCR-20 allow for different scenarios to be constructed to consider different types of violence risk, given what is known about the individual's risk factors and antecedents. It is important to begin with scenario planning, informed by a good and detailed understanding of the patient, which then allows for the consideration of possibilities that can range from the more likely scenario of less serious violence to the extremely rare scenario of serious violence. However, this sort of scenario planning is time consuming (and can be a period of weeks or months) and may not be feasible in adult general services.

31. In my experience even if a risk assessment is undertaken, a common problem is not "completing the journey" from risk assessment to management plan to actually having the resources to implement the plan properly. In my view psychiatric services have been systematically under resourced for many years. There are not enough psychiatric beds, community services are under resourced and there are often overwhelming structural psychosocial or socioeconomic factors, such as access to proper accommodation, that play a major part in risk management, but over which psychiatric services have little or no control. My work at FTAC allows an insight into how variable psychiatric services can be across the country, in terms of resources and experience of staff.

32. Approaches to assessing violence risk have evolved from simple unstructured clinical judgment to the use of actuarial tools to the use of a structured professional judgement (SPJ) approach to assessing and managing risk. In forensic practice most clinicians use a combination of so-called actuarial risk factors such as nature and degree of previous offending, the fact of having a mental illness etc, with dynamic risk factors, such a substance abuse, which can change, and which might be the focus of work aimed at reducing any risk. This is the SPJ approach and is embodied by the HCR-20. Scenarios are then considered, with management plans to reduce the risk in any given scenario.

33. However, I am concerned that relatively complex and lengthy tools like the HCR-20 may not be suitable for use in adult general services where there probably is not the time or the resources to produce a bespoke risk assessment. In this regard I am attracted to the work of Professor Fazel in Oxford, the OxRisk project and OxMiv.[3] It seems to me that OxMiv is an achievable simple scalable risk screening tool that could be used in adult general services. It focuses on the main risk factors for violence, substance abuse being the most important. In my opinion risk assessment tools can be effective. In adult general services it seems to me that tools such as the OxMiv can help in identifying those cases that are in a group who are at low risk, thus allowing services to concentrate on high-risk cases.

[3] https://oxrisk.com/oxmiv/

34. I am a forensic psychiatrist and do not work in general psychiatry but it seems to me that there is a clear disparity in risk assessment between general and forensic settings. There may be issues with the mandatory nature of risk assessment in forensic services, as outlined above, but risk management is nonetheless central to forensic services. In forensic services inpatient and community settings violence risk assessment is routinely undertaken as part of the clinical work and the HCR-20 is used more or less universally. My impression is that general psychiatrists may be anxious about assessing risk perhaps because of a lack of training and a sense in which they feel they lack specialist knowledge. In my view, this should not limit general psychiatrists. There may be a perception held by general psychiatrists that they do not encounter violence frequently enough to gain experience and improve their assessment skills, whereas the key experience required is very detailed knowledge of the patient.

35. I am aware of the Royal College of Psychiatrist's Patient Safety Expert Guidance Working Group 2016 report CR 201 – *"Assessment and management of risk to others"* [**NHFT0015099**]. The report makes several good points, including that risk cannot be eliminated but can be managed; that risk assessments need to be frequently reviewed because of the dynamic nature of some risk factors; that a formulation and plan should specifically describe the current situation and say what could be done to mitigate the risk in future; and that it is important that the management plan is actually carried out. It also emphasises the need to gather as much information as you can about the patient from different sources as knowing your patient well should be the

bedrock of risk assessment. However, it seems to me that it does not provide clear guidance as to how to actually conduct a risk assessment. It implies the use of the HCR-20 but that requires training. The approach fits well in a forensic setting but not well in an adult general setting. In my opinion it needs updating and the emphasis needs to be on a scalable approach that can be easily implemented.

RECOMMENDATIONS

36. As for recommendations. I am principally concerned that there are significant issues with resourcing of services. As stated above, there are not enough beds and community psychiatric services are under-resourced. It is frustrating to conduct a risk assessment, produce a management plan and then lack the resources to properly implement the plan. It seems to me that overall, it is necessary to take a public health model approach to managing risk, as is done for example, with cardiovascular risk. We know that hypertension is a risk factor for various cardiovascular conditions including stroke but it is not possible to predict with total accuracy which of those with hypertension will have a stroke. Rather it is better to treat all hypertension and not worry about predicting who will have the worst outcome. Similarly with violence risk. A screening process could identify and "screen out" the low-risk cases, allowing concentration of resources on the higher risk cases.

37. Good quality appropriate information sharing is key to muti-agency working and managing risk, in fact all work in mental health services. Police and health care

professionals tend to have different approaches to managing risk. This is embodied by the differences between threat assessment and risk assessment. The key is to draw on the relative skills of each agency. The police are obviously good at real time management of threatening scenarios – the immediate "degree" of the problem. Health care professionals are good at stepping back and considering the nature of the problem. Together these two approaches complement each other. Good quality information sharing is fundamental. Multi-agency working does not work if each side remains in a silo.

38. There are existing examples of good multi-agency working. Multi-Agency Public Protection Arrangements (MAPPA) is the obvious example at the very serious end of the spectrum as it is specifically designed to manage the risk posed by the most serious sexual and violent offenders. Multi-agency safeguarding hubs are the most common model for child and adult safeguarding. Multi-Agency Risk Assessment Conferences (MARAC) are focused on "high-risk" domestic abuse cases. In my opinion it would be helpful if the "FTAC model" could be rolled out with closer links between health, social care and the police so that this sort of multi-agency work with the seriously mentally ill is not limited to the protection of prominent people.

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: 20 February 2026

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1	WITN0012003	Email between FTAC Officers, Metropolitan Police regarding incident at Thames House
2	WITN0012004	TOM2 Nominal Status for Valdo Calocane, Metropolitan Police FTAC
3	WITN0415002	Prevalence Rate and Risk Factors of Victimization in Adult Patients With a Psychotic Disorder: A Systematic Review and Meta-analysis
4	**WITN0378003**	Schizophrenia and Violence: Systematic Review and Meta-Analysis
5	**NHSE0000020**	NHS England service specification for Adult High Secure Services
6	WITN0415005	Faculty of Forensic Psychiatry Annual Conference Online 2022 Agenda
7	**NHFT0015099**	Royal College of Psychiatrist's Patient Safety Expert Guidance Working Group 2016 report CR 201 – *"Assessment and management of risk to others*
8	**WITN0415007**	**Communications Threat Assessment Protocol-25, CTAP-25 Manual, Guidelines for the Initial Assessment of Problematic Communications**
9	**WITN0415008**	**Stalking Risk Profile, Guidelines for the Assessment and Management of Stalkers**