Witness Name: Daniel Whiting
Statement No: WITN0456001
Dated: 20 May 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DR DANIEL WHITING

I, Daniel Whiting, of the University of Nottingham, University Park, Nottingham, NG7 2RD (the "**University**"), will say as follows: -

Introduction

1. This witness statement is made to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 Request dated 5 May 2026.

2. I am a Clinical Associate Professor in Forensic Psychiatry at the University of Nottingham, and an Honorary Consultant Forensic Psychiatrist at Nottinghamshire Healthcare NHS Foundation Trust (the **"Trust"**). I am a registered medical practitioner (GMC 7073641) having graduated from the University of Oxford in 2010 (BM BCh). I am on the GMC Specialist Register in Forensic Psychiatry, having gained a Certificate of Completion of Training in 2018. I was elected to Fellowship of the Royal College of Psychiatrists in 2025. I am approved under Section 12 (2) of the Mental Health Act 1983 as having special experience in the diagnosis or treatment of mental disorder. Between 2018 and 2022 I undertook a doctoral research fellowship and was admitted to the Degree of Doctor of Philosophy (DPhil) in Forensic Psychiatry at the University of Oxford in 2022 (thesis entitled "Improving violence risk assessment and intervention in first episode psychosis").

3. I have been asked to set out my role at the University of Nottingham, my relationship with the Trust and the nature and extent of my work with the Trust. I took up the clinical-academic position referred to above in March 2022. In this role, my employer is the University of Nottingham, and my clinical duties with the Trust are under the framework of an honorary clinical contract. This clinical-academic post is funded by the Trust, as part of the partnership between the University of Nottingham and the Trust that is the Institute of Mental Health, established in 2006. In this dual role half of my working week is dedicated to clinical duties at the Trust, and half to academic duties at the University.

4. At the University of Nottingham, my role is mainly to undertake research, as well as provide teaching and supervision on different undergraduate and postgraduate courses and contribute to the wider functioning of the School of Medicine.

5. In the clinical half of my role, between March 2022 and February 2026 I was based in the Offender Health directorate of the Trust, providing psychiatric care within prisons as part of the integrated mental health teams, mainly based at HMP Lincoln and HMP Morton Hall. In February 2026, I moved to the Community Forensic Team, part of the Low Secure and Community Forensic Care Unit. In this role, I am the Responsible Clinician for patients living in the community who are for example conditionally discharged and subject to restrictions under Section 41 of the Mental Health Act 1983, or subject to a Community Treatment Order. I also treat a smaller number of people who are not subject to a formal mental health legal framework but require specialist forensic input due to risks that have been associated with mental disorder. I am also involved in assessing new referrals made to the Community Forensic Team from a variety of sources for advice, assessment or consideration of handover of care. My direct clinical duties undertaken with the Trust are therefore the same as a non-academic consultant forensic psychiatrist, although outside of these direct clinical duties there is some more overarching interface between my academic role and the Trust as is set out

further herein.

OxMIV tool

6. I have been asked whether I use the OxMIV tool in my clinical practice, how and when I use it and whether I find it useful.

7. Clinically I use OxMIV as a complement to my full clinical assessment most typically when undertaking a new assessment where understanding of risk is being developed. By "complement" I mean that I do not link the output of the tool in any directive manner to decision-making, nor does it replace or override my clinical judgement. Rather I use it to anchor my overall assessment in an objective epidemiological basis in terms of the magnitude of risk and the relative importance of different factors to this, to help guide and focus my thinking and clinical assessment. In my new clinical role with the Community Forensic Team, I have used it in this manner to support assessments and consultations regarding people referred to us by adult mental health teams, and I am in discussion with colleagues as to how a more routine role in this service interface might be developed.

8. As the Inquiry is aware, I have published research involving OxMIV, and my doctoral research involved validating the accuracy of the tool for people presenting to Early Intervention in Psychosis (**"EIP"**) services and examining the acceptability and feasibility of its use in that clinical setting. At this stage therefore it is difficult for me to separate my view on how I personally find it useful in clinical practice from my detailed examination of clinical utility at both an individual and service level as a research question. If I were to try to summarise my own view from using it however, I would say that I find it helpful due to its simplicity and transparency. One can see clearly in absolute terms the difference that the presence of certain factors such as past violence and substance misuse makes to risk estimates.

9. I understand that the Inquiry heard evidence from Dr Benjamin Lomas that I

had recently provided a presentation on use of the OxMIV tool to the Trust, and I have been asked what I spoke about. The presentation to which Dr Lomas refers is I believe the one I gave at the Trust's Annual Medical Education Conference, at which I spoke on 28 November 2025. My talk was entitled "Assessing violence risk in adult psychiatry" **WITN0456002**. In this I covered the following topics:

- **The epidemiological context of violence in mental illness.** I outlined that most people with mental illness are never violent, but that there is an increased relative risk compared to the general population, referring to the 2021 review I co-authored with Professor Fazel (WITN0401003), and that for some people with mental illness, violence is an important adverse outcome to reduce as part of treatment. I touched on stigma, including that one path to reducing stigma is to improve prevention of violence in mental illness, rather than not acknowledging evidence of the link, as set out in a 2024 publication (WITN0401006). I offered the context that individualising treatment based on risks of adverse outcomes is a core process in medicine, and that accurately assessing risk can help target resource to where it can achieve greatest absolute risk reduction. I noted the high threshold for forensic services to take over someone's care, and that opportunities for preventing a first serious violent offence exist largely in the clinical population that sits beneath this threshold in general services.

- **The relevance of assessing violence risk in EIP services.** I explained that around 1 in 10 people presenting to EIP services perpetrate violence in the year after first contact. This is a challenge for services that do not specialise in violence risk assessment or management, who are engaging people experiencing their first episode of illness, and are assessing a range of risks and needs. Long structured professional judgement tools that forensic services might use to assess risk typically take many person hours to complete and

are not feasible to support EIP services.

- **Challenges of assessing violence risk in general (non-forensic) settings.** I described a qualitative interview study of staff, patients and carers in EIP services undertaken as part of my doctoral research, published in 2024 (WITN0320015). I summarised four key challenges identified: 1) clinician confidence in knowledge and skills around violence risk assessment being low, 2) clinician hesitancy to broach the subject of violence for fear of reinforcing stigma, which was not a concern shared by patients and carers interviewed, 3) limited access to offence history with inconsistent understanding of the threshold or processes for requesting such information, and 4) inconsistency in how risk factors, especially "static" risk factors such as past violence are weighed by clinicians, an inconsistency that clinicians were both subjectively aware of, and which was reflected in the range of responses to two fictional clinical vignettes used as probes.

- **The potential role of scalable tools to support risk assessment.** I described the use of scalable tools elsewhere in medicine, such as in cardiovascular medicine, and introduced OxMIV in this context. I described the content of the tool and that its use of routine information may make it of potential use to address identified challenges in EIP services. I outlined the stepwise process of developing its clinical role which constituted the rest of my doctoral work, firstly the validation of its accuracy in EIP services (published in 2023, WITN0401016) and the examination of its acceptability and feasibility in clinical practice (published in 2025, WITN0401014). I highlighted findings including OxMIV's sensitivity of 71% compared with 40% with current unstructured clinical judgement. I also detailed the findings from its practical use in services, with feedback from clinicians that it improved confidence, clarified and focused their assessments and helpfully highlighted differences in the magnitude of risk.

- **The future direction of developing linked intervention pathways.**

I described risk assessment tools such as OxMIV as complex interventions, as improving outcomes will rely not only on the accuracy of the risk assessment but how they are embedded in a service, linked to management decisions, and the effectiveness of those linked interventions. I discussed OxMIV as therefore being an evidence-based starting point for linking to a more standardised approach to reducing violence risk in non-forensic services. I outlined some early recommendations for what actions could be linked to the tool, based around further assessment (e.g. allocating resource to gather fuller history and collateral information, understanding dynamic risks linked to specific psychotic symptoms, and identifying if there are any individuals at risk), discussing risks with the patient and their family where possible, bringing cases for discussion within the multidisciplinary team, targeting modifiable factors (substance misuse, psychotic symptoms, insight and disengagement, impulsivity, environmental factors), considering staff safety and crisis plans, and considering whether there are external agencies to involve or improve communication with. I explained my future goal to formally develop and test such an intervention pathway. Finally, I spoke briefly about the relevance and role of Community Forensic Mental Health Services in this area, and the variation in their structure and function nationally.

10. I have also been asked to explain the nature and extent of engagement between my academic research activity and forensic and general adult psychiatry in Nottingham. I have taken this to mean within the Trust. I will summarise this by outlining two main ways in which this occurs, firstly the broad interface for sharing research via different forums, and secondly through direct involvement of the Trust and its clinical services in specific research activities.

11. In terms of the broader interface, I co-chair the Forensic Research Nottingham group, based at the Institute of Mental Health, which brings together those in Nottingham interested in research in forensic mental health. We meet online

6-weekly and hold an annual symposium. Our regular meetings host internal and external speakers on research topics relevant to prison and forensic mental health and provide updates on current active projects locally. Anyone affiliated with either the University or the Trust can join. Given the forensic focus, clinical colleagues joining from the Trust are typically from forensic services. Elsewhere, within the Trust there is a Nottingham-wide weekly case presentation and journal club for all medical grades. The journal club element is chaired by a clinical-academic consultant, such as I or other colleagues in dual University/Trust roles across different specialties. Other interfaces are more ad-hoc, such as the medical education conference noted above, team/unit-based forums, or other annual events hosted by the Institute of Mental Health open to both University and Trust colleagues such as the Research Day. There is also some electronic circulation of research activities and publications, such as through the Institute of Mental Health newsletter and from the Trust's Research and Evidence team.

12. The academic interface with the Trust also occurs directly for specific studies. For example, in a recent externally funded study I led regarding the involvement of patients and carers in risk assessment in forensic services, the Trust was the contracting organisation, and researchers employed by the Trust were funded as part of delivering the study, which included recruiting patients, carers and clinicians from across the secure hospitals in the Trust. Clinical-academic colleagues across different specialties will similarly engage different parts of the Trust in specific studies.

Referrals to forensic psychiatry

13. I have been asked whether in my clinical experience, patients are appropriately referred to forensic psychiatry when required, whether I have any concerns about under or over referral, and what criteria are applied when accepting referrals to forensic psychiatry. I have also been asked if I have a view on whether anything further needs to be done to ensure that referrals are made from general psychiatry to forensic psychiatry when required, and if so,

what should be done.

14. I have reflected on the question of under/over referral to forensic services based on direct experience, both recently with the Community Forensic Team and earlier in my career, as well as my experience over the last four years in prison working with many patients for whom the question of service boundaries could be applied, and time spent during my doctoral research 2018-2022 working clinically in EIP services.

15. My summary impression is not so much that there is a systemic problem with too many or too few patients being referred to forensic psychiatry, but rather that there is inconsistency, with variation in the assessment of risk and the threshold of risk applied to making a referral. My view is that this inconsistency is related to both variation in the unstructured assessment of risk by referring services, and variation nationally in the precise scope and remit of forensic services, outside of scenarios involving Part III of the Mental Health Act 1983 and other clearer situations in which serious violent offending (i.e. causing grievous harm) in the context of mental disorder has already occurred.

16. The criteria applied to referrals to forensic psychiatry differ according to whether the consideration is one of transfer to secure hospital inpatient care under the Mental Health Act 1983 (in low, medium or high secure hospital settings), or for consideration of specialist forensic psychiatric outpatient care in the community. Criteria for transfer into low, medium or high secure inpatient care are set out in NHS England's service specifications (NHSE0000022, NHSE0000023, NHSE0000020), based on evidence of significant, serious or grave risk to others respectively in the context of mental disorder.

17. Community forensic services operate with a somewhat broader remit and less definite criteria. The potential outcome from such referrals is not a binary "accept" or "decline" but may involve professional consultation, assessment and advice. I understand that the Inquiry has heard evidence (WITN0388001)

that details the tiered level of intervention offered by the Community Forensic Team in Nottingham, ranging from advice only, through to assessment, joint working with the referring team, and full case management. Criteria used to consider the appropriate response centre on whether there is an identifiable link between mental disorder and risk of harm to others, the significance of the probability of serious harm, and any need for specialist management by forensic services.

18. Such forensic psychiatric services in the community have been developed and commissioned at local levels and are not bound in the same way as secure hospitals by nationally defined specifications. The core primary function common to these services emphasises supporting people being discharged from secure hospital settings, as well as case management for people who present a significant risk of serious harm to others related to their mental disorder. The tiered model described in paragraph 16 above also illustrates the secondary function of these services, described in a 2013 standards document from the Royal College of Psychiatrists as being to "provide liaison, advice, specialist interventions, educational and skills development" to general mental health services **WITN0456003**

19. It is appreciated that the organisation and function of community forensic psychiatric services varies nationally. In a recently published study (I am senior author), Freedom of Information requests were used to map the provision and function of these services in England **WITN0456004**. This demonstrated variation in core aspects including to what extent they are standalone services rather than for example extensions of secure hospital teams, and from where such services accept referrals. For example, 47% of community forensic services do not accept referrals directly from prison mental health teams, and 37% do not accept referrals directly from general adult community mental health teams. Whilst some local variation is inevitable and appropriate, in the study an overall view is presented that the degree of variation in fundamental characteristics can contribute to ambiguity regarding service roles and remits and complicate the development of coherent referral

pathways.

20. Returning to the question of what should be done to ensure that patients are referred to forensic services when appropriate, my view is therefore that there needs to be more consistency in how general adult services assess risk, and more clarity, consistency and shared understanding between general and forensic mental health services regarding the threshold for, and purpose of, referral to forensic services.

Reflections / Recommendations

21. My summary view from research and clinical practice is that there should be greater emphasis on improving violence prevention where risk to others is identifiable but sits below the high threshold at which forensic services would take over care.

22. In my view this should involve adopting structured, evidence-based and consistent approaches to assessing risk of violence in general mental health services such as through complementing clinical assessment with scalable tools. Crucially, assessments of risk need to be linked to a more defined and standardised approach to addressing modifiable risk factors for violence in general psychiatric services, especially those for psychosis. This is a personal future research interest.

23. As part of developing clearer pathways to manage violence risk in general adult services, the role of community forensic services at their interface with general adult services should be refined and more clearly and consistently defined in terms of purpose and thresholds.

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.

GRO-B

Signed:_________________________

Dated: 20 May 2026_______________

Index to First Witness Statement of Daniel Whiting

No.	Inquiry URN	Document Description
1.	WITN0456002	Presentation titled 'Assessing violence risk in adult psychiatry' by Dr Daniel Whiting, dated 28 November 2025.
2.	WITN0401003	Report dated 20/10/2020, compiled by Daniel Whiting, Paul Lichtenstein and Seena Fazel, re: Violence and mental disorders: a structured review of associations by individual diagnoses, risk factors, and risk assessment
3.	WITN0401006	Report dated 12/01/2024, compiled by Daniel Whiting, Gautam Gulati, John R Geddes and others, Re: Violence in schizophrenia: triangulating the evidence on perpetration risk
4.	WITN0320015	Report dated 06/10/2023, compiled by Wiley, re: Approaches and challenges to assessing risk of violence in first episode psychosis: A qualitative interview study of clinicians, patients and carers
5.	WITN0401016	Report dated 14 June 2023, compiled by Daniel Whiting, Sue Mallet, Belinda Lennox and another, Re: Assessing violence risk in first-episode psychosis: external validation, updating and net benefit of a prediction tool (OxMIV)
6.	WITN0401014	Report dated 20/03/2025, Compiled by Daniel Whiting, Margaret Glogowska, Sue Mallett, Re: Use of violence risk prediction tool in early intervention in psychosis services: mixed methods study of acceptability, feasibility, and clinical role.
7.	NHSE0000022	Policy Document, Re: Service Specifications - Schedule 2 - The services - Adult Low Secure Services including Access Assessment Service

		and Forensic Outreach and Liaison Services (FOLS), NHS
8.	NHSE0000023	Policy Document, Re: Service Specifications - Schedule 2 - Adult Medium Secure Services including Access Assessment Service and Forensic Outreach and Liaison Services (FOLS), NHS
9.	NHSE0000020	Report dated [unknown], compiled by NHS, Re: Schedule 2 - The services
10.	WITN0388001	First Witness Statement of Dr Mark Henry Taylor, Nottinghamshire Healthcare Foundation Trust (NHFT)
11.	WITN0456003	Royal College of Psychiatrists, Standards for Community Forensic Mental Health Services, dated April 2013.
12.	WITN0456004	Report dated 6 March 2026, compiled by Marie Williams, Leah Wooster, Mark Taylor, John Tully, Daniel Whiting, Re: Community forensic mental health services in England: mapping provision, structure and function.